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CONSCIOUS

SYSTEMIC PATH FOR THE RIGHTS

AN INTER-SYSTEMIC MODEL FOR PREVENTING REOFFENDING BY PERPETRATORS GUILTY OF SEXUAL ABUSE AND DOMESTIC VIOLENCE

PROJECT CONSCIOUS

D4.5: GUIDELINES

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Introduction

CONSCIOUS is an innovative project, bringing together a rich partnership composed of Frosinone's Local Healthcare Agency (IT), Centro Nazionale Studi e Ricerche sul Diritto della Famiglia e dei Minori (IT) (Centre for Studies and Research on Family and Juvenile Law), the Lazio Region (IT) and the European Network for the Work with Perpetrators of Domestic Violence – WWP EN (DE). The project hinges on the development and testing of an inter-systemic model for the prevention of reoffending by sex offenders and domestic violence (DV) perpetrators. The overall goal is the prevention of violence - and relatedly, the protection of (potential) victims and the broader community - via the provision of specialised perpetrator treatment and the formalisation of multi-stakeholder networks.

The project's specific objectives comprise: a) the reduction of recidivism among project beneficiaries; b) the provision and/or enhancement of the knowledge and skills of Italian public healthcare professionals, prison and probation staff in the treatment and management of perpetrators of sexual and domestic violence; c) the implementation of a treatment model for sex offenders in prison and the pilot of an experimental treatment model for perpetrators of domestic violence in prison and in an outpatient facility in Italy; d) the consolidation of collaborative relationships between key local and national actors; e) the improvement of operational synergies at the local level to support inmates in the post-sentence rehabilitation phase and f) the production of a financial cost/effectiveness analysis of the provision of treatment.

The CONSCIOUS Project is markedly unique and cutting-edge in that it articulates a model that strives to address the complex needs of a varied offender population. Sex offending has traditionally been shrouded in shame and secrecy. It was only during the '70s in the USA and the '80s in Italy that the issue of sexual violence came out in the open. Along with sexual abuse of women and minors becoming the subject of public debate, came a fundamentally punitive and repressive response, epitomised by increasingly draconian prison sentences. Over the years this approach has resulted in an upsurge in the sex offender prison population; yet it has hardly made a dent in the incidence of sexual violence.

It is worth noting that in the past 30 years significant progress has been made in research and clinical practice on sexual violence, its causes and treatment. Treatment programs for sex offenders, primarily grounded in clinical criminological approaches, have sprung up in the custodial and community settings. Programs for DV perpetrators, inspired by a socio-cultural understanding of gender-based violence, have also emerged, largely as a result of feminist activism. Although recent initiatives have

attempted to reconcile the two outlooks, conceptualising and implementing treatment programs addressed to both offender populations, there remain non-negligible tensions surrounding theory and methodology.

Project CONSCIOUS aims to act as a bridge between these two perspectives, thanks to an ambitious experimentation that combines structured interventions with the consolidation of an inter-systemic cooperation network. Inter-institutional, multi-level cooperation lies at the heart of the project: dialogue and cooperation among prisons (including individual institutions, the Department of Prison Administration and probation), the judiciary and relevant civil society actors are considered paramount to the achievement of the broader goal of reducing sexual and gender-based violence.

While the implementation of CONSCIOUS activities during project life focused on the Lazio Region in Italy, all actions were conceptualised in such manner to be replicable not only in other areas of the country, but also in Europe and internationally.

Aims and structure of the Guidelines

These Guidelines seek to provide theoretical and practical pointers for practitioners working with perpetrators of sexual and domestic violence who may wish to implement the CONSCIOUS treatment model in their local setting, as well as public policy developers, managers, law enforcement agents and volunteers engaged in the private sector and in perpetrator programs.

Drawing on the knowledge garnered during project life through training, model implementation, network-building and collaborative partnership, the intent of the document is that of teasing out the key factors that make the CONSCIOUS model a promising, and potentially scalable, best practice, as well as share lessons learned.

The document is structured as follows. Part 1 (Background and context of the CONSCIOUS Guidelines) delves into the European and Italian legislative framework governing sexual and gender-based violence (SGBV). It provides an overview of the functioning of the Italian custodial setting and unpacks the concept of “recividism”. It moves on to discuss the main theoretical underpinnings of sex offender programs, giving a bird’s eye view of the most renowned international and Italian programs and projects. Similarly, it discusses approaches to the treatment of DV perpetrators, highlighting noteworthy projects. It concludes by exploring European best practices in the treatment of SGBV perpetrators.

Part 2 (The CONSCIOUS model in theory and in practice) focuses on the CONSCIOUS model in its dual application, namely in the context of the treatment of sex offenders and DV perpetrators respectively. Details concerning model implementation – duration and content of treatment, beneficiaries and so on – are provided. Results achieved and challenges faced during the roll-out of treatment programs, including as a result of the COVID-19 pandemic, are also discussed. The document closes with a reflection on lessons learned and considerations for scalability.

PART 1 – Background and context of the CONSCIOUS Guidelines

1. EU legislation on SGBV

Over the last few years, various legal and policy instruments to prevent and address SGBV have emerged at the EU level, as a result of increased awareness of the devasting short-term and long-term consequences of gender-based violence. The Council of Europe (COE) has ushered member States to homogenize their varying national approaches to SGBV via several international agreements. Chief among them is the 2011 Istanbul Convention on preventing and combating violence against women and domestic violence, which stands out as the first internationally binding legal instrument allowing for the protection of women and girls from multiple forms of violence.

Art.16 of the treaty, particularly relevant to the CONSCIOUS Project, calls for the establishment of treatment programs for DV perpetrators and sex offenders, emphasizing that such programs should serve to prevent re-offending, ensure victims' safety and respect for their human rights, including via close cooperation with victim support organisations:

(1) Parties shall take the necessary legislative or other measures to set up or support programmes aimed at teaching perpetrators of domestic violence to adopt non-violent behaviour in interpersonal relationships with a view to preventing further violence and changing violent behavioural patterns.
(2) Parties shall take the necessary legislative or other measures to set up or support treatment programmes aimed at preventing perpetrators, in particular sex offenders, from re-offending.
(3) In taking the measures referred to in paragraphs 1 and 2, Parties shall ensure that the safety of, support for and the human rights of victims are of primary concern and that, where appropriate, these programmes are set up and implemented in close co-ordination with specialist support services for victims.[1]

The European Union has spearheaded further action against SGBV through:

- the 2008 EU guidelines on violence against women and girls and combating all forms of discrimination against them
- the new EU policy framework to fight violence against women, European Parliament resolution of 5 April 2011 on priorities and outline of a new EU policy framework to fight violence against women (2010/2209(INI)), reiterating at point 24 "the need to work with both victims and aggressors, with a view to enhancing awareness in the latter and helping to change stereotypes

[1] For more information on the background to Art. 16, see : https://edoc.coe.int/en/violence-against-women/7144-domestic-and-sexual-violence-perpetrator-programmes-article-16-of-the-istanbul-convention.html

and socially determined beliefs which help perpetuate the conditions that generate this type of violence and acceptance of it".

It is also worth mentioning the creation of the Work with Perpetrators of Domestic Violence in Europe network (WWP EN) in the framework of the Daphne II program. Over the past few years WWP EN[2] has become the glue between a range of organisations engaging in perpetrator work in various EU member States, asserting itself as an important interlocutor at the European level.

Other relevant EU legal instruments in the area of sexual abuse and exploitation, with a particular focus on children, include the 2007 Convention on Protection of Children against Sexual Exploitation and Sexual Abuse, also known as "the Lanzarote Convention", which constitutes the first binding treaty requiring EU member States to prevent and criminalise every form of sexual abuse and sexual exploitation of children; and Directive 2011/93/EU of the European Parliament and of the Council of 13 December 2011 on combating the sexual abuse and sexual exploitation of children and child pornography, replacing Council Framework Decision 2004/68/JHA.

Germane to the matters discussed herein is Art. 15(1) of the Lanzarote Convention providing that:

> Each Party shall ensure or promote, in accordance with its internal law, effective intervention programmes or measures for the persons referred to in Article 16, paragraphs 1 and 2, with a view to preventing and minimising the risks of repeated offences of a sexual nature against children. Such programmes or measures shall be accessible at any time during the proceedings, inside and outside prison, according to the conditions laid down in internal law.

The need for offender treatment is reiterated via Art. 16(2), which states that "Each Party shall ensure, in accordance with its internal law, that persons convicted of any of the offences established in accordance with this Convention may have access to the programmes or measures mentioned in Article 15, paragraph 1". Art. 24 of Directive 2011/93/EU draws and expands on the above-mentioned provisions.

Finally, an important policy instrument is the 2020 Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions EU Strategy for a more effective fight against child sexual abuse.

[2] WWP EN is partner in the CONSCIOUS Project.

2. Italian legislation on SGBV and offender treatment

Italy transposed the Istanbul Convention into national law through Law Decree No. 77 of 27 June 2013, later converted into Law Decree No. 119 of 15 October 2013 (Conversion into law, with amendments, of Law Decree No. 93 of 14 August 2013, on Urgent measures about safety and to combat gender violence, as well as in the area of civil protection and external administration of provinces).

In recent years, various pieces of national legislation targeting SGBV have been enacted. These include: Law Decree no. 212/2015, implementing Directive 2012/29/EU of the European Parliament and of the Council of 25 October 2012 establishing minimum standards on the rights, support and protection of victims of crime[3]; Law no. 4/2018, amending the Civil Code, the Criminal Code and the Code for Criminal Procedure, and including provisions in support of orphans of domestic crimes; and Law no. 69/2019, otherwise known as "Codice rosso"(EN: Code red), amending the Criminal Code, the Code for Criminal Procedure and including provisions for the safeguard of victims of DV and GBV.

Moreover, Italy ratified the Lanzarote Convention on the Protection of Children from Sexual Exploitation and Sexual Abuse, via Law no. 172 of 1 October 2012, thereby amending the Criminal Code, the Code for Criminal Procedure and Prison Rules[4].

Italian legislation underscores the centrality and urgency of offender treatment both in Law no. 119 /2013 and Law no.69/2019. In particular, Art. 6 comma 1 of Law no. 69/2019 provides that the issuance of a suspended sentence in cases of DV or sexual violence is conditional on participation in ad-hoc treatment programs[5]; while Art. 17 comma 1-bis states that individuals convicted of crimes of DV or sexual violence may access treatment programs through collaboration between organisations working with perpetrators and prisons[6].

[3] It should be noted that the Directive places particular emphasis on gender-based violence, highlighting the need for enhanced and targeted support via Art. 9(b) and protecting victims from repeat and secondary victimisation via Art. 22(3) and 23(d) in particular.

[4] The amendments to the Prison Rules regarded exclusion from the possibility of access to prison benefits for offenders under articles 600, 600 bis, paragraph one, 600 ter, paragraphs one and two, 601, 602, 609 octies and 630 of the Criminal Code.

[5] "Nei casi di condanna per i delitti di cui agli articoli 572, 609-bis, 609-ter, 609-quater, 609-quinquies, 609-octies e 612-bis, nonche' agli articoli 582 e 583-quinquies nelle ipotesi aggravate ai sensi degli articoli 576, primo comma, numeri 2, 5 e 5.1, e 577, primo comma, numero 1, e secondo comma, la sospensione condizionale della pena e' comunque subordinata alla partecipazione a specifici percorsi di recupero presso enti o associazioni che si occupano di prevenzione, assistenza psicologica e recupero di soggetti condannati per i medesimi reati".

[6] "Le persone condannate per i delitti di cui al comma 1 possono essere ammesse a seguire percorsi di reinserimento nella societa' e di recupero presso enti o associazioni che si occupano diprevenzione, assistenza

In terms of soft law, it is worth mentioning the extraordinary action plans to combat sexual and gender-based violence 2015-2017 and 2017-2020. The Extraordinary Action Plan against Sexual and Gender-based Violence 2015- 2017 promotes the development and roll-out across the whole country, of methodologically sound actions aimed to prevent reoffending through rehabilitation and support for perpetrators of violent behaviours in close relationships. The plan provides for local agreements and protocols, establishing guidelines for collaboration between centres supporting women in their paths out of violence and treatment centres for male perpetrators. Training courses on perpetrator work may be carried out in the context of partnerships between centres for male perpetrators and the network of support services for women, formalized through conventions or protocols, establishing procedures for collecting/sharing information and evaluating the effectiveness of the measures taken.

The National Strategic Plan on Men's Violence against Women 2017-2020 was elaborated by the Department for Equal Opportunities of the Presidency of the Council of Ministers and a mixed working group with the Ministries concerned, the Conference of Regions, ANCI (National Association of Italian Municipalities), the Police Force, trade unions and women's organisations. The strategic plan also seeks to prevent recidivism, in particular in relation to sex crimes, stalking and violence in the family through treatment of male perpetrators. Objectives include the allocation of specific resources to treatment programs, the definition of the purposes, methodology and contents of treatment, the specification of service provider profiles, as well as the identification of qualitative and quantitative outcomes. The Plan entrusts the Ministry of Justice with drafting a national intervention protocol to identify the most effective models of prison-based treatment for perpetrators of SGBV. It also insists on providing training for the professionals directly involved in treatment implementation, starting from the assumption that the plan’s strategic approach must hinge on the full involvement of all stakeholders. This requires the Department for Equal Opportunities and all the public administrations involved to be fully accountable and synergistic, making a commitment that is not only financial but also, crucially, culturally oriented towards network-building.

3. The Italian prison system

During project implementation, CONSCIOUS treatment activities for sex offenders were rolled out in the custodial setting. In view of assessing the potential transferability of the CONSCIOUS model to

psicologica e recupero di soggetti condannati per i medesimi reati, organizzati previo accordo tra i suddetti enti o associazioni e gli istituti penitenziari”.

other European contexts (see section: Scalability of the CONSCIOUS model), it is paramount to take stock of the specifics of the Italian prison environment.

The Italian prison system is regulated by Law no. 354 of 1975, otherwise known as the Prison Order. This law has undergone various changes over the years, the last of which took place in 2018, affecting aspects such as healthcare, daily life in prison and access to work for inmates.

The Prison Order is based on the key notion that prison treatment is aimed at re-education. Prison staff's observation of the offender's personality is geared towards identifying the optimal individualised pathway for his re-entry and resettlement in society. The sentence passed at trial can be reduced if the prisoner complies with the Prison Rules and treatment. Treatment and security are two sides of the same coin. This duality comes through powerfully in various facets of everyday life in Italian prisons: correctional officers, employed by the Ministry of Justice, are in charge of one and the other; prison educators[7] and social workers, who are appointed to monitor treatment, are also employed by the Ministry of Justice. Educators are part of the "pedagogical-treatment area" and work inside correctional facilities; while social workers work on the outside, taking care of the relationship between prisoners and their families, as well as the local community. Psychologists can be employed by the Ministry of Justice or by the National Healthcare Service. Teachers work for the Ministry of Education, while all other professionals are casual workers employed by social co-ops or other local services.

Such Janus-faced arrangements often result in correctional officers - particularly those working in prisons that do not have a strong organisational culture grounded in "rehabilitation" - resisting "treatment duties", which they consider as extra tasks, over and above their security obligations. In this sense therefore, whenever implementing projects such as CONSCIOUS in the custodial setting, it is essential to invest time and energy in gaining the trust and support of gatekeepers, to facilitate access and crucially, convey the importance of treatment.

The Italian prison system is a single entity with regional ramifications, counting a total of 190 prisons across Italy. While the Italian Constitution stresses that punishment should be geared towards rehabilitation, there are discrepancies among custodial facilities: the quality and quantity of activities organised in each institution depend on factors such as the choices of management, the dedication of

[7] Now known as pedagogical legal officials

correctional officers, the attitude of local institutions, and volunteers and social co-op's access to prison. There are, indeed, institutions offering numerous, well-organised activities, but there are also prisons that require inmates to stay inside their cells or at best, their units, due to lack of educational or training activities.

3.1. Healthcare in Italian prisons: the role of the Public Healthcare System

With regard to the organisation of prison healthcare, the European Prison Rules state that "medical services in prison shall be organised in close relationship with the general health administration of the community or nation"(40.1) and "health policy in prison shall be integrated into, and compatible with, national health policy"(40.2).

A principle of fundamental importance concerns the equivalence of care. Public health and human rights converge in a recommendation of the Prison Rules, further developed by the Committee of Ministers of the Council of Europe in paragraphs 10-12 of its 1997 Recommendation, concerning the ethical and organisational aspects of healthcare in prison.

It is clear that most prisoners will eventually resettle in society, which means that their state of health is, to all intents and purposes, to be understood as a public health issue and that any illnesses contracted - or exacerbated within prisons - also have an impact on the outside world, as does the management of psychological disorders.

Via Law Decree no. 230 of 22 June 1999 and the subsequent Prime Ministerial Decree of 1 April 2008, the Italian government agreed to transfer the matter of prison healthcare to the National Healthcare Service. Although the handover of responsibilities has formally taken place, there is still resistance from a factual - and cultural - point of view. This is symptomatic of a generalised failure to truly view the health of prisoners as a public health issue. As a result, healthcare is not always guaranteed or adequately structured.

Although medical services in prison fall within the purview of the National Healthcare Service, that relies on local healthcare agencies for on-the-ground implementation, there are few doctors, particularly specialists such as psychiatrists, and there is a lack of prevention, diagnosis and treatment. The discrepancy between theory and practice causes longer waiting times than in the community and engenders the need for transfers of prisoners to external facilities.

While the quality of care offered to inmates is often dependent on the specifics of each institution, a common denominator is the dearth of medical, surgical and psychiatric services. Some institutions do

not even have a doctor in attendance for all 24 hours of the day. Lack of prevention, diagnosis and therapy stands out as a critical issue of healthcare provision in Italian prisons. Some specialists (psychiatrists, psychologists, pulmonologists, dermatologists, infectious specialists) visit prisons, but the most severe cases are treated in the nearest hospitals.

As will be further explained in Part 2 of these Guidelines, Project CONSCIOUS takes into account the Italian Healthcare System's duty of care towards inmates - as enshrined in the law - by entrusting the delivery of perpetrator treatment to Frosinone's local healthcare agency, namely a local branch of the broader public healthcare apparatus.

3.2. Inmates' security designation and custody classification

DAP Circular no. 3359/5808 of 21 April 1993 introduced a plethora of administrative measures that led to the creation of differential security designations and custody classifications within Italian prisons, based on the need for security and custody, and the level of danger posed by inmates. The circular identified three types of security designations: high security, medium security and "soft" custody.

In 2009, circular no. 3619/6069 split high security into three distinct sections: High Security 1 (H.S. 1) hosting prisoners and inmates convicted of organised crime; High Security 2 (H.S.2), reserved to those serving sentences for crimes of terror at the national and international level, or for "subversion of the democratic order" through the perpetration of acts of violence (crimes mentioned under articles 270, 210-bis, 270ter, 270quater, 270quinquies, 280, 280-bis, 289-bis, 306 of the Italian Criminal Code); and lastly, High Security 3 (H.S. 3) for inmates involved in the organisation and management of drug trafficking rings (pursuant to art. 4-bis par. 1, subject to the exceptions set forth in Dap circular no. 20 of 19 January 2007).

Alongside formal classifications are also "informal" ones (Santorso, 2018), created to avert violence against specific categories of inmates, as provided by paragraph three of article 32 of the Executive Rules of 2000. Protected categories include sex offenders, transgender inmates and former members of the police force. Despite the justified need for special protection measures for sex offenders, protective custody often fuels feelings of loneliness and isolation, resulting in the increased alienation and stigmatisation of the sex offender population.

The criminal justice approach to gender-based violence fails to grasp the subjective and relational complexity of such crimes, and ends up standardising many of them as common crimes, foreseeing, at best, aggravating factors stemming from familiarity with the victim:

"according to an emergency and punitive rationale, and thereby generating particularly serious distortions significant of the criminal legal culture. Only sexual violence is considered as a "sexual" crime, while all other forms of gender-based violence are classified as common crimes within the articles of the Criminal Code" (Frenza, Peroni & Poli, 2017).

This approach has practical reverberations on the organisation of prison life. In fact, prison management finds itself obliged to separate GBV perpetrators from ordinary prisoners for safety and security reasons. Beyond inmates feeling further vilified, these measures also have a bearing on their rehabilitation process (Tewksbury, 2012).

4. Working with offenders: understanding recidivism

Recidivism among individuals who have served a prison sentence for a criminal offence is a relatively underexplored phenomenon in the Italian context. Though regularly the subject of legal and political debate, knowledge about the nature and scale of the phenomenon is at best, fragmented. On the one hand, there are those who hold that the criminal justice system is ill-equipped to fulfil the rehabilitative function ascribed to it by the Italian Constitution and prison legislation. They point to the "revolving door" phenomenon, namely the high rate of offenders who are sent back to prison after being released, as symptomatic of the criminal justice system's failings. On the other, mainstream legal doctrine and a large swathe of public and political opinion continue to view retribution and the principle of "just deserts" as necessary to prevent re-offending. The debate is marred by incomplete knowledge of recidivism. In the first case, opinions seem to be mainly based on anecdotal information, rather than well-researched data. In the second case, legal dogmatism overlooks the empirical dimensions of the criminal justice system.

The purpose of this section is to problematise the issue by examining the main methodological challenges associated with analysing recidivism rates among individuals who have served a criminal sentence.

4.1. The concept of recidivism: definitional problems

One of the first issues to grapple with when setting about measuring recidivism rates, is the complexity of the phenomenon. The Italian legal system provides a formal definition of recidivism in Art. 99 of the Criminal Code, according to which punishment is aggravated when an individual "commits a new crime following a prior conviction". In addition to this definition of "simple recidivism" (IT: *recidiva semplice*), the Italian Criminal Code defines two other forms of aggravated recidivism: "specific recidivism" (IT: *recidiva specifica*), namely when the perpetrator commits a crime of similar nature to the previous offence; and "five-year recidivism" (IT: *recidiva infra-quinquennale*), when the crime is

committed within five years of the previous conviction. A fourth, more serious categorisation is "reiterated recidivism" (*recidiva reiterata*), occurring when an individual already defined as a recidivist, reoffends. These seemingly neat legal distinctions do not always tally with the reality on the ground. Indeed, the analysis of recidivist behaviour calls for definitions that go well beyond formal legal classifications.

In the late 1980s the Council of Europe launched a project to monitor extant methods used to measure recidivism (Tournier, 1988). The purpose was to collect the main studies conducted up until then, examine the methodologies utilised and put forward standardised tools to monitor reoffending across member States. Twelve member States[8] answered the call and 23 studies were gathered. The report found that only in one case recidivism was defined and measured based on its legal definition. In the remaining 22 cases, the concepts used were so diverse that the researchers concluded: "il y a pratiquement autant de définitions de la récidive qu'il y a d'études sur la récidive"[9] (p. 12). The authors of the study found 15 different criteria in the 23 studies they examined. Departing from these criteria, they created a classification based on four main touchstones:

- a custodial sentence or "re-conviction to prison";
- a conviction leading to a penalty more severe than a fine;
- a conviction of any kind;
- "facts" in respect of which final judgement has not yet been passed.

A critical analysis of the use of recidivism statistics in Great Britain (Lloyd, Mair & Hough, 1994) identified nine criteria for defining the phenomenon, from which further sub-criteria could be derived:

- re-arrest;
- re-conviction;
- re-incarceration;
- parole violation;
- parole suspension;
- parole revocation;
- charge for new offence;
- flight from criminal prosecution;

[8] The countries that answered the call were Belgium, Denmark, France, Ireland, Italy, Luxembourg, Malta, the Netherlands, Norway, the UK, Sweden and Switzerland.
[9] EN: "There are as many definitions of recidivism, as there are studies".

- probation.

Previous empirical studies conducted in the Italian context diverge in their qualification of recidivism. Hence, in some work, offenders who are re-convicted after serving an alternative sentence are considered recidivists (Leonardi, 2007). A handful of studies specify that only individuals whose conviction results in re-incarceration can be viewed as recidivists (Ministero della Giustizia, 1973). Others still, refer to the concept of specific recidivism (Santoro & Tucci, 2006). More recent studies (Manconi & Torrente, 2015; Ronco & Torrente, 2017) describe recidivism as the situation whereby individuals previously released from prison, are found guilty of a different offence and taken back into custody.

Defining the phenomenon is thus the first hurdle to overcome in order to analyse and measure recidivism rates. Given the absence of agreed-upon, universally acknowledged criteria to define recidivism, theoretical and empirical choices often lie with the personal preferences of individual researchers.

Aside from definitional conundrums, the methodological aspects of studies investigating recidivism rates pose non-negligible challenges for researchers striving towards rigour and comparability. There are two particular aspects where methodology is crucial. The first regards sample - choices concerning its size, the social and personal characteristics or the legal situation of research participants have a bearing on the validity and reliability of results. In the aforementioned monitoring study by the COE, for instance, researchers found that the sample populations differed so starkly that, for the sake of comparability, they chose to make a broad distinction between studies conducted among the prison population and studies carried out with non-incarcerated offenders. Yet, even between these two sample populations, the specific contingencies of each study often hindered comparison. Research conducted in Italy further testifies that differences within the offender sample, including in terms of custodial vs. alternative sentencing[10], or presence of a percentage of individuals with drug or alcohol addictions, greatly impacts findings.

The second aspect pertains to the observation period. It is arduous to draw parallelisms between studies relying on a six-month observation period and studies opting for a longer period of time. In

[10] The countries that answered the call were Belgium, Denmark, France, Ireland, Italy, Luxembourg, Malta, the Netherlands, Norway, the UK, Sweden and Switzerland.

this respect, the COE monitoring study report demonstrated that different European countries relied on different time frames, with observation periods ranging from six months up to 21 years. As highlighted by a British researcher: “How much extra value is offered by the latter if the average re-conviction rate in a two-year study is 65 per cent and that in a five-year study is 75 per cent?” (Lloyd, Mair & Hough, 1994: 6).

The use of a longer or shorter observation period depends on the conditions under which the research is conducted and its aims. Nonetheless, discrepancies between observation periods undermine the comparability of outcomes and the evaluation of reported recidivism rates. Another issue concerns the exact kick-off of measurement– for instance, should incarceration itself be included? On this point, it must be stressed that observing the prison population or offenders serving alternative sentences could involve the use of different methodologies which, in turn, influence the interpretation and comparability of results.

Alongside these fundamental methodological intricacies, findings can also be affected by factors linked with context or choice of data sources. While these choices, generally dictated by the surrounding environment, the availability of time and resources, or the ultimate aims, may, in and of themselves be methodologically sound, they are nonetheless likely to dramatically impact how recidivism is interpreted and assessed.

Some scholars have argued that recidivism should be regarded as a highly relative concept, at least from a methodological point of view. Using the language of constructionist sociology (Blumer, 1969), the concept of recidivism per se is the result of a system of social interactions that can only be evaluated in the light of the procedures that led to the construction of the phenomenon.

In taking stock of these complexities, one should not lose sight of the criminological debate surrounding the effectiveness of custodial sentences in reaching the objectives formally assigned to them. Recidivism is an important indicator of the impact of the sentence and treatment on the life of offenders. As already stated, this indicator is the result of methodological decisions that must be clearly laid out.

4.2. Empirical research on recidivism in Europe

At the international level, recidivism has been the focus of increased scrutiny, particularly in Anglo-Saxon countries. Case in point - the annual statistics on re-conviction rates published in the British Government’s Home Office Research Study. International research has shown that recidivism rates

are generally very high among offenders who served custodial sentences (Langan & Levin, 2002; Beck & Shipley, 1989) .

Yet, despite prison's failure to socially rehabilitate offenders, the prison system appears as robust as ever. In many countries worldwide, the US being a blatant example, the incapacitation of convicted prisoners through deprivation of liberty has prevailed over the possibility of prison sentences acting as treatment programs[11]. A direct consequence of this has been the introduction of more stringent laws for recidivists, culminating in the introduction of laws such as the "Three strikes and you're out" in some American States, imposing longer prison sentences on offenders convicted three times, regardless of the crimes committed (Zimring et al., 2001; Shichor & Sechrest, 1996).

Recent studies have investigated recidivism rates among offenders placed under probation orders (Mair & Nee, 1992; MacKenzie & De Li, 2002), on parole (Petersilia, 2003; Travis, 2005; Peters et al., 2015) or subject to community service orders (McIvor, 1992, Steiner et al., 2012), and the strategies implemented to sustain their re-entry into society (Wright et al., 2011; Duwe, 2012).

Despite their merits, these studies have not succeeded in dispelling doubts on the most effective criminal justice policy options to prevent recidivism. In particular, dilemmas surrounding the specific conditions that can help reduce recidivism risks among former prisoners are still very much unresolved. While the majority of studies have found that re-entering the labour market and rebuilding family ties can jointly foster desistance (Blumstein & Nakamura, 2009; Bushway et al., 2011), others have concentrated on the psycho-behavioural variables associated with the person's life path (Giordano et al., 2008)[12].

In the field of public policy, the chasm between those who consider a more extensive use of community sentences to be too costly, in view of the risks associated with re-offending[13], and those who argue the reverse remains stark and seemingly, insurmountable.

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[11] Here it should be noted that this permanent abandonment has been accompanied by a gradual disillusionment with prison treatment programs, starting with the publication of the first studies that shed light on the limited success of investments in this area in relation to the outcomes (Martinson, 1974).

[12] More in detail, these studies refined their analysis by introducing numerous variables. Probably the most significant of these is gender, with some studies examining the processes that lead women to desist from crime as compared to men (Giordano, 2002; Giordano, 2010).

[13] This point has been the subject of a great deal of research from an economic perspective. Among the numerous most recent works, see Bordenhorn (2015) and the extensive body of literature cited therein.

The attention paid to the issue by international scholarship reflects what is, in many ways, a desire to shed light on "what works". European studies have identified indicators, that could be utilised to examine the phenomenon in Italy. While the testing of these indicators goes well beyond the scope of the CONSCIOUS project and these Guidelines, they are mentioned herein as potential hypotheses for future research. Most studies concur that:

a) Recidivism rates are generally higher among men than among women.
b) The number of re-offenders tends to decrease with age.
c) Recidivism rates tend to be lower for first-time detainees than for offenders who have been incarcerated several times.
d) Individuals who have served long prison terms for committing more serious crimes tend to be convicted less frequently than those imprisoned for shorter terms for committing less serious crimes[14].

Despite these common findings, numerous scholars have called for further research and reflection. For instance, in a study analysing, among others, the variable "length of time spent in prison vis-à-vis the actual penalty imposed", the author observed lower recidivism rates for individuals who had served less than 70 per cent of their sentence in prison compared to those who had served all, or almost all of their sentence in custody (Tournier, 1985)[15]. Similar conclusions were drawn by Kensey and Tournier (1991), who reported lower levels of recidivism for conditionally released offenders compared to inmates who served the entirety of their prison sentence[16]. In interpreting their findings, the authors claimed that the lower recidivism rates observed for prisoners released early as opposed to offenders released at the end of their sentences could be related to a range of factors, including to the criteria considered by the authorities in granting access to alternative measures[17].

[14] For the statistical weight of the different variables applying differential analysis, reference should be made to Kensey, Tournier (1991); the authors identified age, the number of previous convictions and the seriousness of the first offence as the most discriminating variables in recidivist behaviour.
[15] Specifically, the study by Tournier reported a recidivism rate of 28.5 per cent for offenders who had served less than 70 per cent of the sentence imposed in prison; this rate gradually increased with the length of time served in prison, reaching 42.6 per cent for those who had served 70-80 per cent of their sentence in prison, 47.7 per cent for those who had served 80-90 per cent of their sentence in prison and 59.9 per cent for those who had served the full sentence in prison.
[16] In this case, 39.8 per cent for those who had served the full term in custody and 23 per cent for conditionally released offenders.
[17] Kensey and Tournier (1991) themselves tempered enthusiasm for the lower recidivism rate among conditionally released offenders, pointing out that many of these were middle-aged or older and did not have a long record of previous convictions, considering these variables to be of greatest relevance in the analysis of recidivism.

Furthermore, empirical research has not yielded consistent findings on the relationship between the length of time spent in prison and recidivism rates. Some studies (Lloyd, Mair & Hough, 1994) reported that, from a statistical perspective, variables such as age and previous offences have more weight than the conditions in which sentences are served. Other studies focusing on the qualitative aspects of treatment programs for specific categories of offenders confirmed the positive effects of releasing offenders from prison and introducing them to alternatives to custody. In particular, research concerning programs for offenders with drug/alcohol addiction argued in favour of the positive impact of social rehabilitation programs on this target group (Van Stelle, Mauser & Moberg, 1994). The conclusions drawn by these studies are extremely encouraging, in that they demonstrate that the completion of community-based treatment programs can reduce recidivism, including among offenders with long-standing criminal careers, who have already served various prison sentences[18]. Moreover, empirical research hints to the fact that crime control policies should make bold decisions aimed at facilitating inclusion, through non-custodial treatment programs. This is in clear contrast with the paradigm that focuses exclusively on the temporary incapacitation of large sections of the population regarded as the "public enemy", increasingly dominant in recent populist rhetoric.

Thus, the scholarship on recidivism has greatly enriched the debate with evidence acquired from extensive fieldwork. It has questioned stereotypes that appear to strongly influence the debate on security. To this end, the role of empirical research in relation to the phenomenon of recidivism can be correctly interpreted as that of problematising the over-simplified models that are all too frequent in media debates. We can therefore agree with the statement: "Quand il est question du devenir des personnes détenues, au cours de débats télévisés par exemple, ou sur les marches du palais après un verdict semblant à certains trop clément, dans la presse ou dans les déclarations de certains hommes politiques sur l'insécurité, on pourrait finir pour croire "qu'ils" "recommencent" toujours [...]. La synthèse qui va suivre met en évidence une réalité moins désespérante" (Kensey, Tournier, 1994: 77), in that research has a role to play in making sense of a generally emotionally-charged and sensationalistic debate.

[18] Van Stelle, Mauser and Moberg (1994) observed an average recidivism rate of 76 per cent for offenders who had not completed the treatment programs. This rate fell to 44 per cent for those who had completed the treatment programs. As for the relationship with the number of previous prison sentences, the same study observed that only 41 per cent of individuals with eleven or more previous prison convictions re-offended, whereas in Great Britain at that time, the average recidivism rate for offenders with the same number of previous convictions was 74 per cent.

4.3. Social rehabilitation and re-entry into society: the limits of correctional approaches

Positivist criminology generally reconstructs a perpetrator's criminal career based on the examination of criminal records prior to and following a criminal conviction. This approach generally falls prey to generalisations, particularly when it comes to determining causality[19] in reoffending[20]; and overlooks the complexity of inmates' individual pathways into the criminal justice system. By acknowledging these caveats, we should move beyond the notion of recidivism to include re-entry into society. While recidivism is broadly defined as a phenomenon pertaining to the criminal justice system and re-offending, re-entry into society is a more expansive concept, encompassing a perpetrator's criminal pathway prior to and after punishment.

The challenges of social re-entry programs for criminal offenders have been amply underscored by the sociology of deviance, most notably the so-called "labelling theory" studies (Becker, 1987). More recently, a large body of research in the United States focusing on the life paths of offenders released from prison has argued that there is a link between the gradual erosion of public resources to support the most vulnerable fringes of society and the devastating impact of mass incarceration policies (Mears & Cochran, 2015; Price, 2015; Price-Spratlen & Golsby, 2012; Wakefield & Wildeman, 2014). This scholarship argues that the absence of re-conviction does not necessarily entail satisfactory re-entry into society, especially in terms of work expectations (Holzer, 2009; Huebner, 2005). Even when former inmates manage to avoid re-conviction, re-entry into society is often taxing. This is where special re-entry programs come into the picture (Duwe, 2102; Leverentz, 2011; Maruna, 2011). Thus, focusing on the re-entry trajectories of offenders participating in crime prevention/deterrence programs can prove more fruitful, compared to the mere measurement of recidivism rates. There are two main reasons why this option ought to be privileged over its contender.

The first has to do with the afore-mentioned rich complexity of biographies and life paths, which cannot be subsumed under court records. Simply analysing quantitative data on recidivism can lead to an incorrect evaluation of the impact of social re-entry. Low recidivism rates may be linked to external factors, that encroach the perpetrator program itself (Ronco & Torrente, 2017). The second relates to the dark figure of crime, namely the percentage of crimes, which remain undetected by the criminal justice system. Surveys on recidivism cannot capture this data. From this perspective, an apt

[19] In the previous section we saw how the studies evaluating the programs in question complained about the lack of detailed information about perpetrators.

[20] For a telling criticism of positivist criminology approaches with regard to recidivism, reference should be made to a recent essay by Alvise Sbraccia (2018).

analysis of an offender's social re-entry trajectory should bring to light information on relapses into deviant behaviour, that cannot attained from court records. The CONSCIOUS model relies on an understanding of recidivism that is comprehensive of the insights gleaned from court records, individual biographies and experiences of re-entry into society.

5. Working with sex offenders

5.1. The sex offender population

Research on sex offending has shed light on the numerous challenges associated with determining the casual factors of sexual violence, which encompass external – i.e. environmental and social - elements, as well as individual psychological traits (Holmes & Holmes, 2002).

Those attempting to disentangle sexual deviancy from "socially acceptable" behaviour, must come to grips with a rich array of acts, characterised by differing frequency, intensity and duration, which often eschew clear-cut diagnoses. Sexual abuse does not fall under the pathologies included in the DSM5[21], yet paedophilia does. Consequently, from a clinical point of view, sex offending can only be framed as a paraphilia[22]. This categorization does not capture the immense variety of behaviours encountered through clinical practice.

As argued by Giulini and Xella (2011) in their book "Buttare la chiave?" (EN: Throwing away the key?):

> There are numerous studies and reflections that problematise such strictly defined criteria(…) it is unclear what the recurrent term applied to fantasies, impulses and behaviours actually means; one does not comprehend whether someone who abuses of a minor once is a paedophile or not (…) the clinically relevant criterion of discomfort is problematic particularly in relation to negation: if the individual does not feel guilty and his actions appear to stem from his own needs and desires, then should he be viewed as a paedophile? Should he be diagnosed with a psychiatric disorder? Two other critical elements are: the age limit of 13 (…)many abusers choose teenage victims, who are nonetheless very young; and the issue of perpetrators in their late teens, who based on DSM V cannot be diagnosed as paedophiles" (Giulini & Xella, 2011: 5).

From a clinical point of view, a further complication relates to the fact that a wide majority of sex offenders present with personality disorders, including antisocial, narcissistic and borderline personality disorders. Common traits across the board are the inability to empathise and make sense of one's emotions and the feelings of others; impulsivity; lifestyle and relationship instability; and a

[21] *The DSM5 is the* Diagnostic and Statistical Manual of Mental Disorders

[22] "Paraphilic disorders are recurrent, intense, sexually arousing fantasies, urges, or behaviours that are distressing or disabling and that involve inanimate objects, children or nonconsenting adults, or suffering or humiliation of oneself or the partner with the potential to cause harm" *(Brown, G.R., 2019)*

general deficit in social interaction and metacognition. Crucially, the personal biographies of many sex offenders are interspersed with experiences of abandonment, neglect, sexual abuse and violence, premature sexualisation and alcohol and drug use during adulthood. In a nutshell, most bear the scars of an unprotected childhood.

Disagreements between the psychological and criminological/legal approaches contribute to further complicating theoretical understanding, clinical practice and treatment of sexual abuse. The two schools of thought depart from starkly different assumptions, that yield a range of somewhat contrasting interventions. Project CONSCIOUS attempts to create dialogue between the two camps, reconciling seemingly opposed outlooks.

5.2. The treatment of sex offenders

The idea that sexual deviance can be treated arose in the 1970s in the USA and Canada. The reasoning behind it was purely behaviourist: if behaviour can be learned, then it can also be unlearned. In this sense, it is therefore conceivable to "correct" deviant sexual behaviours by re-conditioning human impulses. This could be done, for instance, by associating a deviant sexual stimulus, whether visual or auditory, with unpleasant stimuli, such as for instance, a pungent or off-putting smell.

Regrettably, the treatment of this deeply heterogeneous offender population is a far more complex matter than initially envisioned. A one-size-fits-all approach to the treatment of sex offenders is bound to fail. In the past 30 years research has thus strived to address outstanding lacunae, focusing in particular on what makes treatment effective, namely "able to maximise the impact on recidivism risks via the smallest possible allocation of resources". This is why public and political opinion in Europe is reluctant to accept that government invest resources in the treatment of "perverse" and "incurable" individuals, unless there are reasonable and probable grounds that treatment programs achieve their intended results.

Most treatment programs for sex offenders rely on a **Cognitive Behavioural Therapy (CBT) model**, that emphasises the interconnectedness between thoughts, emotions and behaviours. CBT treatment goals include victim empathy and awareness, intimacy development, bolstering of social and relational skills (McGrath et. al, 2010).

A specific adaption of the CBT treatment model is the **Relapse Prevention Model (RP**). Born out of addiction studies, the model seeks to support service users in coming to grips with the emotional, cognitive and behavioural factors that trigger their violent behaviours, so as to prevent future violent occurrences (Redher, 2014). While it has doubtless enhanced knowledge of aspects conducive to sudden loss of self-control engendering sexual violence, the RP model has proved ill-suited to grasp

the functioning of offenders who carefully plan their violent actions, actively seek their victims and experience gratification as a result of their violent behaviours (Kingston, Yates and Firestone, 2012). Although it has historically served as a framework for sex offender treatment, RP popularity has decreased over the years (McGrath et. al, 2010).

A well-known successor of the RP model is the **RNR** (**Risk, Need and Responsivity)** (Andrews & Bonta, 2010). The RNR consists of 3 guiding principles:

1 .Risk principle (match level of program intensity to offender risk level; intensive levels of treatment for higher risk offenders and minimal intervention for low-risk offenders)
2. Need principle (target criminogenic needs or those offender needs that are functionally related to criminal behavior)
3. Responsivity principle (match the style and mode of intervention to the offender's learning style and abilities) (Andrews, Bonta & Wormith, 2011: 735).

The **risk principle** focuses on proportionality – the intensity of treatment is dependent on offenders' level of risk. Lower risk calls for minimal treatment, greater risk implies higher dosage and intensity. Although consensus on a baseline number of treatment hours for each risk level has yet to be reached, it is considered acceptable to provide limited or no treatment at all for low risk sex offenders, 100-200 h for moderate risk sex offenders and 300 h at a bare minimum for high risk sex offenders (Hanson & Yates, 2013).

The need principle turns the spotlight on criminogenic needs, namely lifestyle, personality or environment-related aspects that directly affect recidivism risks. Criminogenic needs are dynamic risk factors, namely they "are statistically associated with increased risk to re-offend and are amenable to change" (ATSA, 2016: 2). In the case of sex offending, these include:

- Any deviant sexual preference
- Sexual preference for children
- Sexualized violence
- Multiple paraphilias
- Sexual preoccupations
- Attitudes tolerant of sexual assault
- Lifestyle instability/criminality
- Childhood behaviour problems (e.g., running away, grade failure)
- Juvenile delinquency
- Any prior offences
- Lifestyle instability (reckless behaviour, employment instability)
- Personality disorder (antisocial, psychopathy)
- Grievance/hostility
- Social problems/intimacy deficits

- Single (never married)
- Conflicts with intimate partners
- Hostility toward women
- Emotional congruence with children
- Negative social influences Response to treatment/supervision
- Treatment drop-out
- Non-compliance with supervision
- Violation of conditional release Poor cognitive problem-solving
- Age (young)[23]

Treatment should give precedence to criminogenic needs, keeping non-criminogenic needs in the background. Finally, the responsivity principle turns to the beneficiaries of the intervention, and focuses on tailoring treatment to offenders' individual characteristics, such as their strengths, learning styles, linguistic and cultural differences, mental health and other needs (ATSA, 2016).

Despite research testifying to its impact on recidivism, the RNR has been criticized for failing to view beneficiaries as complex human beings, with a range of necessities that go beyond their strictly criminogenic needs (Ward et al., 2011).

Developments in the theory and practice of sex offender treatment have given rise to other models for sex offender treatment. **The Self-Regulation Model (SRM)** posits that there are four pathways to reoffending. Offenders may try to avoid sex offending (i.e. they may be avoidant) or directly engage in sexual violence. Moreover, they may be more or less able to self-regulate and aware, at varying degrees, of their sexual offending (Ward & Hudson, 1998). Research has shown than SRM pathways can help distinguish between static and dynamic risk, as well as identify specific factors related to the offence.

The SRM is often incorporated in the **Good Lives Model (GLM)** (Ward e Beech, 2006; Ward e Gannon 2005) one of the most popular models for sex offender treatment nowadays. The GLM places particular importance on the relational aspect of treatment: professionals involved in service provision must be motivated, able to relate to service users and access ongoing training and professional development (Marshall et al., 2006). The model is inspired by humanistic and positive psychology and at its very core lie the notions that all humans share similar primary objectives and that crime is the result of a dysfunctional attempt to reach them.

[23] From table 1 in Hanson RK Yates PM, Psychological Treatment of Sex Offenders, *Curr Psychiatry Rep* (2013) 15:348

The model identifies 11 Primary Goods, that have to do with experiences, activities and lifestyles that individuals pursue for wellbeing and self-realization. These are: (1) life (including healthy living and functioning); (2) knowledge; (3) excellence in play; (4) excellence in work (including mastery experiences); (5) excellence in agency (i.e., autonomy and self-directedness); (6) inner peace (i.e., freedom from emotional turmoil and stress); (7) relatedness (including intimate, family, and friend relationships); (8) community; (9) spirituality (in the broad sense of finding meaning and purpose in life); (10) happiness; and (11) creativity (Good Lives Model, n.d.).

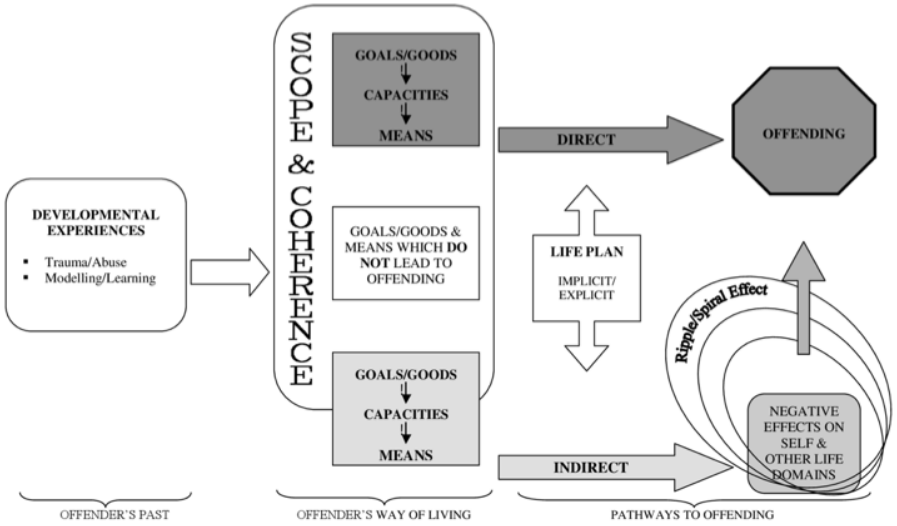

Figure 1: The Goods Etiological Theory[24]

Secondary/Instrumental goods are means and actions that help human beings attain Primary Goods. The GLM views criminogenic needs as obstacles to satisfying primary goods in non-harmful ways. Thus, the causes of criminal behaviour can be traced back to inadequate secondary goods resulting in deviant behaviour, or in other words "omissions or distortions in the internal and external conditions required to implement a good lives plan (GLP) in a specific set of environments" (Ward et al., 2007: 92). These include inappropriate or harmful means; lack of scope in one's GLP; conflict or a lack of coherence; lack of internal and/or external capabilities to satisfy primary goods (Willis et al., 2012).

[24] From: Purvis, M., Ward, T., & Willis, G. (2011). The Good Lives Model in Practice: Offence Pathways and Case Management. *European Journal of Probation, 3*, 28 - 4.

The GLM posits that fostering apt internal conditions such as skills and values and adequate external conditions like social networks and opportunities, is likely to reduce criminogenic needs. The focus is thus on supporting service users in the pursuit of their GLP via adequate secondary goods. What is distinct of the GLM is that in "work(ing) with offenders' narrative identities and core commitments, it places values at the heart of the rehabilitation process"; it "makes it easier (…) to engage offenders in the process of change and for them to feel motivated and understood"; "unlike the RNR, the GLM considers offenders' entire life circumstances and not just those associated with criminal behaviour", and as a result "it is much easier to formulate a holistic and comprehensive plan that incorporates vocational, educational, and therapeutic elements within it" (Ward, Yates & Willis, 2011: 106-107). The GLM model addresses primarily the sex offender population (both adult and minors), but has also been implemented in programs with DV perpetrators, juvenile offenders, offenders with alcohol/drug addiction problems and intellectual disabilities.

An intervention model that has yielded promising results is **Circles of Support and Accountability (CoSA)**. Born in 1990s in Canada, CoSA centres around one former offender (Core Member), who voluntarily agrees to participate in the program and meets regularly with three to seven trained volunteers, forming the inner circle. Around the inner circle there is commonly the outer circle, composed of professionals such as psychiatrists, psychologists, correctional officers, law enforcement agents. CoSA generally targets high-risk sex offenders with the overall objective of supporting them in leading law-abiding lives and preventing further victimisation in the community. CoSA is inspired by restorative justice principles, namely *repair* – making amends for the harm done to victims and the community, preventing further harm and promoting offender healing; *stakeholder participation* –the possibility of victims, offenders and community actively participating in the healing process; and *transformation in community as well as government roles and relationships* **–** the community assisting the criminal justice system in preventing reoffending (Newell, 2007). CoSA also considers risk levels, as well as needs and individual needs. CoSA rests heavily on the GLM model, in that it recognises that the needs of former offenders are akin to those of other community members and therefore aims to support them in engaging in prosocial behaviour and reintegrating in the community (McCartan et al., 2014; Azoulay et. al, 2019).

Another community-level strategy worthy of mention is **Project Dunkelfeld (PPD).** Since 2005, PPD has offered preventive group treatment to individuals who describe themselves as paedophilic or hebephilic. Beneficiaries may have never committed an offense, yet be apprehensive of doing so in the future; or they may have offended without the authorities' knowledge. The PPD recruited

participants via a large-scale social marketing campaign based on the slogan: “If you think about children in a way you shouldn’t… Call for help.” Over the space of three years, 800 individuals responded to the call for action and 200 were assessed as suitable to participate in a one-year treatment program (Tabachnick, 2013). The PPD offers group-based treatment incorporating a cognitive-behavioural approach that includes aspects of self-regulation, relapse prevention and the Good Lives Model (Beier et. al, 2015).

While the benefits and drawbacks of different methodologies are the subject of ongoing debate, there is compatibility between different treatment models. The GLM and SRM are often combined, and it has been argued that RNR and GLM are complementary (Brandt, Prescott & Wilson, 2013; Wilson & Yates, 2009). It is also worth noting that sex offender treatment models have been implemented both in the context of individual and group treatment.

5.3. Treatment programs for sex offenders in Italy

In recent years, the Italian Department of Prison Administration (DAP) has shown willingness to review its practices in an attempt to effectively promote the re-education of sex offenders (Napolitano, 2012). Testament to this strategic shift are several projects spearheaded by the Ministry of Justice and other agencies. Project WOLF (Working on Lessening Fear - 1998-1999) and the subsequent FOR-WOLF (Training for WOLF), promoted by the Ministry of Justice, in collaboration with the Prison Administration, focused on training correctional staff in sex offender treatment. The FOR-WOLF project was based on research, training of professionals and knowledge-exchange in relation to the training of prison and social workers working with sex offenders. Other noteworthy initiatives include Project S.O.Cr.A.T.e.S (Supporto operativo criminologico per l'Arma territoriale e i reparti speciali dei Carabinieri – EN: Operational criminological support for the Territorial Branch of the Carabinieri Corps and the special departments) and the SOGIS (Sex Offender Special Interest) study group set up within the European Confederation for Probation (CEP) with the aim of providing an overview of risk assessment and management tools[25].

Despite these promising developments, it is a fact that the vast majority of treatment programs for sex offenders in the Italian context are not state-run, nor state-funded; rather they are offered by civil society actors working primarily in the custodial setting (Relive, 2019). This poses non-negligible

[25] See: https://www.giustizia.it/giustizia/it/mg_1_12_1.wp?facetNode_1=0_2&facetNode_4=0_2_6_0&facetNode_3=0_2_6&facetNode_2=3_1&previsiousPage=mg_1_12&contentId=SPS1181689

strains on NGOs to secure funding for their activities, as well as prevents the systematic implementation across the national territory (Jovanovic, 2020). Treatment programs run by CIPM Soc. Coop. Sociale (Centro Italiano per la Promozione della Mediazione – Italian Centre for the Promotion of Mediation) are one notable best practice in the Italian context. CIPM has been offering individual and group treatment for sex offenders at Milan Bollate Prison since 2005, as well as community-based treatment for former inmates. Moreover, the organisation relies on the CoSA model, to facilitate sex offenders' reintegration in the community.

CIPM is headquartered in Milan with sister organisations in various Italian cities. All programs run by CIPM organisations rely on a clinical criminological approach, inspired by the Good Lives model. At present, through Project ReSTart (Riabilitare rei Sessuali attraverso il Trattamento – Rehabilitating Sex offenders through Treatment – 2020-2021), funded by Fondo di Beneficenza ed opere di carattere sociale e culturale di Intesa San Paolo, CIPM is providing sex offender treatment in prison and in the community and implementing CoSA in 7 Italian cities.

Key to CIPM treatment programs is the notion of integrated and multi-level support: collaboration with and among relevant institutions – e.g. prison staff, educators, probation, the Surveillance Court, lawyers, the police – is paramount to the successful running of programs. The interconnectedness between treatment in prison and in the community gives rise to the "treatment field", namely the combination of a multitude of spaces, people, institutions and programs that jointly create the treatment environment (Giulini & Scotti, 2014). CIPM also provides group and individual treatment to DV perpetrators both in prison and in the community in the Milan area.
Other NGO's are also working within the prison sector conducting work with sexual offenders (CAM, Florence and Sassari, White Dove Genova, Gruppo Erre Padova).

6. Working with DV perpertrators

6.1. Intervention models

Intervention programs for DV perpetrators can be broadly characterised as having a psycho-educational approach or a psycho-therapeutic approach, or a combination of the two. They may be court-mandated or voluntary. The first treatment programs for DV perpetrators emerged in the 1970s. At that time, increased mobilisation in response to violence against women and the creation of victim support programs and women's shelters, begged the question of what was being done and could be done about violent men.

The Emerge program kicked off in 1977 in the USA, shortly after the first shelter for women victims of DV opened its doors. Emerge is internationally recognised as the first ever voluntary program for violent men. The program, working in close collaboration with women crisis centres and victim support organisations, centres on a reflection about power and the socio-cultural roots of gender-based violence. In a group setting, participants are guided and supported in taking responsibility for their violent behaviours. Emerge aims to prevent violence by educating youth – boys and girls – about the meaning of healthy relationships. The approach is mostly psycho-educational with specific anger management modules.

The Duluth program is the first community-based program for DV perpetrators. The Duluth model hinges on a psycho-educational approach applied in the context of group sessions with perpetrators. Any community that is using the Duluth model:

- has taken the blame off the victim and placed the accountability for abuse on the offender.
- Has shared policies and procedures for holding offenders accountable and keeping victims safe across all agencies in the criminal and civil justice systems from 911 to the courts.
- Prioritizes the voices and experiences of women who experience battering in the creation of those policies and procedures.
- Believes that battering is a pattern of actions used to intentionally control or dominate an intimate partner and actively works to change societal conditions that support men's use of tactics of power and control over women.
- Offers change opportunities for offenders through court-ordered educational groups for batterers.
- Has ongoing discussions between criminal and civil justice agencies, community members and victims to close gaps and improve the community's response to battering" (Domestic Abuse Intervention Programs, 2017).

The Duluth model combines a feminist perspective with an educational approach, with the intent to challenge perpetrators' ingrained beliefs about gender and masculinity (URBIS, 2013). A key aspect of the Duluth model is the notion of Coordinated Community Response, which prioritises close cooperation between practitioners and structured interagency interventions to safeguard the victim's safety above all else. The Duluth model is present in Canada, the UK, Germany, the Netherlands and South Africa. From the 1990s onwards, it has served as inspiration for the development of programs for sex offenders.

The Alternative to Violence di Oslo (ATV) Program is the first program for DV perpetrators implemented in Northern Europe. It relies on a psycho-therapeutic approach, that interprets violence through a psychological lens, viewing it as a by-product of adverse childhood experiences.

Nonetheless, the socio-cultural aspects of violence are also considered. ATV is based on individual sessions leading up to group sessions.

The UK-born **RESPECT Program** has stood out in recent years for its innovative work in the field of domestic abuse. Particularly noteworthy is RESPECT's accreditation for DV perpetrator programs and work with male victims. The RESPECT accreditation for work with perpetrators hinges on ten key principles, guiding organisational management, delivery of interventions, diversity and access, multiagency work and innovation[26]. The backbone of the RESPECT standards is the notion of "doing no harm", namely preventing at all costs any negative repercussion on victims/survivors, as a result of organisational action or inaction. Accreditation is proof of an organisation's commitment to the safety and wellbeing of service users, staff, and crucially, victims/survivors. It is also evidence of transparency and accountability, that in turn engender organisational credibility and stakeholder confidence, whilst also boosting overall reputation.

It should be noted that programs for DV perpetrators have increasingly combined psycho-educational approaches, such as the Duluth model, with psycho-therapeutic interventions, involving cognitive-behavioural therapy (URBIS, 2013).

6.2. DV intervention projects in Italy

CAM[27] was the first ever Italian Centre to implement specialized programs for DV perpetrators in Italy. It was established in 2009 in the city of Florence and has local branches in Ferrara, Rome, Monteleone, Olbia, Sassari, Cremona, Pistoia and Montecatini. It works through initial telephone contact, individual assessments, psycho-educational and follow-up groups, phone contact with partners victims of violence. It also carries out training and awareness-raising activities, clinical supervision and consultations.

RELIVE – Relazioni Libere dalle Violenze[28] [EN: Relationships free from violence] is a national association born in 2014, which formalized the collaboration between the first 9 Italian Centres for

[26] See: https://www.respect.uk.net/pages/64-respect-standard
[27] See: https://www.centrouominimaltrattanti.org/page.php?sede_di_firenze
[28] See: http://www.associazionerelive.it/

perpetrators of domestic violence, in order to "create and promote a national network to combat gender violence, particularly violence against women". In particular, Relive aims to "foster and implement programmes to prevent domestic violence and to support and treat perpetrators, working in close cooperation and collaboration with victim support services". Relive currently has 21 Centres across various Italian regions.

Consultorio per Uomini di Bolzano[29] (EN: Bolzano's Centre for Men) was set up by Caritas in 2000 to support both GBV victims and perpetrators. The methodological approach hinges on an open group, where the following core models are repeated on a loop: 1. definition of violence; 2. responsibility-taking; 3. emotion management; 4. strategies to deal with anger and violence .

Liberiamoci dalla violenza (LDV)[30] (EN Let's free ourselves from violence) is a program run by the Emilia Romagna healthcare agency. The program is inspired by the ATV model and is structured in 4 steps: 1. Violence (behaviour) 2. Responsibility 3. Personal history (connections) and 4. Consequences of violence.

Over the past few years, a range of projects for DV perpetrators have surfaced across Italy. More information on organisations offering DV perpetrator programs can be found on the RELIVE website: www.associazionerelive.it.

7. European best practices in work with perpetrators of sexual and domestic violence

Best practices in programs with SGBV offenders fulfil the following criteria[31]:

1. **They ensure support for victims**, as per Art. 16 of the Istanbul Convention.

[29] See: http://www.provincia.bz.it/famiglia-sociale-comunita/persone-in-difficolta/consulenza-uomini.asp
[30] See: https://www.auslromagna.it/servizi/servizi-alfabetico/schede-informative/1197-ldv-liberiamoci-dalla-violenza
[31] The original extended versions of this section were authored by: Sandra Jovanovic of WWP EN in her expert paper "Probation and prison based programs for perpetrators of domestic and sexual violence: a European overview". The document can be accessed here: https://www.work-with-perpetrators.eu/fileadmin/WWP_Network/redakteure/Expert%20Essays/Expert_paper_prison_and_probation_final.pdf; and Bertha Vall Castelló in the Project CONSCIOUS Mapping Report, available at this link: https://www.work-with-perpetrators.eu/fileadmin/WWP_Network/redakteure/Projects/CONSCIOUS/D_4.3_Mapping_Report_eng_rev.pdf

Inspiring programs in this regard include programs that integrate services for both perpetrators and victims, such as :

- the Scottish Caledonian System, comprising a Men's Programme, a Women's Service and a Children's Service, that collaborate closely with each other;
- Association NAIA in Bulgaria, supporting victims of DV through the provision of social, psychological and legal assistance and concurrently working with DV perpetrators. The two services collaborate within the scope of couple therapy or when other institutions require it (e.g. in cases involving children).

Worthy of mention are also organisations that do not offer support for victims within their portfolio of services, but have formalised collaboration with women's crisis centres/victim support agencies, such as:

- The Anti-Violence Program in Vienna (Austria) based on cooperation between the Domestic Violence Intervention centre and the Men's Centre;
- The Domestic Violence Intervention Centre (Austria) that has partnered with the Anti-violence program and the Men's Centre. The program is co-coordinated by the three organisations and decisions are taken jointly, meaning that intakes and terminations are agreed upon together, management is shared and the contribution of women through their work is emphasised .

2. They focus on the safety of victims and potential victims (in the event of a relapse)

The focus on safety entails embracing a "victim-centred approach", which requires "placing the needs and priorities of victims/survivors of violence at the forefront of any response" (UN, 2019). Best practices of organisations that embrace this approach comprise:

- The above-mentioned Domestic Violence Intervention Centre (Austria), which holds that "safety of survivors means more than risk assessment and safety planning". Primarily, this means supporting and empowering survivors, including by equipping them with the tools to live an independent life.
- The "Buducnost" Association of Citizens (Bosnia and Herzegovina), that runs a centre for male perpetrators of DV and concurrently, manages a shelter for women victims of violence, equipped with video cameras and security guards at night. The organisation collaborates closely with the police.

- The “Duga Zagreb”, a home for juveniles and victims of domestic violence offering individual support to victims of DV, whilst their perpetrators are enrolled in perpetrator programs. The main focus of work with victims is risk assessment and safety planning.
- SPAVO (Cyprus) that also offers shelters, face-to-face counselling and a 24/7 helpline. Women’s and children’s safety is “at the forefront of case planning, decision making and intervention” in the organisation. As well as the counselling and psychotherapy provided for women and children, women receive help with job-seeking, accommodation and schooling for their children.
- MOVE Ireland, that prioritises direct contact and open cooperation with victims. The organisation carries out safety planning together with victims, whilst also focusing on outlining the dynamics of DV, so as to empower women to better understand what they have been through.
- Association NAIA (Bulgaria) providing support to victims of DV through social, psychological and legal assistance. NAIA points out the importance of inter-sectoral/multiagency cooperation, especially when it comes to children’s safety.
- The Albanian organisation Woman to Woman, that develops individual safety plans for victims in each and every case it deals with. The safety plan includes risk analysis, general circumstances of a woman’s life and future safety plans.

Some services strive to guarantee victim safety through structured referrals. These include:

- The Crises Center Mobile in cooperation with the Psychotherapy Training and Research Centre, University of Jyväskylä (Finland), that starts its programs with an individual session for offenders. Victims are contacted by crises centre workers and offered individual or group meetings. While men are enrolled in the perpetrator program, their partners are interviewed at the start of the program, midway and upon program completion. All interviews are conducted by the Psychotherapy Training and Research Centre. Two-year follow-up interviews are then carried out both with the victims and the offenders. The important aspect to note here is that informing the victim about the nature of violence and the perpetrator program that her offender is enrolled on, takes the burden of responsibility for violence off the victim’s shoulders.
- Swedish organisation Unizon, that works hard to ensure a high level of safety for women and children coming in contact with its member organisations. The organisation regularly gives trainings in risk assessment and victim safety planning for the personnel and volunteers of local member organisations. Part of Unizon’s yearly budget is allocated to the so-called “Crisis Management Fund”, accessible by local member organisations who wish to urgently apply for funding in cases of emergency. Moreover, one of the goals of Unizon’s advocacy work, at both

national and regional levels, is to push the authorities to prioritise the safety of women and children subjected to men's violence.

- FJC Antwerp's (Belgium), which conducts safety planning through direct contact with victims. The organisation also provides intensive case management when the risks to women's and children's lives and safety is high.

3. They are gender-sensitive

Given that the vast majority of SGBV victims are women and girls, gender sensitivity in program delivery is of crucial importance. Inspiring practices in this regard include:

- The Crises Center Mobile in co-operation with Psychotherapy Training and Research Centre, University of Jyväskylä (Finland), that connects gender identity constructions and violent behaviour in perpetrator programs.
- Men of 21st century – M21 (Russia), that views gender stereotyping and women's objectification as the root cause of violence. Work with gender stereotypes is an important component of its perpetrator programs.

Gender sensitivity shouldn't be applied simply in program roll-out, but also imbue the organisation's culture as a whole. An important implication of a gender-sensitive approach to group treatment with SGBV perpetrators concerns mixed-gender co-facilitation. More specifically, the presence of a female co-conductor allows for greater accountability, particularly with regard to "challenging the male co-facilitators' issues of privilege and dominance in the group programs, and to pick up on abusive and sexist behaviour not necessarily identified by the male co-facilitator" (Apps & Gregory, 2011: 30).

4. They are based on multi-agency work

The British National Offender Management Service is a good example in this respect, as it allows for both intra-sector (i.e. between prison and probation) and inter-sector cooperation (between the prison/probation service and external agencies). In this context, all inmates with a history of DV attend DV perpetrator programs, regardless of the crime for which they were incarcerated.

5. They are sustainable

Lack of funding for perpetrator programs is a recurring issue in most countries worldwide. Securing ongoing funding is essential for sustainability. The Caledonian system stands out for its success in

ensuring that its three above-mentioned programs are comprehensively funded by different government services.

6. **They address both offender populations either by program design or via collaboration with relevant organisations**.

The evidence shows that oftentimes that sex offender treatment programs and interventions for DV perpetrators are separate, with organisations that run them working in silos. Both types of programs would doubtless profit from "overcoming current isolation one from another, and establishing clear cooperation pathways" (Jovanovic, 2020: 15)

Part 2 -The CONSCIOUS MODEL IN THEORY AND IN PRACTICE

1. Design of the CONSCIOUS model

The CONSCIOUS model is inter-systemic "by design". In fact, its very development involved dialogue and knowledge-exchange among a range of professionals, including:

- Healthcare professionals with psychotherapeutic competencies, tasked with delivering treatment
- Prison staff (including correctional officers, educators, prison directors)
- Probation officers
- The Surveillance Court, in charge of monitoring the adequate execution of prison sentences and managing alternative sentencing
- Lawyers defending perpetrators of violence, in light of their role in influencing the judiciary's decision to grant access to treatment programs, and in making client referrals
- Prison directors, who may wish to replicate the program in their institutes
- Volunteers involved in perpetrator programs

The CONSCIOUS approach to treatment is inspired by CIPM's decades-long experience working with SGBV perpetrators in the Italian context. To this end, CIPM professionals were roped in to provide training to ASL Frosinone staff, tasked with treatment implementation. CIPM was further involved in project activities through the provision of ongoing clinical supervision.

Decisive in the CONSCIOUS model is the role of the Public Healthcare System. As elucidated in Part 1 of the Guidelines (refer to section: Healthcare in Italian Prisons: the role of the Public Healthcare System), the Public Healthcare System is responsible for the provision of healthcare in Italian prisons. The CONSCIOUS model moves from this consideration, embracing a comprehensive vision of healthcare that includes treatment and rehabilitation of perpetrators. This approach gives prominence to the State's duty to support inmates in their effective reintegration, and all citizens by guaranteeing their safety from harm.

On this view, the CONSCIOUS model has the potential to spark broader cultural and policy change in the area of offender treatment, as well as promote sustainable practices. As was previously mentioned (see Section 5.3. on Treatment programs for sex offenders in Italy), in the Italian context, the vast majority of treatment programs, particularly those for sex offenders, are led by civil society

organisations. The involvement of the Public Healthcare System via its trained staff (e.g. psychologists and psychotherapists) can help ensure ongoing funding for such programs, as well as ideally, foster the homogenization of practices.

Therefore, the CONSCIOUS model presupposes that the Lead Commissioner, in this case the Department of Mental Health and Pathologies linked to addictions services of the Public Healthcare System:

- has in depth knowledge and experience of Commissioning services for perpetrators of sexual and domestic violence;
- has knowledge of the system's response and of each role
- is familiar with best practices in multi-stakeholder and multilevel collaboration.

The Lead Commissioner should work with service providers to deliver integrated rehabilitation pathways, whilst ensuring that:

- there are solid communication pathways in place to ensure information-exchange between senior service managers;
- treatment outcomes are evaluated;
- the application of protocols is evaluated;
- the budget and other resources are shared;
- the funding mechanism supports all stakeholders for the implementation of the mode.

1.1. Key principles, essential requirements and specifications of the CONSCIOUS model

The **overarching principles** of the CONSCIOUS model can be articulated as follows:

- Rehabilitation is part of an inter-systemic coordinated response
- Management and Coordination are spearheaded by the Public Healthcare System
- Rehabilitation is part of a broader treatment field (see Section: Treatment programs for sex offenders in Italy)
- Treatment draws on the GML model and focuses on the identification of the key needs and objectives of each service user, alongside assessing risk
- Treatment is rooted in an individualized, person-centred approach
- In-depth training and ongoing supervision of professionals are essential and serve to foster a healthy and supportive work environment
- The safety of victims and potential victims is a key concern
- The alliance between professionals delivering treatment and service users is crucial to service user engagement and overall program success

- Access to ongoing community-based treatment following release is critical to sustain and maximise program outcome
- It is essential to evaluate the results of interventions.

These core principles translate into the following essential **requirements**:

- Protocols and agreements need to be drawn up between the relevant parties involved to formalise the inter-systemic coordinated response and establish roles and responsibilities;
- clear conditions for participation in treatment programs need to be established from the start;
- treatment should commence with individual assessments, aimed at laying the foundations of rapport-building, determining risk and exploring individual biographies. Individual intake sessions should determine suitability and access to subsequent individual/group treatment;
- building a working alliance with service users is an ongoing process, which should be formalised first and foremost via a treatment contract through which service users commit to the treatment process;
- frequency of contact should be tailored to offenders' personal and social characteristics;
- individual and group treatment are mutually reinforcing and complementary;
- group treatment should be co-conducted, preferably by a male and female facilitator;
- treatment should focus on the development and consolidation of new skills that can effectively change behaviour and cognition to reduce risk and recidivism;
- the main focus should be on the harm caused, rather than more narrowly, on the crime committed
- efforts should go toward maximising service users' motivation and engagement;
- the treatment team should meet regularly for the purpose of discussing and monitoring progress;
- supervision sessions should be conducted regularly to avoid burn-out both at an organizational level and for dealing with countertransference and ambivalences in working with severe cases of violence;
- to ensure continuity, service users should have access to treatment in the community. The transition between prison-based treatment and community-based treatment should be facilitated by clinicians themselves;
- research to ensure treatment effectiveness should be built into program design. Its findings should be considered by service providers for greater program impact.

The principles and requirements outlined above apply to the treatment programs conducted both with sex offenders and DV perpetrators in the context of Project CONSCIOUS. The choice to root treatment for both sex offenders and DV perpetrators in the Good Lives Model was intentional and motivated by the below key factors:

- The GLM allows for a holistic approach to treatment, that considers the person in their entirety, with a host of individual needs and life objectives. While risks are also addressed, the GLM rejects identifying service users wholly with their crime. The GLM model is more likely to motivate participants and yield positive outcomes, regardless of the specific crime committed (DV or a sex offence). As argued by Langlands, Ward and Glichrist (2009), the GLM can be successfully adopted for interventions targeting DV perpetrators because it is:

(…) a broad intervention framework and, as such, can incorporate both the evaluative tenets of the Duluth model and the capacity-building focus of CBT (...) First, the important focus of the Duluth model on gender socialisation issues is addressed by the GLM's insistence that human beings are interdependent and rely on a range of social resources and relationships to achieve their goals. Furthermore, the ability to effectively implement a GLM plan is critically reliant on internal and external conditions. For example, the achievement of a healthy intimate relationship requires certain external conditions such as the provision of social resources (e.g., dating partners, supportive networks etc.) and internal conditions such as appropriate gender and relationship norms, and intimacy skills (…) Second, with respect to CBT approaches, according to the GLM offender treatment is an evaluative and capacity (skill) building process and therefore specific CBT techniques can be useful in this process (Langlands, Ward & Gilchrist, 2009: 122)

- In addition, given the all too frequent divide between services for DV perpetrators and sex offenders and the project's aspiration of bridging such chasm, a holistic model such as the GLM, was deemed particularly appropriate.

This notwithstanding, it is undeniable that the two target groups also require ad-hoc interventions, in light of the particularities of the crimes committed. The CONSCIOUS MODEL acknowledges this and therefore foresees the following specifications:

SEX OFFENDERS	DV PERPETRATORS
Treatment is generally more intensive (in line with CIPM's experience conducting intensive treatment for sex offenders in prison)	Treatment is less intensive compared to sex offender target group
Initial assessment is conducted through the administration of STABLE-2007 and wherever possible, STATIC 99-R (see section 1.2. for further information)	Initial assessment based on an in-depth psychological and criminological evaluation (see section 1.2. for further information)
Treatment targets particular dynamic risk factors with strong links to *sexual recidivism*	Treatment targets dynamic risk factors associated with violent reoffending
Treatment relies on specific methodologies demonstrated to reduce sexual violence	Treatment relies on specific methodologies demonstrated to reduce violence in close relationships, including sexual violence.
STABLE-2007 and STATIC 99-R (if applicable) are administered at the end of treatment to measure progress	Clinicians conduct an in-depth evaluation of each service user's progress and risk level upon completion of the treatment pathway

TABLE 1: CONSCIOUS MODEL SPECIFICATIONS BASED ON TARGET GROUP

It should be noted that the socio-cultural aspects of violence should be addressed in both model adaptions, particularly when working with DV perpetrators.

1.2. Initial Assessments

Under the CONSCIOUS Model, initial individual assessments mediate access to treatment for both DV perpetrators and sex offenders.

Initial assessments of DV perpetrators consist of a psychological and criminological evaluation, composed of the following items:

Psychological evaluation:
a) personality-related factors
b) individual history
c) quality of intimate relationship
d) other specific themes (e.g. jealousy; dependency levels; intrapsychic aspects such as low self-esteem; personality disorders; presence of addictions)
e) reoffending risks

Criminological evaluation:
a) understanding and perception of events (crime)
b) relationship with and approach to responsibility
c) emotions associated with committing a violent crime
d) ability to consider the psychological impact on the victim
e) relationship with the law

Psychological and criminological evaluations allow to clinically assess immediate risks of acting out, midterm risks of reoffending, severe risks of violence, risks of escalation, drop-out risks, risks of physical/psychological abuse of minors. Each risk should be rated as low, medium or high at the start and at the end of the intervention.

Initial assessments of sex offenders are conducted utilising STABLE-2007, a renowned international instrument employed to assess risk-relevant propensities for adult males convicted of a sexual offense. Wherever possible, STATIC-99R is also employed. By way of example, STABLE-2007 items for sexual recidivism include: significant social influences; intimacy deficits; capacity for relationship stability; emotional identification with children; hostility towards women and so on.
Another tool used for initial assessment was the Impact Toolkit. The IMPACT Toolkit measures several perpetrator programme outcomes, stated by the perpetrators and their (ex-) partners. Some of these outcomes include: behavioral change, motivation to change, responsibility, awareness of behavior impact, children situation, and safety issues. Therefore, it does not just measure behavioural change, but also the impact of the violent/abusive behaviour on the victims. Furthermore, this tool gives the possibility to assess these aspects over time, during the course of the treatment, at five designated time points. Finally, it also allows to explore the outcome from the (ex-) partner perspective. This is a

crucial tool that has been developed in order to harmonize the outcome assessment tools available to evaluate perpetrator programmes. Moreover, it is the first tool to provide an outcome evaluation measure for the men in treatment and one for their (ex-) partners, allowing to compare their accounts, and thus to triangulate data for a better reliability of the results.

1.3. Treatment modules

The Project CONSCIOUS model consists of five key modules, preceded by an assessment phase to determine program suitability. The program is structured as follows:

MODULE 1 : AWARENESS-RAISING	**NO. OF SESSIONS**
1. Objectives of the treatment program **2.** Ground rules **3.** Confidentiality and suspension of judgement **4.** Choosing a name to the group that everybody can identify with **5.** Motivating users to change **6.** Group exercises, learning to work together and respect each other.	6
MODULE 2: CONSCIOUSNESS	
1. Introduction the emotional-rational cycle (A-B-C) **2.** Ability to identify precursors and their consequences **3.** Grasping the importance of cognition in terms of the activation of the behavioural chain **4.** Defence mechanisms: minimization and negation **5.** Cognitive distortions, corporal techniques (mindfulness) **6.** Group exercises (the colours of emotions, facial expressions, how to distinguish them and recognise them) **7.** Applying the model to real-life situations	8
MODULE 3: SOCIAL SKILLS TRAINING	
1. Social skills (what they are and how they can help us) **2.** Communication styles **3.** Conflict resolution **4.** Role play	4
MODULE 4: RESPONSIBILITY-TAKING	
1. Recognising emotions in oneself and in others	8

2. Empathy (putting oneself in other people's shoes) **3.** The cycle of crime (describing it in cognitive, emotional and behavioural terms) **4.** Sharing one's reflections in a group setting **5.** Writing a letter to the victim or relatives	
MODULE 5: INTEGRATION	
1. The progress made : perceptions of change and expectations **2.** The vision of the future **3.** The ability to open up and manage vulnerabilities **4.** Improving one's life objectives against the backdrop of a broader good life plan	8
TOTAL SESSIONS	34

Cross-cutting topics addressed in the Consciousness, Social Skills, Responsibility-taking and Integration modules concern the socio-cultural root causes of violence and gender norms. It should also be noted that the CONSCIOUS model leaves room for individual sessions to be conducted with service users - particularly those who may benefit from additional individual support due to specific factors associated with risks and needs - alongside group treatment.

2. Model implementation

The main developer of the model and its key implementer is the Department of Mental Health and Pathologies linked to the addictions department of the Public Healthcare System of Frosinone. Model implementation was supported by the Prisons of Cassino and Frosinone, the Regional Superintendency of the Penitentiary Administration of Lazio, Abruzzo and Molise, the Department of Penitentiary Administration, the Surveillance Court of Rome, the Probation Service of Frosinone , the Association of Lawyers of Frosinone and Cassino, Be Berlin, Insieme Verso Nuovi Orizzonti and CNCA Lazio.

The model was implemented both in the custodial setting and at community level. Access to the custodial setting was enabled by operational protocols, signed with correctional facilities in the framework of the project. More specifically, implementation took place in three different locations:

- The Prison of Frosinone
- The Prison of Cassino
- The Outpatient Addictions Service (Ambulatorio Esterno Ser.d Frosinone)

The target group at the Prison of Cassino were inmates convicted of a sex offence. Thanks to an experimental protocol, the treatment was also extended to perpetrators of domestic violence both in the prison setting, namely at the Prison of Frosinone, and at the Outpatient Addictions Service. Treatment was carried out by psychologists and psychotherapists employed with Frosinone's local healthcare agency (ASL Frosinone).

2.1. Sex offender treatment at the Prison of Cassino

Duration: 16 months **(**March 2019-July 2020)

No. of beneficiaries: 24 (of which 12 participating in group treatment)

In March 2019, 54 inmates held in protective custody were approached and received a first individual assessment. The identification of program beneficiaries took place with the support of professionals belonging to the prison's Pedagogical Area in particular. Access to treatment under CONSCIOUS is voluntary - of the 54 inmates initially contacted, 24 were deemed suitable to access treatment services and signed the treatment agreement. Of these, 12 accessed individual treatment and the remaining 12 signed the treatment agreement for group treatment, whilst concurrently continuing to benefit from individual sessions.

Group treatment kicked off in April 2019 with the Awareness-raising and Social Skills modules. Sessions took place weekly. The program followed the CONSCIOUS structure and modules; however, contents and number of sessions were tailored to the needs of the sex offender population, whilst also taking into consideration the individual characteristics of each inmate. As a result, the number of sessions envisaged under most modules was increased. A breakdown is provided in the table below.

Awareness-raising module: 9 sessions (instead of 6) **Topics:** ground rules for group participation, objectives of treatment, inclusion and exclusion criteria, motivation to change, the life cycle, life objectives, the life plan, cognitive frameworks and distortions.
Social skills module (1st part) : 5 sessions **Topics:** ground rules, rules of behaviour, role play, communication styles, non-verbal communication
Consciousness module: 23 sessions (instead of 8)

Topics: cognitive frameworks and distortions, strategies for cognitive restructuring, emotions and feelings, guilt, shame, resentment, fantasies, behaviours and action strategies to concretely tackle problems
Social skills module (2nd part): 17 sessions (for a total of 23 sessions instead of 4) Topics: role play, communication styles and non-verbal communication
Responsibility-taking module : 17 sessions (instead of 8) **Topics:** the cycle of crime, personal strengths and weaknesses, empathy, letter from the victim, reparation letter for the victim, discussion about the crime cycle.
Integration module: 14 sessions (instead of 8) **Topics:** the emotional-rational cycle of behaviour, emotion management techniques, management of personal vulnerabilities, cognitive restructuring for change, discussion on sexual recidivism, handing out and discussion of the self-regulation plan, handing out and discussion about the life goals' improvement plan, reading of letters from victims and of reparation letters for victims.
Final meeting
TOTAL: 86 SESSIONS (including final meeting)

TABLE 2 : GROUP TREATMENT MODULES FOR SEX OFFENDERS (PRISON OF CASSINO)

It is worth mentioning that between March and May 2020, all prison-based group activities were halted. To avert the abrupt and likely damaging interruption of the inmates' rehabilitation journeys, the treatment team continued offering individual psychotherapy and tutoring sessions during this period. Group treatment recommenced in May. The user retention rate was satisfactory, with only one inmate dropping out. During treatment delivery, 2 inmates were transferred to other prisons and 3 others accessed alternative measures to detention, made available during the pandemic.

2.2. Treatment of DV perpetrators at Frosinone prison

Duration: 18 months, of which approximately 15 effective (April 2019-October 2020)

No. of beneficiaries: 37 (of which 13 participating in group treatment)

Two treatment groups for DV perpetrators were set up at Frosinone prison, the first running from April 2019 to February 2020 and the second from May until October 2020.

Group 1 : April 2019–February 2020 (10 months)

With regard to the first treatment group, in April 2019, 30 service users were approached with the support of the prison's Pedagogical-Educational Area and individually assessed. 28 accessed individual treatment, with 10 of them also agreeing to take part in group treatment. Treatment abided by CONSCIOUS guidelines, yet several amendments to module structure and intensity were made, in light of the target group and the individual characteristics of service users. In general, the treatment team opted for a" lighter" program, compared to that implemented for the benefit of the sex offender population.

Awareness-raising module: 6 sessions **Topics:** program objectives, ground rules, confidentiality, naming the group, motivation to change, group exercises and "homework"
Consciousness module: 8 sessions **Topics:** Theoretical concepts, situations (A), emotions and feelings (B), thoughts (C); the emotional – rational cycle; the ability to recognise precursors and their consequences; understanding the importance of cognition in activating behaviours; cognitive distortions; corporal techniques (mindfulness), group exercises and "homework".
Social skills module: 4 sessions **Topics:** Social skills, communication, communication styles, conflict resolution, role play
Responsibility-taking module: 8 sessions **Topics:** Ability to recognise one's emotions and the ones of others, empathy, the crime cycle, group rendition, letter to the victim/s (family members)
Integration module: 8 sessions **Topics:** progress made; perceptions of change and expectations; the vision of the future; objectives; emotion management skills; breathing and relaxation techniques; ability to open up and manage vulnerabilities; the life objectives' improvement plan
TOTAL: 34 SESSIONS

TABLE 3: GROUP TREATMENT MODULES FOR DV PERPETRATORS(GROUP 1 AT FROSINONE PRISON)

It should be noted that during program roll-out, 3 inmates were transferred to other prisons, 1 inmate completed his sentence in the community; 1 inmate was put on house arrest and 1 inmate obtained benefits under Art. 21 and was entitled to exit the prison to work.

<u>Group 2 : May-October 2020 (5 months)</u>

A second treatment group was initiated in May, following an initial assessment, 9 inmates accessed

the treatment program, 3 of whom committed to group treatment. The treatment team implemented a condensed and shortened version of the treatment modules envisaged under the CONSCIOUS model due to time constraints and COVID safety measures. The content of treatment modules broadly reflects the outline presented in Table 3. A session on resilience, namely the ability to bounce back after stress, was incorporated in the module on Social Skills, in light of the unprecedented challenges posed by the pandemic, particularly in the carceral environment. The adjustments made to the number of sessions for each module is expounded in Table 4 below.

Awareness-raising module: 4 sessions (instead of 6)
Consciousness module: 4 sessions (instead of 8)
Social skills module: 2 sessions (instead of 4)
Responsibility-taking module: 3 sessions (instead of 8)
Integration module: 4 sessions (instead of 8)
TOTAL: 17 SESSIONS

TABLE 4: GROUP TREATMENT MODULES FOR DV PERPETRATORS (GROUP 2 AT FROSINONE PRISON)

Establishing a collaborative environment within the group proved more taxing than with Group 1, primarily due to the tight schedule and the marked individual differences between participants, rendered more patent by the small size of the group. Professionals put great effort into bolstering intra-group trust, that eventually gave way to an empathic and participatory environment.

2.3. Treatment of DV perpetrators at Ambulatorio Esterno Ser.d Frosinone (Outpatient Addictions Service)

Duration: 18 months, divided into two phases (April 2019 – October 2020)

No. of beneficiaries: 12 (of which 10 participating in group treatment)

A community-based group treatment pathway was enacted at the Outpatient Addictions Service managed by Frosinone's local healthcare agency. The choice to conduct treatment in this setting was motivated by considerations related to venue space and previous encounters with service users presenting violent tendencies, requiring urgent attention. This service was open to: a) perpetrators charged with, but not yet convicted of domestic violence; and b) individuals who had manifested aggressive tendencies towards their family members (primary prevention). Community-based recruitment proved more burdensome – this was a clear reminder of the pivotal role of inter-systemic partnerships in successfully structuring and sustaining treatment programs. In October 2019, an info

session for local healthcare professionals was conducted. A dedicated phone number and email were set up for the purpose of referrals from other services.

The treatment program was subject to changes in the course of implementation, primarily due to the pandemic. In the **first phase**, lasting 10 months (from April 2019 to February 2020), 8 individuals took part in an individual assessment and were recruited to take part in the program. 4 took accessed both individual and group treatment, while the remaining 4 benefitted only from individual treatment. Treatment was akin in structure and modules to that provided to DV perpetrators held at Frosinone Prison between April 2019 and February 2020 (TABLE 3: GROUP TREATMENT MODULES FOR DV PERPETRATORS(GROUP 1 AT FROSINONE PRISON). The only difference consisted in the introduction of 2 additional sessions under the Awareness-Raising Module for a grand total of 36 sessions for the entire group treatment program.

During this first phase, 1 service user interrupted treatment and accessed a residential program. After dropping out of the latter, he was re-admitted on the treatment program through individual sessions at first, and a later stage, via group treatment (during the 2nd phase described below). In February, all group activities were suspended due to the pandemic. However, individual treatment continued to be provided.

The **second phase** of the program, lasting 5 months, (May-October 2020) kicked off at the beginning of May 2020, once COVID-related restrictions were eased. 4 new users signed the treatment agreement, 2 in May and the remaining 2 in August. In June 2020 a new group was set up, bringing together two service users from the previous group, two new users from June onwards and an additional two as of August. Group treatment lasted a total of 3 months and relied upon a succinct version of the modules, with a specific session dedicated to resilience.

Awareness-raising module: 3 sessions (instead of 6)
CONSCIOUSness module: 4 sessions (instead of 8)
Social skills module: 2 sessions (instead of 4)
Responsibility-taking module: 2 sessions (instead of 8)
Integration module: 3 sessions (instead of 8)
TOTAL: 14 SESSIONS

TABLE 5: GROUP TREATMENT MODULES FOR DV PERPETRATORS (OUTPATIENT ADDICTIONS SERVICE)

Service users who commenced treatment in August continued to be supported via individual treatment after the group was dissolved. The interaction between service users who had already benefitted from group treatment and newly recruited users proved particularly beneficial and conducive to constructive discussions. A general drawback to be highlighted with regard to the community-based treatment provided at the Outpatient Addictions Service, relates to users' concurrent and overlapping addiction issues. These were dealt with both in individual and group sessions, yet posed significant challenges for group facilitators in terms of covering module content and on a par, for service users to digest it. A positive development was the rise in the number of referrals from lawyers and social services during testament implementation. This is testament to the consolidation of multi-level networks, as well as to the need for treatment provision.

3. Overall results

The implementation of the CONSCIOUS model has led to relevant shifts in competencies, culture, agreements and local practices. More specifically:

- Healthcare staff directly involved in project activities has accrued **specialised skills** for the treatment of sex offenders and DV perpetrators. The skills gained will prove instrumental to the provision of treatment to other patients, who present high levels of impulsivity and violent tendencies;
- during treatment, the theme of SGBV was discussed in a prevention perspective, overriding the negation mechanisms, typical of individuals who commit violence. This was beneficial to service users, as well as allowed professionals to better grasp the importance of treatment in prioritising **victim safety**, reducing recidivism and preventing re-victimisation;
- formal agreements and informal interaction with relevant institutions have favoured **network-based action**, with reverberations on the treatment of perpetrators of sexual and domestic violence, but also more broadly, on other interventions requiring multi-level collaboration;
- awareness-raising has served to garner the attention of professionals working in government and in the non-profit;
- local, regional and national policy-makers have recognised that CONSCIOUS has audaciously opened up the debate on **the role and responsibilities of institutional actors and the Public Healthcare System** in particular vis-à-vis perpetrators of sexual and domestic violence
- Individuals benefitting from treatment, regardless of individual specificities, have made significant **progress in terms of rehabilitation**. While the pandemic prevented the

administration of follow-up risk assessments to all service users, the evaluations conducted show a general decrease in risk levels following treatment;
- CONSCIOUS has allowed to **successfully test a model**, which sees the Public Healthcare System as primary provider of treatment to SGBV perpetrators.

Positive feedback on the project from service users was further consolidated by that received from prison directors and staff. In this sense therefore, CONSCIOUS was able to involve all relevant actors, overcoming any existing reluctance.

4. Lessons learned

Project implementation, particularly in terms of treatment, suffered primarily from the unexpected challenges stemming from COVID-19. Nevertheless, these too, offered food for thought, providing insight into auspicious measures and strategies for increased preparedness vis-à-vis similar future situations.

Lessons learned can be summarized into the following main themes:

a) Risk management planning – One of the direct consequences of the COVID-19 outbreak was the impossibility to carry out final risk assessments with all service users benefitting from treatment. This had a bearing on the ability to measure impact. While this challenge could not be foreseen, it is important that prior to implementing a treatment program for perpetrators, a thorough risk management strategy is laid out. The strategy should identify potential risks and mitigating measures. Relevant issues should be discussed and shared with prison staff in the context of prison treatment, so as to evaluate their potential involvement in risk mitigation. Should it be deemed appropriate, specific clauses could be included in protocol agreements with relevant institutions. In terms of evaluating risk, wherever feasible and depending on program duration, it is advisable to include midterm checkpoints, in addition to ex-ante and ex-post risk assessments.

b) Implementation planning – Unless implementation planning is part and parcel of the protocol development process, protocol agreements risk remaining purely cosmetic. Implementation plans should serve the purpose of : nominating representatives vested with protocol implementation on behalf of each organisation involved; establishing clear roles, responsibilities and modes of communication; and defining shared monitoring procedures (e.g. periodic meetings among all

representatives). Implementation plans should include reference to a final review meeting, to be held prior to protocol termination, in view of agreement renewal.

c) **Awareness-raising –** The treatment team initially faced hurdles with regard to referrals of service users to the Outpatient Addictions Service. While this changed in the course of project implementation, thanks to the organisation of info sessions and other events, brand new treatment programs should foresee at a bare minimum a period of 3 months of intensive awareness-raising at the local and regional levels in particular. Awareness-raising events should be replicated at regular intervals.

d) **Ongoing training and supervision of staff –** Training and supervision are embedded in the CONSCIOUS model. In general, the involvement of professionals working with a local healthcare agency, yielded positive outcomes. Nevertheless, programs should envisage the provision of additional training and supervision, particularly for the benefit of staff with limited experience working with perpetrators of sexual and domestic violence. Planning ahead in this regard can help prevent tension within the treatment team, avoid burn-out and drop-out.

e) **Addressing toxic masculinity –** Although the CONSCIOUS model allows to address and challenge the socio-cultural aspects of violence and the traditional gender norms that give rise to violent behaviours, in future treatment programs further attention should be given to these issues, both in the work with sex offenders and DV perpetrators.

f) **Collaboration with victim services –** For the purpose of greater collaboration with victim services, particularly in cases of violence in close relationships, additional formal agreements could have been drawn up between the treatment team of ASL Frosinone and women's crisis centres/ victim support agencies, paving the way for formalised partnerships and contributing to enhancing victim safety.

g) **Linking prison-based treatment with community-based treatment –** in prospective programs there should be greater interconnectedness between prison-based and community-based treatment, allowing for service users who commence treatment in the custodial setting to continue benefitting from ongoing support following their release (to this end, please refer to point g).

h) **Impact of treatment on service users –** Aside from recidivism risks, tools allowing to assess the impact of treatment on service users in broader terms should be included in program design. These could consist of a service user self-assessment via a dedicated questionnaire and/or qualitative interviews. While similar tools (see Perpetrators Evaluation Kit in "Scalability of CONSCIOUS Model" Section) were developed by the CONSCIOUS project team, due to COVID-19 restrictions, they were not thoroughly utilised.

i) **Managing addictions –** One of the most complex aspects of treatment implementation at the Outpatient Addictions Service concerned the management of aspects related to service users' addictions. A careful assessment of a service users' eligibility for treatment in light of problems related to alcohol/substance abuse should be conducted at the very start of each program. A positive aspect of treatment implementation with this target group was that professionals offering treatment possessed the skills and knowledge to support users both in dealing with their addictions and their violent tendencies. However, it may be preferable to conduct community-based treatment in a "neutral space" - i.e. not in the framework of an Outpatient Addictions Service - so as to maximise the focus on violence and prevention of aggression, thereby attracting users who do not necessarily suffer from addiction-related issues.

j) **Use of technology –** While the use of technology for treatment purposes is not risk-free, particularly when it comes to issues of access, privacy and confidentiality, our fast-paced world calls for increased experimentation of the use of technological solutions. A case in point are CoSA service providers[32], who during the pandemic switched to online tools to continue supporting high-risk sex offenders (McCartan et al., 2020). Community-based treatment programs could begin incorporating hybrid online-offline methodologies, so as to test their feasibility. Research should be conducted to measure efficacy.

5. Scalability of the CONSCIOUS model

In the framework of Project CONSCIOUS, a feasibility study[33] was conducted, focusing in particular on the transferability and scalability of the model. The study found that the CONSCIOUS model is robust

[32] See page 26 for more information on CoSA.
[33] The CONSCIOUS feasibility study is available at this link: https://www.work-with-perpetrators.eu/fileadmin/WWP_Network/redakteure/Projects/CONSCIOUS/D_4.6_Feasibility_Study__engl_.pdf

and lends itself to implementation in different local and national contexts. This conclusion was motivated with reference to following aspects of the CONSCIOUS model:

- Operational Protocols

Three operational protocols were drafted and signed by a range of local institutions and organisations for the purpose of formalising inter-systemic cooperation. The protocols aimed to give solidity to multi-level and multi-stakeholder cooperation, promote knowledge/information-sharing (whilst safeguarding privacy) among parties involved. All signatories committed to promoting the CONSCIOUS treatment program.

Both Protocol 1 and Protocol 2 establish referral responsibilities and pathways. Thanks to Protocol 1, upon completion of investigations testifying to a person's guilt, lawyers or police officers can obtain informed consent for referrals to treatment to the local healthcare agency. Protocol 2 allows for similar arrangements in the context of the community-based services offered at the Outpatient Addictions Service. Protocol 3 is tailored to the prison setting, with the Prison Departments of Cassino and Frosinone as signatories. The protocol represents an agreement for specific treatment pathways (group and individual) for sex offenders and DV perpetrators to be implemented in the custodial setting.

While appetite and support for the treatment of sex offenders varies across European countries, an array of programs for sex offenders – mostly prison-based – has emerged in recent years. Communication gaps between treatment providers and various law enforcement agencies often impact referrals. For this reason, CONSCIOUS operational protocols can act as a best practice to overcome such hurdles in other countries.

- Networking Agreement

The Networking agreement signed by the Local Health Authority of Frosinone, the Centre for Studies and Research on Family and Juvenile Law, the Lazio Region and the European Network for the Work with Perpetrators of Domestic Violence (WWP EN), allows for information exchange and sharing of good practices among signatories, with the ultimate objective of building a social system that can protect victims and provide psycho-social treatment to perpetrators, so as to prevent victimisation and re-victimisation.

The Networking Agreement is framed in such a way to be transferable to other countries, particularly given the general increase in government support and funding of projects to assist victims.

- Training Course

The CONSCIOUS training consisted of various events involving prison administration and prison staff, probation, healthcare staff, volunteers, social services, Surveillance Courts and more. Training contents (clinical model, practical implications, management of critical cases, assessment of results, coordination with the penitentiary system) were aligned with the needs of professionals in attendance and partly tailored to the local and national implementation contexts. Nevertheless, the CONSCIOUS training is replicable in other countries, both in terms of structure and content, because it is grounded in research/clinical practice, and rests on tenets that are valid well beyond the Italian context.

- Social reintegration plan

This plan is rooted in a restorative approach and more specifically, in the Co.Re. Community of Restorative Relationships theoretical model (Patrizi, 2019) based on the generation/regeneration of social bonds via consensus, sharing and security of the community.

The plan seeks to support perpetrators in the definition of a better life and the containment of the risks of further harmful behaviours, in accordance with social expectations (ecological level of the Co.Re. model: reciprocity and obligations, responsibility).

The reintegration plan is easily transferable to other contexts, where there is a wish to further involve communities in the reintegration of offenders. In countries with a good track record of restorative justice practices, such as the UK, France and Belgium, the social reintegration plan is tenable. Through their legislation, other countries beyond the ones mentioned, have shown varying degrees of interest in adopting restorative justice approaches[34]. In countries such as Poland, Hungary and Germany,

[34]For instance some Central and Eastern European countries have adapted to European Directive 2012/29/EU, which envisages the right of victims to recourse to criminal mediation as one of their rights.

national political strategies and other specific initiatives have pushed for a cultural shift in this direction. This highlights that the CONSCIOUS reintegration model could be adopted in other local and national realities.

Perpetrators Evaluation Toolkit

CONSCIOUS created a toolkit consisting of questionnaires designed for perpetrators enrolled on a treatment program and their (former) partners. The Toolkit, designed in English, was successfully tested by the treatment team and is applicable to different regional, national and European contexts[35].

The Impact Toolkit proved useful to assess and evaluate the treatment process, it also helped tackling some difficult issue to be discussed with the men in treatment. Despite the difficulties of contacting the (former) partners, the Impact Toolkit allowed to open-up the discussion and to emphasize the importance of having the partner-contact procedure well-stablished, and to stablish a good cooperation relationship with the victim's services. Regrettably, due to the Covid-19 situation and the time restraints it has not been possible to analyse some of the main outcomes derived from the Impact Toolkit.

Beyond the specific tools outlined above, the CONSCIOUS model lends itself to replicability, given its solid grounding in a renowned international model for treatment (the Good Lives Model), supported by tried-and-tested best practices in the Italian context (please refer to the section "Treatment programs for sex offenders in Italy" for more information). The model itself allows for adaptability in terms of offender population and individual offender characteristics. It goes without saying, that prior to any experimentation in other local or national contexts, a feasibility study, such as the on conducted for CONSCIOUS[36] ought to be carried out.

6. Conclusion

Project CONSCIOUS emphasises the pressing need to uphold the dignity of perpetrators of sexual and domestic violence through access to treatment activities in prison and in the community, and educational pathways geared towards social reintegration. While on the one hand, the project strives towards behavioural change in violent men, on the other hand, it also acts as a gateway to broader

[35] It should be noted that a broader evaluation study drawing on this data is currently being finalised by the project team. For this reason, no specific information can be provided here on the process and the results.
[36] See: https://www.work-with-perpetrators.eu/fileadmin/WWP_Network/redakteure/Projects/CONSCIOUS/D_4.6_Feasibility_Study__engl_.pdf

systemic change at the institutional level, in the custodial environment and beyond. What is truly innovative in fact, is not merely the provision of specialised treatment for sex offenders and DV perpetrators, but the establishment of a solid, long-term network of actors that can outlive the project itself. To this end, it is worth mentioning that the intention is that of renewing the protocols undersigned during project life. The CONSCIOUS experience of inter-systemic collaboration has been positive and has paved the way for ongoing partnership for the promotion of a safer and less violent society.

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