

Treatment responsiveness: Reducing recidivism by enhancing treatment effectiveness

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One of the contemporary concerns in corrections is the risk management of offenders in the community. Thus, in many correctional agencies, treatment is currently viewed as an integral part of the risk management continuum, and therefore, treatment responsiveness is a critical issue for correctional programs. The responsiveness principle has been a largely neglected area of study, despite the fact that responsiveness and other variables related to offender motivation are widely recognised as critical factors mediating the success of treatment.² It is postulated that treatment readiness and responsiveness must be assessed and considered in treatment planning if the maximum effectiveness of supervision and treatment programs is to be realized and if we want to ensure the successful reintegration of the offender into the community.

This article addresses the concept of treatment responsiveness and examines a number of responsiveness assessment measures currently in use. The development of a new standardized assessment battery of offender responsiveness is presented, and a number of responsiveness-related factors are identified and discussed in terms of their potential impact on treatment outcome. The construct of treatment responsiveness is placed in a context that underscores the importance of allocating offenders to programs in the most effective manner and of identifying factors that might mediate the effectiveness of treatment services.

Four general principles of classification

The research of Andrews and colleagues outlines the four general principles of classification for purposes of effective correctional programming.³ These principles are based on their detailed analysis of programs that showed above-average success in reducing recidivism.

The risk principle states that the intensity of the treatment intervention should be matched to the risk level of the offender. This is because research has demonstrated that higher risk cases tend to respond better to intensive and extensive service, while low risk cases respond better to minimal or no intervention. Rehabilitation programs should, therefore, be reserved for higher risk offenders in order to achieve the greatest reductions in recidivism. The reality is that low risk offenders usually do well without intensive treatment.

The need principle distinguishes between criminogenic and non-criminogenic needs. The

former are dynamic risk factors,⁴ which, if changed, reduce the likelihood of criminal conduct. In contrast, such non-criminogenic needs as anxiety and self-esteem may be appropriate targets when working on responsiveness issues; however, such needs would be inappropriate targets for risk reduction, as their resolution would not have a significant impact on recidivism.

The responsiveness principle states that styles and modes of treatment service must be closely matched to the preferred learning style and abilities of the offender.⁵ Treatment effectiveness depends on matching types of treatment and therapists to types of clients.

The professional discretion principle states that, having reviewed risk, need and responsiveness considerations as they apply to a particular offender, there is a need for professional judgement. In some cases, then, the application of professional judgement will (and should) override recommendations based on numerical scores alone, thereby improving the final offender assessment on programming strategies.

Definition and model of treatment responsiveness

The responsiveness principle

Three components of responsiveness include matching the treatment approach with the learning style of the offender, the characteristics of the offender with those of the counsellor, and the skills of the counsellor with the type of program conducted. Offenders differ significantly, not only in their level of motivation to participate in treatment, but also in terms of their responsiveness to various styles or modes of intervention. According to the responsiveness principle, these factors impact directly on the effectiveness of correctional treatment and, ultimately, on recidivism.

If the responsiveness principle is not adhered to, treatment programs can fail, not because they do not have therapeutic integrity or competent therapists, but rather because offender responsiveness related barriers, such as cognitive/intellectual deficits, were not addressed. This last factor, for example, could prevent the offender from understanding the content of the program. Consequently, various offender

characteristics must be considered when assigning offenders to treatment programs.

Internal responsivity factors

We can consider responsivity factors as individual factors that interfere with or facilitate learning. They can be broken down into internal and external responsivity factors. The assessment of individuals factors is the first step in helping us develop the best strategies as to how to best address an offender's criminogenic needs. This, in turn, can ensure that offenders derive the maximum therapeutic benefit from treatment.

Internal factors refer to individual offender characteristics such as: motivation, personality characteristics, cognitive and intellectual deficits, and demographic variables.⁶

Specific internal responsivity factors are represented in most settings. Consideration of gender issues, ethnicity, age, social background, and life experiences may prove to be important for some types of treatment because they contribute to the engagement of offenders into treatment and the development of therapeutic alliance.⁷ For instance, recent research⁸ indicates that female offenders score significantly lower than male offenders on measures of self-esteem and self-efficacy.

An offender's level of intellectual functioning is an important responsivity consideration. According to Fabiano, Porporino and Robinson, cognitive skills programs are more effective with offenders of average to high-average intelligence and are less effective with offenders of below-average intelligence.⁹

Similarly, age may be viewed as a responsivity factor. Certainly, the "average" young offender would present different challenges to the effective delivery of a treatment than would be the case for an "average" adult offender. Age, in and of itself however, does not provide the necessary degree of precision required when the assessment of responsivity is the issue. It is important, for instance, to have adequate information on the individual's level of maturity, as this will effect how the individual views the need for change, how he or she relates to others, etc.

Using gender and maturity level to provide the context, then, it is easy to imagine how ignoring responsivity factors can result in the inaccurate

assessment of an individual's treatment motivation or readiness, and how this may seriously impede an offender's compliance with treatment.

Motivation as a dynamic variable

Motivation may be operationally defined as "the probability that a person will enter into, continue, and adhere to a specific strategy".¹⁰ In this context, motivation is dynamic and, therefore, at least some responsibility falls to the therapist to motivate the offender. The counsellor must strive to create effective motivational choices in order to increase the probability that offenders will respond favourably to correctional programming. This includes enhancing offender motivation and dealing with resistant clients after the pre-treatment assessment of treatment readiness.

External responsivity factors

Correctional counsellor/worker characteristics

External factors refer to counsellor characteristics (i.e., some counsellors may work better with certain types of offenders) and setting characteristics (i.e., institution versus community, individual versus group). Regardless of the therapeutic orientation or the characteristics of the client group, a client is more apt to engage in treatment and treatment is more likely to be effective if a good therapeutic alliance is created.¹¹

Unfortunately, there is little systematic research on the quality of the therapeutic alliance and the interaction effects of counsellor and offender characteristics in the field of correctional treatment. This is a much needed area of research, as it has often been found that a group of counsellors working in a common setting and offering the same treatment

approach can produce dramatic differences in terms of client attrition and successful outcome. Counsellor attitudes and competence that do not match the aims and content of a program may lower treatment integrity and reduce its effectiveness.

Appropriate role modelling is also a critical aspect of the counsellor offender relationship. According to Andrews and Bonta,¹² effective workers are able to establish high quality relationships with the client, approve of the client's anti-criminal expressions (reinforcement), and disapprove of the client's

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pro-criminal expressions (punishment), while, at the same time, demonstrating anti-criminal alternatives (modelling).

Setting characteristics/modes of program delivery

Some research has suggested that appropriate treatment programs delivered in the community produce two to three times greater reductions in recidivism than appropriate treatment programs delivered in prison.¹³ With institutional and treatment programs in community correctional centres, offenders typically show up for treatment as a much more captive audience. In the community or outpatient settings, the no shows rate is higher, presumably because the client has more freedom to choose. It is important to understand that external factors, in isolation, may not impact on responsivity, but rather those staff characteristics or setting characteristics interact with offender characteristics to affect responsivity, either positively or negatively.

Responsivity assessment measures

Although responsivity is clearly identified as the third principle of effective correctional treatment, there is a paucity of standardised assessment measures in existence. The need for a systematic and comprehensive assessment of responsivity and its related constructs (i.e., motivation and treatment readiness) is essential for the successful planning, implementation and delivery of appropriate and effective treatment programs. This is especially true when reintegrating offenders into the community. In order to make sound release decisions and enhance the protection of the public by effectively managing the risk that offenders pose; we would want to be able to assess their treatability (level of motivation and responsivity to treatment) prior to releasing them into the community.

The Client Management Classification (CMC) is a widely used responsivity tool in corrections. This instrument was developed as part of the Wisconsin Risk and Needs Assessment system, and became part of the National Institute of Corrections Model Probation and Parole Project.¹⁴ The Client Management Classification differentiates five offender profiles and prescribes detailed supervision guidelines for each profile. It also facilitates case planning. By identifying offender characteristics and

recommending supervision strategies, the CMC represents an attempt to match offenders and staff based on responsivity characteristics.

The Jesness Personality Inventory is another instrument that can help identify offenders' "personality" traits.¹⁵ This instrument is the second most widely used personality inventory in juvenile court clinics in the United States. The Jesness was designed specifically for use with juvenile delinquent populations both male and female, ages 8-18. Similar to the Client Management Classification, the Jesness Personality Inventory helps identify offender personality characteristics that can be an obstacle to treatment.

The Level of Service Inventory-Ontario Revision (LSI-OR)¹⁶ is the first risk assessment instrument to incorporate a section on "special responsivity considerations". In this section the instrument measures motivation as a barrier, denial/minimization, interpersonal anxiety, cultural issues, low intelligence and communication barriers.

A model for assessment of treatment responsivity

Prochaska and his colleagues have conducted important research on the process of psychotherapy change, in the areas of substance abuse, criminality, and a variety of high-risk health behaviors.¹⁷ These researchers believed that individuals vary in terms of their stage of readiness for change and, as such, different therapeutic approaches/techniques need to be applied. To ensure their intervention is sensitive to clients' level of readiness, Prochaska developed and validated a self-report measure, the University of Rhode Island Change

Assessment (URICA), on various samples. According to this model, individuals in the process of change move through a series of stages prior to changing their problematic behaviour. The five stages of change that have been identified are: precontemplation, contemplation, preparation/determination, action, and maintenance.

In the precontemplation stage, the individual is not considering the possibility of change and does not think he/she has a problem. Individuals in this stage typically perceive that they are being coerced into treatment to satisfy someone else's need. If the offender does not participate in treatment then there is little probability that recidivism can be reduced or that the risk level of the offender can be managed effectively.

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The contemplation stage is characterized by ambivalence; in other words, individuals may simultaneously, or in rapid alternation, consider and reject reasons to change. At this stage individuals are aware that a problem exists, but are not ready to commit to therapy.

The preparation/determination stage is characterised by a combination of intention and behavioural criteria. Individuals at this stage may report that they have made some small behavioural changes.

Individuals in the action stage have made a commitment to change and are engaging in actions to bring about change; in other words, they are actively doing things to change or modify their behaviour, experiences, or environment in order to overcome their problems. At this stage they are typically involved in therapy or counselling.

Individuals in the maintenance stage are working hard to sustain the significant behavioural changes they have made and are actively working to prevent minor slips or major relapses. The maintenance stage is not static, but rather dynamic particularly when the individual is exposed to high-risk situations. The problem is not that offenders do not change, but rather that they do not maintain the changes.

Although the assessment work of Prochaska and his colleagues is evolving, it provides a starting point for our work on the development of a multi-method assessment strategy of treatment readiness and responsivity with offenders.¹⁸ Its application to correctional intervention with a wide population of offenders, representing a range of offence types and settings, may well provide the conceptual focus that has been lacking.

Recent developments

A theoretically-based, multi-method assessment protocol for treatment readiness, responsivity and gain was developed in conjunction with the Research Branch of the Correctional Service of Canada in order to contribute to the broader literature on effective correctional programming. The intent was to pilot an assessment battery that could be administered in conjunction with a range of correctional program. Accordingly, the protocol was developed for generic application rather than for a particular type of treatment program. This was the first step in developing a systematic protocol for the assessment of treatment responsivity in the context of a risk/need management framework.¹⁹

The second step is now completed and an interview-based assessment protocol for treatment readiness, responsivity and gain was developed.²⁰ A set of guidelines for counsellors' ratings and a more

explicit scoring scheme was established to maximise reliability. Plans are also underway to develop a training package, to implement the revised protocol with a wide range of correctional programs and to begin to collect data on the assessment protocol.

Treatment participation

Despite the obvious importance of measuring progress in treatment this has been an often-neglected aspect of assessment. It is important for staff to measure knowledge of program content, skills acquisition, individual and group disclosure, offender confidence, transfer and generalisation of skills to real life situations, insight, attendance, participation, performance and therapeutic alliance.

Of course, the true effects of responsivity and other (motivational) factors on treatment can only be determined by examining recidivism rates over extended periods of time. If offenders who both acknowledge responsibility for their crimes and attend and actively participate in therapy, have lowered recidivism rates compared to those who do not, then the motivational (responsivity) variables have demonstrated meaning beyond treatment gains measured during, or immediately upon completion of treatment.

Conclusion

The principle of responsivity, which includes the appropriate matching of offenders to programs and staff, and the identification of factors that might mediate the effectiveness of treatment services, has not been given the attention it deserves. Offenders are not all alike, nor are all staff, settings, or treatment programs. The matching of offenders to treatment, counsellors to offenders, and counsellors to the treatment groups that best match their skills, can improve the effectiveness of correctional intervention. Responsivity should therefore be an important consideration in risk management and risk reduction. Failure to appropriately assess and consider responsivity factors may not only undermine treatment gains and waste treatment resources, but also may also decrease public safety.

Best practices with regard to responsivity starts with good assessment. Knowing an offender's motivation level, cognitive ability, personality traits, and maturity is essential to good case planning. Following assessment, a good case plan takes into account factors related to the treatment settings, the treatment program options and staff characteristics. Finally, understanding the skills and interests of staff should also become part of the case planning process, and will allow for more effective matching of offenders and counsellors. ■

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