

Improving offender motivation for programming

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Implementation of correctional programs in the Correctional Service of Canada has been guided by the principles of effective corrections of Andrews and his colleagues.² Correctional planning adheres to the Risk and Need principles by systematically assessing risk and need level at intake and formulating a correctional plan to address the factors related to their offending (Need Principle) for offenders at a significant risk to reoffend (Risk Principle). Recently, however, we have begun to turn our attention to a more detailed understanding of the nature and impact of the Responsivity Principle. To address responsivity, program designers and program facilitators need to know what adaptations in content or delivery produce better outcomes for specific groups or individuals.

Not all potential clients are equally ready to undertake personal change; yet most interventions presuppose the participants are motivated and prepared. The research on general psychotherapy indicates that client motivation is one of the “most frequently cited reasons for patient dropout, failure to comply, relapse and other negative treatment outcomes.”³ Lack of motivation to change is not a trait, rather motivation is fluid and can be influenced. Recent innovations provide guidance on how to systematically apply techniques that can increase client motivation and spur interest in personal change. In this article, motivation is defined as the extent of the willingness of an individual to engage in changing harmful behaviours. In the correctional area it will specifically refer to offenders’ willingness to address factors related to their offending.

A study of offenders on conditional release in the community demonstrated that even a very basic assessment of the offenders’ motivation to address the needs identified in their correctional plans was significantly related to their outcome.⁴ Supervising parole officers were asked to rate on a three point scale the extent to which offenders were willing to address need domains that were associated with their offending: at the highest level of rating, offenders were described as “self motivated,” at the next, “willing if mandated,” and, at the lowest level, “not willing.” The most motivated offenders had the lowest recidivism rates.

Further evidence that motivation to address criminogenic need is linked to targeted outcomes is found in a study of dropouts from the Cognitive Skills and Anger and Other Emotions Management

programs.⁵ The reason most commonly identified by program delivery officers for offenders dropping out of the programs was grouped under the category “lack of motivation.” The risk level of dropouts was not higher than that of completers, yet in their evaluation of the Anger and Other Emotions Management program, Dowden and Serin⁶ found that dropouts had recidivism rates eight times higher than completers. They created a program performance variable derived from an offenders’ completion of core programs. The variable was strongly associated with recidivism reduction ($r = 0.32$), out-performing the Statistical Information on Recidivism Scale, age, ethnicity, offence history or institutional history. It appears that dropouts are particularly prone to reoffending and that the risk factors contributing to poorer outcomes are not entirely historical, but may be also related to factors grouped under the rubric of motivation. Those who complete the core programs, on the other hand, have a cumulative improvement in outcome, beyond what would be expected based on their risk and need levels.

If increasing offenders’ motivation to address change through participation in their correctional plan is an important contributor to reducing recidivism, the next step is to identify what factors influence motivation. In considering this, we are assisted by years of outcome research in general therapy and the substance abuse treatment fields.⁷ The factors that have been the subject of review may be classified according to key areas: client characteristics, therapist characteristics, therapeutic relationship, service/client matching on conceptual style and provision of environmental or organizational supports. We will discuss only factors that are dynamic or changeable. Among the dynamic client characteristics linked to motivation are the client’s recognition of the extent of problem severity and the client’s self-efficacy (extent to which clients believe they can be successful). Therapists who are sympathetic, experienced and knowledgeable, supportive, and provide advice and an expectation of positive outcome are consistently linked to positive outcome. Therapeutic processes in which the therapist works with the client on mutually agreed-upon goals enhances outcome.⁸ Client/service matching, linking level of complexity to the capacity of the client, and building in a progressive skill attainment approach, aids in increasing self-efficacy

Table 1

Motivation factor	Correctional intervention or service provision
Client characteristics (problem severity, confidence that he or she can change and manage relapse)	Individual or group interventions that help offenders recognize the impact of their problems, support self-efficacy and teach relapse prevention
Therapist (staff) characteristics	Train and recruit staff who meet the characteristics of effective intervenors: enthusiastic, competent, encourage self-efficacy, empathic, model prosocial beliefs and values
Therapeutic (staff-offender) relationship	Establish mutually agreed-upon goals. The relationship should be supportive but directive
Client/service matching	Provide programs that are structured, skills based, progressive, not too cognitively complex
Environmental supports	Provide an environment that supports change, notes and encourages effort to change, identifies other sources of support outside of treatment; provides access to a range of options to assist in change

and reduces information overload. Finally, organizational aspects of treatment such as the lack of waiting lists, continuity of care, and providing a choice of treatment programs positively influence motivation for treatment.⁹ In a similar vein, others point to the importance of assisting the client to identify environmental or social supports for self-change.

The evidence from the general literature on what can be done to increase motivation and treatment compliance can be applied to service provision for offenders. Table 1 translates the information from the general psychotherapy literature to correctional interventions.

There are approaches or interventions that incorporate many of these recommendations. Miller¹⁰ has reviewed various strategies common to successful brief treatment interventions that he has represented under the FRAMES acronym represented in Table 2.

Since this work, the focus on motivation in treatment has turned to the implementation of therapeutic approaches, incorporating strategies such as those listed above. Motivational Interviewing (MI), is one approach used to increase motivation that is based

on the FRAMES principles.¹¹ It has been applied to the area of substance abuse treatment and to health compliance but, to date, has had limited application to the area of correctional populations. Ginsberg has used it as a brief intervention with alcohol abusing inmates¹² others have used it to a limited extent with sex offenders.¹³

Motivational Enhancement Therapy (MET) is an approach that is comprised of 4 sessions conducted over a 12-week span. In general, the sessions include: personalized feedback regarding the negative consequences of alcohol abuse, helping the client develop a clear plan for change, exploring ambivalent feelings regarding changing their behaviour, and summarizing of progress and development of future plans.¹⁴ Typically, the clinicians using this approach use the MI style.

The Transtheoretical Model of change has been applied to many areas of intervention, for example: smoking cessation, alcohol and drug treatment, pain management, domestic violence, and treatment adherence. Prochaska and Di Clemente¹⁵ have identified 5 discrete stages of change that define the extent to which individuals are committed to changing harmful behaviours. Individuals at the Precontemplation stage are not motivated to change, those in the Contemplation stage are thinking of changing, those in the Preparation stage are planning to change, those in the Action stage are already actively engaged in change and those who have made changes but recognize that they need to remain vigilant in case of relapse are in the Maintenance stage.

Prochaska and Di Clemente specify experiential and behavioural processes that support and sustain individuals at each stage. The Precontemplators and Contemplators benefit from consciousness raising, dramatic relief and environmental reevaluation strategies that provide potential clients with an understanding of the impact of their unhealthy

Table 2

Feedback	Provide feedback to increase awareness of his/her situation and the ways in which it is harmful.
Responsibility	Emphasize that it is the individual's own decision to change.
Advice	Provide advice to identify the problems and discuss the necessity for change.
Menu	Provide a choice of strategies for change.
Empathy	Express acceptance and understanding of the person.
Self-Efficacy	Instill client's perception that he or she can implement a change strategy.

behaviours on themselves and others and that help them to realize that behaviour change can be an important part of a new identity. Those in the Preparation stage benefit from exposure to intervention strategies that reinforce self-efficacy, that is, their ability to choose to change and make a commitment to change. For those in the Action and Maintenance stages, techniques such as reinforcement management (increasing the rewards for change and decreasing the rewards from the old behaviours) and encouraging participants to seek and use social support to assist them in sustaining change, using counter conditioning to substitute healthier alternative cognitions and behaviours and stimulus control to remove the cues to engage in the unhealthy behaviours should be components of the intervention strategy.

Recent initiatives that incorporate the motivational enhancement techniques

In the last year, the Correctional Service of Canada has launched a number of projects that combine the interventions derived from Motivational Interviewing and those recommended by the

Transtheoretical Model of change. A three-day, two-day and half-day training package has been developed to train staff in the techniques of MI. Regional trainers have been trained and have begun the process of training program facilitators, parole officers, shop supervisors and correctional officers. All new programs such as the Family Violence Prevention and the Violence Prevention programs have built in motivational enhancement modules at the beginning of the program. All offenders referred to the Cognitive Skills, Anger and Other Emotions and Counterpoint programs are involved in an initial Motivational feedback interview that is built on the principles of Motivational Interviewing. Finally, in collaboration with experts at the Prochange Behaviour Systems lab, we are developing a treatment primer for offenders who meet the criteria for screening into a family violence prevention program but are refusing to participate. These packages of initiatives are designed to enhance responsivity by increasing motivation to address criminogenic risk factors thereby reducing the number of program refusers and dropouts, and in the longer term, contribute to reductions in recidivism and improvements in reintegration. ■

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³ Ryan, R., Plant, R., & O'Malley, S. (1995). Initial motivations for alcohol treatment: Relations with patient characteristics, treatment involvement, and dropout. *Addictive Behaviors*, *20*(3), 279-297.

⁴ Stewart, L., & Millson, B. (1995). Offender motivation for treatment as a responsivity factor. *Forum on Corrections Research*, *7*(3), 5-7.

⁵ Stewart, L., & Montplaisir, G. (1990). *Drop out in the Cognitive Skills and Anger and Other Emotions Management Programs. Program report to Accreditation Panel*. Ottawa, ON: Correctional Service of Canada (May).

⁶ Dowden, C., & Serin, R. *Anger management programming for federal male inmates: The impact of dropouts and other program performance variables on recidivism*. Ottawa, ON: Research Branch Report, Correctional Service Canada (to be published).

⁷ Miller, W. (1995). Motivation for treatment: A review with special emphasis on alcoholism. *Psychological Bulletin*, *98*(1), 84-107. See also Luborsky, L., McLellan, T., Woody, G., O'Brien, C., & Auerbach, A. (1985). Therapist success and its determinants. *Archives of General Psychiatry*, *42*(6), 602-611. And see Najavits, L., & Weiss, R. (1994). Variations in therapist effectiveness in the treatment of patients with substance use disorders: An empirical review. *Addiction*, *89*(6), 679-688.

⁸ Kerns, R., Bayer, L., & Findley, J. (1999). Motivation and adherence in the management of chronic pain. In A. Block, E. Kremer & E. Fernandez (Eds.). *Handbook of pain syndromes: Biopsychosocial perspective*, (pp. 99-121). Mahwah, NY: Lawrence Erlbaum Associates, Publishers.

⁹ Pfeiffer, W., Feueleir, W., & Brenk-Schulte, E. (1991). The motivation of alcohol dependents to undergo treatment. *Drug and Alcohol Dependence*, *29*(1), 87-95.

¹⁰ Miller, W. (1989). Motivational Interviewing: Research, Practice and Puzzles. *Addictive Behaviors*, *21*(6), 835-842.

¹¹ Rollnick, S., & Miller, W. (1995). What is motivational interviewing? *Behavioural and Cognitive Psychotherapy*, *23*(4), 325-334.

¹² Ginsburg, J. (2000). *Using motivational interviewing to enhance treatment readiness in offenders with symptoms of alcohol dependence*. Unpublished Ph.D. dissertation. Ottawa, ON: Carleton University.

¹³ Mann, R., & Rollnick, S. (1996). Motivational interviewing with a sex offender who believed he was innocent. *Behavioural and Cognitive Psychotherapy*, *24*(2), 127-134.

¹⁴ DiClemente, C., Bellino, L., & Neavins, T. (1999). Motivation for change and alcoholism treatment. *Alcohol Research and Health*, *23*(2), 86-92.

¹⁵ Prochaska, J.O., & Di Clemente, C.C. (1986). Toward a Comprehensive Model of Change. In W.E. Miller & N. Heather (Eds.). *Treating Addictive Behaviors: Processes of Change*. New York, NY: Plenum Press.