

# Treatment engagement from the perspective of the offender

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Treatment Engagement from the Perspective of the Offender: Reasons for Non-Completion  
and Completion of Treatment: A Systematic Review

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### **Abstract**

A systematic review of the reasons why detained adult offenders fail to attend or successfully complete treatment programme(s) was conducted. An initial search of the literature identified 2,827 articles, which following evaluation against explicit inclusion/exclusion criteria and a quality assessment, was reduced to thirteen studies. Extracted data from the thirteen studies were synthesised using a qualitative approach. Despite the thirteen studies being heterogeneous in design, there was consensus on the reasons offenders gave for completion/non-completion of treatment. The majority were consistent with the factors outlined in the Multifactor Offender Readiness Model (MORM) and included a perceived lack of self-efficacy, negative perceptions of treatment, staff and peers, an inability to regulate emotions and a lack of perceived choice and control. A lack of opportunity to engage in established, professionally-run, groups, as well as perceived inadequate support from members of staff was also associated with poor engagement and non-completion of treatment.

**Keywords:** treatment readiness, treatment engagement, offender, MORM

## **Background**

### **Engagement and Non-Completion of Treatment**

The completion by offenders of evidenced-based treatment is thought to increase public safety through reduction in recidivism (Polaschek, 2012). However, rehabilitation through treatment is dependent on the offenders' engagement in treatment, which has been identified as characteristically low (McMurrin, 2002). Low engagement includes poor attendance, attending treatment but making little contribution, engaging in inappropriate/disruptive behaviour, poor cooperation with treatment facilitators, and/or failing to complete various tasks, including homework (Howells & Day, 2007). Non-completion refers to the premature cessation of treatment (Howells & Day, 2007). It can take one of three forms; expulsion due to inappropriate behaviour, an administratively based exit due to the offender being transferred or released from their current environment for reasons unrelated to programme attendance/engagement, and patient initiated dropout, in which the offender actively chooses to stop attending treatment (Wormith & Oliver, 2002). For simplicity, throughout this review, the terms low engagement and non-completion will be used interchangeably.

Rates of non-completion of treatment range quite dramatically depending on type of offender and their residing environment. Meta-analysis has revealed that within institutional settings, including prison and secure hospitals, the rate of non-completion for cognitive behavioural interventions is 14.66%, but reaches 45.45% in community samples (McMurrin & Theodosi, 2007) suggesting retention is harder to achieve in the community (Ashford et al., 2008; Cullen, Soria, Clarke, Dean & Fahy, 2011). In terms of offender type, rates of up to 86% are reported for sexual offenders (Larochelle, Diguier, & Laverdiere, 2011) and between 12% to 34% for violent offenders (Hornsveld, 2005).

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Non-completion is associated with an increased risk of recidivism when compared to offenders who complete treatment and even when compared to *untreated* offenders (Day, Casey, Ward, Howells, & Vess, 2010; McMurrin & Theodosi, 2007). Other aversive outcomes associated with treatment non-completion include increased length of stay in secure hospital settings (Long, Dolley, & Hollin, 2013) which in turn is associated with significant costs of up to £749 (\$1206) per day, totalling approximately £273,000 (\$439,530) per annum, per patient (Durcan, Hoare, & Cumming, 2011)<sup>1</sup>. Not only does non-completion waste valuable resources, it also prevents new admissions from benefiting from such services (McMurrin, Huband, & Duggan, 2008).

Non-completion of treatment also has a negative impact on staff morale (Howells & Day, 2007) which itself is associated with reductions in staffing levels and an increase in patients' risk of violence (Totman, Hundt, Wearn, Paul, & Johnson, 2011). Furthermore, poor staff morale can negatively impact upon the therapeutic alliance between staff and offenders, which is an essential component for offender engagement in treatment (Ward, Day, Howells, & Birgden, 2004). Thus, non-completion of treatment results in what can be considered a vicious circle of dis-engagement within secure services.

### **Models of Completion/Non-completion**

Several theoretical models have been designed to guide methods of treatment in a way which increases engagement and thus treatment completion. For example, although not intended for an offending population, the transtheoretical model of change (Prochaska & DiClemente, 1983) suggests an individual's internal motivation is the driving force for behaviour change through participation in treatment. According to this model, an individual works through various stages of change, including pre-contemplation, contemplation and preparation, before arriving at the maintenance stage, in which rehabilitation is achieved and efforts are focused upon the prevention of relapse (Prochaska & DiClemente, 1983). Taking

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account of someone's stage of change when tailoring treatment is considered to result in more optimal treatment outcomes, including retention (Norcross, Krebs, & Prochaska, 2011). The application of this model to offending populations has, however, been criticised. Criticisms include its exclusive focus on internal motivation and lack of consideration for external motivators, which can significantly influence behaviour change (Casey, Day, & Howells, 2005).

The concept of responsivity from the Risk-Need-Responsivity (RNR) model (Andrews, Bonta, & Hodge, 1990) has also been put forward as a means to promote treatment completion (Ward et al., 2004). The responsivity principle refers to the need to consider how the offender's characteristics (e.g., cognitive ability) may influence their capacity to benefit from the recommended treatments and how treatment should be adapted accordingly (Day et al., 2010). Whilst the risk-need principles have been widely attended to by the criminal justice system, the responsivity principle has been somewhat neglected (Andrews & Bonta, 2003; Day et al., 2010). Day et al. (2010) argued this was due to a lack of clarity regarding the construct of responsivity and how it is effectively implemented within clinical practice.

Building on the limitations of the above, Ward et al., (2004) proposed the Multifactor Offender Readiness Model (MORM) which encapsulated the concept of 'treatment readiness'. Treatment readiness is defined 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'* (Howells & Day, 2003, p. 321). The model proposes that treatment readiness is the result of various internal and external factors being present within an individual and their environment respectively, and the way which they interact to influence engagement (Day et al., 2010). Internal factors refer to *'person'* factors and include cognitive (beliefs, cognitive strategies), affective (emotions), volitional (goals, wants or desires), behavioural (skills and

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competencies) and identity (personal and social) factors. External factors refer to ‘contextual’ factors and include circumstances (mandated vs. voluntary treatment, offender type), location (prison, community), opportunity (availability of therapy and programmes), resources (quality of programme, availability of trained and qualified therapists, appropriate culture/climate), interpersonal support (availability of individuals who wish the offender well and would like to see him or her succeed in overcoming their problems) and programme characteristics (e.g., the type and timing of treatment). For a brief description of each of the factors please refer to Table 1 online.

The model can be used to identify the internal and external factors required for an offender to successfully enter and engage in treatment so that necessary changes could be made to his/her environment and the treatment, but also the client to promote treatment readiness and thus retention (Day et al., 2010; Ward et al., 2004).

[See Table 1. online]

### **Characteristics of Non-Completers**

A substantial amount of research has been devoted to identifying the factors which predict dropout within an offending population (Cullen et al., 2011). These factors include lack of formal education, young age and unemployment, psychopathy, personality disorder (including ASPD), perceived pressure to complete treatment, previous participation in sex offender treatment and experience of sexual victimisation, being more hostile, aggressive or violent, a history of substance misuse, and being less motivated to change (DiClemente, Nidecker, & Bellack, 2008; Hornsveld, 2005; Larochelle et al., 2011; Main & Gudjonsson, 2006; McMurrin, Huband, & Overton, 2010; Olver & Wong, 2009; Webb & McMurrin, 2009; Wormith & Olver, 2002). Knowledge of these factors can be used to reduce attrition through the identification of offenders who, based on such factors, are most suitable for treatment (McMurrin et al., 2010). As suggested by the MORM, it can also highlight areas of

need within an offender, as well as highlight aspects of a treatment programme which are not meeting the needs of its target population.

Whilst research into such factors provides practitioners with valuable information regarding an offender's risks and possible needs, it encourages practitioners to seek inherent deficits in the client as explanations for non-completion, rather than providing information on how treatment should be adapted in order to increase responsiveness and thus engagement (McMurrin et al., 2010). Subsequently, such research has been criticised for neglecting the client's experience and beliefs about both the treatment being offered and the service they reside in (McMurrin et al., 2010). Unlike many client characteristics associated with non-completion, a client's perception of treatment is subject to change and thus in order to guide the development of treatment and reduce attrition, more attention should be paid to the client's overall experience of rehabilitation. To the knowledge of the authors there is currently no review synthesising such research. Taking into consideration the previous research discussed, the current review aimed to systematically investigate offenders' reasons for non-completion/completion of treatment in order to further understand the factors influencing treatment readiness amongst detained offenders.

### **Method**

Searches were conducted on the following electronic databases on 30<sup>th</sup> September 2013: Cochrane Library, PsychINFO (1967 to September Week 4, 2013), EMBASE (1974 to 2013 Week 27), MEDLINE (1946 to September Week 3 2013), Web of Science (1900 to 2013) and ProQuest (including ASSIA, British Nursing Index, IBSS, NCJRS, ProQuest nursing and allied health source, social services abstracts and sociological abstracts; 1978 to 2013). The search strategy combined terms for the following concepts: "treatment", "offender" and "treatment completion"/"treatment non-completion". In order to maximise the



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number of articles identified, a hand search of the reference lists from previous reviews was conducted. A search for grey literature was also conducted using the internet search engine Google. Key authors in the area were also contacted. A total of 2,827 articles were identified via this search strategy.

Studies which met the following inclusion criteria were included in the review: (a) participants included detained male and female offenders aged at least 10 years old who were currently undertaking treatment, had dropped out of treatment, completed treatment or had been offered treatment (despite being accepted or declined). The included age range is in accordance with the UK criminal justice system where the age of criminal responsibility is 10 years within England and Wales. An individual between (and including) 10 and 17 years, is considered to be a juvenile offender and at 18 years and above an adult offender. Treatment referred to any treatment programme/intervention provided by a forensic service excluding medical treatment; (b) studies which explored reasons for non-completion and/or completion of treatment; (c) peer reviewed journals, including dissertations, written in English. Studies exploring compliance with medical treatment were excluded as were review articles, opinion papers, commentaries, conference papers and/or editorials.

It should be noted, for the purpose of this review, non-completion of treatment referred to the premature cessation of treatment through client initiated dropout or exclusion due to inappropriate behaviour (Wormith & Olver, 2002). The definition of non-completion also encapsulated failure to attend treatment sessions (a minimum of 1) and low engagement during sessions. Howells and Day's (2007) definition of low engagement (outlined in the Introduction to this article) was used. Although consistent with the current literature (Day et al., 2010; Driescher, Lammers & van der Staak, 2004; Sheldon, Howells, & Patel, 2010), it is acknowledged that in adopting what may appear to be a stringent definition, some individuals included in the current review may have been erroneously categorised as disengaged. As

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there are relatively few studies exploring reasons for and against engagement in treatment, research exploring reasons why offenders refuse to engage in treatment was also included in order to identify further obstacles to treatment engagement. As reasons for refusing treatment cannot be assumed to be the same as those for non-engagement, reasons specific to the refusal of treatment are highlighted within the review as to prevent the inaccurate generalisation of findings.

A broad definition of non-completion/engagement was included to ensure all factors influencing treatment engagement were identified. Whilst non-engagement has been commonly attributed to an individual's lack of motivation or resistance, it has been argued that other reasons, including problems with the treatment environment or legitimate and rational concerns regarding treatment, have often been ignored (Long, Banyard, Fox, Somers, Poynter, & Chapman, 2012). Therefore, by using a broad definition of non-completion/engagement, the current review aimed to address this critique and increase awareness that for some individual's reasons for and against engaging in treatment, even for just one session, may be attributed to organisational factors as well as client factors.

Reasons for non-completion, low engagement and/or failure to attend a session were required to be the offender's opinion. Regarding treatment completion, participants were included if they were reported to have completed a treatment programme or fully engaged in treatment at the time the research was conducted.

Of the 2,827 articles identified via the initial search, 136 were identified as content relevant based on a review of the abstract. After applying the inclusion/exclusion criteria, thirteen studies were deemed suitable for review. Six of the thirteen papers were qualitative studies (Breckon, Smith, & Daiches, 2013; Drapeau, Korner, Granger, Brunet, & Caspar, 2005; Mason & Adler, 2012; McCorkel, Harrison, & Inciardi, 1998; McGrain, 2006; Sainsbury, Krishnan, & Evans, 2004), two were quantitative studies (Polascheck, 2010; Sheldon et al.,

2010) and five were mixed methods (Long et al., 2012; Mann, Webster, Wakeling, & Keylock, 2013; McMurrin & McCulloch, 2007; Strauss & Falkin, 2010; Tetley, Jinks, Huband, Howells, & McMurrin, 2012). These papers were quality assessed to highlight any biases and evaluate their overall methodological quality using the Mixed Methods Appraisal Tool (MMAT; Pluye, Gagnon, Griffiths, & Johnson-Lafleur, 2009; Pluye et al., 2011). This is a new tool but recent research suggests it has good reliability (Pace et al., 2012). For both qualitative and quantitative studies areas of critique included sampling, methodology and analysis of results/outcomes measures. In addition however, quantitative studies were also critiqued on matters regarding completion of outcome data/response rates, depending on the specific design. Matters regarding reflexivity were also critiqued in studies adopting a qualitative design. In reference to mixed method designs, three additional questions were included for critique including the rationale for implementing a mixed method design, integration of qualitative and quantitative data and the limitations associated with this. Criteria relating to the specific study design were coded as present or not present. Depending on the number of criteria met, scores ranged from 25% (1 criterion met) to 100% (all criteria met). Specific to those studies using a mixed methods design, the qualitative, quantitative and mixed methods components were appraised separately using the scoring system above. The overall score was taken from the lowest scoring component (Pluye et al., 2011).

Twelve studies had quality assessments scores of 50% or higher suggesting they were of acceptable quality. One study received quality assessment scores of 25% suggesting that this study is not of optimal quality (McMurrin & McCulloch, 2007). Due to the relatively new status of the quality assessment tool, and the small number of studies available for review, no papers were excluded based on the outcome of the quality assessment.

Information derived from the quality assessments was, however, used to inform ideas for

potential future research and contributed to the overall critique of the current studies (See Discussion section). Just under half of the papers ( $n=6$ ) were independently quality assessed by a two trainee Forensic Psychologists and substantial inter-rater reliability was achieved ( $K = 0.761$ ). Any differences in opinion between raters were discussed and resolved by consensus.

### Results

#### Description of Studies

Of the studies reviewed, three aimed to identify participants' reasons for *engaging* in treatment (Breckon et al., 2013; Mason & Adler, 2012; McGrain, 2006; Sainsbury et al., 2004), four aimed to identify reasons for non-completion (Long et al., 2012; Mann et al., 2013; Sheldon et al., 2012), five investigated reasons both for and against engagement/completion (Drapeau et al., 2005; McCorkel et al., 1998; McMurrin & McCulloch, 2007; Strauss & Falkin, 2000; Tetley et al., 2012), and one assessed whether completers and non-completers could be differentiated using psychometric and demographic variables, although only data regarding reasons for dropout was extracted (Polaschek, 2010).

**Demographic Characteristics of the Sample.** A total of 730 participants were recruited across the thirteen studies of which 34.25% ( $n = 250$ ) were female, 58.22% ( $n = 425$ ) were male and 7.53% ( $n = 55$ ) failed to be differentiated by gender. The age range reported across thirteen of the studies was between 20 to 50+ years, with one study failing to report the age range sampled (Mason & Adler, 2012). Across the nine studies which reported ethnicity of participants, the majority of participants were reported to be Caucasian (Long et al., 2012; Man et al., 2013; McCorkel et al., 1998; McGrain et al., 2006; McMurrin & McCulloch, 2007; Polaschek 2006; Sheldon et al., 2010; Stauss & Falkin, 2000; Tetley et al., 2012). In terms of offending behaviour, violent and sexual offenders were the most prevalent in the sample (Breckon et al., 2013; Drapeau et al., 2005; Long et al., 2012; Mann et al.,

2013; McMurrin & McCulloch, 2007; Polaschek 2006; Sheldon et al., 2010). The United Kingdom was overrepresented in the studies included in the review (Breckon et al., 2013; Long et al., 2012; Mann et al., 2013; Mason & Adler, 2012; McMurrin & McCulloch, 2007; Sainsbury et al., 2004; Sheldon et al., 2010; Tetley et al., 2012).

In terms of treatment setting, six studies recruited participants detained within secure hospital facilities (low, medium and high secure), which comprised 23.42% ( $n = 171$ ) of the overall sample, including some patients exclusively from wards for individuals diagnosed with personality disorder and intellectual disability (Breckon et al., 2013; Long et al., 2012; Mason & Adler, 2012; Sainsbury et al., 2004; Sheldon et al., 2010; Tetley et al., 2012). Time since admission ranged from less than 1 year to 36 years with two studies not reporting this variable (Mason & Adler, 2012; Sheldon et al., 2012).

Seven studies sampled from a prison population, comprising 65.62% ( $n = 479$ ) of the overall sample size (Drapeau et al., 2005; Mann et al., 2013; McCorkel et al., 1998; McGrain 2006; McMurrin & McCulloch, 2007; Polaschek, 2006; Strauss & Falkin, 2000). Two studies reported length of sentence which ranged approximately around 6 months up to 5 years (McCorkel et al., 1998; McMurrin & McCulloch, 2007) and one reported the mean amount of sentence currently served by the participants, which ranged from 2.1 ( $SD=2.6$ ) to 3.3 ( $SD=3.4$ ) depending on the participant group<sup>2</sup> (Mann et al., 2013). Prison security level ranged from low to high, however, this variable was only reported in two studies (McMurrin & McCulloch, 2007; Mann et al., 2013).

Two studies incorporated additional participants in their samples (Breckon et al., 2013; Tetley et al., 2012). These were professional members of staff working in a hospital setting, representing 8.36% of the overall sample ( $n = 61$ ), and non-forensic psychiatric outpatients, representing 2.6% of the overall sample ( $n = 19$ ). As such participants did not

meet the inclusion criteria for this review, where possible, findings relating to these participants were not included in the review.

In terms of the treatment being offered to participants, this included psychological/psychosocial treatment, any form of treatment that was part of the care plan, group-based treatment programmes (e.g., Sex Offender Treatment Programme, Enhanced Thinking Skills, drug user treatment programme), therapeutic communities, and in one case the study failed to report the type of treatment being undertaken (Sainsbury et al., 2004).

### **Descriptive Data Synthesis**

To clarify how the results of the review relate to current theoretical thinking on treatment readiness, the findings are presented here, where possible, within the structure of the MORM (Ward et al., 2004). Findings from two of the studies were coded independently against the MORM by two professionals in order to assess the reliability of the coding scheme; there was a percentage agreement of 85%. A summary of each study can be found in Table 2 online.

[See Table 2. online]

#### **Internal Factors.**

*Cognitive Factors.* Cognitive factors were reported within eleven of the studies. Specifically, poor self-efficacy regarding one's ability to effectively engage in treatment and ability to change was identified as a significant barrier to treatment engagement. Perceiving treatment to be too difficult and complex was noted by participants as influencing decisions to engage, as was the perception that homework was too demanding. Negative appraisals of treatment and expected outcomes were negatively associated with treatment engagement and in some studies resulted in treatment dropout and refusal of treatment. Examples of negative appraisals included beliefs that treatment was patronising in its delivery, ineffective, stressful, boring, intrusive, challenging, unnecessary, repetitive, and unable to help participants achieve

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their goals. In two studies, negative appraisals originated from participants prior negative experience of treatment. Furthermore, treatment refusers were more likely than treatment completers to have witnessed negative changes in others engaged in treatment, and therefore it is possible that attitudes towards treatment may be influenced vicariously through the experience of others. Disagreement with the treatment rules, how these were implemented and subsequent restrictions placed on their freedom (i.e. not having enough free time) caused some participants to feel like they were being victimised, precipitating dropout. For some participants a disparity between their expectations of treatment and the treatment offered resulted in their dropout. McCorkel et al. (1998) noted that for some participants engaged in a Prison Therapeutic Community, dropout was precipitated by their perception that the treatment they had received was not actually what they considered to be “treatment” which subsequently triggered feelings of disappointment with the programme being offered. With the exception of one-to-one sessions with a qualified member of staff, dropouts did not perceive the peer-based treatment they received as “treatment”. The authors concluded that their perception of what constituted optimal treatment reflected “*the popular stereotype of a passive, hierarchical relationship between a psychologist and a client*” (p. 46). Providing offenders with the resources to increase their understanding of treatment and make an informed decision regarding their engagement was noted in several studies to facilitate and subsequently maintain engagement in treatment. Conversely, positive appraisals of treatment and expected outcomes were found to facilitate treatment engagement and aid completion. Perceiving treatment as informative, helpful in dealing with issues and facilitating personal development and growth was reported to encourage engagement in treatment. Specifically to participants in prison, participation in treatment was maintained by the perceived advantages of being in the treatment programme over the general prison population (Strauss & Falkin, 2000). Offenders who completed treatment perceived the programme as interesting, positive,

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enjoyable, and appropriate to address their needs and were more open to the potential benefits of different methods of treatment besides one-to-one therapy.

Negative perceptions of staff also impeded treatment engagement. Reasons for participants' negative perceptions were a lack of trust towards professionals and the anticipation that staff would be disrespectful due to the nature of the crime they committed. Perceiving staff as prejudice hindered engagement. In contrast, motivation to engage in treatment was higher amongst participants who perceived staff to be trustworthy and able to promote a sense of safety through their ability to effectively manage a challenging client group.

Within a group setting, participants' negative appraisal of other group members, again often due to a lack of trust, negatively impacted upon motivation, treatment engagement and completion. Difficulties integrating into the group or conflict between group members also hindered treatment engagement. Participants reported avoiding close relationships with peers and withholding certain information for fear that such information would be used against them, particularly when in groups aimed at addressing criminogenic issues. This subsequently impacted on their willingness to engage with treatment as it would put them in a vulnerable situation. Subsequently, in one study, participants expressed a preference for individual interventions. Such fears seem to bear out with completers reporting being victimised more often than non-completers.

Denial or minimisation of offending behaviour was a barrier to treatment engagement and therefore treatment completion. The way treatment is offered to those in denial was highlighted as important: Participants who denied their offence and subsequently refused to engage in treatment, were more likely to report being offered treatment in a derogatory manner by staff and receiving little information about the treatment programme in comparison to those who both accepted treatment and admitted their offence.



***Affective Factors.*** Ten studies included in the review identified the role of affective factors in influencing treatment engagement. Experiencing negative affect towards treatment, particularly anxiety, was associated with dropout. Feeling uncomfortable, under too much pressure and stressed as a result of engaging in treatment also precipitated dropout in one study (Strauss & Falkin, 2000). Poor emotional regulation was implicated among female participants in two studies. Several studies highlighted the relevance of affective factors in the treatment engagement of personality disordered offenders. Feelings of guilt regarding one's offending appeared to motivate participants' to engage in treatment in an attempt to reduce such negative affect.

***Volitional and Identity Factors.*** These factors were found within the majority of studies reviewed. For example, realising and acknowledging the need for change was identified as vital for engagement in treatment and was often associated with the establishment of prosocial goals which in turn was found to facilitate treatment engagement. Supporting this, attrition was lower for sessions that offenders rated as important to their recovery and/or future goals. Recognising the need for help in achieving ones goal to change was reported as a reason for completing treatment. For others engagement was motivated simply by their desire to have a sense of pride in having completed something (Strauss & Falkin, 2000).

Conversely, an inability to set goals and incongruence between offenders' goals and those of the treatment being offered was associated with poor treatment engagement and non-completion. However, McMurrin and McCulloch (2007) also noted that some treatment non-completers reported perceiving treatment as useful and relevant to their needs, which suggested that for these individuals factors unrelated to the content of the treatment programme influenced dropout.

For some participants, specifically those detained within prison settings, engagement in treatment was motivated purely by a desire to gain parole, early release, or a desire for

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freedom, rather than a desire to reduce their risk of recidivism and address their criminogenic needs. However for others, the belief they would be paroled regardless of whether they were engaged in treatment or not, precipitated dropout (Polaschek, 2010). Drapeau et al. (2005) noted that not one participant made reference to engaging in treatment for the purpose of addressing their offending behaviour. Whilst for some of these offenders, engagement in treatment naturally increased their internal motivation to achieve rehabilitation, some perceived treatment to be of little benefit and were described by their peers as “faking” engagement (see McGrain, 2006). In reference to those motivated to engage, being in treatment with those considered to be “faking it” resulted in feelings of dissatisfaction towards the treatment programme (Strauss & Falkin, 2000).

Perceived choice and control over one’s participation in treatment was noted by five studies as related to treatment engagement. Having little choice or control, feeling powerless and lacking in autonomy or feeling coerced to take part in treatment were all found to be associated with poor engagement in both prison and hospital settings. Whilst perceived coercion might encourage attendance, it was less successful in promoting therapeutic engagement and for some, precipitated negative appraisals of treatment.

Identity factors also impacted upon engagement. Specifically, three studies found that an inability to relinquish one’s identity as an offender, be it through an inability to disengage from a criminal lifestyle or refusing to dissociate one’s self from the street mentality or “code of the streets”, negatively impacted upon treatment engagement or resulted in expulsion from treatment. Furthermore, Sheldon et al. (2010) found non-completion to be associated for some participants with the denial of their identity as a “mental patient” or an individual diagnosed with personality disorder.

***Behavioural Factors.*** Behavioural factors were reported to be associated with treatment engagement in six studies however, two of these studies incorporated both offender and staff

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opinions. It is therefore difficult to ascertain if offenders viewed these factors as influential. Nevertheless, both fluctuations in mental health, for example hearing noises during therapy and poor compliance with medication were reported to negatively impact upon treatment engagement. In reference to the latter, this was considered to precipitate periods of instability which negatively impacted on the participant's ability and willingness to engage in treatment. An ability to manage distress however, allowed participants to talk openly regarding difficult and painful topics, and consequently was considered a vital skill for treatment engagement.

Factors regarding the impact of intellectual disability (ID) on treatment engagement were also noted, particularly regarding understanding the importance of therapy. Similarly, a lower educational level, concentration and memory difficulties negatively impacted upon treatment engagement, whereas an ability to "think psychologically" facilitated treatment engagement (Tetley et al., 2012).

***Additional Internal Factors.*** Tetley et al., (2012) identified a number of factors impacting upon treatment engagement which they reported could not be classified using the factors of the MORM. For example they noted "being avoidant" (trait factor), "having psychopathic traits" (trait factor), "being unable to trust others" (relating factor), "having other psychiatric conditions" (comorbidity factor) and "having physical problems" (physical factor) as barriers to treatment engagement; whereas having "lower impulsivity" (trait factor), "being able to build a therapeutic relationship" (relating factor) and "having a good diet" (physical factor) as facilitating treatment engagement (p. 103). It should be noted that this study also incorporated the opinion of both staff and non-forensic patients and so it is difficult to determine the extent to which offenders consider these factors to impact upon their engagement.

### **External Factors.**

***Opportunity, Resources, Support.*** In terms of support, six studies found feeling safe in one's environment to improve treatment engagement. For example, one study reported that

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offenders dropped out of treatment because they did not feel safe due to the harassment they were experiencing in treatment from their peers (Polaschek, 2010). Feelings of safety were enhanced by practical methods of security (e.g., CCTV, alarms, rules) and also by staff who the participants perceived to be competent in managing challenging behaviour and who gave consistent responses to offenders. The stigma of mental health was reported amongst some participants as a barrier to engagement. In contrast, the availability of a calm, therapeutic environment facilitated treatment engagement.

Perceived support from staff facilitated treatment engagement and retention in eight of the studies reviewed. Support from staff increased participants' willingness to talk about their difficulties, increased their willingness to accept the treatment being offered, and enabled them to manage negative feelings precipitated by treatment. Participants perceived their relationships with staff as important in helping them to address their needs and achieve their goals. Encouragement to pursue treatment and feedback regarding their therapeutic progress from staff also aided continued treatment engagement. This extended beyond staff directly involved in treatment to ward staff. Taking this all into account, it is not surprising that any withdrawal of such support was reported to negatively impact upon treatment engagement. Perceived negative relationships with both staff and peers were also noted to precipitate dropout. It is important to note, however, that support from staff was not perceived by all participants as relevant in explaining their non-completion.

As well as verbal reassurances from staff being important in aiding engagement, visual aids and behavioural rewards were beneficial as acknowledgments of participants with ID's therapeutic progress. In the study by McMurran and McCulloch (2007) participants who had completed treatment reported that whilst they received no support from the prison, they acknowledged that they had been paid to attend the course and thus on this occasion the

negative consequences associated with a lack of support may have been compensated for by their financial gain.

Three studies identified the availability of treatment as impacting on treatment engagement. Specifically, having a variety of therapies available which are facilitated by professional, experienced and motivated staff aided treatment engagement. Perceptions that treatment should not be delivered by psychological assistants were common amongst treatment refusers. The unavailability of immediate treatment decreased motivation to engage in treatment due to consequent feelings of ‘bureaucracy’ increasing the “them-us” perception between staff and those seeking treatment.

**Circumstance & Location Factors.** Specific to those participants residing in prison, a desire to be relocated nearer to family members was noted as a reason for dropout in one study (Polaschek, 2010). Furthermore, legal coercion to attend treatment was reported by a small number of participants.

***Additional External Factors.*** Within five studies, staff decisions to exclude an individual from treatment due to inappropriate behaviour, for example non-compliance with rules, were identified as a common reason for treatment non-completion. Whilst this would appear to be an external factor, reasons for the behaviour which lead to exclusion may represent the lack of an *internal* readiness factor (Breckon et al., 2013). Removal from treatment precipitated negative affect within such participants. Offender transfer from the unit was also found within two studies as a reason for treatment non-completion. Physical factors such as being sleep deprived, having a poor diet, and experiencing illness were also found to impede treatment engagement.

### **Discussion**

To date, theoretical models regarding offender rehabilitation have focused on what factors prevent client engagement in treatment. Whilst these models aid practitioners in the assessment of an individual's level of risk and needs, they have been criticised as providing little guidance in the way of responsivity (Ward et al., 2004). Although limited, more recent research has begun to explore client's perceptions of treatment, specifically what encourages/discourages their engagement in therapy, in order to guide practitioners in development of responsive treatment programmes. This review therefore represented the first effort in this area to synthesise what is known about offenders' perspectives on factors that affect treatment readiness.

Overall the findings of the review support the contention made in current theoretical models, such as the MORM, that treatment readiness is not just the result of internal, person centred factors, but external, contextual factors and their subsequent interaction. Internal factors associated with poor engagement identified by participants in the studies reviewed included cognitive (e.g., low self-efficacy, negative appraisals of staff, treatment, outcomes and other group members, denial/minimisation), affective (e.g., anxiety, stress, poor emotion regulation), and behavioural factors (e.g., fluctuations in mental health, learning difficulties and poor compliance with medication/rules). Engagement issues consequent of one's intellectual ability would suggest that the treatment being offered is not responsive to the specific needs of the client and therefore potentially reflects an issue external to the offender, rather than internal. It may be that such clients are motivated to engage but the treatment they are receiving is too complex. This is likely to precipitate negative affect and reduce one's self-efficacy to achieve change, which, as highlighted in this review, is associated with treatment non-completion.

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Volitional/identity factors (e.g., poor motivation to change, inability to set goals, incongruence between personal and treatment goals, strong subscription to identity as a “criminal” or the “street code”, perceived lack of choice and control) were also seen. The mismatch between personal and treatment goals reported in these studies highlights the need to properly assess the goals of the offender when recommending treatment in order to prevent non-completion of treatment. If an offender’s goals are still in accord with their previous criminal lifestyle, treatment aimed at rehabilitation will have little impact and thus treatment planning should take account of the offender’s status in the stages of change to ensure matters of responsibility can be adequately met (Prochaska & DiClemente, 1983).

A number of additional factors were also identified including trait, relating, co-morbidity and physical factors (Tetley et al., 2010). However these factors appeared to be specific to individuals with PD suggesting an extended version of the MORM is required for this population. In an attempt to meet this requirement Tetley et al., (2012) developed the Treatment Readiness Model of Personality Disorder (TReMoPeD). Future research should aim to explore the extent to which the TReMoPeD provides a more comprehensive model of treatment readiness amongst this specific population.

External factors identified by participants as encouraging engagement were support, treatment availability, and feelings of safety, indicating the presence of support, opportunity and resources factors of the MORM. Mason and Adler (2012) highlighted the importance of staff support on influencing treatment engagement stating that internal factors such as choice and control are to an extent removed from an offender once detained, and consequently internal sources of motivation for treatment are depleted. As a result, they suggested that offenders are dependent upon external motivation through staff support and encouragement, emphasising the importance of the therapeutic alliance in engaging clients in treatment but also support outside of treatment itself, as identified by the participants in this review.

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Although less commonly reported, a desire to be relocated nearer to family members as well as being mandated to treatment was noted to influence engagement amongst those residing in prison settings only, indicating the presence of both location and circumstance factor of the MORM.

Other external factors identified that are not included in the MORM were the client suffering from physical illness, sleep deprivation, and poor diet. Some of these external factors identified were staff- or organisation precipitated, for example, expulsion from treatment or transfer to another prison.

### **Strengths and Limitations of the Current Review**

The current review provides a unique contribution to the existing literature surrounding offender treatment readiness. The review implemented a thorough search strategy including searches across five electronic databases considered relevant to the field of research, a general search using the internet search engine Google, a hand search of the reference lists of previous reviews and through contact with key authors in the area. As no additional papers were identified by these authors, the search was considered comprehensive. The inclusion of dissertation papers in the review reduced the likelihood of publication bias, and was a further strength (Hopewell, McDonald, Clarke, & Egger, 2008). However, restricting papers for inclusion to those written in English is a limitation of the review because additional studies may have been missed.

In addition to the above, all participants included within the review were detained either in secure hospital or prison settings and subsequently the findings cannot be generalised to offenders residing in the community. Whilst this is a limitation of the review, factors regarding location (e.g., prison or community) have been noted to impact upon treatment readiness and therefore distinguishing offenders who were detained from those in community settings was deemed necessary (Ward et al., 2004). Although this review did not



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highlight any significant differences between those individuals detained in prison as opposed to secure hospital settings, as the research in this area expands, independent exploration of reasons for and against engaging in treatment between these populations would be warranted. It should be noted that two studies included for review did not report participants offending behaviour and therefore it cannot be concluded with certainty that all participants included in the review were convicted of an offence (Mason & Adler, 2012; Tetley et al., 2012).

Only a small number of studies were identified for review and these were heterogeneous in design, reflecting the emerging nature of research on treatment readiness. Regarding the latter, a quality assessment was identified that could accommodate qualitative, quantitative and mixed-method studies, however, this variation makes it more challenging to draw firm conclusions in this area. This is, however, the state of the literature as it stands and with more research investment in this area, it will be possible in the future to compare across studies that have adopted a similar design.

The definitions of engagement varied across all thirteen studies included for review, from failing to attend a required number of sessions (Sheldon et al., 2010) to poor engagement when attending sessions (Long et al., 2012). Furthermore, four of the studies failed to provide an explicit definition of engagement/non-completion (Breckon et al., 2013; Drapeau et al., 2005; McMurrin & McCulloch, 2007; Tetley et al., 2012). The lack of a consistent definition across all studies prevents definitive conclusions from being drawn. This limitation in particular has been identified in previous reviews regarding non-completion of treatment within offending populations and thus appears to be a limitation of the literature as a whole (McMurrin et al., 2010; Laroche et al., 2011).

In reference to the above, Tetley, Jinks, Huband and Howells (2011) define treatment engagement as “*the extent to which the client actively participates in the treatment on offer*” (p. 927). Specifically they suggest six aspects of participation which should be considered

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when assessing treatment engagement including, (1) attendance at requisite sessions, (2) completion of treatment within the expected timeframe, (3) completion of expected between-session tasks (where appropriate), (4) expected contribution to therapy sessions (including self-disclosure and/or other tasks activities), (5) appropriate alliance with the therapist, and (6) supportive and helpful behaviour towards other participants (in group therapies)” (p. 929). In support of this definition, similar aspects of engagement have been highlighted by Day et al. (2010; p. 154). Not only do Tetley et al. (2011) provide what would appear to be a comprehensive definition of engagement, but they also provide specific constructs in which engagement may be assessed.

Whilst various measures of treatment engagement exist, they typically fail to measure the construct of treatment engagement in its entirety (Tetley et al., 2011). Therefore, in order to accurately assess treatment engagement, both for the purpose of future research and clinical practice, validated and reliable measures which take account of each of the six identified constructs of treatment engagement need to be developed (Tetley et al., 2011). In the absence of such, reliance on an individual’s clinical notes or post intervention reports to provide details of engagement is necessary. Not only is this method likely to be very time consuming but it is also unlikely that such sources would provide consistent and comprehensive details regarding the construct of treatment engagement. However if such information and/or measures were available, this might provide a more sensitive way of assessing lack of engagement

### **Strengths and Weaknesses of the Studies**

As identified in the quality assessment, there are limitations amongst the studies included for review which require consideration. Reasons for engagement/disengagement were collated using semi-structured interviews and/or questionnaires, or via reference to clinical notes. Regarding the latter, reliance on retrospective clinical notes to assess

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offenders' reasons for non-completion is a significant limitation (Polascheck, 2010; Sheldon et al., 2010). As acknowledged by Sheldon et al., (2010) clinical notes may in part reflect staff's attributions for dropout and therefore the extent to which the findings accurately reflect the participant's opinion is unclear.

A bias towards adult, male offenders is apparent in the studies. Whilst this is reflective of the larger population of convicted male to female offenders (Blanchette & Brown, 2006), gender differences and/or similarities regarding treatment readiness cannot be assumed and therefore more research utilising female populations is required. Taking into consideration the fact that female detention rate is increasing (Blanchette & Brown, 2006), ensuring the availability of responsive treatment would appear vital in preventing recidivism.

In reference to those studies which implemented semi-structured interviews, the majority interviewed participants on one occasion and therefore only collected data regarding a limited period of time (Breckon et al., 2013; Drapeau et al., 2005; Mann et al., 2013; Mason & Adler, 2012; McMurrin & McCulloch, 2007; Sainsbury et al., 2004; Tetley et al., 2012). It should be noted that whilst Strauss and Falkin (2000) conducted two separate interviews, only the latter explored reasons for completion/non-completion of treatment. Both Long et al. (2012) and McGrain (2006) are an exception and their studies likely produced more comprehensive and accurate data. The studies also varied in whether they collected data on reasons for completion/non-completion prospectively or retrospectively. By adopting a retrospective approach, participant's experiences of having completed/not completed treatment are likely to have influenced their views.

Matters regarding reporting bias, as highlighted in the quality assessment, particularly with concern to the treatment status of the participant was problematic across the majority of studies included for review. Whilst authors reported on whether the participant was engaged in treatment or not, more specific details regarding their treatment status at the time of data

collection was absent. For example, of those studies which interviewed participants engaged in treatment, their level of engagement or how near to completing treatment they were when interviewed was rarely reported (Drapeau et al., 2005; Mason & Adler, 2012; Sainsbury et al., 2004). Similarly, the recency with which participants had dropped out/refused to engage or had completed treatment in relation to the timing of the interview was also rarely reported (McCorkel et al., 1998; McMurrin & McCulloch, 2007; Tetley et al., 2012). This is problematic because reasons for/against engaging in treatment are likely influenced by the participant's specific treatment status. Future research in the area needs to accurately report information regarding the sample used.

In addition to the above, as highlighted by the quality assessment, of the eleven studies which incorporated interviews within their design, only five provided explicit information regarding the interviewer and their affiliation with the research setting (Drapeau et al., 2005; Mann et al., 2013; McGrain, 2006; McMurrin & McCulloch, 2007; Sainsbury et al., 2004). Consequently, matters of reflexivity were poorly discussed. Of those studies which did report such information, in one study the interviewer although not directly involved in treatment was familiar with the participants (Sainsbury et al., 2004) and in another the interviewers were directly linked with the treatment programme in question (McMurrin & McCulloch, 2007). Subsequently, the risk of demand characteristics and response bias is increased.

Finally, as identified in the quality assessment, the qualitative data were often poorly reported in those studies utilising a mixed methods design. As a result the integration of both qualitative and quantitative data for these studies was not always clear. For example, where possible, three studies coded participant responses using the factors of the MORM (Long et al., 2012; Sheldon et al., 2012; Tetley et al., 2012). Whilst appropriate, direct quotes from participants to support the findings were not reported. Whilst both McMurrin and McCulloch

(2007) and Strauss and Falkin (2000) provided a general discussion on reasons for completing/not completing treatment, specific themes were not identified nor was sufficient evidence provided to support the findings discussed. One study failed to fully report the findings of the qualitative stage (Mann et al., 2012). Consequently, in reference to the studies discussed above, the extent to which the qualitative findings were drawn accurately from the results generated in the research and not influenced by biases is unknown.

### **Implications for future research**

Several suggestions for future research have already been made above. In addition, of the studies included for review, only two explored engagement amongst exclusive offender types, i.e., sex offenders (Mann et al., 2013) or violent offenders (Polaschek, 2010), yet the reasons given might vary by offender type. Subsequently, future research with exclusive offender types would help determine this. For example, with regards to violent offenders, attrition rates, particularly amongst those referred to intimate partner violence (IPV) programmes are high, with research reporting non-completion rates of up to 75% (Buttall & Carney, 2008; Day et al., 2010). Such findings would suggest that for this population either treatment programmes are simply not engaging individuals, or they are not viewed as relevant by those referred (Brown, 2012). Considering the latter, violent offenders are heterogeneous not only regarding their offence, but also in terms of their needs and causal influences on their offending behaviour (Day et al., 2010). Therefore, referral to highly structured programmes based on an individual's offence alone, without consideration of their specific needs, is likely to negatively impact on treatment engagement as offenders may perceive such programmes as irrelevant or unnecessary (Day et al., 2010). This perception is likely to precipitate dropout and/or treatment refusal, even amongst those motivated to address their risk (Day et al., 2010). Furthermore, particularly amongst offenders convicted of IPV, denial and minimisation of offending has been noted to coincide with the perception that one has

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been treated unfairly by the criminal justice system regarding their arrest and subsequent detention (Levesque, Velicer, Castle & Greene, 2008). Mandating such individuals to engage in treatment programmes is likely to reinforce this perception further, creating additional resistance to treatment, increasing the risk of poor engagement and even dropout (Day et al., 2010; O'leary, Day, Foster & Chung, 2009). Taking the above into consideration, further exploration of the factors that impact on treatment readiness in specific offender groups, particularly violent offenders, is vital in reducing recidivism and helping offenders pursue better lives.

Few studies included in the review (Drapeau et al., 2005; McCorkel et al., 1998; McGrain, 2006; McMurrin & McCulloch, 2007; Polaschek, 2010; Strauss & Falkin, 2000) provided adequate descriptions of the treatment programmes explored. Future research should ensure that treatment programmes are adequately described in order to allow the generalisation of results to other similar treatment programmes and subsequently aid the development of more targeted treatment programmes.

Furthermore, amongst the external factors identified in this review, exclusion from treatment was noted in several studies as the reason for non-completion of treatment (Long et al., 2012; Polaschek, 2010; Sheldon et al., 2012; Strauss & Falkin, 2000). Whilst this is clearly an external reason, the reasons why participants engaged in particular behaviours that led to expulsion were not explored and likely reflect internal factors. Exploration of these reasons would appear of particular importance as for some reason these offenders are choosing not to dropout nor are they choosing to engage and therefore the motivation for attending treatment is unknown.

Finally, when considering the implications associated with treatment non-completion, mainly increased risk of recidivism (McMurrin & Theodosi, 2007), future research should focus its attention on developing measures of treatment readiness in order to allow

practitioners to identify those individuals who are unlikely to engage and require preparatory intervention (Casey, Day, Howells & Ward, 2007). Derived from the internal factors of the MORM, the Corrections Victoria Treatment Readiness Questionnaire (CVTRQ) would appear, based on the outcome of this review, to reflect factors which offenders themselves perceive to impact their treatment readiness. However, validation of this tool is limited to male offenders referred to a cognitive skills programme delivered in community and prison settings in Victoria, Australia. Validation of this tool amongst both male and females in varying offender groups, as well as with different types of intervention is required before it can be accurately used to assess suitability for treatment (Casey et al., 2007).

### **Implications for Practice**

The review highlights several implications for practice. First, the findings revealed that for some offenders, failure to detach themselves from their previous criminal lifestyle/identity negatively impacted on their engagement in treatment because achieving rehabilitation was not considered a personal goal (McGrain, 2006; Polascheck, 2010; Tetley et al., 2012). Specifically within the context of secure hospitals, assisting clients to perceive themselves as “patients” rather than “criminals” or “prisoners” may help such individuals to detach from their previous criminal lifestyle and goals and instead work towards rehabilitation with the aim of pursuing a prosocial life. Engaging clients in such work prior to offence-focused treatment, is likely to ensure their personal goals are in accordance with those set by the treatment programme and thus increase motivation to engage.

Furthermore, the findings revealed that, for some individuals, negative perceptions of treatment were influenced by their inaccurate assumptions of the treatment experience.

Whilst some participants perceived treatment negatively due to aversive past experiences, be it their own (Mason & Adler, 2012; Tetley et al., 2012) or others (Mann et al., 2013), others failed to perceive the treatment being offered as comprehensive due to a disparity between

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their ideal preconception of treatment and the treatment being offered (McCorkel et al., 1998). As positive perceptions of treatment were noted to facilitate treatment engagement (Mason & Adler, 2012; McGrain, 2006; McMurrin & McCulloch, 2007; Tetley et al., 2012; Strauss & Falkin, 2000), engaging offenders in preparatory work, aimed at increasing their understanding of the aims of treatment, what it involves and the evidence base behind it, may alleviate negative preconceptions and encourage engagement (Kozar, 2010). Such preparatory work would also allow practitioners to assess clients' treatment readiness, learning style and level of ability in order to identify areas of need and ensure matters of responsibility can be addressed.

Furthermore, it was highlighted in the review that engagement in treatment was strongly precipitated by the realisation of the need to change and pursue a more prosocial lifestyle. Engaging clients in brief interventions, such as motivational interviewing, has not only been noted to increase readiness to change and self-efficacy (McMurrin, 2002), but also reduce treatment attrition and recidivism (McMurrin, 2009). Additionally, the findings of the review highlighted the importance of future goals upon offender engagement in treatment (Drapeau et al., 2005; McCorkel et al., 2007; McGrain, 2006; Long et al., 2012; Sainsbury et al., 2004; Sheldon et al., 2010; Tetley et al., 2012; Strauss & Falkin, 2000) and the subsequent negative impact of perceived coercion (Mason & Adler, 2012; McGrain, 2006; Strauss & Falkin, 2000). It is well documented that individuals are more likely to strive to achieve goals they set themselves as opposed to those set by others (Deci & Ryan, 2000). Thus practitioners should aim to work collaboratively with clients to establish prosocial goals and guide offenders to the realisation that such goals can be achieved via engagement in treatment (McMurrin, 2010). This will not only allow clients to have ownership over their own goals, but also ensure they are in accordance with those of the treatment being offered,



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preventing the likelihood of dropout due to the discrepancy between personal and treatment goals.

The negotiation and agreement of goals between a therapist and a client is reported to be essential for the development of a therapeutic alliance (McMurrin, 2010). In line with existing research, this review highlighted the importance of the therapeutic alliance and subsequent perception of external support in facilitating treatment engagement within an offending population (Kozar, 2010; Ward et al., 2004). With research suggesting the therapeutic alliance can accentuate the positive outcomes of treatment (Arnow et al., 2013; Meier, Barrowclough & Donmall, 2005; Polaschek & Ross, 2010) and increase motivation to change and pursue goals (Meier et al., 2005; Polaschek & Ross, 2010), practitioners should strive to establish such a relationship early on in an offender's treatment pathway. Once established, the therapeutic alliance should be used in a "motivationally-supportive way" to encourage an individual's progress through the various stages of change in an attempt to encourage engagement in treatment (p. 108, Polaschek & Ross, 2010) and facilitate therapeutic change (Kozar, 2010). Establishing a therapeutic relationship prior to treatment engagement would appear particularly important for those professionals facilitating group programmes as offenders are often reported to be treatment resistant, hostile and non-complaint, especially in the early stages of intervention (Day et al., 2010). With research suggesting such behaviour can negatively affect staff engagement with group members, for example not addressing violent behaviour or becoming overly reactive or punitive, increasing treatment readiness through the development of a therapeutic relationship prior to intervention would appear imperative (Day et al., 2010; Kozar & Day, 2009 as cited in Day et al., 2010).

Finally, the review highlighted the importance of internalised feelings of safety upon treatment engagement (Breckon et al., 2013; Drapeau et al., 2005; Mann et al., 2013; Mason

& Adler, 2012; Polascheck, 2010; Tetley et al., 2012). According to Maslow's Hierarchy of Needs (1943), safety is a basic human need and therefore it is not surprising that offenders' perception of safety would impact upon treatment engagement and ultimately the refusal of treatment (Mann et al., 2013). It is vital that all staff working with offenders feel able to manage challenging behaviour appropriately, in order to promote feelings of safety amongst others.

### **Conclusion**

Overall, despite the limitations discussed, the current review provides a unique insight into factors which impact upon offender treatment readiness. Findings from the review highlight that engagement in treatment is not solely the responsibility of the offender and their motivation to change but the organisation in which they reside. In the absence of professional, competent and supportive staff, working in a safe environment equipped with all the necessary resources, even those individuals who are motivated to change may fail to do so. The findings from the review emphasise the importance of investing time and building a therapeutic alliance with clients, prior to engaging them in treatment, if attrition is to be avoided. Such an investment is likely to reduce negative affect precipitated by both the treatment programme being offered and the environment and instead increase feelings of support, self-efficacy and control, which, as indicated by those participants included in the review, is important for treatment engagement.

Furthermore, the review also highlights the lack of consistency regarding the definition of engagement, and the implications this subsequently poses to the current field in terms of generalising the findings of what is already considered to be a limited research area. In order for research within the area of engagement to meaningfully progress, it would appear

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vital that a more consistent definition of engagement is adopted. A potential definition has subsequently been provided in this review (Tetley et al., 2011).

Consequently, the current review provides support for the MORM and its applicability amongst adult offenders, both with secure hospital and prison settings. However, it should be noted that a number of additional factors, both internal and external, were also identified. Whilst the additional internal factors appeared to be specific to those individuals with PD, the additional external factors identified, including exclusion by staff and transfer to another facility appeared to be endorsed across several studies. Based on the findings of the review, adapting the MORM to include such external factors is likely to provide a more comprehensive model of treatment engagement for offenders as a whole.

Finally, as highlighted by the current review, research exploring reasons for and against engaging in treatment from the perspective of the offender is sparse. If dropout and ultimately recidivism are to be prevented then it would appear vital that the opinions of those at whom intervention is targeted are listened to.

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**Endnotes**

<sup>1</sup> Based on the British Pound to U.S. Dollar conversation rate (£1=\$1.61) as reported on the 25<sup>th</sup> October 2014.

<sup>2</sup> It should be noted that this study was split into two phases. These means are taken from phase 2, the “main phase” of the study (p.6). In this phase participants were split into three groups, those who had admitted their offence and had accepted a place on a treatment programme (2.1, SD=2.6), those who had admitted their offence but refused a treatment place (3.3, SD=5.1) and those who denied their offence and refused a treatment place (3.2, SD=3.4).

Treatment Engagement from the Perspective of the Offender

Treatment Engagement from the Perspective of the Offender: Reasons for Non-Completion  
and Completion of Treatment: A Systematic Review

TABLES

## Treatment Engagement from the Perspective of the Offender

Table 1.

*Internal & External Factors of the MORM as taken from Ward et al. (2004).*

Readiness Factor	Description
<b>Internal Factors:</b>	
Cognitive Factors	<p><b>Self-efficacy:</b> refers to an individual's perception of his/her own ability to successfully pursue, perform and change their offending behaviours through participation in treatment. Clients who perceive themselves as unable to engage in the process of treatment and unable to develop and implement new prosocial skills, are unlikely to engage in rehabilitation.</p> <p><b>Attitudes &amp; Beliefs:</b> Refers to an individual's attitudes and beliefs regarding treatment and potential outcomes that are likely to influence engagement, particularly if the benefits are perceived to outweigh the associated costs of participation. It also refers to an individual's attitude/beliefs towards the therapists and/or their offending behaviour.</p>
Affective Factors	<p><b>Emotional dysregulation:</b> A lack of control over one's emotions is likely to hinder treatment readiness due to heightened feelings of hostility and physiological arousal however the experience of what is termed generalised distress can positively influence treatment readiness as the distress acts as a precursor to the contemplation of behaviour change. As many treatment programmes rely on an individual's ability to be able to experience, express and reflect on various emotional states is considered to aid treatment readiness.</p> <p><b>Guilt &amp; Shame:</b> Feelings of guilt are considered to aid treatment readiness whereas feelings of shame are considered to hinder treatment readiness. Whether the individual experiences feelings of guilt or shame is dependent on their emotional reaction to both their offence and their subsequent label of an offender. Feelings of shame are thought to evoke the perception that one is inferior, incompetent and overall a bad person which in turn is amplified by the heightening perception of being negatively judged by others. Such feelings of shame are likely to evoke behaviours of avoidance, whereas feelings of guilt are likely to result in confession and amendment. As a result, feelings of guilt are associated with a motivation to engage in emotional disclosure during treatment unlike that of shame.</p>

## Treatment Engagement from the Perspective of the Offender

- Behavioural Factors**      **Behavioural/Cognitive Skills:** An ability to recognise offending behaviour as a problem, actively seeking for help for such a problem as well as possessing the necessary skills and competencies to engage in treatment is considered necessary for treatment engagement. Individuals with a mental disorder or an intellectual disability may face additional challenges as the symptoms of mental illness/intellectual disorder may hinder some of the skills necessary for engagement in treatment.
- Volitional Factors**      **Internal Motivation:** Refers to an intrinsic motivation to change one's behaviour and involves the formulation of pro-social goals which the individual intends to pursue. The extent to which an individual perceives they have an element of choice over his/her goals and the subsequent control to pursue them is proposed to increase internal motivation. Incongruence between the goals of the client and that of the treatment programme being offered is considered to decrease internal motivation and prevent engagement in treatment. If a client perceives themselves as unable to effectively pursue a set goal, his/her motivation to engage in treatment decreases.
- Identity Factors**      This factor encapsulates an individual's values and beliefs about themselves as a person which is influenced by their age, gender, culture, class etc. This factor suggests that in order for an individual to effectively engage in treatment they must be open to changing their behaviour in the direction of the treatment being offered, for example a pro-social lifestyle void of criminal activity. Clients need to embrace the notion of developing a new identity which promotes an offence-free lifestyle.
- External Factors:**
- Circumstance Factors**      This refers to the extent to which an individual's personal circumstances are able to assist their engagement in treatment. This factor is heavily influenced by

## Treatment Engagement from the Perspective of the Offender

the extent to which treatment is voluntary or mandatory as a lack of choice over the decision to engage in treatment is likely to impair engagement. Even if voluntary, the level of perceived coercion to enter treatment from the environment around them is also likely to result in a lack of engagement.

### Location Factors

An offender's location, for example hospital, prison or the community, will impact upon treatment readiness this is likely to affect whether the skills acquired through treatment can be implemented in a meaningful way. Furthermore, an individual's location in relation to their family will also influence treatment readiness if his/her family is considered to be a valuable support network. The more distant his/her family is, the less contact there will be with this support network than what would be considered optimal.

### Opportunity Factors

**Availability:** This refers to the availability of treatment programmes and one-to-one therapy within an individual's current environment. A client may possess the motivation to engage in treatment however a lack of suitable programmes means they are unable to work towards rehabilitation.

**Environment:** The lack of a non-threatening therapeutic environment can negatively impact upon any positive progress made within treatment. A violent offender learning to manage their anger through anger management treatment, maybe unable to implement the skills learnt due to an overly provocative environment, characterised by anger and violence.

**Sentence:** An offender's sentence may influence treatment readiness. For example, those nearing the end of his/her sentence may not have enough time to complete a treatment programme before their release and so may not be offered the opportunity to engage. Those individuals serving particularly long sentences may not perceive an urgency to pursue treatment straight away.

### Resource Factors

Resources refer to the capacity of the environment to effectively facilitate a treatment programme/individual sessions with trained members of staff and the necessary materials required for optimal treatment. It also refers to the number of spaces available for treatment in relation to the number of individuals



## Treatment Engagement from the Perspective of the Offender

requiring treatment. An individual may be internally ready to engage in treatment, however if the treatment programme is already full or is offering less than optimal treatment, then this is likely to prevent/influence engagement.

### Support Factors

Refers to the extent to which the client is provided with, and subsequently perceives they are supported, predominantly by staff. Motivation to engage and complete treatment is thought to be heavily influenced by the support of staff to succeed in rehabilitation.

### Programme/Timing Factors

This refers to the extent to which an individual perceives a particular type of treatment as relevant to their needs and necessary to achieve rehabilitation. While the client may have a positive appraisal of the treatment, his/she may not be ready to pursue engagement straight away. The occurrence of a negative event, external to the individual, which causes them to contemplate the urgency of change, persuades him/her to partake in treatment sooner rather than later.

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## Treatment Engagement from the Perspective of the Offender

Table 2.

*Summary of Included Studies (n=13)*

<b>Author &amp; Date</b>	<b>Study Design</b>	<b>Treatment Type</b>	<b>Definition of non-completion/Engagement</b>	<b>Research Question</b>	<b>Sample Size</b>	<b>Main Findings</b>	<b>Quality Assessment score</b>
Breckon et al. (2013)	Qualitative	Psychological Intervention	None stated.	Factors associated with readiness to engage in treatment.	6 male forensic inpatients & 6 professionals	<p>Factors that were identified as contributing to treatment readiness</p> <p><i>Internal Factors:</i> Acceptance of help, liking yourself/enhanced self-image, having attained a sense of purpose/belonging, being in a good place emotionally, stability of mental health and impact of intellectual disability, complying with the rules of the environment, feeling safe within the residing environment, realising change is needed and willingness to discuss offending</p> <p><i>External Factors:</i> Reassurances about progress via visual representations, behavioural rewards, verbal reinforcement from staff, availability of therapy and resources, stability/predictability of the environment/staff, development of therapeutic relationships with staff.</p>	75%

## Treatment Engagement from the Perspective of the Offender

Author & Date	Study Design	Treatment Type	Definition of non-completion/Engagement	Research Question	Sample Size	Main Findings	Quality Assessment score
Drapeau et al. (2005)	Qualitative	Sexual Offender Treatment	None stated.	Factors which influence participation and/or avoidance of therapy	15 male prisoners	Three superordinate motives for treatment were identified: a desire to (a) recover their freedom, (b) have a sense of mastery and (c) avoid criticism/rejection and be accepted. These motives were also found to be related to the avoidance of treatment.	75%
Long et al. (2012)	Mixed-methods	All care-planned treatment.	Non-attendance. Also included sessions which the participant attended but failed to engage.	Reasons for treatment non-attendance. Perceived importance of attending sessions missed and relevance to recovery.	63 female forensic inpatients	<i>Internal Factors:</i> Cognitive factors (i.e. negative appraisal of treatment/self-efficacy) were common reasons for non-attendance. Affective and volitional factors were also identified. <i>External Factors:</i> Reasons for non-completion reflected the participants' circumstances at the time of treatment and frequently included medical reasons, e.g. illness/attendance at medical appointments at time of session.	75%

## Treatment Engagement from the Perspective of the Offender

Author & Date	Study Design	Treatment Type	Definition of non-completion/Engagement	Research Question	Sample Size	Main Findings	Quality Assessment score
Mann et al. (2012)	Mixed-methods	Sex Offender Treatment	<p><i>Treatment accepters:</i> those who had admitted their offence and had accepted a place on the programme.</p> <p><i>Treatment refusers:</i> those who had refused to participate in the programme.</p>	Factors associated with treatment refusal. Also explored barriers to treatment as perceived by both treatment accepters and refusers.	121 male prisoners <i>Phase 1 (n =11)</i> <i>Phase 2 (n = 101)</i>	<p>Six themes were identified as impacting upon an offender's decision to refuse treatment.</p> <p><i>Internal Factors:</i> Belief that treatment is ineffective, concern about the side effect of treatment, concern about stigma associated with offence and the impact of this on their survival in prison, perceptions of the focus of treatment and a disagreement with its intended aims/perceived outcomes, lack of trust and confidence in key professionals and feeling unsafe due to previous experiences of "the system".</p>	50%
Mason & Adler (2012)	Qualitative	Therapeutic group work	Active participation in treatment and not just 'obedience' and 'attendance'.	Reasons for engagement	11 male service users	<p>Identified 6 themes associated with engagement in therapeutic group work: motivation, content of group work, choice, expected outcomes, external locus of control and relationships.</p> <p><i>Internal Factors:</i> The following hindered engagement: the notion of detention within a high secure hospital results in</p>	75%

## Treatment Engagement from the Perspective of the Offender

Author & Date	Study Design	Treatment Type	Definition of non-completion/Engagement	Research Question	Sample Size	Main Findings	Quality Assessment score
						negative affect (i.e. disempowerment, de-motivation, distrust, helplessness), previous negative experience of group work, assumption that group work is difficult, challenging and intrusive. A lack of trust in facilitators and group members. Perceived lack of choice and control.	
McCorkel et al. (1998)	Qualitative	Therapeutic Community	Offenders who requested to leave the TC prior to graduation.	Factors associated with dropout/completion of treatment.	50 female prisoners (treatment dropouts = 32; graduates = 18)	Identified several factors associated with dropout: <i>Internal Factors:</i> Dissatisfaction with the programme offered. Negative perception of staff and group members. Aspects of the programme including surveillance and forceful probing precipitated feelings of powerlessness and cynicism towards the programme negatively impacted on engagement.	100%
McGrain (2006)	Qualitative	Therapeutic Community (TC)	In reference to treatment engagement the following was stated:	Factors which influence engagement	30 male prisoners	Identified several areas associated with treatment engagement. <i>Internal Factors:</i> Negative perceptions of treatment structure/delivery (i.e. the inclusion of small/large groups,	100%

## Treatment Engagement from the Perspective of the Offender

Author & Date	Study Design	Treatment Type	Definition of non-completion/Engagement	Research Question	Sample Size	Main Findings	Quality Assessment score
			“Clients who are engaged in treatment are actively involved in treatment and recovery”			rules, punishments) triggered lower levels of engagement. Those unwilling to relinquish the “codes of the street” failed to fully engage; the recognition of a need to change one’s lifestyle was associated with treatment engagement. Perceived lack of choice to engage.  <i>External Factors:</i> Family/friends were external motivators to engage in treatment. Rapport with staff maintained engagement. Legal coercion to engage in treatment by authority figures.	
McMurran & McCulloch (2007)	Mixed-methods	Enhanced Thinking Skills (ETS) programme	None stated.	Reasons for non-completion and completion of treatment	24 male prisoners (non-completers =18; completers = 6).	Reasons for dropout included: personal problems, drug use, group dynamics, group members not taking programme seriously, not liking the course, difficulties with tutors, out of session work too demanding, other commitments and staff exclusion. Reasons for completion included: an awareness that engaging in treatment would impact on parole decisions,	25%

## Treatment Engagement from the Perspective of the Offender

Author & Date	Study Design	Treatment Type	Definition of non-completion/Engagement	Research Question	Sample Size	Main Findings	Quality Assessment score
						prevent recidivism, learn new skills, learn to manage anger, increase confidence/improve self as a person.	
Polaschek (2010)	Quantitative	The Rimutaka Violence Prevention Unit (RVPU)	Non-completion was defined using categories described by Wormith and Olver (2002).	Can completers be distinguished from non-completers using psychometric and demographic variables related to risk/criminogenic need. For the purpose of this review, the outcome indicator was the reasons for non-completion	138 male prisoners	Reasons for non-completion were categorised into the 6 groups:  Withdrawn from treatment by the criminal justice system for reasons unrelated to programme involvement; withdrawn by the therapist due to their behaviour during treatment (i.e. hostile/disruptive); prisoner initiated withdrawal for reasons including a desire to be relocated to a prison nearer to family, perceiving treatment to be unnecessary, finding sessions too anxiety provoking or believing they would be paroled anyway; prisoner feared for safety from their peers on programme; removed due to engaging in offending behaviours; unknown reason.	75%

## Treatment Engagement from the Perspective of the Offender

Author & Date	Study Design	Treatment Type	Definition of non-completion/Engagement	Research Question	Sample Size	Main Findings	Quality Assessment score
Sainsbury et al. (2004)	Qualitative	Not specified	None stated.	Factors which influence engagement in treatment.	6 male forensic inpatients	<p><i>Internal Factors:</i> Feelings of safety; attaining a sense of belonging across a variety of areas including treatment; support network; Internal motivation relating to positive long term goals (i.e. leaving secure services).</p> <p><i>External Factors:</i> External support from staff both inside and outside of treatment increased treatment engagement; unavailable treatment, long waiting times and lack of understanding of the assessment process hindered motivation for therapeutic engagement; a stable therapeutic relationship was found to increase motivation to engage. The sudden loss of this relationship was associated with reductions in engagement.</p>	75%
Sheldon et al. (2010)	Quantitative	Various psychological therapies.	Non-completion: Referred to any participant who had	Rate of non-completion	28 male forensic patients	<p><i>Internal Factors:</i> Cognitive (lack of self-efficacy with regard to one's ability to engage in treatment, negative appraisal of the treatment programme being offered and negative appraisals of</p>	50%



## Treatment Engagement from the Perspective of the Offender

Author & Date	Study Design	Treatment Type	Definition of non-completion/Engagement	Research Question	Sample Size	Main Findings	Quality Assessment score
			failed to attend the required number of sessions, either through patient withdrawal or failure to meet attendance requirements. Did not include treatment refusers or those excluded from participation.	Participant reasons for non-engagement		other patients within the group and the facilitating staff), volitional (incongruence between participant goals and that of the treatment programme) and affective (feelings of anxiety, embarrassment and distress associated with treatment) factors were the most common reasons for non-completion of treatment. Identity factors regarding the denial of being ‘a mental patient’ or an individual diagnosed with PD were also reasons for non-completion.  <i>External Factors:</i> External factors of the MORM including support, location and circumstances were not commonly referred to as reasons for non-engagement. Factors, as identified by the authors, including staff exclusion for inappropriate behaviours in session, and transfer to another unit/prison were the most commonly endorsed.	
Strauss &	Mixed-	Drug user	Non-completers included	Explored reasons for	101female	<i>Internal Factors:</i> A desire to be sober, acknowledgment of a	75%

## Treatment Engagement from the Perspective of the Offender

Author & Date	Study Design	Treatment Type	Definition of non-completion/Engagement	Research Question	Sample Size	Main Findings	Quality Assessment score
Falkin (2000)	methods	treatment	those who quite the programme or received an administrative discharge.	and against completion of a drug user treatment programme.	prisoners (completers=55; non-completers=46)	<p>need for help and a wish to avoid the general prison population facilitated engagement in treatment. Wanting to complete treatment in order to achieve a sense of pride was also noted. Perceiving the programme rules as unfair was noted to result in feelings of victimisation and thus dropout. Feeling stressed, under too much pressure and having a negative perception of treatment was a reason for dropout. Others reported feeling forced to attend</p> <p><i>External factor:</i> Positive relationships with staff/peers were reasons for completion; negative relationships with staff/peers precipitated dropout. Participants who engaged in fighting and threatening behaviour towards others were removed from the programme.</p>	
Tetley et al. (2012) <sup>a</sup>	Mixed-methods	Psychosocial Therapy	None stated.	Barriers to and facilitators to	19 non-forensic community	Barriers & Facilitators to treatment engagement as identified by the MORM:	50%

## Treatment Engagement from the Perspective of the Offender

Author & Date	Study Design	Treatment Type	Definition of non-completion/Engagement	Research Question	Sample Size	Main Findings	Quality Assessment score
				treatment engagement	outpatients 41 male and 16 female forensic inpatients (Detained)	<p><i>Internal Factors:</i> Cognitive factors i.e. denying/minimising offending, feeling inappropriately detained, low self-efficacy regarding ability to change/engage in treatment, negative perceptions of staff/authority hindered engagement. Affective factors including emotional dysregulation, negative affect i.e. feeling fearful/anxious about treatment were barriers to engagement; an ability to cope with distress/recognise emotions facilitated engagement. Volitional factor i.e. motivation to change, setting goals and taking medication facilitated engagement. Behavioural factors i.e. having to be open and honest was a barrier to engagement; an ability to think psychologically was a facilitator. Identity factors including a difficulty dissociating from a criminal lifestyle impeded engagement.</p> <p><i>External Factors:</i> Previous negative experience of treatment was a barrier to engagement. Resource &amp; Opportunity factors</p>	

## Treatment Engagement from the Perspective of the Offender

Author & Date	Study Design	Treatment Type	Definition of non-completion/Engagement	Research Question	Sample Size	Main Findings	Quality Assessment score
						<p>i.e. shortage of staff, inconsistency in staff responses, negative environment and long waiting times hindered engagement.</p> <p>Support factors i.e. members of treatment not getting on and the stigma of mental health was a barrier to engagement.</p> <p>Identified four additional factors including trait, relating, comorbidity and physical factors.</p>	

<sup>a</sup>As the focus of the current review is regarding engagement in forensic samples, findings regarding the non-forensic PD sample implemented within Tetley et al. (2012) study were not reported within this table. For details regarding this, please refer to full text.

