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The challenges of creating the treatment readiness scale for youths taking part in mandatory psychosocial counseling

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ABSTRACT

The focus of this paper is directed to the treatment readiness of juveniles, who were mandated to psychosocial counseling upon committing an offence or misdemeanor. Several aims were in the focus: describing a measure for assessment of treatment readiness accompanied with psychometric testing, assessing treatment readiness and examining the relationship between treatment readiness, youth characteristics, and youth readiness to change, problem recognition and passage of the time.

The test results point to very good psychometric characteristics of the constructed scale. Treatment readiness can be explained through three factors: *appropriateness* and timeliness of counseling, *emotional* perception of counseling and *resistance* to counseling. Higher level of treatment readiness is correlated with higher level of problem recognition. Despite expectations, no connections were found between age, type of committed offence, circumstances of sentencing or the presence of earlier treatment interventions. But, the results indicate that there is a high level of correlation between readiness to change, and appropriateness and timeliness of counseling. In other words, the respondents who were in the pre-contemplation stage were to a lesser degree assessing counseling as appropriate and timely, while those who were in the action stage had exhibited a lesser level of resistance to treatment. In discussion, potential treatment implications were proposed.

1. Introduction and background

Even though the most appropriate intervention towards juvenile offenders is primarily set on the basis of a risk and needs assessment, the constructs in the area of responsivity,[1] treatment readiness, and willingness to change in particular, are garnering increasing attention (Breda & Helfinger, 2007; De Leon, 1996; DiClemente & Scott, 1997; Drieschner, 2004; Kennedy, 2000). A client's motivation to participate in services has been recognized as a relevant component in the treatment of behavior problems. Although motivation may be relevant for all client age groups (Lambert, Hurley, Tomlinson, & Stevens, 2013), the juvenile offenders or youth with behavior and emotional needs may be resistant to taking part in the treatment, because they commonly come to treatment pressured by parents, school, or the judicial system. Consequently, youth may lack skills of self-reflection which would help them define the problem that they are meant to address in treatment (Karver, Handelsman, Fields, & Bickman, 2006). Difficulties in inclusion in the treatment may manifest themselves (e.g. inappropriateness or unavailability of treatment, treatment taking place at an unsuitable time), as may the difficulties concerning the youth's behavior (resistance, absenteeism, taking part in treatment as a formality), particularly if the treatment is mandated.

The characteristics described above are reflecting the concept of treatment readiness. It has been defined by Ward, Day, Howells, and Birgden (2004, p. 650) 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". *Treatment readiness* is aimed at conceptually grasping the motivation to seek assistance, or readiness to take part in treatment activities. *Being ready for treatment* denotes a stage at which a person is motivated for change, is able to take part in the treatment, has the capacity to become involved, and perceives his/her ability to respond to the needs of the treatment, while considering the treatment meaningful and purposeful (Ward et al., 2004).

Research thus far has concluded that readiness for change, and treatment readiness, have important roles in the treatment process, as a series of evidence shows that the beneficiaries' motivation is positively correlated with seeking assistance, continued participation in treatment, and the outcome of the treatment (Edelen et al., 2007; Joe, Simpson, & Broome, 1998; Nock & Photos, 2006; Ryan, Plant, & O'Malley, 1995; Schroder, Sellman, Frampton, & Deering, 2009). Research indicates that understanding a person's treatment readiness

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[1] This term is being used to describe those factors related to the beneficiary of the intervention which contribute to a positive outcome of the treatment. The components of responsivity refer to matching the treatment approach to the beneficiary's style of learning and other personal characteristics, such as intelligence, self-respect, anxiety, and motivation.

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may assist in the process of selecting the adequate type of intervention or work methods, and may also prevent premature abandonment of treatment, contribute to a better use of intervention resources, and assist in the creation of techniques for working with those individuals who are not ready for treatment (Burrowes & Needs, 2009; Casey, Day, & Howells, 2005; Howells & Day, 2007).

The development of the instruments of assessment, and thus the research in this area as well, has been accompanied by difficulty in conceptualization of treatment readiness from the similar concepts, such as motivation, responsivity, and willingness to change. Accordingly, some of the work has been based on the concept of motivation (Reimer et al., 2012; Sellen, McMurran, Cox, Theodosi, & Klinger, 2006), while Serin and Kennedy (1997) have utilized the concept of responsivity. If we compare the research on constructs of treatment readiness and those of related concepts (readiness to change and responsivity), we find that the former has commenced later, and exclusively with the population of offenders. Additionally, they were preceded by research on readiness to change and responsivity. The conclusions of this work pointed to a necessity of developing specific instruments for assessment of readiness, both in terms of treatment-specificity and population-specificity (Day et al., 2009; Serin, 1998; Serin & Kennedy, 1997). Apart from conceptual inconsistence, this area of study is characterized by lack of evidence of psychometrically satisfactory assessment instruments (Day, Casey, Ward, Howells, & Vess, 2010; Lambert et al., 2013). Research and instruments aimed specifically at the population of offenders, and aimed at explaining and assessing their readiness for treatment, only appeared when it became clear that the concepts which are not primarily designed for assessing treated person's behavioral change were not sufficient.

The first protocols for assessment of treatment readiness were developed by Serin and Kennedy (1997) through analysis of constructs related to responsivity factors, and the motivation and acceptance of treatment (*Interpersonal Style Rating Scale* and the *Treatment Evaluation Rating Scale*). The scales include topics such as problem recognition, insight into the potential gains from participation in the treatment, social support, problem denial, possibility of applying the lessons learned in everyday life. Subsequently, Serin, Mailloux, and Kennedy (2007) developed *The Treatment Readiness Clinical Rating Scale*. This scale is based on the idea that numerous internal and external factors may affect one's readiness to take part in the treatment. The scale consists of 16 items separated into two areas, the internal and the external factors, with follow-up factor analysis confirming that the two are independent sub-scales.

A special place in this area of treatment readiness research is taken by the Multifactor offender readiness model (Casey, Day, Howells, & Ward, 2007) which, along with the most wide-ranging description of factors that affect treatment readiness, also includes a somewhat larger degree of reliability of the assessment instruments. The research with which the authors followed up the creation of the model has focused on the estimation of psychometric characteristics of the self-assessed treatment readiness and further estimation of the potential for predicting the outcome of treatment. In accordance, a questionnaire was designed aimed at assessing treatment readiness of offenders included in social skills training program (Ward et al., 2004). The *Corrections Victoria Treatment Readiness Questionnaire* consists of 20 items which cover cognitive processes, affective factors, behavioral readiness factors, factors of willingness/eagerness, characteristics of identity, contextual factors (including those related to circumstances, location, situation, sources, and support), and finally treatment goals (which include behavioral change, specific problems, type of intervention and its time frame). This questionnaire is based on a Likert-type self-assessment scale. In their research, aimed at 177 adult male offenders referred to a cognitive skills program, Casey et al. (2007) tested the above described instrument. Factor analysis showed that there were four components of the instrument: attitudes and motivation, emotional responses, beliefs, and effectiveness, which is in congruence with the five individual factors of the treatment readiness model. The items related to willingness/eagerness were the only ones that did not form a separate factor, which is not surprising given that the aim to achieve a particular goal is evidently difficult to measure by means of self-assessment. The results show that the sub-scale of attitudes and motivation has the strongest connection to treatment involvement, and that the instrument has the ability to act as a predictor of treatment involvement and treatment performance. Even though this particular research has not set the norms for the instrument, it has, nevertheless, provided an instrument that can produce relevant information for treatment planning. As a higher score (which can be between 20 and 100) points to a greater degree of readiness for treatment involvement, an ROC analysis showed that it is the score of 72 that represents a border after which a probability of 61.2% points to a positive outcome, with a 67.9% probability of an unfavorable outcome in cases below this border.

Based on these findings, Day et al. (2010) construed an adapted self-report questionnaire that assesses readiness to participate in and engage with a violence program. Their research was aimed at 96 convicted adult male offenders referred to semi-intensive or intensive violence intervention programs, who filled in a set of 10 questionnaires which addressed the issues of treatment readiness, self-assessed effectiveness, perceived control, involvement in the treatment and level of satisfaction with the treatment. The scale result was highly correlated with a self-assessed level of treatment involvement, higher than in previous research (Rollnick, Heather, Gold, & Hall, 1992; Williamson, Day, Howells, Bubner,& Jauncey 2003). The higher values of post-treatment scores indicated a dynamic structure of the construct, which was increased with further participation in treatment. It is hardly surprising that the results showed that the beneficiaries of the treatment were better able to identify changes in attitudes, motivation, and emotional responses, at the end of the treatment. Another one of this research's findings is that the application of instruments aimed at assessing treatment readiness contributes to an increase in awareness of the problem, and motivation for entering the treatment program. The results thus show that treatment readiness increases over time spent in treatment.

Only one example of a scale aimed at assessing treatment readiness in juvenile offenders can be found in the literature. *Motivation for Youth Treatment Scale* was originally designed for those youths who were involved in community services (Bickman et al., 2010), and was only subsequently tested on those who are in residential treatment (Lambert et al., 2013). This scale consists of two subscales: problem recognition, and readiness for participation in treatment. With a “mere” 8 items, it is designed to be a condensed scale which can be utilized during intervention, with the aim of motivation assessment. The results of the test of psychometric characteristics show that the scale holds a satisfactory level of internal validity with the Cronbach's alpha scores above 0.80 (Bickman et al., 2010; Lambert et al., 2013).

Same as with the instrument creation, the literature contains only few instances of research utilizing the above construct in the population of juveniles. Some research has been done on substance – abusing youths or in residential placements, but very little in community – based settings (Breda & Reimer, 2012). They sum the mixed findings from the extant research on the correlates of youths' treatment motivation. Regarding age, race and mandated treatment research have found opposite results (Melnik et al., 1997, Battjes et al., 2003, all in Breda & Reimer, 2012). Mental distress, negative consequences from alcohol and drug use, greater mental health severity and level of legal pressure are related to lower treatment readiness. Harder, Knorth, and Kalverboer (2012) reported on a project researching motivation in 135 youths in institutional type of treatment. They found that adolescents for whom motivational problems are reported in the treatment documents are significantly more likely to have a poorer relationship with care workers than adolescents without motivational problems. Such diverse findings leave questions about what influences youths' motivation for treatment, particularly at the beginning of treatment when readiness can create a