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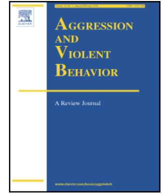

A critique of models and measures of treatment readiness in offenders

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ABSTRACT

Assessing offender readiness for treatment has major implications in terms of determining program referrals, dropout rates and, hence, program efficiency and efficacy. To be treatment ready means that the offender is motivated, finds programming relevant and meaningful, and has the capacity to successfully engage in and complete treatment. The objective of this paper is to systematically review the current methods of defining and measuring the construct of offender treatment readiness. A review of 11 measures assessing treatment readiness is described. Commonalities and differences between the measures are discussed, as well as their psychometric properties and different theoretical models. This paper concludes that there is a lack of consensus regarding the construct of treatment readiness and highlights the need for its standardized assessment. While there are various instruments developed to examine treatment readiness, there have been few efforts in validating the variables and elements encompassed by this construct. The need for a solid theoretical model is identified. Implications regarding best practices are described, as well as future directions on how to develop a psychometrically sound measure.

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Contents

1. Introduction . . . 383
2. Methods . . . 384
3. Theoretical models & frameworks of treatment readiness . . . 384
4. Measures of treatment readiness . . . 385
   4.1. Transtheoretical model of change . . . 385
   4.2. Multifactor offender readiness model . . . 387
   4.3. Measures based on other theories . . . 387
5. Results and discussion . . . 387
   5.1. Evaluation & critique . . . 388
6. Conclusion . . . 388
References . . . 388

1. Introduction

The principles of risk and need (from Risk–Need–Responsivity — Andrews, Bonta, & Hoge, 1990) have been comprehensively addressed in the programming literature; yet, factors of responsivity are not as clearly understood. While treatment readiness, however, is a key responsivity factor it remains conceptually unclear. The main issue interfering with a clear understanding of offender readiness lies in the terminology: terms like treatment motivation, offender motivation to change, motivation to engage, treatment readiness, readiness to change, and readiness to engage, are all often used concurrently and sometimes interchangeably. Ward, Day, Howells, and Birgden (2004, p.650) have defined treatment readiness as “the presence of characteristics (states or dispositions) within either the client or the therapeutic situation, which are likely to promote engagement in therapy and which, thereby, are likely to enhance therapeutic change”. Despite first being considered in an offender context over a decade ago, there have been few attempts to clearly operationalize the readiness construct and develop suitable measurement tools (Day, Casey, Ward, Howells, & Vess, 2010). Many of the existing measures are based on different models, and define and assess readiness in various ways. Consequently, the field lacks a standardized assessment of treatment readiness.

The issue of dealing with non-compliance in clinical populations is not new. More than 30 years ago, Meichenbaum and Turk (1987) synthesized the vast literature on the subject and formulated specific

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procedures for improving patient participation, such as anticipating non-adherence, considering the self-care therapeutic measures from the patient's perspective, improving the patient–therapist relationship, and customizing treatment (Meichenbaum & Turk, 1987). Conceptualizing non-compliance in terms of offender readiness was not explored until a decade later: Serin and Kennedy were the first to think of readiness in offender context in 1997, as part of their broader responsivity model. Since then, there have been few additional attempts to clarify readiness or operationalize the readiness construct and develop appropriate measurement tools (Day et al., 2010).

The implications of having a proper definition of the construct of treatment readiness are significant. Treatment readiness is an important responsivity factor in that overall program efficiency is linked to attrition rates and treatment failure. Specifically, getting offenders to participate in treatment is essential since treatment completion is associated with lower risk of reoffending, while non-completion can have a negative association with recidivism (Cann, Falshaw, Nugent, & Friendship, 2003). In a recent meta-analysis, Olver, Stockard, and Wormith (2011) identified specific predictors of program attrition and reoffending. In addition to demographic and criminal risk factors, responsivity indicators such as negative treatment attitudes, motivation, and engagement/change levels (i.e., readiness) were some of the strongest predictors of attrition. Upon examination of attrition and its effect on recidivism, Olver and colleagues (2011) reported that treatment attrition was associated with increased recidivism irrespective of program type and outcome. Given the link between dropout and recidivism, as well as the link between readiness factors and dropout, minimizing attrition could likely be achieved by assessing offenders' readiness before they enter programs and targeting low readiness through pre-program primers. Correctly targeting individuals and addressing their readiness factors before/during treatment could optimally yield more efficient programs and reduce recidivism risk. This is also very important operationally since program attrition and drop-out rates are very costly to the correctional system. Being able to assess readiness is central in the selection of offenders for treatment.

In an attempt to provide clarity, the current paper provides a systematic review of the current methods of defining and measuring offender treatment readiness, and both identifies gaps and offers suggestions for future development of this construct. Commonalities and differences between the measures are discussed, as well as their psychometric properties and differing theoretical foundations.

2. Methods

In order to comprehensively review the current state of treatment readiness, an examination of the underlying models/frameworks was completed, and a search to find all the existing scales that measure readiness and related constructs (engagement, motivation, etc.) was conducted. A thorough search of the published literature (via PsycINFO and GoogleScholar) identified four frameworks and eleven measures of treatment readiness, which are described below.

3. Theoretical models & frameworks of treatment readiness

The Transtheoretical Model (TTM) of behavior change (Prochaska & DiClemente, 1982). This model suggests that individuals pass along five stages on their way towards behavior change: Pre-contemplation, Contemplation, Determination/Preparation, Action, and Maintenance (Stages of Change, SoC). Each progressive stage is characterized by an increased motivation to engage in the process of change. In the pre-contemplation stage, the individual is not even considering the possibility of change. The contemplation stage is characterized by ambivalence, whereby individuals may simultaneously consider and reject reasons to change, or alternate between the two. The determination stage involves intention and planning behavior. The action stage involves having made a commitment to change and engaging in actions to bring about change. Lastly, the maintenance stage works to sustain the significant changes made and individuals actively work to prevent relapse.

Breaking the process of change down into a series of stages is intended to allow practitioners to assess an individual's readiness and tailor interventions towards their current state of readiness (Burrowes & Needs, 2009). Although the TTM was not conceptually designed to be a model for offender readiness and motivation, it has been often used as a foundation in the development of measures in this area. TTM provides a good starting point for work on assessment strategies of treatment readiness with offenders (Serin & Kennedy, 1997). That being said, TTM has garnered criticism by some key scholars in the field of offender motivation and readiness e.g., relationship between the stages and what occurs for an offender to move to the next stage is not clear or consistent and the model is too inflexible (Drieschner, Lammers, & van der Staak, 2004); and change does not really occur in genuine stages (McMurran, 2009).

If an offender can be in more than one stage of the SoC at one time, can skip stages, and is able to move backwards as well as forwards in the cycle, then identifying the offender's stage is of limited utility as it says little about where he or she is now or is likely to be in the future (Burrowes & Needs, 2009). Drieschner et al. (2004) criticize the TTM by pointing out that the relationship between the stages and what occurs for an offender to move to the next stage is not clear or consistent, and "in spite of its widespread use, the Stages of Change model is an inappropriate conceptualization of treatment motivation". Similarly, McMurran (2009) has questioned the TTM because change does not really occur in genuine stages, and suggests that it therefore does not reflect offender change. In exploring this more specifically, measures based on the TTM stage model oppose key Evidence Based Assessment aspects (Day et al., 2010): the TTM may have been guided by scientific theory for its initial use in the area of smoking behavior, however, it's application in the offender context lacks empirical validation. The possibility of moving back and forth between stages makes the model hard to test, and, therefore, raises issues about its internal coherence (Burrowes & Needs, 2009). The TTM does not offer empirical evidence that establishes important facets of offender behavior, and measures based on this model are not psychometrically strong as they are likely to have poor construct validity (McMurran, 2009).

Conceptual model of treatment responsivity (Serin & Kennedy, 1997). This model includes treatment readiness, interpersonal style, and treatment performance dimensions. The readiness domain involves ratings on problem recognition, motivation, expectations, goal setting, self-appraisal, behavioral consistency, views about treatment, and self-efficacy (Serin, Kennedy, Mailloux, & Hanby, 2010). These factors are conceptualized to potentially influence treatment engagement and performance. The model is intended to assist clinicians in determining treatment placement, and although there are no comprehensive tests of this model, there does appear to be some empirical support for it (Serin, Kennedy, et al., 2010; Serin, Lloyd, & Hanby, 2010).

Multifactor Offender Readiness Model (MORM) (Ward et al., 2004). This model recognizes that readiness is as much a feature of the therapeutic setting as it is of the internal characteristics of the client: "readiness is a complex structure that incorporates a number of psychological and behavioral dispositions and states, particular contextual features, and distinct therapeutic dimensions" (Ward et al., 2004). This model involves constructs of motivation and responsivity but goes beyond these traditionally understood concepts by aiming to identify ways of enhancing offender engagement and overall treatment effectiveness. Readiness conditions involve internal (e.g., beliefs about treatment, offender goals) and external factors (setting in which treatment is õdelivered, extent to which treatment is coerced) which are thought to have a direct relationship with treatment engagement and performance. Internal factors, such as cognitive, affective, volitional, behavioral, and identity, interact with external factors like circumstances,

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