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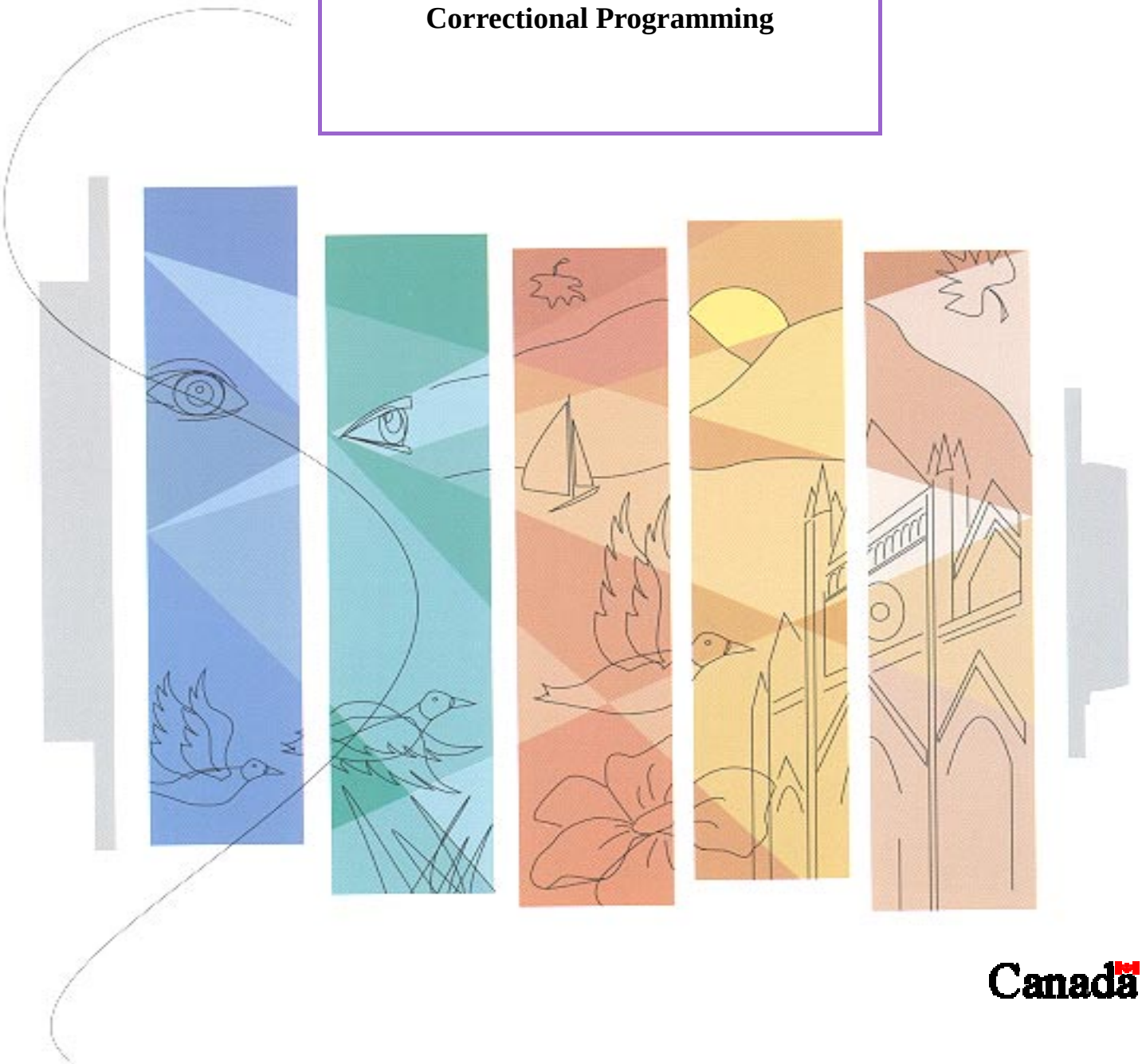
Treatment Readiness and Responsivity: Contributing to Effective Correctional Programming



Canada

Treatment Readiness and Responsivity:

Contributing to Effective Correctional Programming

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Executive Summary

The present report provides an overview of issues related to the effective treatment of offenders. Treatment responsivity is considered to be comprised of two related constructs, treatability, a term used in forensic settings, and treatment effectiveness. The former describes aspects of motivation and treatment compliance, while the latter considers the assessment of treatment gain and generalization of treatment effects. The purpose of this paper is to integrate these constructs into a contemporary model to guide the development of an assessment protocol for use by clinicians and program staff in correctional settings. The resultant protocol is generic, permitting its application across a range of programs. Preliminary data are presented which support its utility and recommendations are made regarding its further development prior to implementation.

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In most Correctional agencies today, treatment is viewed as an integral part of the risk management continuum and offender responsivity is a critical issue for correctional programs. Therefore, this research report, which is set in the context of a risk/need management framework, will present a theoretical overview of the concept of offender treatment responsivity. Preliminary findings from a standardized assessment battery of offender responsivity will be presented and a number of responsivity-related factors will be identified and discussed in terms of their potential impact on treatment outcome. Our objective is to place the construct of treatment responsivity into a context which underscores the importance of allocating offenders to programs in the most effective manner and to delineate factors that might mediate the effectiveness of treatment services.

To date, the Correctional Service of Canada (CSC) has invested heavily in the development of systematic assessment and re-assessment of criminogenic needs and offender risk (Motiuk, 1997) in order to plan for the delivery of correctional programs. A strategy has been developed to ensure each offender receives a correctional treatment plan which reflects this assessment. Further, a variety of core programs are available (Cognitive Skills, Anger and Emotions Management, Living Without Violence, Parenting, Offender Substance Abuse Program) across all sites and security levels, including the community. Preliminary outcome data regarding reduced recidivism and positive program

evaluation are encouraging. These findings demonstrate that the provision of correctional programs with high integrity is good correctional management (Millson, Weekes, & Lightfoot 1995; Robinson, 1995). Further, this strategy of identifying offenders' risk level and targeting their needs is consistent with CSC's Mission Statement. Additionally, environmental scans in the form of staff and offender surveys have yielded important information regarding their views and expectations about correctional programs (Correctional Service of Canada, Lariviere; 1994, 1995). Overall there is strong support by staff and offenders for correctional programs in the CSC. Moreover, reports by the Auditor General (May 1996, November 1996) and the Reintegration Task Force (January 1997) highlight the critical role of programs in the correctional process. Therefore, CSC has taken a strong stance in support of treatment programs for offenders.

The work of Andrews and his associates (1986, 1990) outlines the key principles of effective correctional programming. These principles are based on their in depth analysis of programs that showed above average success in reducing recidivism. The risk principle states that the intensity of the treatment intervention should correspond with offenders' risk of recidivism. This is because higher risk cases tend to respond better to intensive service, while low risk cases respond better to less intensive service. Once offenders are appropriately matched in this manner, attention should be directed to the sorts of needs that the treatment program should address. The need principle distinguishes between criminogenic and noncriminogenic needs. The former are dynamic risk factors (Gendreau et al. 1994), which if changed reduce the likelihood of criminal

conduct. In contrast, noncriminogenic needs, which are derived from personality variables such as personal distress and self-esteem (Gendreau et al,. 1994), are considered less relevant targets for treatment since their resolution does not have a significant impact on recidivism. Finally, the responsivity principle states that styles and modes of treatment service must be closely matched to the preferred learning style and abilities of the offender to enhance efficacy (Bonta, 1995).

Although the principles of risk and need have been clearly articulated in the literature, the precise role and function of offender responsivity and other variables related to motivation are not yet clearly understood in correctional intervention. This is despite the fact that these variables are widely recognized as key factors mediating the success of treatment programs, notably in the area of addictions (Miller, 1985). It is our view that treatment readiness and responsivity must be assessed and considered in treatment planning if the maximum effectiveness of treatment programs is to be realized.

RESPONSIVITY AND RELATED CONSTRUCTS

It is commonly accepted that behavioral, cognitive-behavioral, and multi-modal intervention strategies yield the best outcome for correctional samples (Andrews & Bonta, 1994). However, the provision of well designed programs with therapeutic integrity, while necessary, is not a sufficient requirement for effective intervention with offenders. Not only must intervention target criminogenic needs, but, therapists and service providers must consider offenders' learning styles and characteristics, and then match offenders' and therapists' styles. Several of

these issues are fundamental to the principle of treatment responsivity, a term used to describe client-based factors which influence the potential for positive treatment effects. Below, we review the responsivity principle, its related constructs and their relationship to risk, need, and effective intervention in corrections.

Treatability

Rogers and Webster (1989) suggest that treatability refers to the clinical determination of which patients (offenders), under what treatment modalities and environmental conditions will respond most favorably. Their conclusion was that clinicians who attempt to assess treatability are hampered by a lack of consentual understanding of the construct and its relationship to treatment outcome. This is consistent with data reported by Quinsey and Macguire (1983) which revealed that mental health staff demonstrate poor interclinician reliability when assessing the treatability of offenders with personality disorders. Although most offenders meet the DSM-IV diagnostic criteria for personality disorder (APA, 1994; Marshall & Serin, in press), clinicians disagree about relevant treatment strategies and treatment efficacy for these offenders. This creates a dilemma for informed treatment planning.

Heilbrun and his colleagues (Heilbrun, Bennett, Evans, Offult, Reiff, White, 1988; Heilbrun, Bennett, Evans, Offult, Reiff, White, 1992) took the initial steps to develop a means of assessing treatability. First, they identified four key aspects: (a) appropriateness (fit between treatment goals and patient deficits), (b) response history (previous experience with this form of treatment, (c)

motivation, and (d) contraindications. Then, they created individual items and organized them into the following areas: i) biological (appropriate disorder, history of response, physical contraindications, and motivation); ii) educational/training (lacking in relevant skill, response to past educational/training interventions, likelihood that training will be productive, and motivation for specific training, with these four items rated separately for vocational skills, social skills, living skills, anger management, medication management, and communications skills); iii) management (frequency of threatening or aggressive behavior, past response to management interventions, likelihood that management will be effective); and iv) psychotherapy (extent of discontent or ineffectiveness, past response to psychotherapy, contraindications, and motivation). By creating a scale using these items, Helibrun et al (1992) demonstrated modest overall reliability, with the strongest findings in the areas of psychotherapy and biological treatment. These data support the view that even the treatability aspect of responsivity is a multifaceted concept and that a great deal more work is required to operationalize the construct in a meaningful and empirically sound manner.

Motivation and Treatment Readiness

The traditional view of motivation, that it is a personality characteristic, was both restrictive and simplistic. Thus, motivation was conceptualized as a state factor (i.e., motivated or unmotivated) and, the desire to change was perceived as a quality one had or did not have. Importantly, this perspective failed to include factors which influence a person's desire to change his or her

behavior. This view has been replaced in recent years with a one that emphasizes the complexity of change. This interactional model asserts that internal and external factors influence the change process. From this perspective, motivation is viewed as an interactional and interpersonal process that can be influenced in a positive way by the clinician. Motivation in this context is dynamic and it therefore behooves the therapist **to motivate** the offender (Miller & Rollnick, 1991).

Thus far, we have emphasized the importance of multi-method assessment of criminogenic treatment targets, the need for programs of high integrity which reflect good correctional practices, appropriate matching of offenders to treatment modalities, consideration of therapist and offender characteristics, and the assessment of treatment readiness. The next stage is to create effective motivational choices so that offenders are most likely to respond favorably to correctional programming. This includes enhancing offender motivation and dealing with resistant clients after the pre-treatment assessment of treatment readiness. Motivation may be operationally defined as "the probability that a person will enter into, continue, and adhere to a specific strategy". Therefore, it cannot be adequately measured by self-report, but must include behavioral referents. Treatment motivation can be measured by attrition rates, attendance, and participation levels, including willingness to complete homework and disclosure in sessions. Offenders who are resistant to treatment may well require pre-treatment priming in order for the formal treatment program to be effective.

Many offenders view their criminal behavior in an ego-syntonic manner. That is, they are relatively unconcerned about their actions, except in terms of their legal consequences. Accordingly, many offenders feel coerced into treatment, consenting only because the contingencies for refusing to participate are sufficiently negative. Minimization of the effects of their behavior on others, denial of responsibility, and rationalization of their law violations are common among offenders. Treatment engagement must address these obstacles, primarily by focusing on therapeutic alliance and assisting offenders to develop a cost-benefit analysis for comparison purposes (Preston & Murphy, in press). Further, the content, intensity, and style of intervention must be consistent with the offender's current stage in the change process. This complex interaction forms the cornerstone for incorporating motivational interviewing into correctional programming (Miller & Rollnick, 1991). Treatment progress then becomes, in part, a index of the effectiveness of the match of the offender to type of treatment modality, as well as the interaction between therapist and offender. Currently, however, there appears to be little or no empirical data to indicate the relative contribution of these factors to treatment progress.

Motivation as a Dynamic Variable

There has been considerable work completed on the process of psychotherapy change by Prochaska and his colleagues (Prochaska & DiClemente, 1986; Prochaska, DiClemente, & Norcross (1992), mainly in the area of addictions. To ensure their intervention is sensitive to clients' level of readiness, Prochaska developed and validated a self-report measure, the

URICA, on various samples. Four stages of change have been identified: precontemplation, contemplation, action, and maintenance. In the precontemplation stage, the individual is not even considering the possibility of change. Individuals in this stage typically perceive that they are being coerced into treatment to satisfy someone else's need. The contemplation stage is characterized by ambivalence, in other words individuals may simultaneously or in rapid alternation consider and reject reasons to change. Individuals in the action stage have made a commitment to change and are engaging in actions to bring about change. Typically at this stage they are involved in therapy. Lastly, individuals in the maintenance stage, are working to sustain the significant changes they have made and are actively working to prevent relapse. This transtheoretical treatment model (Prochaska & DiClemente, & Norcross, 1992) highlights the importance of treatment readiness and is consistent with the responsivity concept. To ensure their intervention is responsive to clients' level of readiness, Prochaska and his colleagues developed and validated a self-report measure, the URICA (University of Rhode Island Change Assessment Scale) on various samples. Although their assessment work is evolving, it provides an initial starting point for our work on the development of a multi-method assessment strategy of treatment readiness and responsivity with offenders. Its application to correctional intervention with offender populations may well provide the conceptual focus that has been lacking.

Preliminary research supports the utility of the assessment of motivation in predicting risk in offenders under community supervision (Stewart & Millson,

1995). Motivation (low, moderate, high) and need (employment, marital/family, associates, substance abuse, community functioning, personal/emotional, and attitude) was related to release failure. Failure rates varied across the seven criminogenic domains and motivation was significantly related to conditional release outcome ($p<.001$). Those offenders rated by staff as low on motivation failed sooner. Further, need and motivation interact such that offenders rated as low need/high motivation consistently performed better on release than offenders rated as high need/low motivation ($p<.001$).

Treatment Responsivity

By conceptualizing responsivity as a broad concept which incorporates treatability (treatment readiness and motivation) and is related to treatment response and outcome, it may be possible to advance our efforts at detailed assessments of responsivity (See Figure 1). Gains in our understanding of effective correctional programming will also be helpful so that appropriate treatment is provided as a backdrop against which the assessment of responsivity occurs. Concepts such as amenability, motivation, compliance, treatment response, and treatment gain all contribute to the notion of responsivity. Importantly, the extension of the assessment of treatment gain to reflect the degree of change and the identification of thresholds for knowledge and skill, have appeal. The relation of responsivity to outcome and risk are also important issues to investigate. For instance, are there data to support the often expressed belief that most high risk offenders are not amenable to treatment? The construct, then, should not be limited to pre-treatment state measures,

rather it is best conceptualized as a process, as a dynamic variable with offenders differing in terms of their entry level at the beginning of treatment. Just as offenders have case-specific treatment targets, they also have differing distances to travel along the change process. The clinical question seems to be - How do you know if and when a particular offender will respond to treatment?

It is widely accepted that offenders differ substantially, not only in their level of motivation to participate in treatment, but also in terms of their responsivity to various styles or modes of intervention. According to the responsivity principle, these factors impact directly on the effectiveness of correctional treatment and ultimately on recidivism. Consequently, various offender characteristics must be considered when assigning offenders to treatment programs.

Individual characteristics that interfere with or facilitate learning can be broken down into internal and external responsivity factors. Internal factors refer to individual client characteristics: motivation, personality characteristics (i.e., psychopathy, anxiety, depression, mental illness, self-esteem, poor social skills), cognitive intellectual deficits (i.e., low intelligence, concrete oriented thinking, inadequate problem solving skills, poor verbal skills), and other demographic variables (i.e., age, gender, race, ethnicity). External factors refer to therapist and setting characteristics. It is important to understand that external factors, in isolation, do not impact on responsivity. Rather, therapist and/or setting characteristics interact with offender characteristics to affect (impede or assist) responsivity.

Specific responsivity factors merit comment in that they are represented in most settings (See Figure 2). Consideration of gender issues, ethnicity, age, learning style, social background, and life experiences all contribute to the engagement of offenders into treatment and the development of therapeutic alliance (Dana, 1993). Ignoring these issues will significantly impede offenders' compliance with treatment. Similarly, failure to consider these factors may contribute to inaccurate assessment of the motivation or readiness of individuals referred for treatment. This is not to imply that offenders and clinicians must share similar characteristics and backgrounds, rather, treatment will be enhanced with respect to the extent such factors are considered. Effective matching of offenders' and therapists' "styles", as well as intensity of intervention are central to the principle of treatment responsivity (Bonta, 1997).

From a correctional perspective, there are a range of offender characteristics which also influence treatment responsivity (Bonta, 1995; Van Voorhis, 1997). Within the context of risk assessment, several strategies have been proposed which identify risk factors, some of which are relevant for treatment. For instance, the MacArthur Risk Assessment Study (Monahan & Steadman, 1994) have proposed the following dynamic factors: anger, personality style, impulsiveness, psychopathy, cognitive impairment, prior treatment compliance, psychiatric symptoms (nature and severity), violent fantasies, and substance abuse. In this context dynamic refers to factors that can change over time, in part as a function of some type of intervention. Similar factors have been reflected in other contemporary risk assessment strategies

(LSI-R, Andrews & Bonta, 1995; HCR-20, Webster, Eaves, Douglas, & Wintrup, 1995).

Differential Treatment

Efforts to clarify offender sub-populations according to certain clinical and offense-specific variables have furthered our knowledge of effective correctional treatment. For example, differentiating among sex offenders according to type of victim, degree of sexual deviance, and pervasiveness of sexual assault history, among other variables, distinguish empirical "types" (Knight, Prentky, & Cerce, 1994). These types have differential outcomes, both for those who have received treatment and those who have not received treatment (Marques et al, 1994; Barbaree, Seto, & Maric, 1996; Hanson & Bussière, 1996). Similarly, violent offenders can be distinguished in terms of their anger problems, the degree of instrumental violence employed, their use of weapons, their attributions towards others, the degree of planning in their crimes, and their level of impulsivity. This array of variables will clearly yield a heterogeneous sample of violent offenders referred for treatment. In this respect, one treatment strategy cannot be expected to meet all these offenders' needs equally. Additionally, it is reasonable to anticipate such heterogeneity will yield differential treatment effects, similar to those seen in the sex offender treatment literature. A good differentiation of offender classification types according to risk and need may further advance the precision by which treatment can be prescriptively applied and should lead to a more comprehensive assessment of responsivity related factors (Serin, 1995b; Seto & Barbaree, in press).

Treatment effectiveness depends on matching types of treatment and therapists to types of clients and the general psychotherapy research has shown that the personal variables of a therapist are very important for effective intervention. However, with the exception of the CaVic research conducted by Andrews and Kiessling (1980) on characteristics of effective probation officers, there is little systematic research on the impact of therapist characteristics on correctional treatment. This is a much needed area of research as a group of therapists working in a common setting and offering the same treatment approach, often produce dramatic differences in terms of client attrition and successful outcome. Therapists' attitudes and competence that do not match the aims and content of a program may lower treatment integrity and reduce its effectiveness.

Assessment of Treatment Gain

The ultimate measure of an offender's treatability is the gain that he/she has made by participating in treatment. Therefore, assessing treatment gains is an important part of any program evaluation and helps one to understand the extent to which responsivity has been factored into the treatment plan. When the principles of effective correctional programming previously noted are met, programs are relatively effective. For instance, meta-analytic reviews suggest that effective correctional programming can result in 20-40% reductions in recidivism (Gendreau, 1996). While these data are cause for optimism, there are substantive issues that must be addressed if we are to progress further. Many programs are methodologically weak - having small samples, lacking control

groups, and limited follow-up times. Comparison across studies is further compounded by disagreement regarding independent measures, e.g., lack of standardized tests, and differing outcomes, e.g., suspension, re-arrest, reconviction. Also, ratings of treatment gain typically rely on self-report information and often include retrospective coding. These limitations reflect an absence of an integrated and concerted effort to investigate the efficacy of specific correctional treatment(s). Such an effort, however, requires an investment of time, resources, and conceptual clarity. Only then will empirical data be available to withstand criticisms that correctional programs are ineffective and philosophically flawed (Quinsey, Rice, Harris, & Lalumiére, 1993).

Other issues relating to the assessment of treatment gain are worth considering briefly. As noted previously regarding criminogenic need, multi-method assessment is critical. Clinicians should be especially suspect if self-report methods yield significantly more positive evaluations than behavioral methods. The tendency to over-rely on self-report is partly out of convenience because it is relatively simple to have offenders complete test batteries. This is a major concern for offender populations given the inherent incentives to present socially desirable responses. The lack of convergence between self-report and behavioral measures has also generally been ignored. The issue of social desirability can be partly controlled by statistical procedures during analyses if measures of social desirability are available. While sites attempt to develop their own assessment measures, often these are site or program specific. Again, limited resources make the development and validation of new measures

problematic for most sites. Inter-rater reliability concerns and the practical difficulties of coding interview-based data and behavioral measures are additional reasons for the reliance on self-report measures. Unfortunately, the evidence for the predictive validity of self-report measures is weak (Barbaree, Seto, & Maric, 1996; Quinsey, Khanna, & Malcolm, 1996; Serin & Kuriychuk, 1994). Self-efficacy is also relevant for the assessment of treatment gain. Clinically, it appears that some offenders have high efficacy, but low skills, leading to inflated self-perceptions. Others with low efficacy, but high skills, may be reluctant to attempt to generalize treatment gains across situations. Both circumstances limit treatment gain. Further, process measures are beginning to emerge as dynamic indices of treatment gain, with evidence of incremental prediction of outcome relative to static or statistical estimates (Barbaree et al, 1996). This brief overview suggests that promising strategies exist to improve the assessment of treatment gain, thus enhancing the evaluation of treatment efficacy.

Lastly, defining outcome is important in determining treatment effectiveness. While a fundamental issue is whether recidivism is reduced as a function of correctional programming, other dependent measures may facilitate a finer analysis of treatment effects. For instance, generalization of treatment effects is a different issue than demonstration of treatment gains. Offenders can learn new knowledge and skills, but fail to apply them to new situations (Marques et al., 1994). Further, delays in the onset of relapse, i.e., recidivism, or the

amelioration of the seriousness of relapse are additional legitimate measures of the impact of treatment.

DEVELOPMENT OF A PROTOCOL FOR THE ASSESSMENT OF TREATMENT RESPONSIVITY IN OFFENDERS

With this review of the literature completed, we believe that the development of a theoretically-based, multi-method assessment protocol of treatment readiness, responsivity, and participation is attainable and should contribute to the broader literature on effective correctional programming. The paucity of standardized measures suggested that a simple compilation of existing tests would be less successful than their incorporation into a new assessment strategy. Partly, this initiative was specifically developed to meet the need for systematic assessment of treatment readiness and the identification of treatment responsivity factors in a new treatment program for persistently violent offenders (Serin, 1995). Our intent was to pilot an assessment strategy which could be initially applied to that treatment program, but eventually for a range of correctional programs. Accordingly, the protocol was developed for generic application rather than being specific for a particular treatment program.

For our pilot work the assessment protocol[1] comprised: University of Rhode Island Change Assessment scale (URICA, Prochaska & Diclemente, 1992); Balanced Inventory of Desirable Responding (BIDR, Paulus, 1984). Interpersonal Style Rating scale (IRS, Kennedy & Serin, 1996); Treatment Evaluation Rating scale (TER, Serin & Kennedy, 1996). These latter two measures are interview-based assessments of responsivity factors and treatment gain/participation, while the former measures were self-report paper

and pencil questionnaires. The entire protocol was completed pre and post-treatment. The principal domains sampled by the Interpersonal Style Rating scale and Treatment Evaluation Rating scale are presented in Table 1. Sample items from The Stages of Change Questionnaire, Orientations Towards Treatment, and Readiness to Change Questionnaire are presented in Table 2.

Results

The protocol was completed by 72 offenders (21 treated sex offenders; 20 untreated sex offenders; 31 treated non-sex offenders). The mean age for the sample was 37.7. The mean sentence length was 54 months, plus 11 offenders had indeterminate sentences. Only 16% of the sample had nonviolent index offenses. Regarding program type, 29% completed sex offender treatment, 19% completed substance abuse programs, 18% completed Cognitive Skills, and 5% completed anger management. An additional 20 offenders completed the protocol during an intake assessment process, prior to participating in correctional programs. The majority of offenders were married (61%) and were in minimum security (64%).

Treatment Readiness

With respect to pretreatment assessment of treatment readiness (URICA), using published cutoffs, 45% were in pre-contemplation stage at pre-treatment. Also, none of the offenders were in the more advanced stages of change, i.e., contemplation, action, or maintenance at pretreatment. This did not change at post-treatment with 43% of the sample exceeding cutoffs for precontemplation.

[1] Other measures (Orientation to Treatment Scale; Robinson & Weekes, 1994; Readiness for Change Questionnaire; Rollnick, Heather, Gold & Hall, 1992) were administered but not included

None of the offenders reported being ready for treatment using the clinical norms available. Further, calculating treatment readiness differences scores for all 4 of the stages of change failed to yield significant differences pre and post-treatment. On a recently developed Treatment Readiness Score[2] the sample scored less than half that of a male batterers sample (comparable normative data provided by Cancer Prevention Research Consortium). Relative to sex offenders, the non-sex offenders had lower treatment readiness scores, but the differences were not statistically significant. Table 3 presents correlations among the independent measures.

Interpersonal Style and Treatment Evaluation

The Interpersonal Style Ratings have 11 domains with 2 items each rated on a 4 point scale. Total scores range from 0-66, with higher scores purported to indicate enhanced treatability. Comparisons pre and post-treatment yielded significant different total scores ($M = 9.4$, $SD = 9.0$, $p < .001$). This pattern held for each of the 11 domains with Bonferoni correction ($p < .005$).

Pre-treatment and post-treatment ratings of Interpersonal Style were significantly correlated with Treatment Evaluation (Pre-treatment , $r = .50$, $p < .0002$, 7 of 11 items significantly correlated, Bonferoni corrected; Post-treatment; were significant at pre-treatment ($r = .69$, $p < .0001$, 11 of 11 items significantly correlated, Bonferoni corrected). The pre/post difference total was also significantly correlated with Treatment Evaluation ($r = .46$, $p < .005$).

Interpersonal Style Ratings and self-reported current treatment

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in the data analyses because they were shown to be redundant.

satisfaction were not significantly correlated. The only significant difference between sex offenders and non-sex offenders on changes on Interpersonal Style was victim stance ($p < .004$), with sex offenders showing decreased victim stance. Self-reported current treatment satisfaction was significantly correlated with social desirability as measured by total BIDR scores and impression management subscale scores. ($r = .48$, $\underline{p} < .0001$), but this was only a factor for non-sex offenders ($r = .40$, $\underline{p} < .003$). There were no significant correlations between URICA scores and Treatment Evaluation. Table 4 presents pre and post-treatment scores for the independent measures.

Discussion

Several key findings resulted from this pilot study. First, many offenders report low readiness for treatment and this did not change as a function of treatment. This has important implications for the planning and delivery of correctional programming and intervention. Related to this finding is the possibility that the URICA may be less applicable to offender populations that other clinical populations. Second, the Interpersonal Style Ratings proved to be dynamic, with significant pre/post-treatment changes in the desired direction, and these ratings were significantly correlated with post-treatment evaluations. Third, self-report measures are influenced by social desirability and do not significantly correlate with behavioral measures. Related to this finding was the result that offenders' self-reports regarding treatment gain were discrepant from clinicians' evaluations.

[2] This calculation was provided by research staff at the Cancer Prevention Research Consortium, University of Rhode Island.

There are several limitations to this pilot study. The data are limited by the small sample and the methodological problem of having the same clinicians rate Interpersonal Style and Treatment Evaluation is problematic. Also, treatment was not standardized in terms of intensity and duration. Other issues include the need for inter-rater reliability for the rating scales, the lack of a control group for comparisons of pre-post measures, and the lack of recidivism data. The minimal variance on the URICA and the failure to assess denial and minimization (Barbaree, 1993) for the sex offenders were also limitations. Nonetheless, based on feedback from staff, the protocol was easy to complete, took little time, and assisted them to complete a post-treatment report by structuring their comments regarding an offender's response to correctional treatment.

The next step is the development of an interview-based assessment of Treatment Readiness to complement the Interpersonal Style Ratings and Treatment Evaluation. A set of user guidelines and more explicit scoring guidelines are under development so that issues of reliability can be addressed. Plans are also underway to develop a training package and to implement the revised protocol in a range of correctional programs. This the first step in an initiative to develop systematic assessment of process measures of treatment readiness and responsivity and link them to criminogenic risk and need. The intent is to administer the protocol in various settings (institution and community), to various offender types (sex offenders and nonsex offenders), in various programs (Living Skills, Sex Offender programs, Counterpoint). Optimally, such investigation of readiness and treatment performance will yield specific targets to

incorporate into a pre-treatment primer, such that subsequent correctional intervention would be enhanced.

Figure 1

Treatability: Treatment Responsivity and Treatment Effectiveness

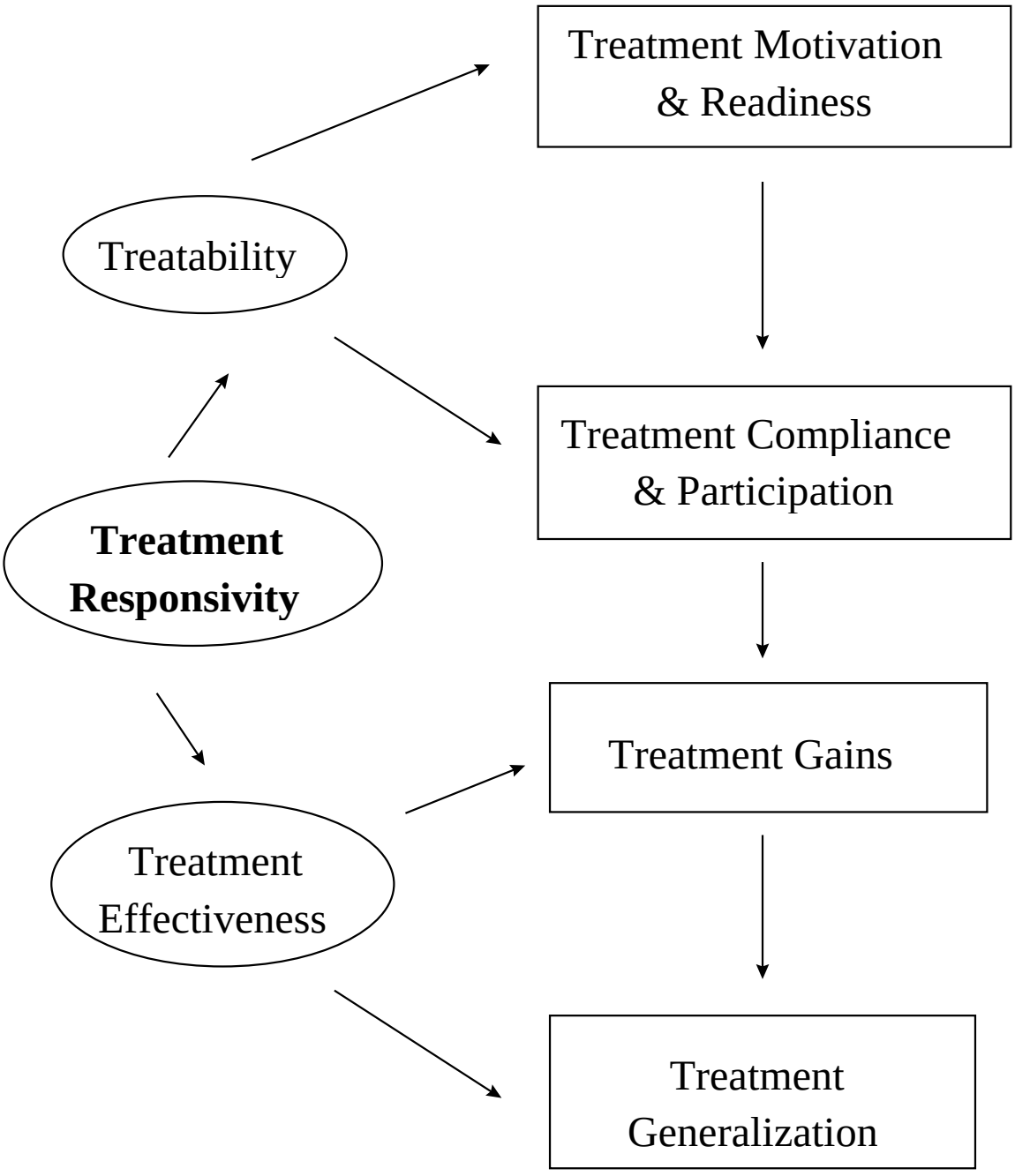

Figure 2

Factors Relating to Treatment Responsivity

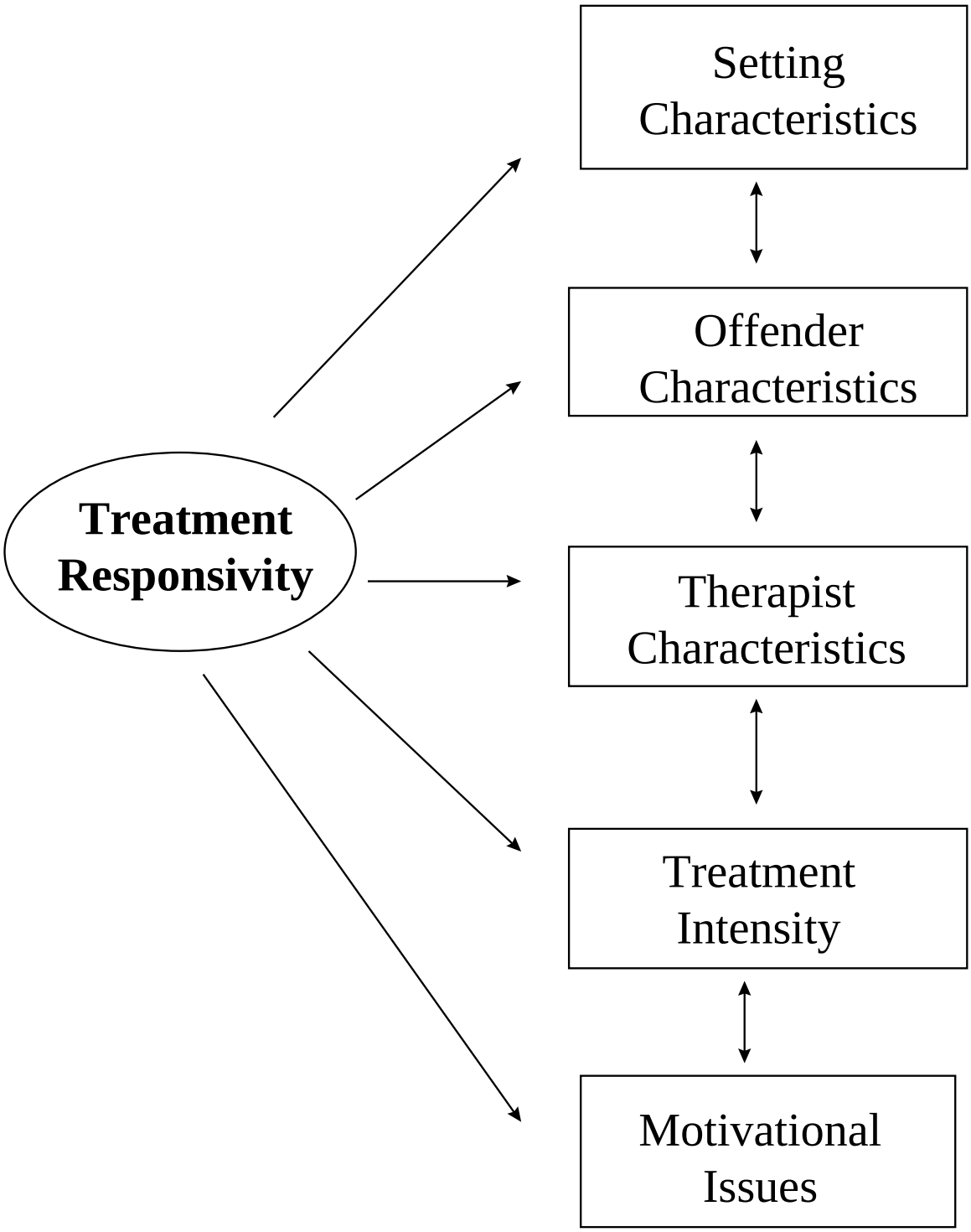

Table 1

Interpersonal Style Ratings

1. Procriminal Views	2. Procriminal Associations
3. Grandiosity	4. Callousness
5. Neutralization	6. Impulsivity
7. Procrastination	8. Motivation for anger
9. Power and control	10. Problem-solving
11. Victim Stance	

Treatment Evaluation Scale

1. Knowledge of program content	2. Skills acquisition
3. Disclosure	4. Offender confidence
5. Knowledge application	6. Skills application
7. Understanding of criminality	8. Motivation
9. Insight	10. Attendance
11. Disruptiveness	12. Appropriateness
13. Participation	

Table 2.

University of Rhode Island Change Assessment scale (URICA; Prochaska & DiClemente, 1992)

Precontemplation

As far as I'm concerned, I don't have any problems that need changing.

Contemplation

I think I might be ready for some self-improvement.

Action

I am doing something about the problems that have been bothering me.

Maintenance

It worries me that I might slip back on a problem I have already changed, so I am here to seek help.

Orientation to Treatment Scale (OTS; Robinson & Weekes, 1994)

I can learn new ways of thinking about my behavior.

I am willing to be open and honest about myself.

If I let down my guard, others will manipulate me.

I don't like it when someone is trying to figure me out.

Readiness to Change Questionnaire (Rollnick, Heather, Gold, & Hall, 1992)

Precontemplation

I don't think I drink too much.

Contemplation

Sometimes I think I should cut down on my drinking.

Action

I am trying to drink less than I used to.

TABLE 3.

Intercorrelations between independent measures

Variable	1	2	3	4	5	6	7	8	9	10	11	12	13
Interpersonal Style Rating													
1. Pre test	--	.84*	-.08	-.13*	-.26	-.16	-.19	-.21	-.13	-.23	.06	.02	.50*
2. Post test	--	--	-.12	-.34	-.40	-.25	-.27	-.32	-.26	-.35	-.04	-.01	.69*
Stages of Change: Pre test													
3. Precontemplation	--	--	--	.58*	.44*	.51*	.28*	.37	.45*	.36	.03	.31	.08
4. Contemplation	--	--	--	--	.34	.43*	.43*	.32	.53*	.36	-.08	.22	-.18
5. Action	--	--	--	--	--	.73*	.34	.46*	.61*	.47*	-.00	.22	-.04
6. Maintenance	--	--	--	--	--	--	.43*	.43*	.62*	.65*	.05	.24	-.04
Stages of Change: Post test													
7. Precontemplation	--	--	--	--	--	--	--	.77*	.69*	.43*	.05	.11	.09
8. Contemplation	--	--	--	--	--	--	--	--	.84*	.70*	.05	.28	-.00
9. Action	--	--	--	--	--	--	--	--	--	.72*	.04	.32	-.07
10. Maintenance	--	--	--	--	--	--	--	--	--	--	.22	.30	-.09
11. BIDR[a]: Pre test	--	--	--	--	--	--	--	--	--	--	--	.50*	-.11
12. BIDR: Post test	--	--	--	--	--	--	--	--	--	--	--	--	.12
13. Post Treatment: Evaluation	--	--	--	--	--	--	--	--	--	--	--	--	--

Note. [a]BIDR = Balanced Inventory of Desirable Responding, *$p < .004$ (.05/13)

Table 4.

Pre and post test scores for independent measures

Measure	Pre test M (SD)	Post test M (SD)	t-value
Interpersonal Style Rating	34.60 (15.03)	45.22 (15.41)	6.57**
Stages of Change			
Precontemplation	14.67 (4.22)	13.51 (3.80)	-2.00*
Contemplation	12.58 (3.25	13.12 (3.65)	n.s.
Action	3.24 (3.62)	12.68 (3.44)	n.s.
Maintenance	14.93 (3.91)	15.21 (3.38)	n.s.
BIDR[a]	119.52 (18.18)	126.81 (18.30)	n.s.
Post treatment Evaluation Rating	NA	28.14 (6.83)	NA

Note. [a]BIDR = Balanced Inventory of Desirable Responding. *$p < .05$; **$p < .01$

References

American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, DC: Author.

Andrews, D. A., & Bonta, J. (1994) The psychology of criminal conduct. Cincinnati, OH: Anderson Publishing.

Barbaree, H. E. (1993). Denial and Minimization Among Sex Offenders Forum on Corrections Research, 3, 30-33.

Barbaree, H. E., Seto, M. C., & Maric, A. (1996). Sex offender characteristics, response to treatment, and correctional release decisions at the Warkworth Sexual Behaviour Clinic. Research Report, Forensic Division, Clarke Institute of Psychiatry.

Correctional Service of Canada. (1994). All staff survey: Final Report. Research Report SR-1. Ottawa, Canada: Correctional Service of Canada.

Correctional Service of Canada. (1995). National Inmate Survey: Final Report. Research Report SR-2. Ottawa, Canada: Correctional Service of Canada.

Dana, R. (1993). Multicultural assessment perspectives for professional psychology. Boston: Allyn & Bacon.

Gendreau, P. (1996). The principles of effective intervention with offenders. In A. T. Harland (Ed.), Choosing correctional options that work: Defining the demand and evaluating the supply. (pp. 117-130).Thousand Oaks, CA: Sage.

Hanson, R. K. & Bussière, M. T. (1996). Predictors of sexual offender recidivism: A meta-analysis. User Report: 1996-04, Ottawa: Solicitor General of Canada.

Heilbrun, K. S., Bennett, W. S.. Evans, J. H. Offult, R. A., Reiff H. J., & White, A. J. (1988). Assessing treatability in mentally disordered offenders: A conceptual and methodological note. Behavioral Sciences and the Law, 6, 479-486.

Heilbrun, K. S., Bennett, W. S.. Evans, J. H. Offult, R. A., Reiff H. J., & White, A. J. Assessing Treatability in Mentally Disordered Offenders: Strategies for Improving Reliability. Forensic Reports, 5, 85-96.

Knight, R. A., Prentky, R. A., & Cerce, D. D. (1994). The development, reliability, and validity of an inventory for the multidimensional assessment of sex and aggression. Criminal Justice and Behavior, 21, 72-94.

Marques, J. K., Day, D. M., Nelson, C., & West, M. A. (1994). Effects of cognitive-behavioral treatment on sex offender recidivism: Preliminary results of a longitudinal study. Criminal Justice and Behavior, 21, 28-54.

Marshall, W. L. & Serin, R. C. (in press). Personality disorders. In S. M. Turner and M. Hersen (Eds.), Adult Psychopathology and Diagnosis (Third Edition).

Michenbaum, D., & Turk, D. C. (1987). Facilitating treatment adherence: A practitioner's guidebook. New York: Plenum.

Miller, W. R. (1985). Motivation for treatment: A review with special emphasis on alcoholism. Psychological Bulletin, 98, 84-107.

Miller, W. R., & Rollnick, S. (1991). Motivational Interviewing. New York: Guilford.

Millson, W. A, Weekes, J. R., & Lightfoot, L. O. (1995). The Offender Substance Abuse Pre-Release Program: Analysis of intermediate and post-release outcomes. Research Report R-40. Ottawa, Canada: Correctional Service of Canada

Monahan, J. & Steadman, H. J. (1994). (Eds.). Violence and mental disorder: Developments in risk assessment. Chicago, IL: University of Chicago Press.

Motiuk, L. L. (in press). Assessment methods in corrections. Expanding on What Works, Conference Proceedings. International Community Corrections Association.

Preston, D. L. & Murphy, S, (in press). Therapeutic engagement of treatment-resistant-clients. Forum on Corrections Research.

Prochaska, J. O.& DiClemente, C. C. (1986). Toward a comprehensive model of change. In W. R. Miller and S. Rollnick (Eds.). Motivational interviewing: Preparing people to change addictive behavior. Guilford Press: New York.

Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992) In search of how people change: Applications to addictive behaviors. American Psychologist, 47, 1102-1114.

Quinsey, V. L. (1988). Assessments of the treatability of forensic patients. Behavioral Sciences and the Law, 6, 443-452.

Quinsey, V. L., Khanna, A., & Malcolm, B. (1996). A retrospective evaluation of the Regional Treatment Centre Sex Offender Program. Unpublished manuscript.

Quinsey, V. L. & Maguire, A. (1983). Offenders Remanded for a Psychiatric Examination: Perceived Treatability and Disposition. International Journal of Law and Psychiatry, 6, 193-205.

Quinsey, V. L., Rice, M. E., Harris, G. T., and Lalumière, M. L. (1993). Assessing treatment efficacy in outcome studies of sex offenders. Journal of Interpersonal Violence, 8, 512-523.

Quinsey, V. L., & Walker, W .D. (1992). Dealing with dangerousness: Community Risk Management Strategies with violent offenders. In D. V. Peters, R. J. McMahon, & V. L. Quinsey (Eds.), Aggression and violence throughout the lifespan (pp. 244-262). Newbury Park, CA: Sage.

Rice, M. E., Harris, G. T., Quinsey, V. L. (1996). Treatment of forensic patients. In B. Sales, & S. Shah (Eds.), Mental health and the law: Research, policy, and practice (pp. 141-190). New York: Carolina Academic Press.

Robinson, D. (1995). The impact of cognitive skills training on postrelease recidivism among Canadian Federal Offenders. Research Report R-41. Ottawa, Canada: Correctional Service of Canada.

Rogers, R. & Webster, C. D. (1989). Assessing Treatability in Mentally Disordered Offenders. Law and Human Behavior, 13 , 19-29.

Serin, R. C. (1995a). Psychological intervention in corrections. In T. A. Leis, L. L. Motiuk, and J. R. P. Ogloff (Eds.). Forensic psychology: Policy and Practice in Corrections, (p. 36-40). Correctional Service of Canada.

Serin, R. C. (1995b). Treatment responsivity in criminal psychopaths, Forum on Corrections Research, 7, 23 - 26.

Serin, R. C. (1995). Persistently violent (Nonsexual) offenders: A program proposal. Correctional Services of Canada Research Report, R-42.

Serin, R. C. (1996). The Antecedents to Crime Inventory: Preliminary findings. Manuscript in preparation.

Serin, R. C., & Kuriychuk, M. (1994). Social and cognitive processing deficits in violent offenders: Implications for treatment. International Journal of Law and Psychiatry, 17, 431-441.

Seto, M. C. & Barbaree, H. E. (in press). Sexual aggression as antisocial behavior: A developmental model. In D. Stoff, J. Brieling, & J. D. Maser (Eds.)., Handbook of antisocial behavior. New York: Wiley.

Shapiro, D. A. & Shapiro, D. (1982). Meta-analysis of comparative therapy outcome studies: A replication and refinement. Psychological Bulletin, 92, 581-604.

Webster, C. D., Eaves, D., Douglas, K., & Wintrup, A. (1995). The HCR-20 Scheme: The assessment of dangerousness and risk. Simon Fraser University and Forensic Psychiatric Services Commission of British Columbia: Simon Fraser University Press.

Webster, C. D., Harris, G. T., Rice, M. E., Cormier, C., & Quinsey, V. L. (1994). The violence prediction scheme: Assessing dangerousness in high risk men. Toronto, Ontario, Canada: Centre of Criminology, University of Toronto.

Zamble, E. & Quinsey, V. L. (1991). Dynamic and behavioral antecedents to recidivism: A retrospective analysis. Research Report R-17. Ottawa, Canada: Correctional Service of Canada