TREATMENT PROGRAMME UPDATES AND REORIENTATION TOWARDS A MORE COMPREHENSIVE PREVENTION OF RECIDIVISM OF SEXUAL VIOLENCE OFFENCES

Work carried out with the collaboration of the General Secretariat of Penitentiary Institutions and the funding of the Ministry of Social Rights and Agenda 2030.

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1. EXECUTIVE SUMMARY

The main objective of this research is to gain a deeper understanding of treatment program dropout rates. To this end, 44 professionals participated—11 of whom were interviewed in depth—and completed a survey to identify the periods of greatest risk of dropout, characterize the profile of users who do not complete the treatment program, and ultimately propose recommendations to improve treatment adherence, thereby ensuring program completion.

The results of this research, in relation to the rate and times of greatest risk of dropping out, indicate that:

- Between 60 and 70% of users who start treatment programs manage to complete them.
- The average number of users who drop out is 2.4 users per treatment group.
- The moments of greatest risk of dropping out are between the third and tenth sessions of the program, with the risk decreasing once the halfway point of the program is reached.
- The reasons for dropping out during the first half of the program are usually voluntary, while the dropout that occurs once the midpoint is reached is due to external causes, mainly incompatibilities.
- The main reasons for dropping out of the treatment program are: 1) legal problems, especially re-imprisonment for breaches of sentence or pending charges, 2) scheduling conflicts due to work commitments, 3) active substance use, 4) language difficulties, 5) financial problems, 6) lack of motivation during the program, 7) health problems, and 8) resistance to the program

Regarding the profile of users who drop out of the treatment program, professionals identify the following characteristics:

- From a sociodemographic perspective, they identify a profile of a young man, mostly foreign-born and from a low socioeconomic background. However, they also point out that users with higher incomes tend to exhibit greater opposition to the program.
- Regarding risk factors, they point to the presence of psychopathology and poor impulse control, as well as alcohol or drug use during the program.

Professionals highlight several factors that ensure participation in the treatment program, thus reducing the dropout rate. These factors include:

- Having different schedules available to be able to combine attendance at the program with other responsibilities.
- Having the option to switch users to different groups in the early stages of the program.
- Offer an online or hybrid methodology for those users who live far away or work, thus avoiding travel time.
- Properly informing the user about the program's objectives prior to treatment facilitates participation in the program, thus reducing dropout rates.

On the other hand, among the strategies used by professionals to encourage continuation in the treatment program, the following stand out:

- Motivation strategies.
- The link between the user and the professional.
- Group cohesion.
- The professional's willingness to address the more personal aspects of the users individually.
- The participation of all users during the program sessions, giving space for them to share experiences and reflections.
- The participation of two professionals of different genders.

Finally, professionals distinguish the following differences regarding the dropout rates from the PRIA-MA and PCAS programs:

- The dropout rate of the program targeting sex offenders (PCAS) is lower than that of the program for intimate partner offenders (PRIA-MA).
- Users of the PCAS treatment program have greater difficulties opening up during sessions, hindering the acquisition of learning.
- Users of the PRIA-MA treatment program have a much more defiant attitude and present greater opposition to the program.
- Users of the PCAS treatment program have little or no support network.

2. INTRODUCTION

Violence against women is one of the major social problems of our time, constituting a serious violation of human rights and a constant challenge for prevention and protection policies. In recent years, the number of reports of this type of violence has increased significantly. According to data from the latest report by the Government Delegation against Gender Violence, 182,065 reports of gender violence were filed in 2022, an 11.8% increase compared to the previous year (State Observatory of Violence against Women, 2024). Regarding sexual violence, in 2023 there were a total of 21,825 reported incidents of sexual offenses, representing a 12.9% increase compared to the previous year (Ministry of the Interior, 2024).

In response to this reality, legal measures have been implemented to protect victims. The entry into force of Organic Law 1/2004, of December 28, on "Comprehensive Protection Measures against Gender Violence," has led to continuous improvement in this area. More specifically, Article 42 establishes that "the prison administration will implement specific programs for inmates convicted of crimes related to gender violence" and that the Treatment Boards will assess, in the context of prison classification progressions, the granting of permits and parole, the inmates' participation in and benefiting from these programs. In this regard, Article 35 stipulates that if an inmate has been convicted of a crime related to gender violence, the prison sentence may only be replaced by community service, in which case, in addition to certain obligations and duties, participation in specific re-education and psychological treatment programs will be imposed. For its part, the Council of Europe Convention on preventing and combating violence against women and domestic violence (2011) in its article 16 establishes that the Parties shall take legislative measures for the implementation of programs aimed at preventing recidivism by offenders, especially offenders of sexual offenses.

Regarding programs for the control of sexual assault, the first pilot program in Spain was launched in the late 1990s in the Brians and Quatre Camins prisons in Barcelona (Garrido and Redondo, 1996, 1997). The program, called the Sexual Assault Control Program,

The Sexual Offenders Program (PCAS) has the primary objective of reducing recidivism. Currently, two programs for adult sex offenders in prison are implemented in Spain: the PCAS, which is applied throughout almost the entire country, and the SAC program, an adaptation applied exclusively in Catalan prisons. Also in Spain, since 2023, an initiative targeting sex offenders with intellectual disabilities has been underway.

In the case of programs for intimate partner abusers, the first experience with the application of this type of program dates back to the pilot project promoted by the General Secretariat of Penitentiary Institutions, in which a program developed by Professor Enrique Echeburúa was implemented with 61 convicted individuals during the 2001-2002 period (Alarcón Delicado, 2023). Currently, the Intervention Program for Gender Violence Abusers in Alternative Measures (PRIA-MA), created in 2015 and based on the Intervention Program for Abusers (PRIA) that had been implemented since 2011, is offered throughout Spain (Ruiz et al., 2010). The PRIA-MA is a program whose objective is for abusers to take responsibility for their behavior in order to modify their conduct and acquire the necessary skills for conflict resolution and ensuring egalitarian behavior within the context of a relationship.

National and international scientific literature generally supports the effectiveness of psychological intervention programs for perpetrators of domestic violence, both intimate partner violence and sexual assault. These programs have demonstrated not only therapeutic change among participants (Arias et al., 2020; Grady, Eddwards, & Pettrus-Willis, 2017; Oliveira & Marins, 2023; Pérez-Ramírez et al., 2013), but also a reduction in recidivism rates. For example, in the case of intimate partner violence, the recidivism rate has been reduced from 21% to 8%, according to international studies (Tutty & Babins-Wagner, 2016). On the other hand, around 20% of sexual offenders who do not receive the treatment program end up reoffending, while if they participate in such programs, reoffending is reduced to around 10% (Franke et al., 2021; Gannon et al., 2019; Hanson, 2009; Harrison et al., 2020; Mpofu et al., 2008; Redondo and Margot, 2017; Schmucker and Lösel, 2017; Tyler et al., 2021).

Failure to complete a treatment program has a direct impact on its effectiveness (Carl & Lösel, 2021; Nunes & Cortoni, 2008), as recidivism rates are higher among users who do not receive adequate program support. Treatment programs for intimate partner abusers have dropout rates ranging from 9% to 67% (Cunha et al., 2024), while those for sexual offenders range from 15% to 86%.

86% (Larachelle et al., 2011; Olver and Wong, 2009). In Spain, a previous study conducted by the H-Amikeco Association and FIADYS estimated the dropout rate in treatment programs at around 24% (Pérez Ramírez et al., 2023).

Several studies have shown that a higher dropout rate in treatment programs is associated with increased relapse rates. Therefore, it is crucial to thoroughly analyze the risk factors that can predict dropout, with the aim of reducing it and ensuring participation in and completion of treatment. In this regard, the present study aims to deepen our understanding of the profile of users who drop out of these programs, in order to optimize retention strategies and improve the effectiveness of interventions.

3. OBJECTIVES

The aim of this study is to gain a deeper understanding of individuals who drop out of treatment programs for those convicted of gender-based violence and for perpetrators of sexual offenses, in order to improve program management. Specifically, the following objectives have been set:

1. Identify the phases or moments of treatment with the highest risk of abandonment and generate mechanisms to prevent such abandonment.
2. To identify early on the profiles at highest risk of dropping out so that the available resources can be strengthened to ensure continuity in the program and to guarantee its completion.
3. Explore the differences regarding abandonment between intimate partner abusers and sexual abusers.
4. To provide recommendations to reduce the risk of dropout and ensure adherence, continuity and completion of treatment programs.

4. METHOD

To achieve the aforementioned objectives, this research employs a mixed-methods approach. The first part consists of a quantitative study based on information gathered from professionals who deliver the PRIA-MA, PCAS, or both treatment programs. The second phase involves conducting in-depth interviews with some of these professionals, selecting those with more extensive experience implementing one or both programs. Their testimony and opinions will provide a deeper understanding of the phenomenon of program dropout among some users, culminating in proposals for improvement.

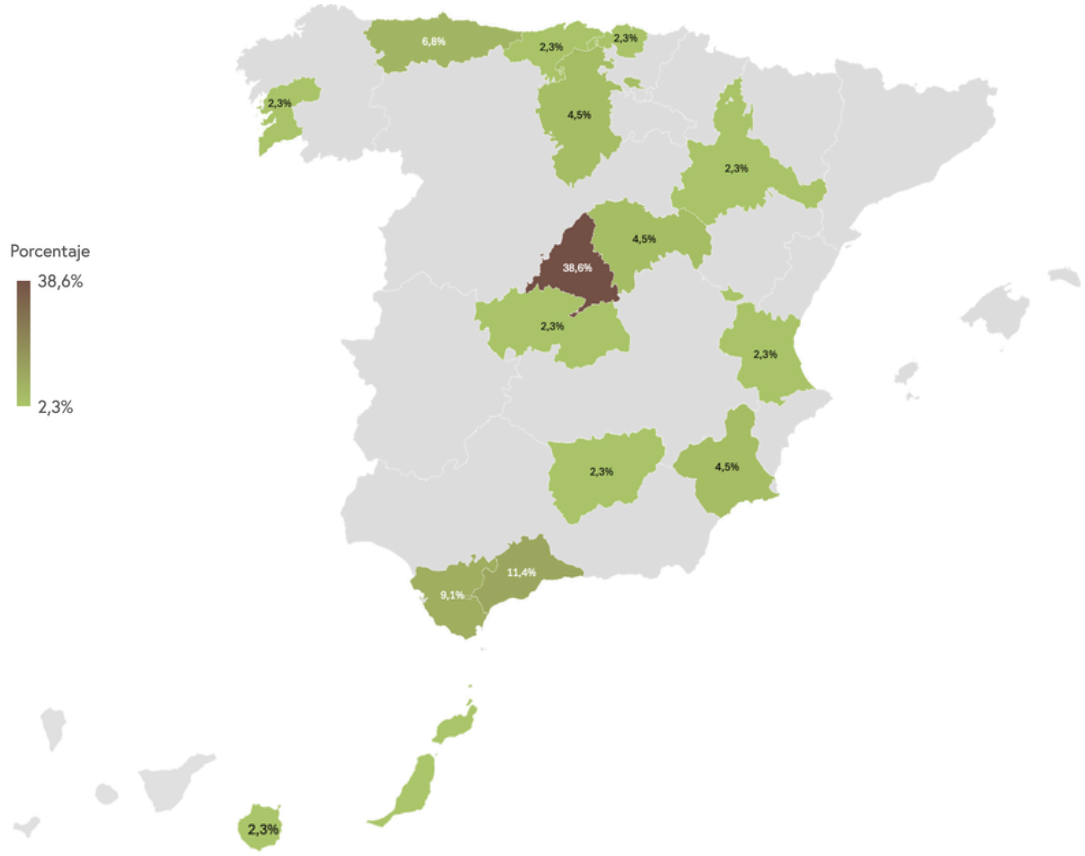
However, the results of both will be presented under the same heading, with the understanding that the interview results will serve to provide complementary and more detailed information on aspects already covered in the questionnaire.

4.1. Sample

4.1.1. Total sample of professionals surveyed

The surveys included the voluntary and anonymous participation of 44 professionals from various Spanish organizations responsible for delivering PRIA-MA, PCAS, or both treatment programs. Figure 1 shows the distribution of the provinces where the surveyed professionals work (N=44). The provinces most represented in this study were Madrid (38.6%), Málaga (11.4%), and Cádiz (9.1%).

Figure 1. Frequency distribution by province



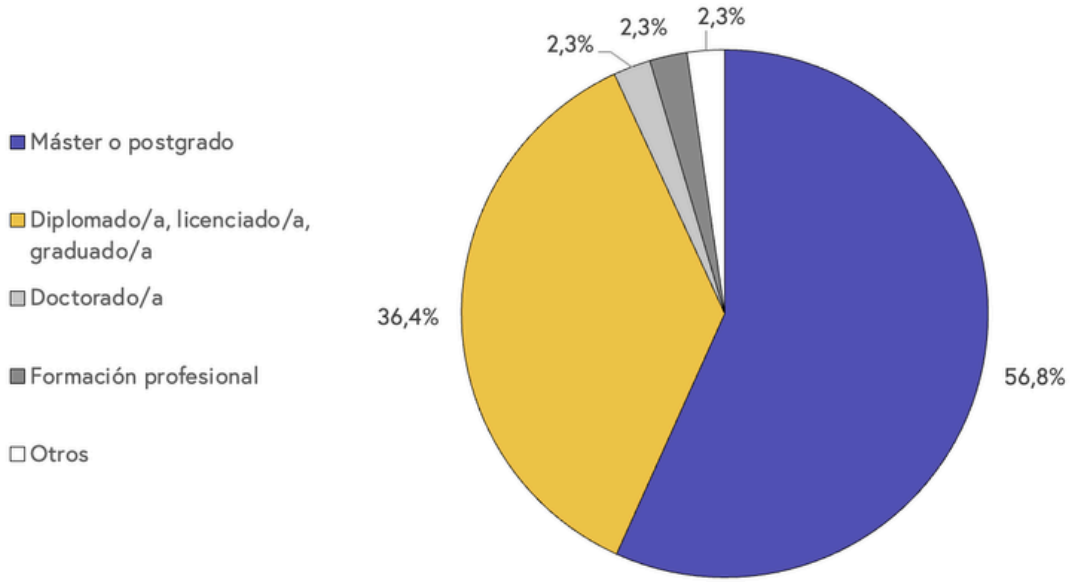
Regarding the organizations where the surveyed professionals work, it can be observed that the majority of them come from the H-Amikeco Association (43.2%), followed by the Arrabal Association (15.9%). These results can be seen in Table 1.

Table 1. Distribution of the entity in which the professionals work

Entity	Frequency (n)	Valid percentage (%)
H-Amikeco Association	19	43,2
Arrabal-AID Association	7	15,9
Psychology Without Borders Foundation	2	4,5
Álava Reyes	2	4,5
Victoria Kent Association	2	4,5
Autonomous	2	4,5
Aspacia Foundation	2	4,5
Souls Psychologists	1	2,3
New Life Association	1	2,3
R-initia-T Association	1	2,3
Mª José Ochoa Psychology Center	1	2,3
Nea Clinic	1	2,3
Ministry of Education	1	2,3
UmayQuipa	1	2,3
YES!	1	2,3
Total	44	100,0

Regarding the professionals' academic qualifications, 56.8% of the sample have completed their master's or postgraduate studies, and 36.4% have completed university diploma, bachelor's, or equivalent degree programs. A smaller proportion (2.3%) of the professionals have vocational training qualifications, a doctorate (2.3%), and other types of studies (2.3%) (See Graph 2).

Chart 2. Academic training of professionals



The vast majority of the professionals surveyed hold a degree in Psychology (95.4%), 2.3% hold a degree in Social Education and the remaining 2.3% hold other degrees such as Criminology and Psychosocial Support.

Overall, the professionals surveyed have exclusively taught the PRIA-MA program (70.5%), with fewer professionals teaching both the PRIA-MA and PCAS programs (27.3%) and very few teaching only the PCAS program (2.3%). Regarding professional experience in the field, 47.7% of the sample reported more than 10 years of experience, 31.8% between 6 and 10 years, and only 20.5% less than 5 years. However, the number of years of experience decreases when referring to the number of years they have taught one or both programs. Specifically, 54.5% of the sample have been delivering these types of programs for 2 to 5 years, 27.3% for more than 5 years, and 18.2% for less than 1 year. It is observed, therefore, that although professional experience is extensive in most cases, it is reduced with regard to delivering the treatment programs now under analysis. Finally, 61.4% of the sample confirmed having received training for the application of these programs, with 72.4% of these cases being specific training related to the program to be delivered, and considered adequate information in 90.6% of cases.

4.1.2. Total sample of professionals interviewed

To supplement the information gathered in the surveys, professionals from the participating organizations with the most experience in implementing the treatment programs under study were interviewed. A total of 11 professionals from six different organizations participated. Each professional was interviewed by a member of the H-Amikeco Association team, who moderated and guided the interview. The participating professionals are:

- Professional 1, professional of the H-Amikeco Association in Asturias.
- Professional 2, professional of the H-Amikeco Association in the Basque Country.
- Professional 3, professional of Psychologists Without Borders in Madrid.
- Professional 4, professional of the H-Amikeco Association in Madrid.
- Professional 5, professional of the H-Amikeco Association in Murcia.
- Professional 6, professional of the H-Amikeco Association in Madrid.
- Professional 7, professional of the New Life Association in Cantabria.
- Professional 8, professional of the Álava Reyes Association in Toledo.
- Professional 9, professional of Psychologists Without Borders in Madrid.
- Professional 10, professional of the Victoria Kent Association in Cadiz.
- Professional 11, professional of the Aspacia Foundation in Madrid.

4.2. Tools used

In order to gather the information necessary to achieve the objectives of the study, a survey divided into five sections was administered:

- Data of the professionals. Province in which they work, entity in which they work, academic training (diploma, bachelor's degree, graduate; master's or postgraduate; doctorate), professional title (Psychology; Social Education; Social Work; other), years of professional experience (less than 5 years; between 6 and 10 years; more than 10 years), time teaching the programs (less than one year; between 2 and 5 years; more than 5 years), number of groups carried out, training for the application of the program (yes/no), is the training received adequate (yes/no), type of program taught (PRIA-MA/PCAS/both).
- Application and suitability of the treatment program. Modality used (face-to-face/online/both). The online modality: facilitates user participation (yes/no/NSNC), facilitates user adherence (yes/no/NSNC), has interfered with group cohesion (yes/no/NSNC), has facilitated working on the modules efficiently (yes/no/NSNC). Finally, the question is asked whether they apply the treatment program fully and strictly following the manual (yes/no/NSNC) and what modifications they apply.
- The group. Origin of the users (CIS/suspension of sentence/both), how many members the group consists of, have refused to participate in the treatment program (yes/no), how many users have refused, how many users usually drop out of the treatment program, main reasons for dropping out (Incompatibility of schedule with work, imprisonment or revocation of the measure, substance use, language difficulties, economic difficulties, cognitive difficulties, others), in which session the dropout usually occurs, have any users been expelled from the program (yes/no), how many users have been expelled per group, main reason for expulsion (absences, conflicts with the professional, conflicts with other users), percentage of users who finish the program (less than 50%, half, between 60-70%, more than 70%), the users were correctly informed of: the objectives of the program, duration, tasks, rules and consequences for not complying with the rules (none/very few/some/most/all).
- Users who have dropped out. Characteristics: foreigner, does not speak Spanish, unemployed, mental health problems, cognitive difficulties, substance abuse problems, currently using substances, has not integrated into the group (none/very few/some/most/all), other risk factors for dropping out of the program.

- Dropout Management. Do you take any measures to encourage program completion (yes/no)? What measures do you take? What actions are taken when a user has dropped out of the program (notify the Sentence and Measures Management Service (SGPMPA), notify the person in charge at your organization, prepare a discharge report, notify the court, try to contact the user, try to contact the user's family, other)? What measures would you implement to prevent dropout from the program? At what point in the intervention would it be necessary to implement them (before starting the program, during the first sessions of the program, in the middle of the program, at the end of the program)?

The 11 semi-structured interviews were conducted using the question script described in Annex I.

4.3. Procedure

The professionals were contacted via email, which explained the research objective and the proposal for their participation. Once their confirmation was received by email, they were sent the informed consent form to ensure their participation.

The survey was conducted online via Google Forms between May and July 2024. The survey link was shared via email. During September, descriptive analyses of the survey data were performed to develop an interview guide that would complement the information gathered from the professionals' responses. Once this was done, the professionals with the most experience delivering treatment programs were selected, resulting in a total of 11 interviews. The interviews were then conducted during October and November. These were carried out individually via online meetings using the Teams platform. This platform allows for automatic recording and transcription of the meetings, enabling the rigorous and verbatim extraction of information from the various interventions.

4.4. Information Analysis

The analysis of quantitative data is based on a descriptive analysis of the responses provided by the professionals who implement the treatment programs. Statistical analyses were performed using the SPSS statistical package (version 29.0.1.0). Furthermore, the analysis of the data collected during the interviews was conducted following the research protocol, supported by the subsequent transcripts of the sessions.

5. RESULTS

The following section presents information regarding the surveys and interviews conducted with professionals to achieve the objectives of this research. First, the concept of dropout is introduced, along with the processes implemented to manage it. Second, the dropout rate and periods of highest risk are presented. Third, a description of the profile of users who drop out of the treatment program is provided, emphasizing the sociodemographic variables and risk factors that characterize them. Fourth, the factors that promote adherence to the treatment program are identified, and finally, the differences in dropout rates between the PRIA-MA and PCAS treatment programs are discussed.

5.1. Abandonment

Dropping out (or leaving the program) occurs when a user stops attending treatment sessions after the program has begun. This can be due to the user's own decision or to circumstances that prevent them from attending. As Professional 11 describes it: "I define them as withdrawals rather than dropouts. The difference is that the word 'dropout' seems to imply something that happens of one's own volition, that the person decides to leave. And I would say that, based on my experience, they are more often situations that arise in these people's lives that prevent them from continuing."

It is important to distinguish between the concept of dropping out and the concept of expulsion, which was also addressed in the questionnaire. Expulsion implies that the professional leading the treatment program removes the client from the program due to non-compliance with program rules, conflicts with the professional, or conflicts with other clients. According to the survey results, 24 professionals have expelled at least one client from the program (75% of the professionals who answered this question). Generally, the number of clients expelled is not high: 63.6% of professionals reported having expelled only one client in their career, 18.2% two, 4.5% three, and the remaining 4.5% reported having expelled a maximum of four clients.

The most frequent reasons for expulsion are: absences (77.8%), followed by conflicts with the professionals who run the program (14.8%), and conflicts with other participants (7.4%). This was confirmed by the professionals' testimonies during their interviews. In this regard, Professional 7 stated: "It's true that I've had cases where participants exhibited more hostile behavior, but more among themselves than with the professionals. After all, very personal issues come up, right? And they start saying things like, 'You're this, you're that.' I've definitely seen that, and I've had to intervene and expel them. There have also been aggressive cases where I've seen that posed a danger to the victims themselves."

The results presented below describe the processes followed when a user stops attending the program and the main reasons why they leave.

5.1.1. Application procedure regarding abandonment

Regarding the procedure and reasons for removing a user from the program, as Professional 6 explains, there is no single or standardized protocol: "I think that as a protocol... we all have an idea of how to manage removals, but I don't think there's a fixed, written protocol." One of the professionals (Professional 3) mentions that, years ago, an attempt was made to draft and standardize a protocol for the professionals in charge of implementing treatment programs in the community, but that project was never completed. He explains, "We've tried, along with other colleagues, to standardize the protocol and also to make it the same in all the Community Integration Centers (CIS) and with all the staff, even though that was more complicated."

Although there appears to be no specific written, standardized, and accessible protocol for professionals, they report being aware of the rules to follow for the proper development of the programs and the procedure to follow in case of non-compliance. In this regard, the program manuals themselves (Rivera González, et al., 2005; Suárez Martínez, 2015) are identified as the reference texts, both in terms of content and how to apply the programs, including their rules.
The rule most frequently mentioned in the interviews analyzed is the possibility of accumulating a maximum of three unexcused absences per user. These absences can be caused by various reasons, which are detailed in the following section. However, according to the experience of some interviewees, there are exceptional situations, such as medical emergencies or accidents, in which more absences are permitted.

"If there's a medical issue or a justifiable reason like, 'I'm sick, I went to the emergency room, I have a super important doctor's appointment that I can't reschedule, I was in a car accident,' then yes, you allow one more absence" (Professional 6). Other professionals clarify that these exceptions only apply if the user has consistently demonstrated good behavior and a positive attitude throughout the program. Professional 7 explains: "It's true that in some exceptional cases, and if it's someone who has done well throughout the program, who has really worked hard… we try to accommodate them as much as possible."

Regarding the process for justifying absences, these must be reported to the corresponding Social Integration Center (CIS). Professional 7 details how this process occurs: "We take attendance immediately and send a report to the CIS listing those who attended and those who did not. When individuals accumulate three absences, they receive a letter from the CIS. After three absences, they attend a meeting, go to the CIS, and explain the reasons for those three absences. A fourth absence results in expulsion." This procedure aligns with the experience of other professionals interviewed and survey participants, whose main actions when a user misses a program session (see Table 2) include: notifying the Service for the Management of Sentences and Alternative Penal Measures (SGPMA) (90.9%) and filing a discharge report (88.6%), among others.

Table 2. Actions taken in response to user abandonment

Actions	Frequency (n)	Valid percentage (%)
Report it to the SGPMPA	40	90,9
Prepare a sick leave report	39	88,6
Report it to the person in charge at your organization	23	52,3
Try to contact the user	18	40,9
Report it to the court	3	6,8
Try to contact the user's family	1	2,3

Note: It does not add up to 100% because there may be more than one reason

Other rules mentioned include the requirement of punctuality, the proper completion of tasks, and participation during sessions, as well as respect for other users and the professional. In all these situations, the process involves, firstly, confronting the user and warning them about the consequences of continued behavior, and secondly, if the behavior persists, removing them from the program.

5.1.2. Rate and times of highest risk of dropping out

This section explores the dropout rate and the times when the highest number of dropouts occur during the treatment program, thus achieving the first objective of this research.

According to surveys, groups typically consist of between 8 and 15 users. In the experience of professionals, 37.5% report that users sometimes reject the program even before it has begun, before the first session. They say that usually one or two users per group withdraw, typically due to language barriers. Once the treatment program has started, the surveyed professionals indicate that, on average, 2.4 users drop out (max.=6; min.=0), and between 60% and 70% of users successfully complete it.

Regarding the periods of greatest risk of dropout, 88.2% of the professionals surveyed stated that these occur between the third and tenth sessions. The remaining 11.8% indicated that dropout usually happens once the first half of the program is approached. The interviews align with these results, showing that most dropouts occur between the start of the program and its midpoint, this midpoint representing the moment when users are most likely to persevere, having already made a considerable effort. In this regard, Professional 11 noted, "Once they reach the halfway point of the program, they try to finish it because they've already passed the halfway mark."

During the interviews, the professionals were asked if the different reasons for dropping out affect when it occurs. Although they were unable to link specific reasons to the timing of the dropouts, most concluded that, during the first half of the program, the reasons for dropping out are usually related to the user's own decisions, while after the second half, they drop out for reasons beyond their control, mainly due to incompatibilities. Professional 1 explains: "Voluntary reasons, that is, not due to admissions or other external causes, I believe, although I don't have data, but based on experience, it would occur more or less in the first third. In that phase of resistance, of 'this is unfair,' 'I shouldn't be here.'"

The interviews delve into the degree of benefit that professionals believe users have gained from the program prior to dropping out. Only two responses were obtained to this question; however, they are considered particularly relevant. Professional 2 suggests that the degree of benefit varies depending on when the dropout occurs. If the dropout happens at the beginning of the program, users demonstrate a low level of benefit, whereas if the dropout occurs later, the degree of benefit is higher. Professional 6, for her part, establishes a link between the causes of dropout and the degree of benefit. In this regard: "It depends. Those who drop out due to socioeconomic reasons tend to have benefited from the program to a moderately high degree, depending on their profile, but all the work they've done up to this point has been worthwhile. If we're talking about a user who drops out because they oppose the program, the benefit would be practically nil, because they've refused to engage in introspection, to be open to the content and the therapist's messages, so the benefit will be practically nil. In fact, for some of these profiles, dropping out is actually beneficial, because they then realize the consequences. In the second group, they either repeat the program or are placed in another group the following year; they tend to go in with a much more receptive attitude precisely to avoid a second dropout."

5.1.3. Causes of abandonment

The reasons for dropping out vary among professionals. As shown in Table 3, the most frequent reasons users leave the treatment program, according to the survey, are legal problems, specifically imprisonment and the revocation of the court order (52.3%), and practical incompatibility on the part of the users, mainly due to work-related reasons and/or a change of residence (52.3%). These results are supported by the professionals' testimonies. Professional 1 stated: "The dropouts I've had over the years have basically been due to imprisonment, either for violating a restraining order or for other pending legal issues." Professional 11, for her part, explained her experience with users who have left the program due to work: "It's these rotating shifts that have caused the most complications in attending the groups, and there are so many rotating jobs. Either you have a great boss who understands your situation and allows you to do it, or it's impossible."

The next most prominent reason cited by professionals is substance use (18.2%), referring to active addictions or problems related to drug or alcohol use. The professionals interviewed explain that among users who use substances, dropout usually occurs because they don't attend sessions or because they arrive in an altered state after using, which constitutes a breach of program rules. Professional 7 explains: "These people often drop out due to accumulated absences, but other times because they are very agitated individuals who have just used substances. Then we see people arriving in a very agitated state, with active substance use, and others who simply don't come."

Another frequently cited reason, especially among the professionals interviewed, is linguistic (9.1%) and economic (9.1%) difficulties. Regarding language difficulties, they explain that users with these problems often drop out at the beginning of the program because it presents a barrier to understanding the program's content and activities. Professional 10 explains: "The first dropouts are usually due to the language barrier. We often receive students from other countries who have language difficulties understanding, writing, or even completing the exercises. This tends to be the main barrier because, ultimately, they don't benefit from the program. They can't participate, they don't understand it; they're in the room, but they don't do anything." In these situations, some users have been found to try to continue in the program by bringing in an external translator or enlisting the help of another participant.

a colleague who helps them translate the session content. Both situations have hindered the development of the sessions and, eventually, the user has ended up dropping out. This has been the experience of Professional 11: "I even had a group where the person would arrive with the translator. That's no longer the case, because this is a private matter. You can't bring in an outside person because we're talking about a group where other people need to protect themselves. And in fact, it resulted in an immediate dropout. I've also had the situation where there was a program with two people of the same nationality, so one had better comprehension skills and thus provided simultaneous translation for the other, but of course, these are things that slow down the group, that prevent it from flowing smoothly."

On the other hand, regarding economic problems, these substantially hinder users' attendance at the program. In some cases, Professional 7 points out that some users are even living in poverty: "The reason for dropping out is that we have quite a few homeless people. It's difficult to try to stabilize someone and work on certain things when they don't even have a home. The last dropout was due to that. A young man who doesn't have a home, doesn't have a place to sleep, shower, eat... well, it's normal that this young man doesn't come to the program because he's struggling to make ends meet."

Table 3. Main reasons for abandonment

Reasons for abandonment	Frequency (n)	Valid percentage (%)
Work schedule incompatibility	23	52,3
Imprisonment or revocation of the measure	23	52,3
Other reasons	12	27,3
Substance use	8	18,2
Language difficulties	4	9,1
Economic difficulties	4	9,1
Cognitive difficulties	2	4,5

Note: It does not add up to 100% because there may be more than one reason

Throughout the interviews, other reasons not included in the survey were identified. First, low motivation during the program was mentioned. In this regard, Professional 7 noted: "The lack of motivation, that is, people who are just indifferent, to put it more colloquially. 'I'll come, it's no big deal,' they don't realize the seriousness of it, because it's a court order and if you don't come, there are repercussions. That lack of motivation, or the fact that they don't give it the importance it deserves. In these types of cases, when they're absent, it's usually at the beginning."

Secondly, other professionals point out that sometimes the user tends to show a certain lack of effort regarding the tasks assigned by the professional, and even confrontational and aggressive attitudes: "Maybe they don't participate or they do the tasks as minimal as possible, they don't put in any effort. For that reason, I've also had cases where I've had to give them a nudge, to say: 'This isn't right, besides, you know that some entry rules were signed, you have to participate more. The task is this long and you have to get involved a bit.' And then they end up being deactivated, and that type of profile is the one that tends to be quite confrontational and aggressive" (Professional 9).

Thirdly, health reasons such as physical illness, sick leave or long-term hospitalization have also been identified as recurring reasons for dropping out.

Fourth, the professionals highlight cases of users who stop attending without any justified reason, although these situations occur only occasionally. Professional 9 explains: "He came and told me he was only going to miss 4 days due to medical issues (...) Then we saw that one day he came to the CIS and went to the bar."

Finally, the professionals highlighted resistance or difficulty adapting to the program as a cause of dropout. In this regard, Professional 11 noted, "And there are obviously cases where the behavior is disruptive and has led to a dropout because, look, you're in boycott mode. Because if there's constant resistance, we do say that we have to drop out because we can't maintain it; there's a lot of turmoil, and it affects me personally. Last year I experienced a very unpleasant situation, having to end an online session because there was so much defiance, so much aggression."

5.2. Profile of users who drop out of the treatment program

In order to achieve the second objective of this research, this section describes the characteristics of the users who attend the treatment programs, focusing on the common profile of those who do not complete the program.

5.2.1. Sociodemographic characteristics

58.7% of the professionals surveyed were unable to identify common characteristics among those who drop out of the treatment program. However, throughout the interviews, two professionals did manage to outline a sociodemographic profile of the users who drop out: mostly young users, foreigners, and/or those with social exclusion factors. They described it as follows:

> "Basically, the profile would be between 20 and 30-35 years old. That is, younger and with other factors of social exclusion: work, family and substance abuse problems. If I had to make an average profile, that would be it." (Professional 1).

> "Nationality. I mean, those who are Spanish tend to leave less often. Perhaps they have more associated sexist beliefs, or they don't trust the Spanish system as much, or they don't take it as seriously due to a lack of knowledge. Age also plays a role. Those who are very young, who even enter in their early twenties… I mean, their level of maturity, I think that influences it because they take it much less seriously." (Professional 9).

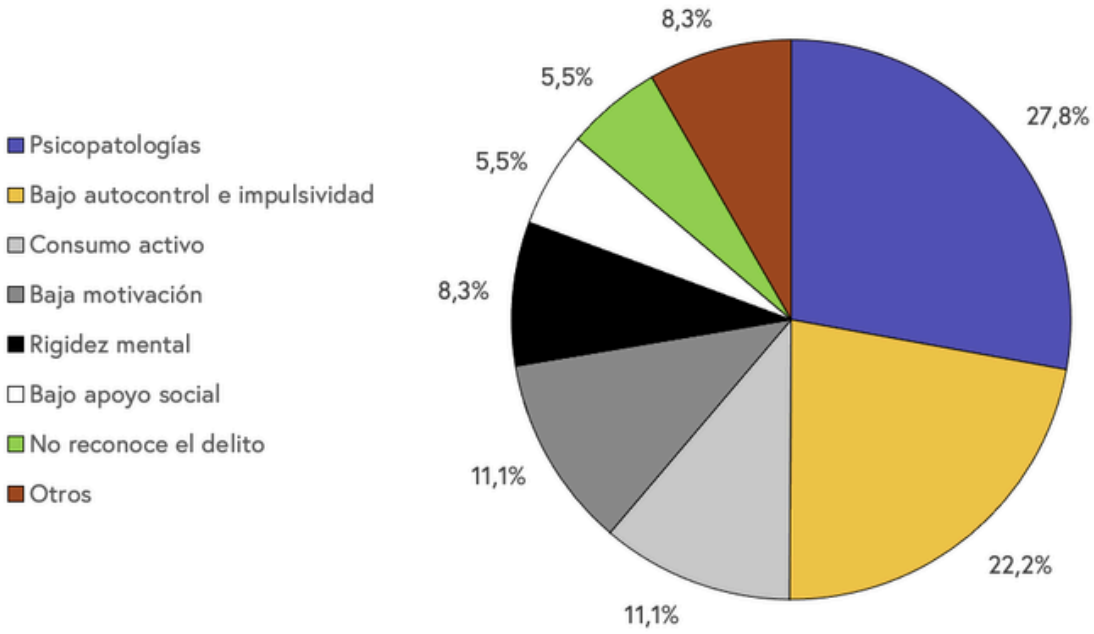
Conversely, other professionals state that the profiles that have dropped out are characterized by having a medium-to-high socioeconomic level, whose work responsibilities and/or attitudes prevent them from continuing with the program. The professionals explain: "I also see them as having a higher profile, which they prioritize and have responsibilities, since they also have a job and financial means, and they don't want to let the company down or make them look bad by telling them that they are in this program, that they have a court order. They are people who are generally more responsible" (Professional 7).

It is also interesting to highlight the reflection made by one of the professionals regarding how an individual's professional position affects their resistance to the program. Professional 9 alludes to this in the following way: "Having held or performed a position of authority makes it less tolerable for them. And in the end, it's not that they quit, but they seek to quit and get fired."

5.2.2. Psychological risk factors

On the other hand, 71.7% of the professionals surveyed identified common psychological risk factors among users who drop out of the treatment program. Among these, as shown in Figure 3, the most prominent are the presence of psychopathology (27.9%) and low self-control and impulsivity (22.2%). Other identified risk factors include active substance use (11.1%) and low motivation to participate in the program (11.1%).

Figure 3. Psychological characteristics that are considered risk factors for dropping out



Although surveys indicate that mental disorders are a significant psychological risk factor for dropping out of the program, it is interesting to note how the testimony of the professionals interviewed suggests that one of the exclusion criteria for selecting participants is the absence of serious mental health problems. However, as Professional 7 points out, this screening is not always carried out correctly: "I understand that it's difficult to screen because the exclusion criteria for the Groups are that they don't have serious mental health problems, that they speak Spanish perfectly, that they can speak and write... but sometimes it's not the case. Sometimes it's a catch-all, and if they have a violent crime, they're assigned to this group."

Another point of interest highlighted in the interviews is the influence of cultural factors, such as generation, country of origin, religion, and upbringing. All of these can influence lifelong learning and cognitive frameworks, which in turn can affect motivation and program dropout rates, as well as preconceived notions about the topics covered (emotional management, the functioning of affective relationships, norms of behavior in romantic relationships, the construction of masculinity, etc.). In this regard, some professionals shared the following opinion:

> "Perhaps they have more associated sexist beliefs, or they don't trust the Spanish judicial system as much, or they don't take it as seriously due to a lack of knowledge" (Professional 9).

> "There are a lot of people who come from the East, very tough people, and Muslim people too. And well, they have very different ideas from what they find here. Sometimes it's difficult to play with all that, especially with the role of women, right? Because there's also very explicit content and things about, well, all the sexual freedom, the freedom of many things. And it can also generate a lot of debates and a lot of confrontations" (Professional 7).

The testimony of the professionals interviewed reveals the difficulty in addressing psychological factors that may pose a risk of dropout, as these often appear in conjunction with other risk factors such as cultural or socioeconomic ones. Professional 2 refers to this as follows:

"They are usually users, but they may not fully recognize what happened to them, they come with very low motivation, and their socio-economic situation is also complicated, and in short, they have multifactorial problems. Basically, they have unstable lives and so, well, they have a low sense of responsibility and, well, they stop attending treatment as they have with other things, like restraining orders or community service."

5.3. Adherence to treatment programs

This section presents the results of the surveys and interviews regarding the factors that promote compliance and adherence to treatment programs, thus focusing on the third objective of this research. On the one hand, it identifies practical factors that encourage user attendance and continued participation in the programs, and on the other hand, it presents the program elements and characteristics that promote adherence and engagement.

5.3.1. Adaptations that favor compliance with the program

To ensure that users attend and complete the treatment program, the Institution itself and the Collaborating Entities may offer certain facilities.

During the interviews, the professionals mentioned three aspects aimed at enabling users to balance program attendance with their work and personal responsibilities. First, regarding the possibility of offering different schedules, which usually depends on the resources available to each CIS (Comprehensive Social Integration Center) or through partner organizations. These schedules are primarily divided between morning and afternoon sessions, although one professional mentioned that they also offer weekend treatment programs. In this regard, most of the professionals interviewed mentioned that morning sessions tend to result in higher dropout rates due to work conflicts. Consequently, afternoon sessions are the most requested. The experience of Professional 7 exemplifies this:

> "For example, right now I'm doing it on Mondays at 6:00 PM, because some people finish work a little earlier or arrive late. Yes, the programs are usually in the late afternoon, because if you put it on a Monday morning and they're working, it's impossible. Unless I have a good relationship with the company or I know their situation and they let them in at that time, but it's true that's why we try to schedule the programs at those times so they can attend."

It is worth mentioning that many professionals highlighted during interviews that there is significant initial resistance to the program's schedules, regardless of the specific schedule. As Professional 1 described it, "It seems like all the schedules are inconvenient for them," although this resistance diminishes as the program progresses and participants adapt to them.

They also mention that, in the initial phases, users can request a change of schedule (called a group change) if attending program sessions is particularly difficult. As Professional 11 explains: "In the PRIA-MA program, we have tried to change groups, but only in the initial phases. This is always done when the person appears capable and has the necessary skills to integrate. It's more about trying to make life easier for these individuals and, if possible, help them comply with the program's requirements."

Another adaptation they've adopted is conducting sessions online. This alternative began to be used in 2020 as a result of the COVID-19 health crisis. Since then, some organizations have maintained this format for certain groups.

The survey data shows that 46.6% of professionals deliver or have delivered treatment programs exclusively in person, another 46.6% do so in a blended learning format, and the remaining 6.2% deliver or have delivered programs exclusively online. When asked whether the format facilitates participation in the program, 61.1% affirm that it does, while the remaining 38.9% do not. An interesting nuance regarding this issue, derived from the survey results, is that although the majority believe the online format promotes user participation, 52.9% state that the knowledge and topics covered are not acquired or understood in the same way.

This last idea is also defended by Professional 7 in her interview: "After the pandemic, quite a few online groups were formed. What have we seen in these groups? That they tend to be more of a disaster. You'd see them in the sessions, disconnected, watching TV in the background, with their child or new or old partner next to them... With little privacy for the rest of the group as well. So this year we decided that everything would be in person. Besides, therapeutically speaking, the truth is that the validity and effectiveness were considerably lower." In this regard, Professional 6 also clarifies, "Yes, I think there are more absences in in-person work because ultimately there's commuting, and it means that 'I'm not just asking my boss for two hours, but for four because I need to get there and back.' However, in remote work, I always tell them, 'Look, if you're working or driving, you can't connect, but if you have headphones or you work from a van, you can park the van and connect while stationary, since it's a private space.' So the time involved in commuting disappears online, which means..."

Another factor identified as relevant to promoting user participation was the prior information provided by courts, lawyers, social reintegration centers, etc., to users referred to therapeutic programs. This prior information pertains to the program's objectives, duration, tasks to be performed, rules of compliance, and the possible consequences of non-compliance. Professional 1 stated, "Without a doubt, the first difficulty is the prior information they receive. I'm telling you, they don't get this information from the court, nor from their lawyer. I don't know whose responsibility that really is, okay? And in terms of sentence management, well, it depends, because I have my doubts as to whether it's that they aren't being explained or that the users don't want to understand. But they arrive at their first contact with the group without any information whatsoever." This lack of information seems to be addressed by the professionals who lead the program during the first session, or in the initial individual interview sessions, which are designed to understand each user's individual characteristics, their personal history, and to foster their motivation toward the program. In the words of Professional 5: "So what I do is, look, today I explain everything to you in the first session, I make it clear, I answer questions, and I explain it to you as many times as you need." The words of Professional 6 on this matter are noteworthy:

"Yes, because the initial interview includes a motivational interview component. So it's true that it doesn't carry more weight than the connection itself, because ultimately the interview also serves this purpose: to build that connection, and it's like the first step. The motivational interview helps them a lot to also connect with the program, and especially to reduce resistance... Absolutely, absolutely... I mean, I think everyone arrives with some information like, well, they've been told to come on this day, at this time, but they don't know how long the program lasts, they don't know how long the sessions are, they don't know if there will be holidays or not... they know almost nothing. When you tell them, "There are 34 sessions and the sessions are about two hours long," they're like, "Wow, I thought this was going to be two hours every day, once a week." And, of course, since it's shocking, new information that they have to organize themselves for (something they generally lack in time management), it creates increased resistance on the first day. I mean, the first day is a constant battle." "It's about overcoming resistance, setting limits, establishing clear rules, and adapting to them. I believe that if there were more prior information, there would be less resistance, much more organization on the first day, and no, they wouldn't spend so much time adapting; there would be more speed in this process."

In this regard, the surveys show that 56.2% of users were correctly informed beforehand about the objectives (all or most of them), 75% were properly informed about its duration, 46.9% about the tasks to be carried out, 65.6% were informed about the compliance rules and 78.1% about the consequences.

5.3.2. Factors that promote adherence to the treatment program

Regarding strategies to prevent dropout, 89.1% of the professionals surveyed stated that they adopt some to promote user continuity and adherence to the program. Five strategies were mentioned in the surveys, as shown in Table 4.

Table 4. Main strategies to avoid dropout

Strategies	Frequency (n)	Valid percentage (%)
Motivate and emphasize the importance of the program	14	34,1
Therapeutic bond	8	19,5
Individual talks	7	17,1
Group cohesion	7	17,1
Encourage participation	2	4,9
Other strategies	2	4,9

The most frequently cited strategy is motivating users and making them understand the importance of the treatment program (34.1% of professionals use it). In this regard, during the sessions, professionals mention the importance of adhering to the program, the personal benefits and learning they will gain, and the satisfaction they will experience upon completion. The next most prevalent strategy involves creating and strengthening the bond between the user and the professional, which is referred to as the therapeutic bond (19.5%). One of the professionals interviewed details her experience: "If there is some way to connect with you, they make more of an effort, or they try not to miss sessions, or they manage to balance their other commitments. I believe that the bond is something that always plays a role in preventing them from giving up" (Professional 4). Another strategy mentioned by professionals is fostering group cohesion. In this sense, creating an atmosphere of trust among users and strengthening their bonds has been interpreted as a factor that improves adherence to treatment programs. Professional 8 explains that: "Because they were cohesive, it was harder for them not to come. I mean, there comes a point where you see them coming and they have their own little group, like they're coming comfortably. A commitment develops among them, yes. Even more so than their alliance with me." Along the same lines, 52.9% of the professionals surveyed state that the online format hinders group cohesion, which, consequently, makes it difficult to conduct the sessions. Professional 11 explains that the only online group she has led worked because the participants had already met. She explains: "Facilitating groups online during the pandemic was a blast. The initial interactions, the expressions… The difference is that these were groups that had already formed in person, and I already knew who was who, which made things easier. The format had simply changed, but the program was clearly being used effectively."

Another strategy mentioned by the surveyed professionals is speaking with participants individually (17.1%). Finally, although less frequently (4.9%), the surveyed professionals try to ensure the participation of all group members during the sessions to encourage their continued participation in the program. In this regard, Professional 7 explains that "It's important to manage everyone's time and make sure everyone has a chance to speak because, it's true that with 15 people, which seems like a lot for a program like this, you have to give everyone some space. Many people I've worked with look at you and say, 'Wow, they never stop talking, and I haven't had a chance to speak.'" Other strategies mentioned by the surveyed professionals include therapist adaptation and providing individual support to participants with the activities.

Among the professionals interviewed, a significant issue regarding adherence to and the relationship with the professional was mentioned, related to the gender factor. Some professionals highlighted that the fact that a woman is leading the treatment program sometimes presents greater challenges. For example, users may not accept the authority figure when the professional leading the program is a woman, a consequence of their ingrained sexist beliefs.

> "This format of doing it between two people works and is more effective. Right now I'm doing the PRIA-MA with a male colleague who is also older, so it may be that the two therapist profiles are completely different, which makes a big difference. For example, when working on the topic of new masculinities, we don't work on the feminine side. He handles all of that, and he handles it very well, but not the sexuality aspect. It's true that I see they can make more progress, but well, they tell me, 'No, since you're a woman, you don't know,' like that masculine side in men, while in other aspects, when working on empathy with the victim and emotions, I can take on more space. They delegate the more emotional part more to me" (Professional 7).

5.4. Differences in the abandonment of the PRIA-MA and the PCAS

Finally, to achieve the fourth and final objective of this research, this section presents the perceived differences in dropout rates between the treatment program aimed at partner abusers (PRIA-MA) and sexual abusers (PCAS).

Although the differences detected are not many, differences have been identified in relation to the dropout rate and the psychological characteristics of risk for dropout between the users of both programs.
According to the survey results, over 70% of users who begin the PCAS treatment program complete it, while for users participating in PRIA-MA, the figure drops to 60%. This indicates that the dropout rate is higher for PRIA-MA compared to the program for sex offenders, PCAS. Interviewee 5 offers an explanation for this phenomenon that is of particular interest: "You see, it's because of the type of crime, I mean, the crime of sexual abuse, especially against children, and all of this is much more severely punished socially. So, the guilt they carry is much greater, and it's like, come on, I have to do everything I know, everything I've been told, at least to feel better and know that I'm doing the right thing."
The surveys also highlight some differences in the psychological risk factors for dropping out of the two programs. In this regard, users who drop out of the PCAS treatment program are characterized by less openness during program sessions, making it more difficult for them to acquire the skills and habits taught. In fact, the professionals interviewed describe them as more "withdrawn and introverted," and, as Professional 2 explains, "They find it much harder to talk about what happened." Conversely, users of the treatment program for intimate partner abusers are characterized by more defiant and oppositional behavior toward the program.

Finally, it is worth noting that, according to the professionals interviewed, users of the PCAS program tend to have little to no support network, while users of the PRIA-MA program have more support from family and friends. Professional 6 explains: "PCAS users typically have a much more limited social network than PRIA users. Especially when there is child sexual abuse. When there is child sexual abuse, I can tell you that the social network is very, very limited."

6. CONCLUSIONS

The main objective of this research is to deepen the knowledge about the abandonment of treatment programs in partner and sexual offenders sentenced to a community penalty, in order to be able to prevent and reduce this phenomenon, thus improving the effectiveness of treatment programs and the protection of victims.

Following the analysis of survey responses and interviews with professionals and therapists dedicated to working with these offenders, it was concluded that between 60% and 70% of participants in treatment groups complete the program, placing the dropout rate at around 30%. The sessions with the highest dropout rates are those between the fourth and tenth sessions, with the reasons for leaving usually being the participant's own decision, resulting from accumulated absences. However, once the program is halfway through, the risk of dropping out is considerably low, and if a participant does have to leave the program, according to professionals, the reasons are usually beyond their control. Eight main reasons for dropping out were identified, including imprisonment and scheduling conflicts due to work commitments.

Regarding the profile of users who drop out of the treatment program, professionals highlight young users, mostly foreigners who do not speak the language fluently and are from a low socioeconomic background. It is also worth noting a profile of users from a high socioeconomic background, holding significant positions in their jobs, who tend to drop out due to resistance and opposition to the program. Among the risk factors that characterize users who drop out are poor impulse and anger control, active substance use during the program, and the presence of psychopathology. These two factors overlap with the exclusion criteria for such treatment programs, leading the professionals interviewed to reflect on the complexity of correctly referring users to a specific treatment program.

Regarding the factors that improve program compliance, professionals differentiate between formal aspects and strategies used.

On the one hand, regarding the formal aspects of the intervention, the professionals first highlight the importance of offering sessions at different times, noting that afternoon sessions have higher participation than morning sessions due to work schedules. Second, they emphasize the possibility of allowing users to change groups in the early stages of the program due to scheduling conflicts or other incompatibilities. The professionals explain that this allows users to balance attendance with their other responsibilities. Third, they identify that the online methodology facilitates attendance at program sessions, as users can avoid the travel time to the center where the sessions are held. However, this methodology is also criticized by some of the professionals. They point out that, although online sessions increase attendance, they are less effective because the attention given to the professional is not the same as when participants are physically present in the same room, learning is not acquired in the same way, and building group cohesion is more difficult, making it harder for users to open up and share experiences or reflections during the session. Finally, fourthly, the professionals highlight that providing information to the user before the program begins allows for a better adjustment of expectations and objectives.

On the other hand, professionals implement a series of strategies to retain clients throughout the treatment program. These include motivational strategies, strengthening the bond between client and professional, fostering group cohesion, providing opportunities to address clients' more personal issues individually, ensuring that all client opinions are heard during sessions, and, finally, having two professionals of different genders on staff. This last factor is particularly important to professionals because, in their experience, clients respond better to therapeutic feedback and are more open about various topics with professionals of one gender or the other, due to preconceived notions about gender. For example, some clients have judged that they could not empathize with female professionals.

Finally, among the key differences between programs for intimate partner abusers and sexual abusers, professionals highlight that the dropout rate is lower among sexual abusers. According to their experience, this is due to the stigma and alarm surrounding crimes against sexual freedom, which leads them to be more aware of the seriousness of the offense and more willing to comply with alternative measures to imprisonment. Sexual abusers also tend to have more difficulty sharing experiences or opinions during sessions, which consequently hinders their acquisition of skills and learning. Finally, it is noted that cases of sexual assault, especially against minors, are characterized by a weaker or nonexistent social network, while in intimate partner abusers, the main problem lies in hostile attitudes, rejection, and opposition to participating in the program.

7. RECOMMENDATIONS

Having presented the results of this research, a series of recommendations are then proposed to reduce the dropout rate in treatment programs for crimes of gender violence and sexual violence.

Regarding the user profile at higher risk of dropping out, the following suggestions are proposed to address the specific needs that this increased risk entails:

- The presence of serious mental illness and active substance use are identified as risk factors for program dropout. These circumstances should be assessed during the initial program interviews. Although both factors are exclusion criteria for the treatment program, their presence not only hinders program attendance but also impedes the individual's ability to benefit from the knowledge and skills acquired during the program. Accurately identifying these cases can allow for referring these individuals to specific programs that address their needs. Referring these individuals to specific programs to address these pre-existing needs before transferring them to programs to serve their sentence could yield more positive results.
- Precarious socioeconomic situations and homelessness are among the causes of dropout. These individuals stop attending treatment programs because their primary priority is meeting their basic needs. Ensuring that individuals can support themselves or offering solutions to these situations would improve the effectiveness of treatment programs.
- Similarly, language difficulties for foreigners are an obstacle to program adherence. Some participants don't fully understand the requirement to attend, or they attend sessions but get lost in the content and discussions, ultimately disengaging. In this regard, it would be necessary to explore possible solutions. For example, offering a language course prior to participating in the program.

- In the PCAS program, particularly in cases of child abuse, a greater lack of social support and difficulty in opening up is observed. In these cases, fostering group cohesion and trust is especially valuable, enabling these individuals to connect with the other group members and begin to open up, thus promoting adherence and allowing therapeutic work to begin on addressing these needs.
- In the case of the PRIA-MA program, there is a greater risk of dropout in cases that present greater opposition and rejection of the program, so in groups where these cases are detected it is recommended to reinforce the motivation and personal benefit phase that the program can entail, working therapeutically to reduce the internal conflict with compliance.
- Younger and more impulsive users may be at greater risk of dropping out because they do not properly value the importance of compliance. Therefore, if these cases are detected in the first sessions or in the initial interview, awareness work can be done regarding the obligation of compliance and possible consequences of dropping out.
- A higher risk is also identified among socioeconomically more affluent individuals, who typically hold significant jobs that they consider very important and therefore prioritize over program compliance. Similar to the previous point, efforts can be made to raise awareness of the mandatory nature of compliance and the potential consequences of dropping out.

The professionals have also contributed a series of strategies that they are already using and that have positive results in preventing the abandonment of some cases:

- Promoting the integration of all group members through team-building activities creates a safe, trusting, and non-judgmental environment where the ultimate goal is personal growth. This includes encouraging active participation, ensuring everyone has a voice and a place within the group. This increases their sense of involvement and interest in the program, often improves their engagement, and fosters a sense of personal reward as they begin to notice changes in themselves, their daily lives, and their relationships with others.
- Fostering a therapeutic alliance and bond between the professional and the client increases adherence to and motivation within the program. Speaking individually with clients, understanding their history, and paying attention to their needs promotes this positive alliance. Initial interviews are a valuable tool for establishing this alliance.

- Providing individual attention when needed, whether for completing tasks (for example, sitting down to explain an activity in more detail, or offering flexibility in completion, such as allowing written or oral submission) or for speaking individually when necessary (for example, addressing a personal question at the end of the session), also helps reduce the risk of users dropping out. This individual support contributes to strengthening the therapeutic alliance and also enhances the personal benefits and benefits of the program for its users, improving their motivation and adherence.
- Having the participation and coordination with other resources to address issues outside the treatment program is crucial. Many professionals explain that clients have unmet needs because they fall outside the program's objectives (active substance use, mental health problems, etc.). Being able to report these needs and having access to other resources to which these clients can be referred would facilitate intervention.

In addition to the correct identification of needs and referral, and the strategies of the professionals when applying the program, other recommendations that facilitate adherence are also identified:

- Encourage users to remain in the program until at least the halfway point, when the risk of dropping out decreases. The highest risk of dropping out is between sessions three and ten, whether due to the aforementioned difficulties (language, substance use, socioeconomic factors, etc.) or the lack of motivation and organization that comes with missing sessions. These latter cases often demonstrate prioritizing other obligations and responsibilities, such as work. However, after the halfway point of the program, the risk of dropping out decreases. Therefore, it will be necessary to pay closer attention to these at-risk cases during this critical first half of the program, encouraging and supporting their attendance so they can stabilize their participation.
- Providing users with advance information allows them to develop realistic expectations and manage their own organization before starting the program. This information should cover the program's objectives, duration, mandatory nature, rules, and consequences of non-compliance. Ensuring that the information received in the steps prior to entering the program (courts, through lawyers, at the Probation and Alternative Measures Services, etc.) is consistent and sufficient reduces feelings of uncertainty and frustration in the initial stages.

- Raising awareness of the legal duties and rights of compliance, since, although the program is mandatory due to a court ruling, the user also has legal protection for this compliance, being able to claim this right at work.

Several of these strategies and recommendations are general for implementing these programs (for example, fostering group cohesion and therapeutic alliance, or providing users with background information before they enter the program). Others, however, must be considered depending on the specific case. Therefore, it is considered especially valuable to conduct a thorough needs assessment at the beginning of the program, whether during the referral, individual interviews, or the initial sessions, so that the most effective strategies can be identified for each individual case.

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9. APPENDIX

Annex I. Interview Script

- In your experience as a therapist, how many users typically drop out before completing the program? (Percentage: total dropouts / total users in group)
- What are the usual reasons for dropping out of the program? (absences, transfers, imprisonment, medical reasons...). Are there any reasons that stand out in your experience?
- Are there usually different profiles depending on the different reasons for leaving work?
- Are there any points during the program where more casualties accumulate? (At the beginning, in the middle, at the end...)
- Does the type of leave usually differ depending on when it occurs? Are there more frequent causes at one point or another in the program?
- In your experience, are there differences in dropout rates between programs that are conducted entirely in person and those that are conducted in a hybrid or semi-online format?
- Are there characteristics that users who end up abandoning the program tend to exhibit more often?
- Are there often problems with lateness or punctuality that might indicate a possible dropout rate? How are these handled?
- Are there usually other problems with non-compliance with other rules within the group, besides attendance? Do you think these might contribute to members dropping out? How are they typically handled?
- Have you had cases of participants repeating the program after previously dropping out of another one? What is their typical trajectory in the new program? Is there a difference in adherence and commitment to the current program? Do they exhibit different resistance compared to the other group members?
- In your professional experience, how does the departure of one member from a group affect the rest of the group? In what way?
- In your experience, does the therapeutic alliance (the relationship established between the therapist and each group participant) influence the likelihood of dropping out?
- In your experience, does group cohesion (the user's relationship with the rest of the group) influence the likelihood of dropping out?

- Does conducting the interview before or after the group sessions make a difference?
- Do you think the content covered in the program might increase or decrease the risk of students dropping out? (For example, topics they might want to avoid and therefore not attend the sessions)
- What kind of benefit do users who don't finish the group before leaving usually get from it?
- Do you feel there's a clear protocol for managing absences and sick leave? Give us an example of how you handle a case of dropout; what steps do you follow as a therapist?
- Have there been any cases where you believe your work as a therapist prevented dropout? How did you act?
- Have there been any cases where you believe your work as a therapist has contributed to the client dropping out? How do you think it played a role?
- Have there been any cases where you believe the actions of other parties involved (e.g., the Sentence Management Service or the court) prevented the abandonment? In what way did they influence it?
- Have there been any cases where you believe the actions of other parties contributed to the abandonment? In what way did they influence it?

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