ENGAGEMENT IN TREATMENT AMONGST A FORENSIC POPULATION

by

DANIELLE STURGESS

A thesis submitted to the University of Birmingham for the degree of Doctorate in

Forensic Psychology Practice (ForenPsyD)

The Centre for Forensic and Criminological Psychology

School of Psychology

University of Birmingham

Edgbaston

Birmingham

February 2016

UNIVERSITY OF BIRMINGHAM

University of Birmingham Research Archive

e-theses repository

Abstract

This thesis aims to gain to a more detailed understanding of treatment engagement amongst forensic populations. Following an introduction outlining the current theoretical thinking in the area, Chapter 2 presents a systematic literature review exploring reasons for completion/non-completion of treatment from an offender's perspective. Despite being heterogeneous in design, consensus regarding reasons for treatment completion/non-completion was found. Reasons provided appeared to support the majority of factors outlined in the Multifactor Offender Readiness Model (MORM), a model of treatment readiness. Overall, research in this area was limited and no papers exploring adolescents' perspectives were identified. Based on the results found, implications for practice were discussed and areas for future research highlighted. In order to further existing research, Chapter 3 presents a mixed methods research study exploring the reasons why young people, detained in a secure hospital setting, choose to attend/not attend their scheduled sessions. Using thematic analysis several themes were identified. Factors relating to the (a) young person, (b) treatment and (c) organisation were identified, supporting the principles of the MORM. Chapter 4 presents a critical review of the Corrections Victoria Treatment Readiness Questionnaire (CVTRQ), a measure of treatment readiness developed using the internal factors of the MORM. Utilised in the research, this chapter explores the overall development and psychometric properties of the CVTRQ, highlighting its strengths and limitations as a result. Finally, an overall discussion of the work presented is provided in Chapter 5, concluding this thesis.

Acknowledgements

I would like to take this opportunity to thank Dr Darren Bishopp, Dr Matthew Tonkin, and Dr Jessica Woodhams for their invaluable guidance and support throughout the completion of this thesis. Without your expertise this would not have been possible. Furthermore, I would like to thank Sue Hanson for her unwavering support through the last three years; you have been an absolute star!

I would also like to express my thanks to all the professionals and participants who were involved in the data collection of this research; your contribution to this thesis is highly appreciated. Furthermore, a huge thank you to Chloe Whatson for not only your contribution to this research, but your friendship also.

To my wonderful friends Jen and Grace, I'm not quite sure what I would have done without you both over the last three years! I can never thank you enough for your support; I will treasure our friendship forever. To my best friend and partner Andrew, thank you so, so much for your love, support and for always making me smile. You've been incredible!

Finally, to my amazing parents and their equally amazing partners, Matt and Sally-Ann; words can never express how much I appreciate everything you all have ever done for me, not just throughout the last three years but my entire life. Your faith in my ability to succeed has truly kept me going and without you all, I could never have achieved this. I hope I have made you all proud.

Table of Contents

List of Appendices

List of Tables

*As these tables are included within a published paper, changes to the table numbers could not be made. Please see associated page number when making reference to such tables.

List of Figures

Chapter 1:

Introduction

In response to the "*nothing works*" dilemma raised by Martinson (1974), the need to establish what works in offender rehabilitation has taken precedence in recent years (Wilson & Yates, 2009). Such research has highlighted the importance of working therapeutically with offenders to educate them as to how to effectively manage their risk, and in turn live more prosocial lives through the provision of high quality, evidence based interventions (Day, Casey, Ward, Howells & Vess, 2010; Ward & Brown, 2004). Although argued to be modest, in comparison to detention alone this approach has been found to reduce rates of recidivism and thus further contribute towards public protection (McGuire, 2012). Such outcomes however are largely dependent on offenders engaging in treatment through to completion, and with research indicating dropout rates of up to 86% (Larochelle, Diguer, & Laverdiere, 2011), attrition would appear to present as a barrier to effective rehabilitation.

In an attempt to guide clinical practice on ways to increase engagement in treatment, various theoretical models have been developed. Influential in establishing the need for empirically based interventions was the Risk-Need-Responsivity (RNR) model (Andrews & Bonta, 2007). Developed as an approach to offender management as opposed to psychological therapy, this model put forth a number of therapeutic principles that, when used to guide offender rehabilitation, are reported to further enhance therapeutic outcomes, namely reductions in recidivism via the completion of treatment (Andrews & Bonta, 2007; Ward, Day, Howells and Birgden, 2004). This model has received considerable support in both correctional research and practice (Ward, Melser & Yates, 2007).

In reference to the model's most influential principles, the *risk principle* advocates that the intensity of treatment offered should positively correlate with the

level of risk posed by the offender (Andrews & Bonta, 2007; Wilson & Yates, 2009). According to the *needs principle*, in order for intervention to be effective, it should directly target those needs considered to be associated with risk of recidivism (i.e., criminogenic needs). Considered to be dynamic and thus subject to change, the RNR model recommends such needs be identified and addressed as priority (Andrews & Bonta, 2007). Finally, in accordance with the *responsivity principle*, the model states that intervention should be appropriately targeted towards the offender's individual characteristics and idiosyncrasies for example, learning style, motivation, cognitive ability and maturity, in order to ensure comprehension, promote engagement through to completion and thus facilitate change (Ward et al., 2007; Wilson & Yates, 2009).

However, whilst the model has made a significant contribution in the assessment and selection of offenders suitable for intervention, its contribution towards the actual practise and understanding of offender rehabilitation is considered to be lacking, thus presenting a limitation of the model (Day et al., 2010). Specifically, this limitation has been attributed to the responsivity principle which, according to the models critics, has been largely neglected and consequently underdeveloped (Day et al, 2010; Polaschek, 2012). According to Day et al. (2010), further progress in the area of offender rehabilitation has been hindered by the construct's lack of clarity, particularly regarding how it might be implemented and therefore used to inform clinical practice (Day et al,, 2010; Polaschek, 2012; Porporino, 2010). When considering the heterogeneity that exists between offenders, a clear understanding of how to tailor treatment to meet the needs of the individual would appear vital in the provision of effective offender rehabilitation.

According to Day et al. (2010) further reductions in recidivism are likely to be found amongst those interventions which in addition to adhering to the risk-need principles, are able to be responsive to the needs of those it is targeting. However, considering the limitations outlined above, what is meant by the term responsivity and how this can be distinguished from other theoretical constructs, namely motivation and treatment readiness, needs to be better established if it is to effectively inform clinical practice (Day et al., 2010; Ward et al., 2004). Poor engagement, especially non-completion of treatment, is associated with a number of negative consequences including a waste of finances and resources, reductions in staff morale and institutional support for programmes, as well as poorer treatment outcomes (Cann, Falshaw, Nugent & Friendship, 2003; Howells & Day 2007; Palmer et al., 2007). Of most concern, and contrary to the overall aims of offender rehabilitation, is increased risk of recidivism (McMurran & Theodosi, 2007). Whilst the selection of offenders suitable for treatment is undoubtedly important, the need to develop an understanding of what facilitates offender engagement in treatment, and exactly how this can be translated into practise, is required if further reductions in recidivism are to be achieved.

Treatment Readiness, Motivation & Responsivity

Upon distinguishing the aforementioned constructs, Ward et al. (2004) have argued that treatment readiness was more robust than motivation or responsivity alone, and as a result is better able to inform clinical practice on offender engagement in treatment. 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 that, thereby are likely to enhance therapeutic change*" (Howells & Day, p. 231), treatment readiness not only incorporates both the constructs of responsivity and

motivation, but it aims to address their limitations. With this in mind, the remainder of this chapter aims to describe these concepts in more detail, before presenting a more recent conceptual model of treatment readiness (Ward et al., 2004).

Motivation. In the context of offender rehabilitation, motivation typically involves assessing the extent to which an offender wants to engage in treatment for the purpose of achieving change (Ward et al., 2004). The Transtheoretical Model of Change, suggests that internal motivation is vital for behavioural change to occur (Prochaska & DiClemente, 1984). The model proposes that when resolving a problem, individuals pass through a number of identifiable stages of change before committing to, and thus acting upon, a particular solution, for example desistance from crime (Prochaska & DiClemente, 1984; See Table 1). Assessment of an individual's motivation using this model has been used to help select individuals who are likely to complete treatment, in an attempt to reduce the risk of dropout and its associated consequences (Day et al., 2010; Ward et al., 2004). However, despite its common application within offender rehabilitation, it was not developed for a forensic population, raising questions regarding the model's applicability (Casey, Day & Howells, 2005). For example, due to the model's focus on internal motivation, extrinsic motivators relevant to this population (i.e. the opportunity to achieve parole) are not fully accounted for (Casey et al., 2005).

Table 1

Stages of change constructs (Prochaska, Redding & Evers, 2008)

Stage of Change	Description
Precontemplation	No intention to pursue action to change within the next 6 months.
Contemplation	An individual is aware of the benefits of changing and even more so the cons. They feel somewhat ambivalent about change and so intend to pursue this within the next 6 months.
Preparation	An individual intends to take action to change within the near future, usually the next month. Individuals at this stage have devised a plan of action to help them achieve change.
Action	This stage refers to those currently in the process of trying to change (usually demonstrated over a 6 month time period)
Maintenance	Referring to individuals who have achieved change and are working towards preventing relapse. Individuals at this stage feel confident in their ability to maintain change.
Termination	Individuals who have achieved change and feel confident in their ability to refrain from relapse are reported to reflect this stage.

The influences of external pressure are however, encapsulated within the self-determination theory (SDT) of motivation (Ryan & Deci, 2000). In brief, the SDT proposes human motivation is intrinsically linked to the attainment of three psychological needs including competence, relatedness and autonomy. According to this theory, when such needs are satisfied, an individual's self-motivation and wellbeing increase. Howells and Day (2003) proposed these needs to be directly associated with factors considered important in promoting positive treatment outcomes amongst offenders, including skills acquisition (competence), self-efficacy (autonomy) and the therapeutic alliance (relatedness). According to this theory, motivation is best

understood as a continuum from amotivation, through four different types of extrinsic motivation, to intrinsic motivation (See Table 2.). The extent to which behaviour is self-determined and thus autonomous, increases as it moves towards the latter, suggesting extrinsically motivated behaviour can be internalised, and thus perceived as important in achieving one's personal goals (Ryan & Deci, 2000). However, like the stages of change model, this theory has not been developed using a forensic population, again raising questions regarding the extent to which it can be used to accurately inform practice.

Table 2

Types of Motivation (Ryan & Deci, 2000)

Type of Motivation	Description
Amotivation	No intention to act or change. May perceive treatment and/or the intended outcome to be of little personal value. Individuals may not consider themselves competent enough to pursue a particular course of action. Lack of perceived control over ones behaviour.
External Motivation	
External Regulation	Behaviour is performed as a result of an external demand and thus is considered to be controlled by external contingencies.
Introjected Regulation	Behaviour is performed in order to (a) avoid guilt and anxiety or (b) precipitate feelings of self-worth and pride. Whilst predominantly externally regulated this behaviour is considered to be somewhat internalised as a result.
Identified Regulation	The value of engaging in a particular behaviour is accepted and viewed as personally important (i.e. incentives associated with doing the right thing)

Integrated Regulation	The most autonomous type of extrinsic motivation. Although executed to attain a separable outcome and thus extrinsically motivated, behaviour is perceived as personally important and in accordance with ones' values/needs (i.e. achieve a healthy lifestyle)
Intrinsic Motivation	Engagement in behaviour is self-determined and thus highly autonomous. Engagement in such behaviour is driven by the inherent satisfaction one gains from engaging in a particular activity. As well as autonomy, such behaviour is considered to satisfy an individual's need for competence and relatedness also.

Overall, consensus regarding what constitutes offender motivation, and the factors that influence this, is yet to be achieved in the current literature, thus far preventing the construct's accurate inclusion within broader models of offender rehabilitation (McMurran & Ward, 2004). Failure to do so has been attributed to the "*over emphasis*" placed upon the RNR model and its sole focus on risk reduction through the use of avoidance based goals, which ultimately are demotivating for offenders, increasing the risk of treatment attrition, offender hostility and more generally a lack of rehabilitative success (Ward et al., 2007; Ward, Yates & Willis, 2012). As it stands, the construct of motivation is unable to fully inform practitioners on ways to increase offender engagement in treatment and so requires development.

Responsivity. This construct has been further divided into internal and external responsivity (Andrews, 2001; Ward et al., 2004). According to Kennedy (2001), internal responsivity refers to those individual characteristics which influence learning, such as personality (i.e. low mood, mental illness and low self-esteem), cognitive

deficits (poor problem solving skills, low intelligence and language deficits), demographic variables (i.e. age, gender and ethnicity) and motivation. External responsivity factors on the other hand, refer to a range of general and specific issues, including the implementation of active and participatory methods in treatment (Ward et al., 2004). These factors can be divided further into (1) counsellor characteristics, for example the quality of the therapeutic relationship and appropriate modelling of prosocial behaviour and (2) the influence of the setting, for example prison or community (Kennedy, 2001). Suggestive of a fairly broad definition of responsivity, Ward et al. (2004) argue that the definition commonly denoted in the literature, narrowly focuses on factors relating to the therapist and the treatment programme alone, and so is predominantly concerned with tailoring treatment delivery in a way that facilitates learning. As a result, the authors argue that the complex interaction between factors relating to the client, therapy and the setting also, have not been fully acknowledged and thus implemented within clinical practise (Ward et al., 2004).

Treatment Readiness. Unlike that of responsivity, treatment readiness is proposed to provide guidance on the conditions *required* for successful engagement in treatment, as opposed to the barriers to this (Ward et al., 2004). In order to achieve coherence of this construct and how the various factors interact to promote treatment completion, Ward et al. (2004) put forth the Multifactor Offender Readiness Model (MORM; See Figure 1.), a framework for understanding offender engagement in treatment. According to this model, treatment readiness is as much a feature of factors external to the individual, mainly treatment and the therapeutic environment (setting), as it is internal factors relating to the individual themselves (Ward et al., 2004).

Internal or "*person centred*" factors identified by the MORM as contributing to treatment readiness include cognitive (beliefs, attitudes, cognitive strategies), affective (emotions, for example, shame and guilt), volitional (goals, motivation for treatment, desires), behavioural (skills and competencies for example their ability to concentrate) and identity factors (personal and social; Ward et al., 2004, p.650). External factors, or "*contextual factors*" identified by the model include circumstances (regarding whether treatment is mandated or voluntary), location (prison or community), opportunity (availability of treatment and programmes), resources (quality of treatment being offered, appropriately trained staff, appropriate culture), interpersonal support (level of appropriate support and encouragement to engage from both staff and family) and programme characteristics (type and timing of treatment; Ward et al., 2004, p.650). For a brief description of each factor please refer to Table 1* in the Appendix. According to this model, rehabilitation via engagement in treatment will only be achieved when offenders possess both internal and external factors which promote the notion of change, in what the individual perceives to be a supportive and facilitating environment (Ward et al., 2004). Through the identification of such factors, professionals can make changes to the client, programme and/or the setting in an attempt to promote
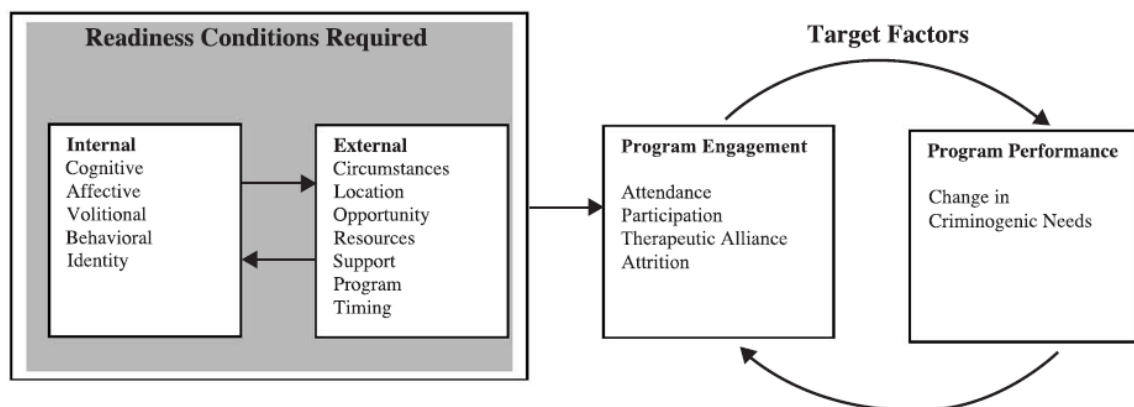
Figure 1. *Model of Treatment Readiness, as cited in Ward et al., 2004).*

Future Directions

Despite the above, poor engagement in treatment continues to present as a prominent problem amongst forensic populations. As highlighted by the MORM, engagement in treatment is vital in addressing clients' criminogenic needs and thus reducing risk. However with treatment non-completion rates ranging from around 12% (Hornsveld, 2005) to 86% (Larochelle, Diguer & Laverdiere, 2011), it is not surprising that recidivism continues to present as a societal problem (Ministry of Justice, 2015). Whilst attempts to understand treatment readiness amongst offenders have been made in recent years, this construct continues to be underdeveloped and thus requires further investigation if it is to effectively inform clinical practice.

Thesis Aims. Taking the above into consideration, this thesis aims to explore treatment engagement amongst a forensic population, as to further existing knowledge. In order to achieve this, this thesis intends to address a number of specific objectives:

1. Firstly, presented in Chapter 2, this thesis aims to investigate offenders' reasons for completion and non-completion of treatment, in order to further understand the factors influencing treatment engagement amongst offenders residing in secure settings, via the completion of a systematic review. The extent to which the existing research supports the current theoretical thinking on treatment readiness is explored. Limitations of the research are discussed and areas for improvement suggested. Recommendations for future research are also reported.

2. Secondly, although included within the inclusion criteria of the systematic review, no papers exploring treatment engagement amongst adolescents detained

in secure services were found. Therefore, in order to further existing research, the current thesis also aims to investigate adolescents' perspectives of engaging in treatment. Chapter 3 addresses this aim by presenting an empirical paper exploring adolescents' reasons for and against attending timetabled sessions using a mixed methods approach. Using thematic analysis, the themes identified are compared to the factors of the MORM in order to evaluate the applicability of this model amongst an adolescent population. Recommendations for future research are discussed.

3. Lastly, the current thesis aims to critique an existing measure of treatment readiness. Specifically, Chapter 3 includes a critical review of the Corrections Victoria Treatment Readiness Questionnaire, a measure of treatment readiness developed based on the internal factors of the MORM (CVTRQ; Casey, Day, Howells & Birgden, 2007). This chapter includes a review of existing measures of treatment readiness before examining the development, clinical utility and psychometric properties of the CVTRQ.

The findings from each chapter are then synthesised and discussed as a whole in Chapter 4. Based on such reflections, implications for practise are outlined.

Chapter 2:

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

Chapter 3:

Adolescents' Perspectives on Engaging in Treatment

Abstract

Aim

As highlighted in the systematic review presented in Chapter 2, exploration of engagement from the perspective of the offender is limited. Whilst some research exists amongst adults, the same cannot be said for adolescents. Consequently, there is a need to establish what influences young people's readiness to engage in treatment in order to promote desistance from crime and prevent the prevalence of offending into adulthood. Therefore, this chapter aims to explore reasons for and against attending treatment, amongst those young people residing in a secure hospital setting, in order to further existing research and provide practitioners with guidance as to how to effectively engage this population in treatment. This chapter also aims to explore the extent to which the Multifactor Offender Readiness Model (MORM; Ward et al., 2004) can be applied to this population.

Method

Using a semi-structured interview, participants were interviewed once a week, for two weeks regarding their reasons for and against attending their sessions. A total of 36 transcripts were analysed using thematic analysis (TA). Differences in treatment readiness amongst the population was explored using the Corrections Victoria Treatment Readiness Questionnaire (CVTRQ; Casey, Day, Howells, & Ward, 2007).

Results

Organised into two overarching themes (reasons for attending and not attending treatment), thematic analysis revealed eight themes in total. In reference to reasons for attending treatment the following themes were identifed: (1) factors relating to motivation, (2) desire to achieve personal goals and future plans, (3) percieved coercion

to attend sessions, (4) acknowledge treatment needs and (5) the influence of relationships on attendance. Reasons against attending tretament were organised into the following three themes: (6) organisational factors, (7) factors relating to the young person and (8) reasons relating to risk. As indicated by the CVTRQ 58% of participants were classified as treatment ready. Whilst treatment readiness did not differ by gender, those participants who were convicted of an offence were noted to score significantly higher on this measure.

Conclusion

The current study revealed both person centred and contextual factors as influential upon young people's willingness to engage in treatment, supporting the overall contentions of the MORM. A number of variations to the original factors of the MORM were identified specific to this population, as was an additional factor, suggesting a model specific to this population is required if guidance regarding how to engage young people in treatment is to be clearly articulated.

Introduction

Young Offenders: The Extent of the Problem

Between 2012 and 2013 in England and Wales, young people (aged under 18 years) committed 98, 837 offences, the majority of which were committed by those 15 years and over (Ministry of Justice, 2014). Overall, 43,601 young people were sentenced at criminal courts across England and Wales, of which 59% were indictable offences (Ministry of Justice, 2014). According to government statistics, between 2012 and 2013, violence against a person was amongst the most common crimes committed by young people (Ministry of Justice, 2014).

In reference to those convicted of indictable offences, 5% of these young people had 15 or more previous offences, a figure which has risen consistently since 2002 (Ministry of Justice, 2014). Between 2011 and 2012, the rate of reoffending in England and Wales was 35.5% suggesting that on average, young offenders were committing 2.88 re-offences each, resulting in a total of 72,147 re-offences during that time (Ministry of Justice, 2014). Youth offending is clearly a serious societal problem. Self-reported levels of crime suggests that arrest rates are unlikely to reflect the true extent of the problem but rather the *"tip of the deviance iceberg"* (Moffitt, 1993, p. 675).

The Consequences of Youth Offending

As with adult offending, youth offending is associated with a myriad of negative consequences including poor educational attainment, school dropout, poor vocational outcomes and engagement in substance misuse (Loeber, 1990; Sweeten, 2006; Tanner, Davies, & O'Grady, 1999; Tarolla, Wagner, Rabinowitz, & Tubman, 2002). With

regards to the latter, this has been noted to be both a precursor to, and a consequence of offending in youth populations (Bui, Ellickson, & Bell, 2000; Newcomb & McGee, 1989).

Overall, the prevalence of mental health issues amongst young offenders is high (Tarolla et al., 2002), especially amongst those engaged in substance misuse (Trupin, Turner, Stewart, & Wood, 2004). However, it should be noted that this is not to suggest a causal relationship, in that all young people with mental health issues will go on to offend, but rather highlight the common demographics of this population. Nevertheless, amongst this population, attention deficit hyperactivity disorder, oppositional defiant disorder and conduct disorder are amongst the most prevalent psychological disorders (Miller, 2014). The latter is typically considered to be a precursor to adult antisocial personality disorder (Miller, 2014) which in turn, is often associated with offending behaviour in adults (Domes, Mense, Vohs, & Habermeyer, 2013). Substance misuse, mood and anxiety disorders are also common amongst young offenders (Miller, 2014; Neighbors, Kempton, & Forehand, 1992)..

Consequently, youth offending places significant demands on the resources of the child protection system, special education, mental health care and youth justice system (Tarolla et al., 2002). Between 2012 and 2013, the average cost of holding one prisoner in a male Young Offenders Institute (YOI) in the UK was £84,158 ($131, 631.53[1]; Ministry of Justice Information Release, 2013). When considering recidivism rates, detaining young offenders would appear to be very costly and merely a short term solution to the problem. In reference to mental health care, young offenders account for up to half of all adolescent referrals made to these services and therefore are a heavy

---

[1] Based on the British Pound to U.S. Dollar conversation rate (£1 = $1.56) as reported on August 5th, 2015.

drain on resources (Borduin & Schaeffer, 1998; Tarolla et al., 2002). Due to the combination of complex needs and level of security required to manage their behaviour, detaining young people in secure mental health services is expensive, averaging £197 ($308.10[1]) per patient, per day (Beecham, Chisholm, O'Herlihy & Aston, 2003). Of concern however, is that treatment offered by such services is considered to have limited effectiveness upon this population due to their diverse treatment needs (Henggeler, 1996; Tarolla et al., 2002). For example adverse childhood experiences (e.g. abuse, abandonment, substance misuse problems and family and community violence) are frequently reported amongst young offenders (Tarolla et al., 2002). Such factors are likely to result in the development of both heterogeneous and complex psychological profiles, as well as maladaptive coping strategies, negatively impacting upon treatment effectiveness (Tarolla et al., 2002). Low motivation for change, lack of trust, psychological skill deficits, immature moral and emotional development and poor aggression management, are also commonly reported amongst this population, and have been associated with a poorer response to treatment (Tarolla et al., 2002)

Additionally, youth offending is associated with various problems during adulthood, including problems in interpersonal relationships, increased risk of divorce, perpetration of intimate partner violence, gambling and further mental health problems including depression, anxiety, paranoia and psychosis (Moffitt & Caspi, 1999; Tarolla et al., 2002). It is also considered to be a risk factor for future offending as an adult (Moffitt, 1993; Tarolla et al., 2002). According to Moffitt (1993), approximately 5% of young offenders will continue to engage in offending and antisocial behaviour throughout their life course. Labelled life-course persistent offenders, Moffitt (1993) proposes that this subgroup are likely to have displayed changing manifestations of

antisocial behaviour from as young as four years old. As the child develops and is exposed to new opportunities, their antisocial behaviour is considered to increase in severity, a process Moffitt (1993) referred to as *heterotypic continuity*. More commonly observed during adolescence, offending behaviour has been hypothesised to relate to specific aspects of development during this time, including (a) the gap between biological maturity and the achievement of adult rewards and responsibilities, (b) their increased association with peers and (c) an increase in freedom (Agnew, 2003). As antisocial/offending behaviour has been noted to perpetuate across generations, young people whose offending behaviour persists into adulthood would appear to be at increased risk of rearing antisocial children, thus continuing the cycle of offending behaviour further (Farrington, 1990; Tarolla et al., 2002).

Young Offenders and Treatment

As indicated, youth offending is a prominent problem within the United Kingdom, both in terms of its prevalence and associated consequences. Subsequently the identification and implementation of effective treatment is imperative if recidivism is to be prevented not only during adolescence, but also in adulthood (Tarolla et al., 2002). A meta-analysis reviewing the effects of treatment in young offenders noted that on average, treatment only resulted in reductions in recidivism of 9% (Grietens & Hellinckx, 2004). In comparison to treatment aimed at young people who are emotionally and behaviourally disturbed, a reduction of 9% is considered low (Lipsey & Wilson, 1993). It has therefore been suggested that youth offending is harder to address via treatment (Grietens & Hellinckx, 2004). However, whilst this may be the case, it is also possible that current interventions aimed at this population are failing to meet their

specific needs, suggesting an inherent flaw in the services provided rather than the client themselves.

Research has also suggested that young offenders are less willing to engage in treatment, particularly substance misuse and mental health treatment in comparison to adults (Cooper, 2001). As outlined in Chapter 2, poor engagement in treatment can take many forms from attending treatment but making little contribution to the session, to refusing to attend a particular session. At its most extreme, poor engagement refers to the premature cessation of treatment (Howells & Day, 2007). In reference to this, the rate of treatment non-completion amongst young offenders has been found to range from 7% (Stinchfield, Niforopulos, & Feder, 1994) to 51% (Edwards et al., 2005) depending on the type of treatment being offered. In a review of the literature exploring the outcome of substance abuse treatment amongst adolescents, Williams and Chang (2000) reported higher dropout rates amongst those young people engaged in residential Therapeutic Communities, in comparison to those engaged in other inpatient and outpatient treatment programmes. With dropout rates ranging from 34% to 90%, the authors suggested this was due to the structured nature and length of this type of treatment. Regarding prison settings, a dropout rate of 14% was found for young male offenders enrolled on two accredited cognitive skills programmes between 1995 and 2000 (Cann, Falshaw, Nugent, & Friendship, 2003). Engagement in treatment is considered vital to achieving positive outcomes, for example reductions in recidivism. As argued in chapter 2, if rehabilitation is to be achieved, developing methods which increase engagement within this population is vital (McMurran & Ward, 2010).

Problems of Poor Engagement & Non-Completion

Poor engagement in treatment particularly non-completion, is associated with a number of negative outcomes. For example, young offenders residing in custody who fail to complete treatment, have been found to receive significantly more adjudications per year than those who complete treatment (Farrington et al., 2002). Similar to adult offenders, research suggests that in comparison to those who complete treatment, young offenders who do not complete treatment are at increased risk of recidivism (Cann et al., 2003; McMurran & Theodosi, 2007). Specifically, in a meta-analysis, reviewing outcomes of drug treatment, Stein, Deberard and Homan (2013) found that in comparison to those who failed to complete treatment, young offenders who completed treatment had significantly lower recidivism rates, both during, and one year after treatment. Research exploring dropout amongst adolescents who have sexually offended, found that treatment dropout was associated with a greater risk of general, violent and combined violent and sexual recidivism (Edwards et al., 2005). Such outcomes however should not be considered a direct consequence of non-completion. It is likely that those factors which influence dropout, for example low motivation to change, may also influence an individual's decision to follow the rules and desist from crime, suggesting such outcomes may be the result of something the individual themselves is bringing to the situation.

Briefly discussed in Chapter 2, problems associated with non-completion of treatment have been noted to go beyond that of the offender. Specific to those residing in secure hospital settings, non-completion of treatment is associated with increased length of stay and as a result, increased costs (Long, Dolley, & Hollin, 2013). With dropout rates nearing 50% for this population (Williams & Chang, 2000), not only does

non-completion waste valuable resources, but it also prevents more motivated individuals from being admitted and engaged in treatment (McMurran, Huband, & Duggan, 2008; McMurran, Huband, & Overton, 2010). Furthermore, non-completion has been noted to reduce staff morale due to the perception that they have failed in engaging their clients (Howells & Day, 2007). Low morale amongst staff working with detained young offenders has been noted to precipitate staff resignation, resulting in high staff turnover (Mitchell, Mackenzie, Styve, & Gover, 2006). Not only is high staff turnover associated with additional financial costs due to having to recruit and train new staff, but it is also associated with indirect costs including decreased productivity, reduced quality of service and breakdowns in communication between staff and offenders (Mitchell, Mckenzie, Styve & Gover, 2006). Reductions in staff morale and its associated consequences are likely to negatively impact upon the therapeutic alliance between staff and the client, which in turn has been identified as vital to engaging offenders in rehabilitation (Ward et al., 2004). Consequently, failure to complete treatment amongst young people is a significant problem for treatment providers.

Predicting non-completion

To date, the majority of research regarding treatment non-completion has focused on identifying factors predictive of treatment dropout/non-completion amongst adults (Cullen, Soria, Clarke, Dean, & Fahy, 2011). With regards to young offenders, the research is somewhat limited and appears to be biased towards sexual offenders. For example, Edwards et al. (2005) found in their research of young sexual offenders that prior involvement with police for a non-sexual offence, history of self-harm, being expelled from school and committing an offence before the age of 10 years, were risk factors for treatment non-completion. Similar research by Kraemer, Salisbury and

Spielman (1998) found that amongst adolescent sexual offenders, whilst previous conviction, psychological maladjustment and preoccupation with sexual thoughts did not predict treatment dropout, age and impulsivity did. Interestingly, they found that non-completers were older and more impulsive in comparison to those who completed treatment. When considering impulsivity is commonly found amongst those diagnosed with attention deficit hyperactivity disorder, oppositional defiant disorder and conduct disorder this is to be expected. Specifically, difficulties managing feelings of boredom, may explain why such individuals are at an increased risk of dropout.

The aim of such research is to allow practitioners to identify those individuals who are at risk of dropout so that necessary precautions can be put in place to prevent attrition (Kraemer et al., 1998). Encouraging professionals to view non-completion as the responsibility of the client's inherent attributes, exploring young peoples' experiences and beliefs about the treatment being offered within the service they reside, is likely to be of greater clinical utility, particularly in terms of informing and improving service delivery and therefore reducing attrition (French, Reardon, & Smith, 2003; McMurran et al., 2010).

Reasons for non-completion

In the previous review (see Chapter 2), no literature examining why forensic adolescent groups fail to complete treatment was identified. With regards to a non-forensic population, French et al. (2003) explored the factors young people perceived impacted upon engagement with a community mental health service. Participants reported perceiving the service as meeting their specific needs, feeling understood and not judged, receiving a confidential service, perceiving a level of control over the

content discussed and timing of disclosures as factors facilitating engagement in treatment. Furthermore, participants discussed the importance of receiving regular contact with the service, particularly between sessions, or when sessions had been missed, in maintaining their engagement.

A number of studies have explored clients' reasons for engagement in adult forensic settings (see Chapter 2 for a detailed synthesis of findings). For example, using participant's clinical notes made by staff, Sheldon Howells and Patel (2010) explored reasons for non-completion of treatment amongst a male forensic population. Where possible these reasons were categorised using the factors of the Multifactor Offender Readiness Model (MORM, Ward et al., 2004; See Chapter 1 for a description). The most common reasons for non-completion related to the MORM's internal factors, including affective (i.e. fearful of engaging in group work), volitional (i.e. perception that treatment was ill suited to their individual needs) and cognitive factors (i.e. negative beliefs about staff, treatment programmes and one's ability to engage in treatment). Frequently endorsed, the authors delineated the cognitive factor further to include the following domains: (a) self-efficacy belief, (b) negative staff evaluation, (c) negative patient evaluation, (d) negative programme evaluation, (e) negative outcome expectation and (f) negative system evaluation. Regarding external factors, although not encapsulated by the MORM itself, being removed/excluded from treatment by the multidisciplinary team (MDT) due to breaking the rules, poor attendance and/or engaging in inappropriate behaviour, and transfer from the hospital unit were amongst the most common reasons for non-completion. The authors subsequently concluded that the MORM, whilst informative, is not entirely comprehensive. Findings from this study

however should be considered cautiously since it was based entirely on staff notes, which might not truly reflect the views of the participants.

In an attempt to address this limitation and build upon this research, Long et al. (2012) explored why female forensic patients refused to attend treatment sessions which they had agreed to attend as part of their care plan. Referred to as the intervention stage, reasons for refusing to attend a session were explored on the same day, or early the next day of the refusal, over a two week period. Attendance rates were also monitored two weeks before (baseline) and after (follow up) the intervention stage. Reasons for non-completion were coded according to the factors of the MORM, including the additional factors highlighted by Sheldon et al. (2012). Similar to the findings of Sheldon et al. (2010), person centred (internal) factors, specifically cognitive factors, were among the most common reasons for non-attendance. Specifically, negative perceptions about treatment and the outcome of treatment were amongst the most frequent reasons for refusing to attend sessions. Particularly in reference to occupational therapy, poor self-efficacy with regards to treatment engagement was also a common reason for refusal amongst participants. With regards to external factors for non-attendance, reasons relating to the circumstances factor of the MORM for example, attendance at medical appointments, were most commonly provided. Similar to Sheldon et al. (2010), an inability to attend sessions due to being excluded by the MDT for engaging in inappropriate behaviour, was also found. As highlighted in Chapter 2 however, whilst being excluded from treatment is clearly an external reason for not attending, the behaviour that led to the expulsion may in fact reflect an internal treatment readiness factor, for example, dissatisfaction with treatment. Exploration of individuals' reasons for engaging in such behaviour during treatment is therefore warranted.

This research, along with that of Sheldon et al. (2010), subsequently highlighted aspects of the setting, treatment and the client which could be addressed in order to increase treatment readiness and thus reduce treatment attrition.

The Current Research

The current research aimed to further the existing research by being the first to explore factors which influence treatment readiness amongst an *adolescent* population. Specifically, this research aimed to replicate the methodology of Long et al. (2012). However, in addition to exploring why adolescents residing in secure services choose not to attend their treatment sessions, the study also aimed to explore the reasons why this population chooses to attend their treatment sessions, in order to inform practitioners of the factors which encourage engagement, as well as the risk factors of non-completion. It was anticipated that by including both perspectives, the research would yield far more comprehensive and informative results. Furthermore, this research aimed to explore the extent to which the MORM is applicable to adolescents residing within secure hospital settings, as this model has yet to be validated with this population.

Method

Analytic Approach

The current study adopted an embedded mixed methods design. Due to the absence of research in the current area the integration of both qualitative and quantitative approaches aimed to provide a more comprehensive understanding of the research question posed, as suggested by Guest, MacQueen and Namey (2012). The qualitative component of the study served as the primary method, with the less

dominant quantitative component embedded within this. Findings from the quantitative component were used to support the interpretation of qualitative analysis. Integration of methodological approaches has been noted as beneficial in assisting researchers explain initial results and generalise exploratory findings (Guest et al., 2012). When considering the lack of research in the current area, such benefits were considered important when expanding the limited research base.

Regarding the qualitative aspect of the current research, an inadequate description of analytic procedures and reasons for their selection is reported to be "*one of the weakest areas in published qualitative research*" (p.253, Guest et al., 2012). Thus, in order to address this weakness and ensure transparency, justification regarding the selection of Thematic Analysis (TA) over other methods, as well as detail regarding the analytic process is provided in Appendix A.

Participants & Setting

Participants were recruited from a secure hospital setting providing specialist secure services for young people with complex mental health disorders, neurodevelopmental disorders and brain injury. Participants from all wards were recruited, including both medium ($n = 2$) and low secure wards ($n = 6$). Of the low secure wards, four provided specialist services for young people with complex mental health needs and two provided specialist services for young people with autistic spectrum disorder (ASD). The two medium secure wards provided specialist services specifically for boys with learning disabilities (LD). All patients presented with challenging behaviour and complex needs. The author was not affiliated with the setting prior to the research and therefore had no existing knowledge of the participants.

The current research adopted a purposive sampling strategy in order to address the research question. As the research aimed to explore treatment readiness amongst adolescents detained in secure hospital settings, only individuals between and including the ages of 13 to 17 years were recruited. Research has noted differences between children (under 13 years) and adolescents' engagement in treatment (Block & Greeno, 2011), and so including those under 13 years was anticipated to result in confounding variables, preventing accurate interpretation of the results. Those 18 years and over were considered to be an adult and so were excluded. Due to limited resources, only those who were fluent in English were recruited. In accordance with ethical standards, only those participants deemed by their responsible clinician (RC), to have capacity to provide fully informed consent were able to participate. All eligible participants were offered the opportunity to take part in the research, after which time sampling ceased. Whilst saturation of data was achieved in the current research, this was not used as a criterion to determine the sample size.

At the time of data collection, a total of 56 young people were considered appropriate for participation. Of this subsample twenty-eight refused to participate, five were discharged prior to recruitment and one was not granted consent by their legal guardian. Reasons for refusal were not reported by these participants. Twenty-two young people provided their consent to participate, however three dropped out before engaging in the interview stage of the research. Reasons for dropout included not having enough time to engage in interviews ($n=2$) and a lack of interest in the research ($n=1$). In total the sample consisted of nineteen young people. It should be noted that two participants in this sample refused to engage in the second interview due to finding it too time consuming, however both permitted the data gained from the first interview

to be included. Whilst this sample size is small in comparison to that utilised by Long et al. (2012; $n = 63$), due to (a) time constraints and (b) their being only one researcher, a larger sample size was not feasible. Nevertheless, Braun and Clarke (2013) suggest that for a moderate to large project, which intends to use TA, 10 to 20+ interviews are sufficient. As the majority of participants were interviewed twice, this sample size was deemed acceptable.

Overall the sample comprised thirteen male and six female participants, recruited from low secure (n=11) and medium secure wards (n=8). The mean age of participants was 16.63 years and the majority were White British. Most participants had received a formal diagnosis of ASD (57.89%), LD (57.89%) and/or conduct disorder (52%). The majority of participants were detained under Section 3 of the Mental Health Act (MHA; 63%) or a Section 37 (26%). Nine participants had received formal convictions and/or cautions for offences including theft, burglary, robbery, arson, assault, battery, sexual assault and possession of an offensive weapon. Four participants had been arrested for engaging predominantly in aggressive and violent behaviour, but not convicted. All participants ($n = 19$) had a history of engaging in aggressive and/or violent behaviour.

Data Collection

Where possible the current research aimed to replicate the methodology implemented by Long et al. (2012). Incorporating a prospective study design, for each participant the procedure was split into two stages, (1) recruitment and consent (2 weeks) and (2) data collection (6 weeks). Both stages are outlined below.

Stage 1: Recruitment & Consent. Overall, this process was staggered over 7 months, recruiting participants from one ward at a time. This method of sampling was adopted for several reasons. Due to the method of data collection, a significant amount of time was needed to collect the data, and so staggering recruitment allowed for the study to be carried out by the one researcher, ensuring all interviews were executed in a similar way, reducing any bias which may have been caused due to multiple interviewers. It also ensured that all participants could be interviewed shortly after providing their consent, reducing the risk of dropout.

Depending on the number of participants per ward deemed able to consent to the research, participants were either approached as a group during their weekly community meetings or individually. Regarding the latter, this was to prevent the author from incorrectly offering those unable to take part in the research, the opportunity to do so. In both cases however, the research and the role of a participant was explained and an opportunity for questions provided. All patients were given a participant information sheet detailing the research (See Appendix B). Participants were given a week to consider their participation before being approached regarding their consent, or for those under 16 years, assent (See Appendix C & D). Regarding the latter, consent from the participant's legal guardian was sought before they were deemed eligible for participation.

Participants were asked to complete the CVTRQ (See Appendix E; Casey, Day, Howells, & Ward, 2007). The CVTRQ is measure of treatment readiness; the content of which is derived from the internal factors of the MORM (Day, Casey, Ward, Howells & Vess, 2010). Scores of 72 or above are considered to indicate that an individual is ready for treatment (Casey et al., 2007). For more details regarding this measure please see

Chapter 4 where a full critique is provided. As many of the participants had poor literacy skills, questions were read aloud by the researcher. Using a pictorial scale of the possible answers, participants were required to indicate their response (See Appendix F).

It should be noted that the CVTRQ is yet to be validated with an adolescent population (Casey et al., 2007). Whilst it is acknowledged that this is a limitation, to the knowledge of the researcher there is currently no measure of treatment readiness specific to this population. When considering that the current research aimed to (a) replicate Long et al. (2012) methodology as accurately as possible and (b) examine the applicability of the MORM within an adolescent population, the CVTRQ was considered the most appropriate measure to ensure these aims were met. As this measure was intended for individuals residing in prison settings, the wording of some of the items was adapted to reflect a secure hospital setting, as to improve the measure's suitability for the current population. Permission to do so was sought from the authors of the tool. The adaptations used by Long et al. (2012) were used to ensure that the meaning and/or content of the items were not changed.

Stage 2: Data Collection. *Session Attendance.* Data collection was split into three stages, spanning over six weeks including baseline (weeks 1 & 2), interview (weeks 3 & 4) and follow up (weeks 5 & 6). Throughout all three stages, session attendance was monitored via reference to participants' clinical notes in order to assess any changes throughout the research. Reference to participants' notes also allowed the researcher to check which sessions had/had not been attended prior to interviews, ensuring accuracy of the data collected.

As well as refusing to attend a treatment session, in accordance with Long et al. (2012), sessions whereby the participant was asleep, disruptive and/or contributed non-relevant material despite being deemed competent to understand the purpose and content of the session, were not counted as having been attended as such behaviours were considered to reflect a lack of engagement.

Treatment sessions included any treatment/therapy (excluding medical) in their care plan offered by the service which the individual had agreed to attend.

Semi-structured Interviews. During the interview stage of data collection (weeks 3 & 4), participants were interviewed once a week, for two weeks, regarding their session attendance over the previous five working days. This was in comparison to Long et al. (2012) where participants were interviewed on the same day, or early the next day. Whilst it is acknowledged this may have impacted upon the accuracy of data collected, due to issues regarding resources, direct replication of this methodology was not possible. In an attempt to increase recall accuracy however, participants were provided with a copy of their treatment timetable during the interview, which outlined the day and time of each session planned. Participants' timetables were used to provide a visual aid which (a) was personal to the participant, (b) promoted a subjective sense of time and (c) encouraged autonoetic consciousness (an individual's ability to mentally place themselves in the past and recall previous experiences), all of which are factors that have been noted to aid the recall of episodic memories (Rubin, Schrauf, & Greenberg, 2003; Tulving, 1984). Activation of this memory system was deemed important in helping participants accurately recall their previous experiences of treatment and subsequent reasons for/against attending sessions.

Participants were interviewed on more than one occasion for several reasons. Firstly, when considering the population, fluctuations in mood and mental state are to be expected and therefore conducting more than one interview per participant allowed for an element of control over such confounding variables. Secondly, due to the participant's age and diagnoses, it was anticipated that for some, their ability to articulate their views and maintain their attention would be somewhat limited, reducing the quality and depth of the data collected. Conducting multiple interviews has been suggested as one way to compensate for this (Morse, 2000). Thirdly, particularly with regards to those sessions not attended, it ensured a variety of reasons were captured.

Interviews lasted between 30 minutes to 1 hour (X = 27.41 minutes, SD = 11.31) and took place in a quiet room off the main ward. Where possible interviews took place on an individual basis to prevent responses being influenced by the presence of a familiar member of staff. In contrast to Long et al. (2012) who made hand written notes, all interviews were audio recorded to ensure responses were accurately recorded and then transcribed verbatim.

The semi-structured interview scheduled was developed based on the schedule used by Long et al. (2012) however, in an attempt to further this research reasons for attending treatment were also explored. Each participant's timetable was worked through in chronological order. For each session the following areas were explored:

- Reason for attending or not attending the session.
- Perceived importance of attended/non-attended session on a scale of 1 to 10 (1 is not important at all, 10 is extremely important) and reason for this.

Debrief. All participants were provided with a debrief of the research after the second interview had taken place during which time participants were given the option to receive a summary of the findings once the research was completed.

Ethical Considerations

Ethical Approval. The National Research Ethics Service Committee, West Midlands, granted ethical approval for this research on the 23rd January 2014 (See Appendix G).

Confidentiality. All participants were allocated a unique identification (ID) number to ensure their anonymity during data collection. ID numbers were deemed necessary if information provided by the participant was to be identified in the case of their withdrawal/loss of capacity to consent to participate. All information, including audio files from interviews was stored on a password protected computer on site. Only the current author had access to these files. Once transcribed, the files were deleted. Participants were informed of the above before providing their consent to participate.

Additionally, participants were made aware that what was said during interviews was confidential and would not be shared with the staff team **unless** they divulged information that suggested they or anyone else was at risk. Participants were reminded of their right to withdraw from the study at any time, without having to provide reason for doing so at the start of each interview.

Capacity to Consent. Due to the age and vulnerability of the participants recruited, only those deemed to have capacity to make an informed decision regarding their participation in the research were included. Declarations regarding participant's

capacity were made by their RC prior to recruitment (See Appendix H). Participants were monitored throughout the research for possible changes in capacity.

Participants Under 16 Years. Participants under the age of 16 required consent from their legal guardian to participate in the research. Information sheets were posted to the individual's legal guardian detailing the research and the role of a participant, along with the information provided to the participant and a copy of the assent form. A legal guardian consent form was also included along with a stamped, addressed envelope for return (See Appendix I).

Data Treatment

Data was analysed using TA. The rationale behind the selection of this method can be found in Appendix A. As advised by Braun and Clarke (2013) the analysis incorporated a seven step procedure including: (1) transcription, (2) reading and familiarisation, (3) coding (complete) across entire data set, (4) searching for themes, (5) reviewing themes, (6) defining and naming themes and (7) writing and finalising analysis. Whilst these steps present as a logical progression through which analysis should follow, some steps were revisited and revised throughout analysis, contributing towards the development of increasingly robust themes and subthemes. This recursive approach advised by Braun and Clarke (2013) is considered optimal in assisting the development of the constructs within the data. To ensure transparency and allow effective evaluation of the current research, details regarding each step are provided in Appendix A.

Validity & Reliability

Efforts were made to enhance both the validity and reliability of the current research. In reference to the former, whilst there are various types, and in turn methods in which to ascertain validity, face validity is more commonly applicable to qualitative research and so was sought in the current research (Guest et al., 2012). Specifically a Forensic Psychologist in Training, external to the research, reviewed the code book, developed by the author during step five of the analysis (See Appendix A). Overall the code book detailed each theme/subtheme and the codes supportive of these. The independent reviewer provided feedback on the extent to which she agreed the information within the code book made intuitive sense. The code book was then amended accordingly. The development of a code book was in itself considered to increase the overall validity of the research as it provided evidence supporting the development of themes/subthemes, increasing overall transparency. Furthermore, in order to make clear to the reader how the author has derived the current themes/subthemes, and thus increase the overall validity of the research, quotes supporting the themes/subthemes derived are provided in the results section of this report (Guest et al., 2012).

Regarding the latter, inter-rater reliability is commonly used to establish reliability during analysis in qualitative research and so was sought in the current study (Guest et al., 2012). Using the code book discussed the same individual as referred to above, independently coded 30% of the transcripts. The extent to which the analysts coding matched that of the authors was calculated using Cohen's Kappa coefficient (Guest et al., 2012). The Kappa statistic ($K=.76$) indicating substantial agreement (Viera & Garrett, 2005).

Quantitative Data Analysis

Please note, due to the small sample size, unequal distributions and lack of statistical power within the data set, non-parametric tests was elected over parametric tests.

Treatment Readiness

The CVTRQ modified for secure psychiatric settings, was completed by all participants (*n*=19). The mean total CVTRQ score for the sample was 73.53 (SD=10.42). Using a cut off score of 72 (Casey et al., 2007), eleven participants (58%) were categorised as "*treatment ready*". The influence of gender, ward security level and presence of formal conviction on treatment readiness, as measured by the CVTRQ (including total score and scores on all subscales) was examined using Mann Whitney *U*-tests (see below). The means and standard deviations are summarised in table 3.

Gender. Mann Whitney *U*-tests revealed no significant differences between male and female participants on their scores on the CVTRQ, suggesting treatment readiness did not differ significantly by gender. However, it should be noted that overall males scored slightly higher on the CVTRQ total score and majority of subscales, excluding emotional reactions. This finding would appear to support literature suggesting that across the life span, females not only experience, but express emotion more intensely than males (Diener, Sandwik & Larsen, 1985; Grossman & Wood, 1993).

Ward Security Level. Participants on the medium secure wards scored significantly higher on the efficacy subscale of the CVTRQ, than those on the low

secure wards (U= 20.0, N_2 = 8, two tailed p=0.051). This would suggest that participants on the medium secure wards perceived themselves as more able to participate in treatment. In comparison to the medium secure wards, the low secure wards provided specialist services to young people with complex mental health needs and ASD. It is possible that participants' scores on the efficacy subscale were influenced by such diagnoses, mainly ASD and mixed disorder of conduct and emotions, which were more prevalent on the low secure wards. Associated symptoms including social skills and communication deficits, difficulties responding to change in routine (ASD) as well as low mood, anxiety and aggressive/antisocial behaviour (mixed disorder of conduct and emotion) may have influenced participants ability to engage in treatment, potentially explaining this finding. No other significant differences were found.

Presence of formal conviction. Formally convicted participants had significantly higher CVTRQ total scores in comparison to those who had not been formally convicted for their behaviour (U = .21.5, N_2 = 9, two tailed p = 0.053), suggesting the former were more ready to engage in treatment. Whilst not statistically significant, all subscales were slightly elevated for those participants who had received a formal conviction. When considering the qualitative findings, especially the subtheme "*attend to reduce risk*", it is possible that convicted participants perceived a greater value in treatment aimed at reducing their risk in comparison to their un-convicted counterparts, increasing their motivation to engage. However, as highlighted in the theme "*to maintain or access more freedom (from leave to discharge*", compliance with treatment may have also been driven, by their awareness of the need to do so in order to achieve discharge. Despite all participants having engaged in behaviour warranting

detention, it is also possible that this finding reflects the increased applicability of the measure amongst convicted participants.

Table 3

Comparison of gender, ward security level and presence of conviction on treatment readiness scores as measured by the CVTRQ

		CVTRQ SCORES								
		Total score		Attitudes & Motivation		Emotional Reactions		Offending Beliefs		Efficacy	
		M	SD	M	SD	M	SD	M	SD	M	SD
Gender	*Male*	75.31	9.78	24.00	4.10	22.38	5.56	13.92	3.17	14.77	3.17
	Female	69.67	11.62	22.00	5.51	24.00	4.05	11.17	2.56	12.50	2.07
Ward security level	*Low*	70.27	10.74	22.91	4.78	21.91	5.36	11.91	3.18	13.00	2.93
	Medium	78.00	8.64	24.00	4.41	24.25	4.65	14.63	2.67	15.50	2.62
Convicted	*No*	69.10	10.54	22.40	4.62	21.20	5.14	11.80	3.46	13.10	3.00
	Yes	78.44	8.22	24.44	4.45	24.78	4.55	14.44	2.35	15.11	2.80

Session Attendance

Mean attendance rates during each stage of data collection are presented in Table 4. For each participants' percentage attendance rates across the three stages of data collection, please refer to Appendix J. A Friedman test was conducted to explore any statistically significant differences in attendance between the various stages of the research, none of which were found. Whilst not statistically significant however, in comparison to baseline, attendance appeared to reduce somewhat during the interview stage.

Table 4

Percentage attendance rates at sessions across the three stages of data collection

| Participants | Stage of research | | | | | |
| | Baseline | | Interview | | Follow-up | |
	M	SD	M	SD	M	SD
All (*n*=19)	71.08	17.15	62.11	16.31	64.62	23.18
Low secure (*n*=11)	60.88	15.13	57.79	17.06	51.14	21.02
Medium Secure (*n*=8)	85.11	6.37	68.06	14.08	83.15	8.51

Differences in attendance across the three stages of data collection by ward security level were also examined using Man Whitney *U*-tests. In comparison to those on the low secure wards, attendance was significantly higher during both the baseline ($U = 0.00$, $N_2 = 8$, two-tailed $p=0.00$) and follow-up stages of data collection ($U = 2.00$, $N_2 = 8$, two-tailed $p=0.00$) for those of the medium secure wards (See Figure 2.). Attendance during the interview stage did not differ significantly between the two wards. Exploration of qualitative data revealed a number of participants, particularly on the medium secure wards, were unable to attend sessions during the interview stage due to matters related to their risk, and issues regarding the availability of staff (see subthemes *"issues relating to staff"* and *"risk levels hinders attendance"*). This therefore may explain why participant's attendance reduced somewhat during this time.
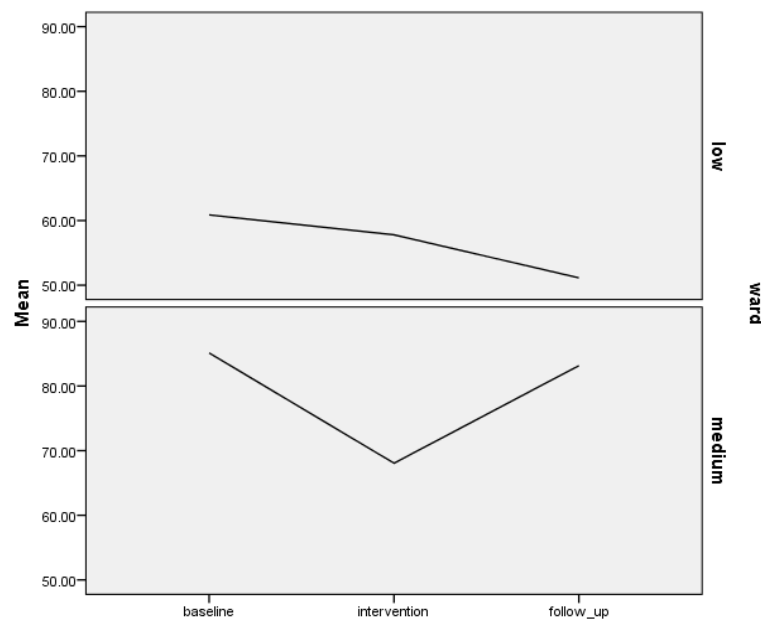
Figure 2. *Attendance at session during the three stages of data collection (baseline,*

interview and follow up) amongst participants on both low and medium secure wards.

Perceived importance of attending session

Overall participants viewed attendance at all sessions, regardless of discipline, to

be of somewhat equal importance. See table 5.

Table 5

Perceived importance of session as rated by participants on a scale of 0-10.

Session	Rating (0-10)
Psychology	6.78
Occupational Therapy	6.06
Education	8.31
Physiotherapy	6.67
Art Therapy	6.31
Sport and exercise	7.00
Speech and Language Therapy	6.60
Social Work	7.33

Qualitative Data Analysis

In order to effectively answer the research question, data analysis was structured into two overarching themes including (1) reasons *for* and (2) reasons for *not* attending treatment. References relating to both of these were then organised into themes, subthemes and where necessary, delineated further into subordinate themes to help accurately convey the findings. These are presented below. In order to contextualise the findings, illustrative quotes taken from participants interviews are provided in support of each theme.

Reasons for attending treatment

Five themes were identified as reflecting participants' reasons for attending treatment. These themes are presented in Table 6, along with the frequencies in which these themes were endorsed by participants across both interviews. The hierarchical nature of this overarching theme is further summarised in Figure 3.

Table 6

Participants reasons for attending treatment (n= 19) organised by theme and frequency with illustrative quotes.

Theme	Number of Participants Reporting Theme		
	Interview 1 (n=19)	Interview 2 (n=17) †	Total (n=19)
Factors relating to motivation	19	17	19
Enjoy session, precipitates positive affect "*I find it amusing like exciting cause ya do things like it's things like the world scientists on what they find and cures and stuff…it's interesting*" (participant 106)	19	17	19
To achieve a sense of normality	5	4	6

"*it's nice to be able to do something normal*" (participant 118)

To try and keep oneself occupied "*so you can get off the ward so you can do stuff*" (participant 105)	13	14	16
Attendance driven by incentive "*er because ye get paid to do it*" (participant 114)	13	13	16
The availability of resources encourages attendance "*cause we do like different activities and the game that we played was nice play different card games and that do new things every time*" (participant 108)	11	12	16
Desire to achieve personal goals and future plans	18	16	19
Achieve a healthy lifestyle "*because it's gonna get me fit and healthy in ma life I might live a bit longer as well*" (participant 107)	13	8	15
Getting an education "*last year I didn't get a chance to do my GCSE's so this year I have to I wanna achieve that so that when I get out I can get a job I can do I can just do things ye*" (participant 101)	16	14	18
Working towards discharge "*it's part of my treatment programme so I have to participate in DBT if I wanna get out here so I went to that and participated to get out of here*" (participant 118)	8	11	13
Prepare for life after discharge "*cause it's important that you learn to cook cause if ya living on ya own then which I'm going to be in about six weeks' time cause I'm leaving*" (participant 106)	16	13	18
Perceived coercion to attend sessions	15	14	17
Attendance is expected, it's not optional "*I go there but only cause its compulsory if it wasn't compulsory I wouldn't go*" (participant 121)	10	11	12
To maintain or access more freedom (from leave to discharge)	12	16	17

"cause I had to there's any any session on your planner you have to do it you can't refuse- you can refuse but then it does down as a refusal and does affect your levels and it does affect what you do on a weekend" (participant 107)

Acknowledge treatment needs	16	11	16
Attend to reduce risk *"cause it can help me so I don't do the thing I done in the future so I don't do it again"* (participant 105)	6	4	8
Attend to address clinical need *"I wanna learn something more about ma self so I wanna know what disorders I've got and how to make them not make them better but how to cope with better and how to live with them better that's why I go to psychology"* (participant 117)	13	9	15
The influence of relationships on attendance	17	13	17
To avoid interpersonal conflict & stay out of "trouble" *"cause if you're not on the ward you won't get recordings or get into arguments cause it keeps you out of arguments"* (participant 105)	6	4	8
Having a positive perception of staff and the therapeutic relationship facilitates attendance *"cause like I've seen her for one to one art therapy for like three years so she was quite a big part really she she helped me talk about st- she helped me talk about painful subjects like my brother's death so it's quite important that I go and see her"* (participant 103)	12	9	13
To socialise with peers *"so I can meet other people from wards… the only other time I get to meet other people is like when I go football, drum circle or youth club"* (participant 102)	11	9	11
The influence of family relationship on attendance *"I don't really know why I go I just go because ma granddad always asks me to go cause he wants me home"* (participant 104)	4	7	7

† *Two participants refused to engage in the second interview.*
NB: all frequencies in the table relate to the number of individual participants expressing a theme.

Factors relating to motivation. Reasons relating to motivation were endorsed by all participants as precipitating attendance at sessions (*n*=19). Specifically, attendance was at times driven by the inherent satisfaction and enjoyment participants gained from the session itself. On other occasions, participant's engagement was instrumentally driven by their desire to attain a particular outcome, be it through the acquisition of an incentive or the avoidance of becoming bored or institutionalised. Motivating factors were organised into five subthemes and are discussed below:

Enjoy the session – precipitates positive affect. All participants reported attending certain sessions, mainly occupational therapy (OT) and sport and exercise sessions, due to the enjoyment they experienced as a result of their engagement (*n*=19). Participants reported finding these sessions fun, interesting and reflective of their own hobbies or "*passions*" in life, precipitating their experience of positive affect. For others, participation was encouraged by their sense of achievement in developing their knowledge and skills further. Being good or able to do something well, appeared to increase participants' feelings of self-efficacy and in turn their enjoyment in the session. Three participants reporting enjoying certain OT sessions which required them to either look after animals or help members of the community. For these participants, they discussed how engaging in such sessions increased their feelings of importance and responsibility, contributing to the development of their self-esteem. For other participants, having an element of choice over the session content was reported to increase feelings of enjoyment in the session (*n*=7). A small number of participants discussed that whilst they enjoyed the session, they did not perceive it to be personally beneficial in addressing their needs and/or helping them move on from the hospital, demonstrating insight into their rehabilitation (*n*=2):

"I love meal cook, I love cooking...it's just cooking's my, brings my spirit out, like it just makes me feel good for a little while, it's just, I can cook millions of things as well but, cause I know my cooking's good" – *Participant 101*

"I just find it really interesting so I thought erm, ye I just go to it...but it doesn't really benefit me cause I don't take drugs and I don't take alcohol" – *Participant 123*

"er because I love working with animals and I look after them all over the weekends I look after them on a Wednesday....there just cute I love them I love animals all in all and if I could do animal care on every single session I didn't like I would do it.... it makes me feel quite important, knowing that I'm helping an animal to live" – *Participant 107*

To achieve a sense of normality. For some participants, particularly males, engaging in certain sessions created a temporary sense of normality (*n*=6). Specifically, participants discussed attending sessions which mirrored what they would be doing if they were living in the community, for example baking, playing football or gardening, likening such activities to *"normal stuff"*. One participant reported attending such sessions in order to avoid becoming institutionalised. For some participants, attending these sessions elicited feelings of nostalgia as they often reflected on engaging in similar activities with family members prior to coming to hospital. One participant in particular reflected on how attending the session allowed her to keep up to date with current affairs, enabling her to maintain relationships outside the hospital:

"I wanted to see what the news was so that I could talk to people outside of here about it and make me feel a bit more normal" – *Participant 118*

"I used to do gardening with my dad every weekend so I got into it as well so that session is pretty important to me knowing that I had- I done it with my dad and now I'm carrying it on still" – *Participant 107*

"Because it gets me active I like being active I used to do sports when I was outta here did lots of sports did sports every day loads of different sports cricket football rugby…makes me feel happy like I'm at home like doing more normal stuff" – *Participant 108*

To try and keep oneself occupied. Participants commonly reported attending various sessions in an attempt to keep themselves occupied (*n*=16). Whilst most commonly endorsed in relation to OT, other sessions including psychology, education and sport and exercise were also included. Participants discussed attending these sessions in order to prevent themselves from becoming bored, and in turn frustrated, due to spending too much free time on the ward. As a result, participants often reported attending sessions to simply "*get off the ward*" and "*do something*"; this desire appeared to motivate attendance at those sessions which some described as uninteresting or unimportant in their overall rehabilitation. For other participants, attending off ward sessions appeared to be a behavioural management strategy as they discussed how keeping occupied prevented them from getting into "*trouble*" on the ward. A small number of participants discussed how attending sessions provided them with a psychological distraction, maintaining their emotional wellbeing.

Participants also reported attended sessions for reasons relating to convenience. For example, in reference to those sessions facilitated on the ward, some participants reported attending simply because they were on the ward at the time and had nothing else to do. Others reported attending sessions for no other reason other than they were allowed to ("*on the right levels*"). For these participants it is possible that they were making the most of what they perceived to be a temporary freedom.

"The reasons I go is cause it got me off the ward and gave me summet to do for a while" – Participant 117

"It's not like it helps you in the future but it just gives you summet to do so" – Participant 119

"Keeps me distracted instead of just sitting in a corner ruminating" – Participant 120

Attendance driven by incentive. Predominantly in reference to OT and educational sessions, a large proportion of participants reported attended sessions due to the incentives they received as a result of engaging, indicating positive reinforcement (*n*= 16). In comparison to 67% of female participants, 92% of male participants endorsed this subtheme. Most commonly, attendance was driven by the opportunity to earn "*free time*" whereby participants were permitted sometime within the session to do as they wanted. Not only was the availability of free time noted to motivate attendance, but it was also appeared to positively influence participant's perception of the session and the staff member facilitating it. Other incentives included financial rewards, the

availability of food and drink and the acquisition of behavioural monitoring rewards (e.g. "*stars and ticks*").

> *"Just cause I like doing a job that I'm getting paid to do" - Participant 102*

> *"cause I get a nice drink and some snacks" – Participant 111*

> *"Sometimes you get a free session…you can go on the internet and play games and listen to music" – Participant 105*

The availability of resources encourages attendance. The availability of resources, be it the availability of staff to provide one-to-one sessions, the chance to participate in a new session or the opportunity to engage in wide variety of activities on a weekly basis, was noted by a large proportion of participants as reasons for attending (*n*= 16), the latter of which was most commonly endorsed by the sample. Although closely linked with enjoying the session, the opportunity to do something different each week appeared to maintain participant's interest in the session, motivating attendance. Having the option to choose from a variety of activities during the session, as opposed to being restricted to single task, was also discussed by some as facilitating their decision to attend:

> *"Just you get to play different games every time you go so it's not the same thing over and over again" – Participant 110*

> *"Ye cause you have more choice… you've got multiple choices you get to pick which one you like so and if you don't like it you can go and*

do another choice and if you don't like that you can do another choice

so it doesn't get boring" – Participant 117

"because it's just a one person session it's just me…I don't like two- I

don't like when there's two people or three people or more cause I

just- I don't like socialising with other people…like I don't like it

makes me- it stops me concentrating" – Participant 108

Desire to achieve personal goals and future plans. All participants reported attending certain sessions in order to help achieve their personal goals and future plans (*n*=19). Participants commonly discussed attending OT, psychology and educational sessions in particular, as they understood the potential utility and value which engaging in these sessions would have on attaining their goals and improving their future quality of life. Participants' goals often reflected primary human goods including healthy living, knowledge and excellence in work (Ward & Brown, 2004). Whilst on the whole attendance was considered compulsory, participants concurred with the need to attend due to their perception that the session was helpful in achieving their goals. This theme was organised into four subthemes detailed below:

Achieve a healthy lifestyle. A large proportion of participants reported attending cooking (OT) and sport and exercise sessions in order to help them achieve a healthier lifestyle (*n*=15). Specifically, participants discussed wanting to lose weight, build muscle and/or improve their fitness generally. Participants acknowledged the importance of being healthy, both physically and psychologically, and articulated that attending these sessions would help them to achieve this goal, demonstrating insight. One participant reported that he had established this goal collaboratively with staff and

felt supported in achieving it as a result. Overall, in comparison to female participants (67%) a larger percentage of male participants (85%) endorsed this subtheme:

> *"Ye cause I'm trying to build up so I need to put weight on so I can turn it into muscle" – Participant 102*

> *"It helps me to keep fit and healthy…so I don't put on weight and end up being grumpy" – Participant 120*

> *"Because when I swim then you tone up you lose weight you feel better about yourself" – Participant 118*

Getting an education. A common subtheme amongst participants included the desire to achieve an education and the motivating influence this subsequently had on their attendance at educational sessions (*n*=18). Participants discussed the importance of gaining qualifications and developing their academic skills in order to help them achieve their long term future goals, including pursuing further education and getting a good job (*n*=16). Whilst some participants discussed not liking the session or the individual facilitating them, due to the foresight they had about their future they continued to attend. A number of participants reflected on having missed out on an education prior to admission, due to their behaviour at the time. These sessions were subsequently perceived by some as a second chance at gaining an education and bettering their future.

> *"cause it helps me get qualifications that I need and eventually get the GCSE's I want then I'll be able to go to college and do courses" – participant 103*

"well its interesting but now I feel like I've let ma self-down cause I didn't try hard enough in the past like when I was at home I didn't try hard enough but now I've managed to like have help" – participant 106

"because it's something which will help me or be useful for me in the future- in the long term future for example getting a job so I need to get decent grades so I can get good qualifications" – Participant 117

Working towards discharge. A desire to achieve discharge was noted amongst several participants as reason for attending sessions (*n*=13). Specifically, participants believed that in attending their sessions they could demonstrate their rehabilitative progress to staff and positively influence decisions regarding their discharge at formal meetings, such as tribunals and care programme approach (CPA) meetings. Engaging in psychology, and to a lesser extent OT sessions, was often perceived as vital when trying to achieve discharge. Unlike other sessions, participants often described psychology as being "*part of my treatment*" and consequently the main reason for their admission. Whilst some participants demonstrated insight into their treatment needs and the reasons why engagement in these sessions was necessary, others did not. Sessions which were directly linked to discharge were perceived as particularly important and were commonly attended as a result. This theme was more commonly endorsed amongst female (83%) participants in comparison to male (62%).

"Er its helping me in er getting me back out in the community…because erm that's the most important thing in my life to get me out of hospital to do my psychology sessions" – Participant 107

"I wanna show them that I'm actually trying er instead of just sitting around and not doing anything cause if you show them that your trying then they might give you a release date or they might think he's he's getting better he wants to achieve something" – Participant 117

"psychology helps ya a bit looks good in ya tribunal and stuff" – Participant 122

Prepare for life after discharge. In addition to the above, a large number of participants discussed attending sessions which they believed would help improve their vocational and independent living skills, in preparation for living in the community (*n*=18). This subtheme was most commonly noted when exploring reasons for attending OT and educational sessions. Participants discussed wanting to improve their daily living skills, for example cooking and learning to manage finances. Participants reported wanting to develop their social skills in order to help them interact within society upon release and avoid conflict. In terms of vocational skills, participants reported attending OT sessions in particular in order to gain work experience and thus, increase the likelihood of them gaining employment in the community.

"I go to it just to develop ma cooking skills ye…because I'll need them in the future when I either leave and live with someone else or on my own I'll need to know how to cook" – Participant 117

"cause I really enjoy it I really enjoy it I think it benefits me and I'm getting work experience as well cause I'm on the tills now and I wanna work in clothes shops so that will help with that" – Participant 121

"um I like it I do it is it's good cause then I'm like get to learn how to withdraw ma money n everythink ye…cause when I get out I'm not gonna be livin with ma mum so… I kinda need to learn how to control ma money and not just spend it on any old crap" – Participant 101

Perceived coercion to attend sessions. A substantial number of participants reported feeling coerced to attend their sessions (*n*=17). Unlike other themes discussed, this theme did not appear to be specific to a particular session or discipline. For many, attendance was simply a means to an end in terms of achieving an increased level of freedom, both within and outside of the hospital. For others, attendance had become part of a routine which was perceived by most as unwillingly imposed upon them, often for reasons unknown. Consequently, attendance at sessions appeared, for some, to be more of a cultural expectation as opposed to a conscious decision making process whereby choice was valued. The trade-off between attendance and increased levels of access would appear to reflect attempts made by the organisation to encourage individuals to both enter and stay in treatment. This theme would also appear to highlight the "them vs us" attitude commonly held amongst those residing within secure services. Overall two subthemes were identified:

Attendance is expected, it's not optional. A general view amongst participants was that attendance was expected and not a personal choice, causing them to feel controlled by professionals (*n*=12). Whilst some participants discussed an awareness of

the potential benefits of engaging in such sessions, others did not and subsequently reported an aversion towards the session and the member of staff facilitating it. Overall, participants often failed to report why they felt forced, suggesting attendance was somewhat habitual, reflecting an element of passivity:

"well I don't have a choice in the matter so… erm it just makes me feel like a robot or something cause I always have to do what people say and have to do it a certain way and have to be told how to do this and how to do that have to be told erm you're going to this your dinner is at this time everything is set and I feel really controlled I don't like it"
– Participant 118

"I only go cause I have to I don't think it's benefitting me" –
Participant 121

"if I had a choice on if I could go or not I would say no cause it's that boring…you just sit round in a group and we talk about all random stuff it's horrible I don't like it" – Participant 107

To maintain or access more freedom (from leave to discharge). All but two participants endorsed this subtheme (*n*=17). Participants reported feeling coerced by professionals into attending sessions in order to maintain and/or gain more access, both within and outside of the hospital, and ultimately achieve discharge. This subtheme may therefore explain why participants on the whole perceived their sessions to be of equal importance. Such feelings of coercion were commonly found to precipitate participants feeling of frustration towards staff, suggesting a negative impact on the therapeutic relationship. Due to the importance placed upon such rewards, fewer participants

reported attending sessions in order to benefit from them as intended. Participants discussed a number of negative consequences associated with refusing sessions, mainly cessation of leave including community leave and home visits, as well as increased length of stay at the hospital. Motivated to avoid such consequences, participants disclosed not only attending but engaging fully in sessions, regardless of whether they wanted to or not, highlighting the influence of negative reinforcement. Despite not liking the session and/or perceiving it as irrelevant to their needs, participants discussed feeling forced to attend by professionals. A couple of participants reported pretending to engage in order to manage professional's impression of them. It is possible that such feelings of coercion stem from a disparity between staff and patients overall rehabilitative goals:

> *"it's something I don't really give a shit about and it doesn't interest me in the slightest and it doesn't benefit me in the slightest but I have to go and pretend I care cause if I don't I get marked down for shit like that 'he didn't engage properly ooo he's such a risk' " – Participant 121*

> *"that's what I did for my first few weeks I just used to sit there but then they wouldn't give me my levels because they said I wasn't participating to my full potential so now I have to sit there and participate or else I don't get my levels" – Participant 118*

> *"cause you have to…they don't force you but you have you have to go or you lose ya levels" – Participant 108*

Acknowledge treatment needs. For a large number of participants attendance at sessions, predominantly psychology, was driven by their insight into the extent to which these sessions could meet their perceived needs (*n*=16). Recognition of their clinical and forensic needs appeared to motivate participant's willingness to seek help in order to achieve personal change, demonstrating treatment readiness. Despite being viewed as compulsory, participants frequently reflected on how the sessions were benefitting them personally, perpetuating their motivation to attend in spite of such barriers. This theme was divided into two subthemes:

Attend to reduce risk. Some participants reported attending psychology sessions in order to reduce their future risk (n=8). A larger number of males reported this theme in comparison to female participants, reflecting the higher proportion of convicted males within the sample. Participants recognised the need to develop their coping skills in order to avoid engaging in further antisocial and/or offending behaviour in the future. Participant's insight into their risk factors appeared to increase both their understanding of the need for treatment, as well as their motivation to engage. Exploring offending behaviour collaboratively with other patients was noted as particularly beneficial by some participants, possibly highlighting the benefit of peer support when exploring challenging topics. One participant discussed wanting to address his risk due to the guilt he felt regarding his offence. More generally, participants reported wanting to learn how to manage risky situations in the community:

> *"gets me better that's it really…I dunno like you learn skills to help*
>
> *you stop you doing same mistakes again" – Participant 107*

"it's helping me tryin t'think like how to control ma anger…and trying to use ma coping skills when I get angry…cause if I go back out in the community and I av anger- lose ma anger I'll end up going back- lock locked back up" – Participant 102

"it helps you stay out of trouble because it's partly the reasons why I didn't get these sessions about not getting in trouble that got me in trouble in the first place…so like when I eventually leave here and I walk into trouble when I'm out again it will make me think just remember all them psychology sessions and then I'll think ooh if I do that I'll end up back in hospital if I do this I can just take the right path… everybody in this hospital feels the same cause they didn't have the right coping strategies is kinda what lead to us all being here" – Participant 103

Attend to address clinical needs. Predominantly in reference to psychology sessions, and to a lesser extent OT, fifteen participants reported attending these sessions in order to address and gain support for their clinical needs. Generally, participants discussed wanting to (a) gain a greater understanding of their clinical diagnosis, (b) understand how to manage symptoms (c) develop insight into their emotions and (d) develop effective coping strategies. Whilst attendance at such sessions was considered by most as vital when trying to achieve discharge, participants also appeared to acknowledge the benefits of developing such skills in preparation for community living. On the whole, participants viewed psychology sessions in particular as a fundamental source of support in helping them effectively manage and problem solve daily stressors.

All female participants articulated this theme, in comparison to 69% of males.

> *"cause it helps- it's a good session it helps me understand stuff ma autism...it helps me understand ma autism" – Participant 108*

> *"because it- you know that it could help you change and it it stops you like it helps me already and I've only done it a couple a month's...[it helps you] just to think differently at different times cause if I hadn't done DBT I'd probably be worse off now...[it] just helps me get out of hospital and build a future that's why I think DBT helps cause it changes the way you think and act so if you change the way you think and you act you're more likely to live better in the community" – Participant 119*

> *"cause it helps me to learn new coping skills...because then I don't feel like I have to do anything...like self-harm I can use my coping skills" – Participant 120*

The influence of relationships on attendance. Supported by the large number of participants advocating this theme (*n*=17), participants need for relatedness and interpersonal support, both within and outside of the hospital, was strongly apparent and key to maintaining treatment retention. Interestingly, whilst female participants more commonly reported positive relationships with staff as influencing their decisions, male participants appeared to value their relationships with peers and family more so. Possibly reflecting the constraints of being detained, participants also appeared to use their sessions as a behavioural management strategy when trying to avoid and manage interpersonal conflict. This theme was delineated into four subthemes:

To avoid interpersonal conflict & stay out of "trouble". Some participants reported attending sessions in order to get off the ward and avoid interpersonal conflict, be it personally or amongst others (*n*=8). Due to feelings of boredom precipitated by the perceived monotony of the ward environment, participants discussed how they felt the occurrence of conflict was more likely in comparison to when they were engaged in sessions off the ward. Aware of the negative consequences associated with engaging in such conflict (i.e. increased risk levels, behavioural monitoring and cessation of leave), participants reported attending sessions in order to avoid this eventuality, demonstrating consequential thinking. For a small number of participants, attending sessions was seen as an opportunity to calm down and/or effectively problem solve conflict positively with the support of staff. This theme did not appear specific to a particular session, rather participants simply appeared to value the opportunity to get off the ward and avoid conflict:

> *"socialisin' with everyone cause you don't really get much on the unit*
>
> *cause on the unit you normally like peoples is always like arguing on*
>
> *the unit or somethin I mean so when we do do social group it's just*
>
> *socialising n you're talking about your problems so talking about*
>
> *everything that's nice ye...cause you can talk about your problems*
>
> *instead of just fightin it out" – Participant 101*

> *"it gets you off the ward and ya not like say like someone on the ward*
>
> *is pissing you off and their like proper naughty and ya tryin to get*
>
> *away from em best place to go is youth club just to get away for a hour*
>
> *then they can calm down and think whatever you can calm down and*

when you get back they might say sorry to ya cause then you've gev em some time" – Participant 102

"so I don't get in trouble on the ward with em cause sometimes when we are just on the ward we get into trouble but if were doing something together off the ward we don't get into trouble" – Participant 105

Having a positive perception of staff and the therapeutic relationship facilitates attendance. In comparison to 100% of female participants only 54% of males endorsed this subtheme (*n*=13). Participants frequently reported attending sessions in order to spend time with staff members whom they had established a positive relationship with. Feeling supported and able to confide in staff about personal problems was noted to encourage attendance, as did the perception that staff were competent and responsive to their learning needs. Some participants also reported attending due to staff encouragement. Overall this subtheme appeared to highlight the importance of the therapeutic alliance on maintaining young people's motivation to comply with their treatment pathway.

"I like the person I love the staff... their good they explain stuff in a way that you can understand it's easier" – Participant 108

"just talkin to [staff name] about erm how hard I'm feel- how hard it is to move and stuff move around and meet new people and [staff name] helps me with that she supports me" – Participant 107

" the woman who teaches badminton the gym teacher woman thing…she's mega ye she's mental like me…er she just like on ya wave length like she understands you all the time…and she's easy to talk to"
– Participant 114

To socialise with peers. Predominantly in reference to OT and sport and leisure sessions, participants commonly reported attending in order to socialise with their peers in fun activities (*n*=11). More frequently reported amongst males (77%), in comparison to females (17%), participants appeared to value the opportunity to develop and maintain friendships, particularly with peers from other wards whom they had less contact with, increasing their feelings of peer support. Two participants in particular reported attending a certain OT session in order to spend time with peers of the same culture due to their perceived affinity with each other, potentially increasing feelings of belonging. Furthermore, two participants reported attending sessions in order to socialise with the opposite sex, reflecting natural adolescent tendencies and desires to establish romantic relationships:

"ye I do like it cause you get to work together for once and no-one ever works together really on the unit your always your own man when you're on the unit and you have to actually work together" – Participant 101

"because it's one of them sessions where if you don't wanna go you don't have to but I went because you keep in touch with people from other wards" - Participant 107

"ya see people off different ward...their my culture so I like- I don't mind other cultures but I just prefer- I like to hang around with my culture like...just easier to talk to them they've just got- there's things you can talk about like food and that" – Participant 108

The influence of family relationships on attendance. Although less commonly endorsed, some participants reported attending sessions for reasons relating to their family highlighting the importance of family support in motivating young people to engage in their therapeutic pathway (*n*=7). Overall this subtheme was more frequently reported by male (77%) than female participants (17%) and was delineated further into the following subordinate themes:

i. *Wanting to make family proud.* Five participants reported attending sessions for reasons relating to this subordinate theme. Specifically, participants discussed wanting to do something nice for their family for example, make gifts as well as prepare for a family visit. In reference to both, the need to impress their family members was apparent. One participant reported attending an educational session upon the request of a valued family member. One participant reflected on the need to change and reduce his risk for the sake of his family, precipitating attendance at his psychology session:

     "cause I'm making ma mum a chair for her birthday...I like making stuff for ma mum" – Participant 104

     "I need to start being a betta person for my brothers and my sister and everythink I'm one of the oldest and that they're looking at me thinkin

ye he's cool and I'm not cool I'm just someone who got lost along the road…um I'm tryin find myself again" – Participant 101

ii. *Desire to see family.* Five participants reported attending sessions in order to gain more leave to see their family and eventually return home. Whilst similar to "*to maintain or access more freedom*" what differentiates this subordinate theme is the specific reference participants made to their family and a desire to be with them as opposed to simply gaining more community access.

"so I can tell ma dad that I'll be getting more leave and I can take him out" – Participant 105

"ye if I get level four and keep it for a couple of months I'm back to Scotland for forever" – Participant 114

Reasons for attending treatment

Factors relating to motivation	Desire to achieve personal goals & future plans	Perceived coercion to attend sessions	Acknowledge treatment needs	The influence of relationships on attendance
Enjoy session, precipitates positive affect To achieve a sense of normality To try and keep oneself occupied Attendance driven by incentive The availability of resources encourages attendance	Achieve a healthy lifestyle Getting an education Working towards discharge Prepare for life after discharge	Attendance is expected, it's not optional To maintain or access more freedom (from leave to discharge)	Attend to reduce risk Attend to address clinical need	To avoid interpersonal conflict & stay out of "trouble" Having a positive perception of staff and the therapeutic relationship facilitates attendance To socialise with peers The influence of family relationship on attendance • *Wanting to make family proud* • *Desire to see family.*

Figure 3. *Thematic hierarchy of factors regarding the reasons why participants attended treatment.*

Reasons for *not* attending treatment.

Overall, three themes were identified as reasons for not attending treatment amongst participants and are depicted in Table 7, along with the frequencies in which these themes were endorsed during both interviews. The hierarchical nature of this overarching theme is further summarised in Figure 4.

Table 7

Participants reasons for not attending treatment (n= 19) organised by theme and frequency with illustrative quotes

Theme	Number of Participants Reporting Theme		
	Interview 1 (*n*=19)	Interview 2 (*n*=17)†	Total (*n*=19)
Organisational Factors	16	15	19
Availability of staff "*It was cancelled cause the person wasn't here to do it*" (participant 107)	16	15	19
Issues with the timetable "*I didn't go to it cause I was at maths*" (participant 105)	7	8	12
Other commitments "*ma mum and dad come to visit so I didn't go*" *(participant 110)*	10	5	12
Factors relating to the young person	10	13	16
Lack of motivation to attend "*I can't be arsed with that*" (participant 121)	5	4	6
Able to exert choice over attendance "*it's an optional thing I don't have to go if I don't want to*" (participant 117)	4	5	6
Clinical factors "*I kinda just come out a seizure before it so they was like you can't go off the ward for a while so I was like yay*" (participant 114)	2	3	5
Cognitive factors "*it bores me silly it does like…so I told em- I tell*"	10	11	15

em every week this sessions not for me ok" (participant 114)			
Reasons relating to risk	8	9	11
Not eligible due to risk "*couldn't go wasn't allowed cause of ma levels*" (participant 119)	7	8	9
Avoid interpersonal conflict "*I didn't go cause I weren't getting on with this person, me and this person had an argument so I didn't wanna go cause I didn't want it to effect ma levels*" (participant 102)	2	2	4

† *Two participants refused to engage in the second interview.*
NB: all frequencies in the table relate to the number of individual participants expressing a theme.

Organisational Factors. Delineated into three subthemes, all participants reported not being able to attend their sessions due to issues relating to the organisation and therefore matters out of their control (*n*=19). On the whole these reasons were often in relation to OT and sport and exercise sessions. It should be noted however that participants generally appeared to have more of these sessions per week in comparison to other sessions, and so inevitably there was a greater chance of being unable to attend such sessions. This theme highlights the influence of external factors on young people's opportunity to engage in treatment.

Availability of staff. All participants reported not attending various sessions due to reasons relating to the availability of staff (*n*=19). Due to staff absences, including annual leave, sickness and training, sessions were sometimes cancelled by staff and consequently a common reason for non-attendance. For some, this precipitated feelings of relief as participants often reported not wanting to attend the session in the first place, either because they did not like it or they felt they needed a break from their timetable. Staff cancellations therefore appeared to provide these participants with a valid reason

for not attending, devoid of any negative consequences associated with a direct refusal. Although less commonly reported, an inability to attend session's precipitated feelings of frustration amongst some participants as they were unable to get off the ward, engage in a session they enjoy and/or seek necessary support.

Due to the number of participants wanting to take part in certain sessions, attendance was sometimes rotated with other clients to ensure all interested individuals were given the opportunity to attend, preventing continuity of treatment. Often owing to staff needing to attend to, and thus manage other incidents within the hospital, participants sometimes discussed being unable to attend sessions. Similarly, participants often reported there not being enough staff to manage both the patients on the ward and those attending sessions due to their risk and subsequent observation levels, preventing compliance with their timetable. Due to these reasons, participants often pre-empted that certain scheduled sessions would not go ahead as planned, possibly reflecting the frequency with which this problem occurs.

> *"That wasn't on Wednesday it was cancelled cause the person wasn't here to do it which made me happier as well cause it meant I got an even longer break" – Participant 107*

> *"it really annoys me when there's no staff for sessions cause the only reason there's not enough staff is cause there's not that many patients on the ward there's not that many staff so no one gets out…[it's] really frustrating...all the other wards are fully staffed and we're not all the other wards take our staff when they're down really fucks me off" – Participant 121*

"er no it wasn't on this week…um cause [staff name] weren't here…I was actually quite um unhappy because like I like moral reasoning we get to talk about obviously our offences and how we've done wrong obviously that's big for me cause like my offence I have to think about it every day you know I have to think here we go again I'm just same old [101] which I'm not but that's what I think sometimes I do get a bit down but it's nice to talk about it" – Participant 101

Issues with session timetable. A total of twelve participants reported not attending their sessions due to issues regarding their session timetable. Most commonly, participants reported not attending the sessions stipulated on their timetable due to administration errors, including failure to update timetable to reflect their current treatment plan and/or a clash of sessions. In reference to the latter, participants discussed not being able to get from one session to the next in enough time. One participant in particular reported being unable to attend a session due to a lack of attendees, suggesting consideration of this had not been given prior to including it on the timetable:

"oh ye I didn't go to it cause I was at maths" – Participant 105

"I leave ma session then so I can't I can never go to that cause of the time by the time I get back and have a shower it's done" – Participant 121

"cause I went gym instead I used to do it on [ward name] but now I'm on [ward name] I don't have to do it again" – Participant 105

Other Commitments. For a number of participants, attendance at other commitments, as stipulated by the organisation, meant they were unable to comply with their session timetable (*n*=12). Split further into three subordinate themes this subtheme further highlights the influence of external factors upon young people's ability to engage in treatment:

i. *Mandatory appointments.* Overall seven participants reported being unable to attend their timetabled sessions due to attending other mandatory appointments including tribunals, CPA meetings, healthcare appointments, exams, and scheduled clinical assessments. Another participant reported being unable to attend due to temporally residing on another ward as part of a gradual transition.

> *"ok maths I didn't do because they swapped it for SALT cause I had to do a test for autism"- Participant 114*

> *"I wasn't there because I had a tribunal for four an half hours" – Participant 106*

> *"no because I had a hospital appointment" – Participant 104*

ii. *Visits.* Five participants discussed not attending their session due to being on a visit with their family at the time. Whilst participants perceived seeing their family as a priority, for some it also meant they did not have to attend sessions they did not enjoy precipitating feelings of relief.

> *"I didn't go to that…I had a home visit instead" – Participant 107*

"I had a home visit and I wanted to get off ma sessions so I could go home" –

Participant 106

iii.   *Accessing the community.* In total, four participants reported being

unable to attend their scheduled sessions due to attending community

leave at the time. Due to the perceived importance of accessing the

community over their sessions generally, participants did not report

experiencing any negative affect as a result of being unable to comply

with their timetable:

"I didn't go… cause I needed to do my fifth stage five exposure and it

was the only time I could go" – *Participant 123*

"I didn't go to that cause I went out instead…I didn't care to me leave

is more important than the gym" – *Participant 118*

Factors relating to the young person. A significant proportion of participants

made reference to person centred factors when discussing reasons for not attending

sessions (*n*=16). Overall, in the absence of intrinsic motivation and external pressure

from professionals, compliance with remediation attempts was negatively impacted

amongst some participants. Having a negative perception of both treatment and staff

was also highlighted; whilst this may reflect issues with regards to a lack of motivation

and/or insight into the need and benefits of treatment, it may also reflect wider issues

relating a lack of treatment responsivity and difficulties amongst staff in establishing

therapeutic relationships with some clients.

Lack of motivation to attend. A small number of participants reported refusing to attend sessions, due to a lack of motivation to engage (*n*=6). Most commonly in reference to OT and sport and exercise sessions, a lack of incentive to attend as well as a general apathy towards the session being offered, appeared to hinder willingness to engage. Due to already being on low levels as a result of her risk, one participant discussed having nothing left to lose, precipitating her decision to refuse a session. This would appear to highlight the disadvantages associated with perceived coercion in that once individuals no longer views their behaviour as having any repercussions, a state of helplessness is induced, promoting non-attendance.

> *"cause I can't be bothered I want to chill out at that time of day I don't wanna be off the ward all day well I wanna be off the ward all day but not doing football cause I don't wanna do it" Participant 122*

> *"no I don't usually go to ma early sessions…cause when I'm on low levels I don't go to any sessions cause I just sleep but when I'm on high levels I go to all ma sessions…cause on low levels you don't have any motivation to do anything…cause got nothing to lose" – Participant 119*

> *"I just don't have the patience for it very much and I don't have free time after" – Participant 111*

Able to exert choice over attendance. Permitted by staff, an ability to exert choice over ones attendance was noted amongst less than half of participants as a reason for declining sessions, particularly those they did not enjoy (*n*=6). Generally this theme appeared to relate to sports and exercise

sessions, possibly suggesting that staff perceive these sessions as less pertinent to rehabilitation. Given the choice, it is possible that participant attendance would decline, affirming the influence of perceived coercion upon compliance. This may also suggest a lack of agreement and/or insight amongst young people into the need for certain sessions, reflecting a need for a greater level of preparatory work in order to increase treatment readiness:

> *"er she gives me the choice if I wanna go and I just can't be arsed with it so I don't" – Participant 121*

> *"if football effected ma levels like if I didn't go they'd drop ma levels then I'd just go and get it out the way but because it's not its optional you don't really have to go I wouldn't cause I don't enjoy it" – Participant 117*

> *"erm cause I come back a bit late as well and then they was leaving but [staff name] said go get ya-self a shower have a rest cause I'd worked really hard in the last session but that didn't go down as a refusal cause a member of staff said I didn't have to go" – Participant 107*

Clinical factors. A small number of participants stated that they did not attend sessions due to clinical factors (*n*=5), for example ill health and low mood. Although person related, this subtheme highlights the fact that failing to attend a session is not always a conscious decision to defy remediation attempts but sometimes a result of matters beyond the individual's control.

"I can't do swimming anyway cause I have a skin condition" –
Participant 114

"I was ill yesterday I wasn't- I was in bed so I was I was asleep way
until lunch till like one o'clock in the afternoon so I missed all those
sessions anyway" – *Participant 122*

Cognitive factors. More commonly endorsed by male participants, a significant number of participants reported not attending their sessions due to cognitive factors (*n*=15), which comprised negative perceptions (beliefs and attitudes) towards both treatment and staff:

i.   *Negative perception of treatment.* Commonly in reference to OT and sport and exercise sessions, participants (*n*=13) reported that they chose not to attend due a general dislike for the session. On the whole participants discussed finding various session boring due to a lack varied resources/activities to engage in and an absence of rewards. Finding the session too challenging, be that emotionally, cognitively or physically, was also noted as reason for not attending sessions. Whilst this may reflect a lack of internal treatment responsivity, it may also demonstrate the negative impact of poor self-efficacy on motivation to attend. Perceiving treatment as irrelevant to ones needs and/or achieving discharge was also articulated, possibly reflecting disparity between client and staff's rehabilitative goals. In reference to this, despite attending due to feelings of coercion, one participant reported refusing to engage as a result:

"no I don't like it…its shit…boring… it's just like one of these day areas but it's got a pool table and that's it it's shit there's nothing to do" – Participant 122

"I said I don't wanna go I went and then I went back cau- I don't feel good in TEACCH it's all hot it's like it's boring" – Participant 113

"I really don't give a shit to be honest about psychology because their like 'its part of you treatment' I don't need psychology if I needed psychology I'd ask for it" – Participant 114

ii. *Negative perception of staff.* Some participants reported not attending due to their negative perception of staff (*n*=7). Specifically, participant's perception that staff members were uninteresting, too strict, untrustworthy and dishonest was noted to negatively impact upon motivation to both attend and engage in sessions. A perceived lack of co-operation and support from staff in facilitating their engagement was also found to prevent attendance and precipitate negative perceptions of treatment, hindering future willingness to engage. Feeling angry with staff or uncomfortable in their presence also precipitated refusal:

"cause its hard and I don't trust what the staff write about me" – Participant 104

"I hate the OT's… all of them…their just boring I dunno you can just tell their assessing you everything you do whereas psychologists and nursing team make it like less obvious and teachers make it less obvious that their assessing you so it makes you feel more relaxed

whereas with them you know their like monitoring everything you do
and they kinda judge you and I just don't like them I just don't feel
comfortable with them" – Participant 119

Reasons relating to risk. Eleven participants discussed factors relating to risk as reason for not attending sessions. Whilst for some, non-attendance appeared to be a conscious attempt to manage their risk, for others it was their inability to effectively manage their risk that prevented their attendance. This theme was divided into two subthemes:

Not eligible due to risk. Due to engaging in inappropriate behaviour, participants commonly reported not being allowed to attend certain sessions, mainly those taking place away from the ward environment, due to the level of risk they were considered to pose to themselves and/or others (n=9). Depending on their behaviour, eligibility to attend was either prevented for a single session, or several sessions. This was usually due to the participant needing to demonstrate a period of settled behaviour before being eligible to attend again. Whilst for some being unable to attend precipitated feelings of frustration and boredom, others appeared unaffected by this restriction reflecting their disinterest in the session itself:

"I didn't went to that…ye cause I was rude to staff… ye so they said I
couldn't go" – Participant 105

"I didn't go…no half these sessions I haven't been able to do cause
I've not been on the correct levels" – Participant 103

"I didn't go cause I wasn't on the right levels" – Participant 120

Avoid interpersonal conflict. A small number of participants permitted this subtheme (*n*=4). Whilst three participants reported refusing sessions in order to try and avoid interpersonal conflict with peers, one participant discussed leaving a session early in order to escape such conflict. Due to feeling low in mood, one participant articulated concerns that he was more likely to argue with his peers if he were to attend his session. Aware that such behaviour may result in him losing his access within/outside of the hospital, his decision to refuse the session appeared to be a preventative strategy. Taking into consideration the importance participants placed on their access generally, it is likely that this is the reason for other participants wanting to avoid conflict.

> *"I didn't go cause I weren't getting on with this person me and this person had an argument so I didn't wanna go cause I didn't want it to effect ma levels plus we was learning about Irish stuff…I had my levels it's just I didn't wanna go… in case I have an argument or a fight with someone if he'd of said something I probably argue with him…ye so I thought I'd take myself away and not go to it"* – Participant 102

> *"I'd been arguing with her again and she was in that session erm she was telling staff like what I'd said and that I was gonna kill ma self and then psychology were like "I need to speak to you after this" and I was like you can fuck off…and then she goes to call me back and I walks away and goes "nah" they all walked out and I went back in the day area"* – Participant 114
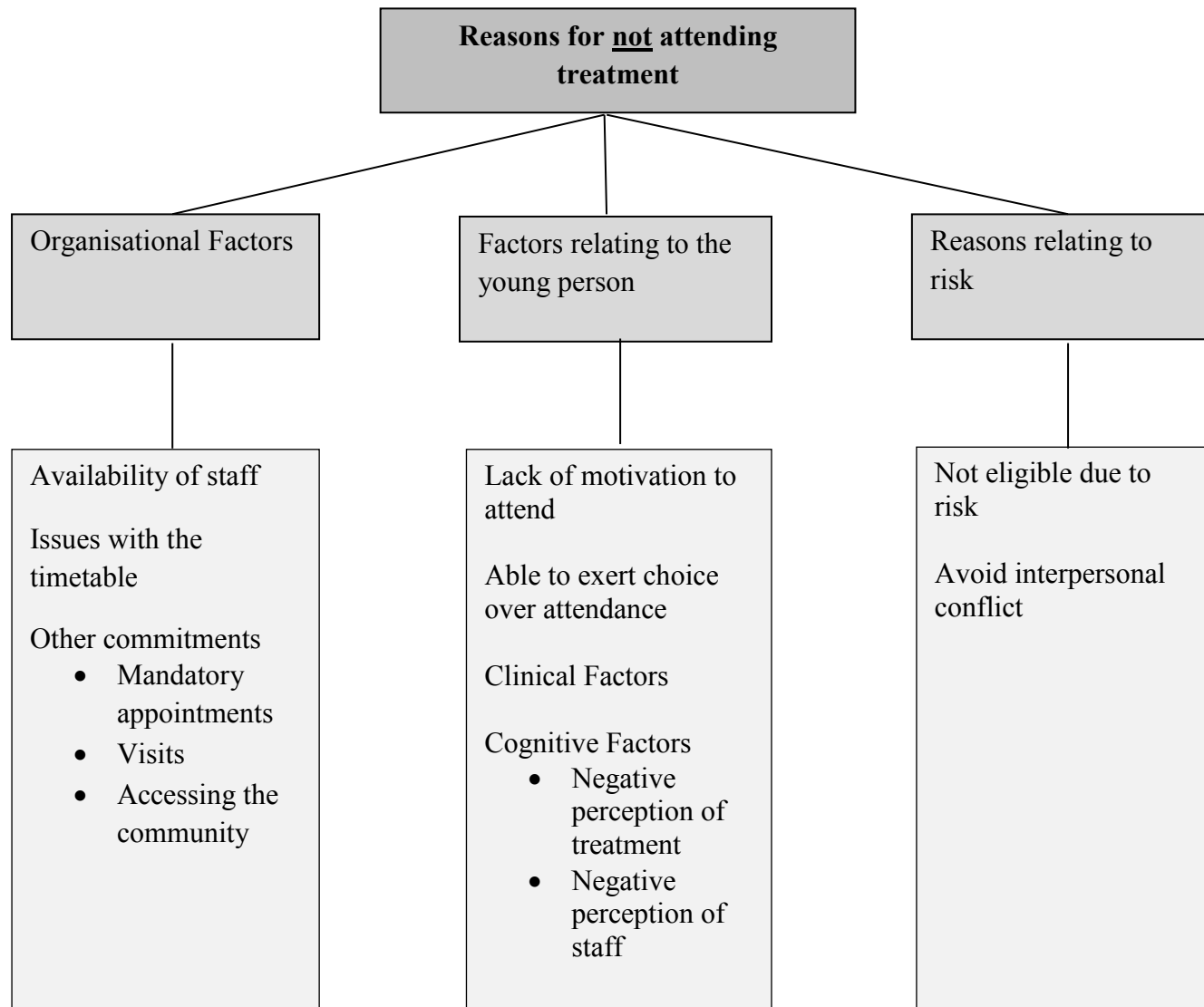
Figure 4. *Thematic hierarchy of factors regarding the reasons why participants did not attend treatment.*

Discussion

In an attempt to further existing research, the current study aimed to explore factors which influence treatment readiness among young people residing in a secure hospital setting, using a qualitative approach. Building upon research conducted by Long et al. (2012), thematic analysis (TA) was used to explore the reasons why young people attend or chose not to attend their timetabled sessions, in order to help advise practitioners on ways to prevent treatment dropout and in turn the aforementioned negative consequences associated with this.

Despite a number of themes being extracted, the need for competence, relatedness and autonomy appeared to underlie a number of themes, particularly those referring to reasons for attending treatment. This is consistent with the Self-Determination Theory (SDT) of human motivation and personality (Ryan & Deci, 2000). Attainment of such needs is considered vital in facilitating individual's personal growth, social development and psychological wellbeing (Ryan & Deci, 2000). Supporting young people to achieve such needs appeared to increase feelings of empowerment and as a result treatment readiness. Integrating the opportunity to attain these needs within the content of rehabilitation would therefore seem vital in promoting engagement and preventing treatment dropout. The incorporation of personally valued rewards, presented as an additional overarching theme which again appeared to encourage attendance amongst the majority of participants. As suggested in the early theories of learning and conditioning (Skinner, 1953) as well as reward or goal directed principles outlined in evolutionary theory (Solway & Botvinick, 2012), this highlighted

the influential role of positive and negative reinforcement when working with young people, although we should focus on positive reinforcement here.

In addition to the above, the current study also aimed to explore the extent to which the MORM (Ward et al., 2004) could be applied to young people residing within secure hospital settings. In order to provide a succinct discussion of the outcomes of this research, extracted themes are subsequently discussed below, where possible, within context and structure of the MORM (Ward et al., 2004). Whilst conceptually consistent with this model, reasons provided by participants were commonly multifaceted, resulting in considerable overlap between factors with some variations from the original model. It should be noted that on the whole, regardless of gender and residing ward, quantitative analysis revealed the sample to be comparable in terms of their treatment readiness. However, treatment readiness was found to be significantly higher amongst those with a conviction as discussed previously.

Internal Factors

Support for the internal factors of the MORM was found in the current study, as outlined below.

Cognitive and Affective Factors. In support of both Long et al. (2012) and Sheldon et al. (2010) cognitive factors as described by the MORM, represented a dominant theme for both attending and refusing sessions (Ward et al., 2004). Having a positive perception of staff, peers, treatment and its anticipated outcomes were commonly provided as reasons for attending sessions. Although less commonly reported, beliefs regarding their self-efficacy to engage were also provided. As a result of such beliefs, engagement in sessions appeared to precipitate participant's experience

of positive affect, perpetuating their engagement, demonstrating an interaction between cognitive and affective factors. In contrast, having a negative perception of staff, peers and treatment, as well as a perceived lack of competence to engage, appeared to promote negative affect, precipitating their refusal at timetabled sessions. These findings would appear to support the further delineation of this factor as proposed by Sheldon et al. (2012).

Whilst frequently endorsed in relation to OT and sports and leisure sessions, the fact that attendance was commonly precipitated by participants' positive perception and experience of these sessions as being fun and enjoyable, would appear to highlight the role of intrinsic motivation upon young people's willingness to engage (Ryan & Deci, 2000). Whilst not directly focused on reducing one's risk, research has found the provision of such activities to reduce aggression, property destruction, self-harm, and in turn increase adaptive behaviours, outcomes of which support those of offender rehabilitation. Similarly, Brooks and Kahn (2015) found young people who were intrinsically motivated were less aggressive. An inability to manage one's emotional arousal and subsequent behaviour has been noted to negatively impact upon treatment readiness (Long et al., 2012; Ward et al., 2004). Increasing clients' intrinsic motivation through the provision of personally valued and enjoyable activities, is therefore likely to create a social climate supportive of therapeutic change, potentially promoting engagement in more intense, risk directed treatment. Professionals therefore should aim to provide a variety of treatment modalities in order to support compliance with remediation.

For others, decisions to attend were extrinsically influenced by participants' beliefs and expectations regarding the outcome and value of engaging in the session.

Referred to by Ryan and Deci (2000) as "*regulation through identification*" (p. 72), this form of extrinsic motivation reflects a somewhat autonomous or self-determined form, in which the outcome associated with a particular behaviour (i.e. attendance), is accepted as personally important. Whilst not always the primary purpose of the session, a number of participants believed attending OT and sports and leisure sessions in particular, would help manage their feelings of boredom, enable them the opportunity to avoid interpersonal conflict and create a sense of normality. For these participants, attending such sessions appeared to present an effective emotional management strategy, preventing participant's experience of strain, therefore enabling them to manage their risk and engage in treatment more effectively. The fact that some participants refused to attend sessions due to the risk of engaging in interpersonal conflict would appear to support this finding. Specific to attending sessions in order to achieve a sense of normality, it is possible that for these participants, feelings of social support and connectedness were increased, facilitating their ability to cope and in turn increasing their willingness to engage. Whilst beliefs regarding the outcome of engaging in treatment are encapsulated as a cognitive factor within the MORM, these reasons would appear to provide specific insight into the factors important to young people in particular, highlighting an extension of this factor, and therefore the model, amongst this population.

The above is in contrast to attendance at psychology sessions, whereby decisions to participate were driven by the expectation that the treatment on offer could meet their clinical and forensic needs, reflecting a positive attitude towards treatment and insight into rehabilitation. This would appear to support the findings of French et al. (2003). It is possible that for some clients, their ability to manage the challenges associated with

this type of therapeutic involvement was partly alleviated by their attendance at more recreational sessions, which facilitated their ability to manage their emotions, increasing their resilience to such work. The need to support and promote the psychological and emotional wellbeing of young people, whilst simultaneously addressing their risk, supports the current theoretical thinking of offender rehabilitation, mainly the Good Lives Model (Ward, Mann & Gannon, 2007).

In specific reference to participants' forensic needs, despite those with a conviction scoring higher on treatment readiness, only one participant reported wanting to pursue change due to the feelings of guilt he experienced as a result of his offending behaviour. For the majority, acknowledgement of the need to reduce their risk appeared to stem from their desire to avoid future detention and thus achieve freedom. Whilst it is possible that for some participants, the presence of cognitive distortions or a general lack of insight regarding their offending/antisocial behaviour may have minimised their emotional response to their behaviour (Chambers, Eccleston, Day, Ward & Howells, 2008), it is also possible that for this population, the opportunity to achieve rewards is a more motivating factor. This would appear to be supported amongst those participants who refused sessions due to a lack of incentive to attend. The influence of rewards upon attendance provides evidence for the support factor of the MORM (Ward et al., 2004).

Regarding participants' perception of staff, the current findings support existing research emphasising the importance of the therapeutic alliance upon an individual's treatment readiness (Kozar, 2010; Ward et al., 2004). Overall participants' perception that professionals were trustworthy, supportive and responsive to their needs was noted to facilitate treatment, whilst the opposite was found to precipitate refusal. Consequently, willingness to engage in treatment would appear to go beyond that of the

professional and their ability to demonstrate warmth, empathy and genuineness (Truax & Carkhuff, 1967), and instead rely on the client's *perception* and interpretation of the therapist and their interpersonal style (Marshall et al., 2003), supporting the cognitive factor of the MORM (Ward et al., 2004). Support for this is offered by studies which have revealed a positive correlation between an individual's perception of the quality of the therapeutic relationship, and their perception of a favourable treatment outcome (Walborn, 1996). This relationship has been noted to impact upon an individual's willingness to engage in treatment, and in turn precipitate more positive therapeutic outcomes (Ford, 1978; McLeod, 1990; Marshall, 2003; Ryan & Gizynski, 1971; Saunders, 1999). Given the challenges of working with this group (Grietens & Hellinckx, 2004), establishing a sound therapeutic relationship, as perceived by the young person themselves, is considered to be a vital prerequisite to facilitating therapeutic change (Florsheim, Shotorbani, Guest-Warnick & Barrat, 2000). In comparison to adult offenders however, guidance on "*what works*" when developing a therapeutic alliance with young people involved in, or at risk of offending, is yet to be fully established (Burnett, 2004; Mason & Prior, 2008). Future research would benefit from exploring this from the perspective of the young person, in order to help further existing research and thus guide clinical practice.

Behavioural, Volitional and Identity Factors. Overall the findings of the current study would appear to provide some support for the behavioural, volitional and identity factors of the MORM (Ward et al., 2004). In comparison Long et al. (2012) and Sheldon et al. (2010), these factors were less commonly endorsed as reasons for not attending treatment, however more readily endorsed when discussing reasons for attending treatment.

For the majority, attendance at certain sessions was driven by the desire to pursue a number of personal goals, or volitional factors (Ward et al., 2004). Intrinsically linked with this however, were behavioural factors, as such goals were often related to an awareness of the need for change in order to achieve a better life. The fact that participants continued to engage in such sessions and speak about them positively, would suggest they had the required abilities to engage effectively in treatment, as well as a positive attitude towards such sessions and the extent to which they could help achieve their goals (Ward et al., 2004). Whilst not directly reported by participants, behavioural factors were therefore considered to be present in the current study.

Whilst not all participants acknowledged the need to address their antisocial and/or offending behaviour, the majority of participants recognised the need to gain an education, work towards a career, as well as develop their emotional management and independent living skills, in order to ensure successful integration in the community upon release. A desire to achieve discharge from the hospital was also noted to be a personal goal by many. Sessions considered as contributing towards the attainment of these goals precipitated attendance. In the pursuit of their goals, participants demonstrated a willingness to achieve an identity supportive of a prosocial, offence-free life style, thus providing support for the identity factor of the MORM (Ward et al., 2004).

Willingness to engage therefore appeared to be increased amongst those young people whose personal goals were compatible with that of rehabilitation and thus supported by the organisation. Despite an awareness of external pressures to attend their sessions, the presence of mutually endorsed goals increased participants' feelings of

choice and autonomy. This would appear to support the GLM framework of offender rehabilitation which proposes the best way to reduce an individual's risk, is by helping them achieve more fulfilling lives through the attainment of personally valued goods (Ward et al., 2007). In doing so, offenders are considered as more likely to view treatment as relevant to their needs, as opposed to something which is unwillingly imposed upon them (Ward et al., 2007). The principles of the GLM are considered to underpin that of the MORM (Day et al., 2010). The incorporation of these models has been proposed to present as a "*useful conceptual model of intervention preparation*" for professionals working with offenders (Day et al., 2010, p. 60). Specifically, issues in the development and implementation of an offender's good lives plan, are considered to reflect deficits relating to their treatment readiness and extent to which they possess the necessary capabilities (internal factors) and environment (external factors) required to support prosocial change (Day et al., 2010). Identification of such deficits, both internal and external, can be used to inform preparatory intervention in an attempt to increase treatment readiness.

The above is in contrast to those participants whose attendance was driven purely by feelings of perceived coercion from professionals. As highlighted by the MORM, volition requires the ability to consent to treatment without coercion or constraint, which for some participants was not considered to be the case (Ward et al., 2004). Perceived coercion to attend sessions, particularly those which participants did not enjoy or consider relevant to their needs, commonly precipitated a negative perception of treatment and in turn, professionals. Attendance was either viewed as a way to gain more access within and/or outside of the hospital, or a way to prevent losing it. On such occasions participants' attendance was driven by a need to satisfy an

external demand and thus gain rewards and/or avoid punishment, as opposed to a desire to benefit from the session as intended, reflecting disparity between the goals of the individual and that of treatment. This finding may provide an explanation as to why all sessions were rated to be of similar importance amongst participants, despite whether they liked the session or not (see quantitative analysis). Externally regulated behaviour such as this is reported to stifle feelings of autonomy and competence, negatively impacting upon an individual's personal development, wellbeing and overall psychopathology (Ryan & Deci, 2000). Contrary to the overall aims of rehabilitation, such consequences are likely to hinder willingness to engage in treatment, precipitating resistance (Ward et al., 2004). Whilst for some, such resistance may result in dropout, for others, as supported in the current study, it may trigger a need to fake engagement in order to ensure goals are achieved (i.e. more access/community leave). In reference to the latter, not only is this likely to be a waste of resources but in terms of group treatment, such behaviour has been found to negatively impact upon other members perception of treatment and in turn their treatment readiness (McGrain, 2006).

Congruence between a young person's goals and that of the organisation would therefore appear to protect against the consequences of perceived coercion and promote engagement (Ryan, Plant & O'Malley, 1995). Supporting this, Wild, Cunningham and Ryan (2006) found that despite social pressures, participants personal reasons for seeking treatment were more influential in predicting engagement than coercion from external agencies. Engagement was found to be related to participants' perception that they sought help as a result of identifying with the goals of treatment, precipitating their personal decision to attend, increasing feelings of choice and autonomy. Conformity between the goals of therapy and the individual are also considered to increase the

likelihood of long term success (Karoly, 1999). It is therefore recommended that practitioners explore treatment targets in the wider context of the young person's personal goals and motivation to change, in order to promote engagement and thus avoid therapeutic failures (Karoly, 1999). The implementation of approach based goals as opposed to avoidance based goals commonly encouraged by the Risk-Needs-Responsivity model (Andrews & Bonta, 2006), is likely to be more successful when engaging adolescents in treatment.

External Factors

Whilst not always explicitly articulated by participants as much as it was inferred, support for the external factors of the MORM was found in the current study in the following themes:

Opportunity, programme, resources & support. As discussed, the desire to achieve a personal goal was commonly provided as reason for attending treatment amongst participants. The timing and availability of such sessions facilitated participants' volition to pursue such goals and therefore their overall readiness to engage, providing some support for both the opportunity and resources factors of the MORM (Ward et al., 2004). However, this was never directly articulated by participants and so this finding should be considered tentative.

In further support of the resources factor however, the opportunity to engage in a wide variety of activities off of the main ward, as well as the provision of incentives appeared to maintain participant's interest in sessions and keep them occupied, whereas the absence of these precipitated feelings of boredom and thus refusal (Ward et al., 2004). Unlike with perceived coercion whereby attendance was often considered to be

a means to an end in terms of achieving greater levels of autonomy, the availability of such resources appeared to increase participant's enjoyment of the session itself, maintaining motivation to engage. The inclusion of simple incentives such as "*free time*" may reflect a youth-friendly strategy which practitioners could implement to help minimise negative thoughts and preconceptions regarding treatment, and thus encourage a more positive attitude, supportive of engagement. Kim, Munson and McKay (2012) recommended practitioners collaboratively incorporate concrete and intermittent incentives into young people's treatment plans, in order to promote long term engagement and thus prevent dropout. The inclusion of physical resources and rewards is therefore important when trying to deliver effective treatment to adolescents and highlights a slight variation of the resources factor of the MORM, specific to adolescents.

Issues regarding the availability of staff were noted to prevent willing participants from engaging in scheduled sessions, again highlighting issues relating to the resources factor of the MORM and in turn the wider organisation (Ward et al., 2004). This finding is considered to account in part, for the reduction in participant's attendance at session during the interview stage of the research (see quantitative analysis). Depending on participant's motivation to attend, they either reported experiencing feelings of relief or frustration as a result. When taking into consideration the influential role emotion plays upon an individual's thought processes (Storbeck & Clore, 2008), it is possible that the experience of such affect, particularly frustration, may trigger negative perceptions of both staff and treatment, as well as aggression (Berkowitz, 1989). In reference to the latter, due to hormonal changes during adolescents, their propensity to experience intense, fluctuating emotions is increased. As

highlighted in both the current study and existing research, negative attitudes towards treatment have been noted to precipitate treatment refusal (Long et al., 2012; Sheldon et al., 2010), highlighting the need for effective contingency plans if the goals of rehabilitation are to be achieved.

Issues regarding the availability of staff are also likely to negatively impact upon the therapeutic climate of correctional settings, hindering willingness to engage in treatment. For example, challenging behaviour has been noted to reduce when individuals residing in secure settings are engaged by professionals in activities (Brusca, Nieminen, Carter & Repp, 1989). This is in contrast to being left alone, which is reported to be amongst one of the most common factors perpetuating challenging behaviour amongst patients (Matson & Boisjoli, 2007). When directed towards staff, engagement in such behaviour has been noted to result in reductions in the quality of care provided to in-patients (Arnetz & Arnetz, 2001). The provision of a positive social climate however, has been noted to result in lower behavioural disturbances and higher patient motivation, engagement and therapeutic alliances (Long et al., 2011). Dependent on the availability of staff, the opportunity to engage in both psychological therapies and/or group activities has been noted to reduce participant's length of stay in secure units (Castro, Cockerton & Birke, 2002). As a result it would appear vital that organisations ensure they are fully resourced and have alternative provisions in place to guarantee participation in treatment is actively encouraged, not only to create a therapeutic climate supportive of engagement, but to ensure the safety of both patients and staff through effective risk management (Day, Casey, Vess & Huisey, 2011; Long et al., 2012; Sheldon et al., 2010).

The availability of staff is also likely to impact upon clients support network within an establishment. In reference to the support factor of the MORM, Ward et al. (2004) argued that the presence of staff that encourage and thus support engagement in treatment is "*critical*" in facilitating engagement in treatment (p. 664). This was supported in the current study amongst those participants who reported wanting to spend time with those staff that they got on with, and considered to be supportive of their needs. However, as put forth by Howells and Day (2003) the "*notion of the therapeutic alliance implies reciprocity between the client and the therapist and suggests that responsibility for ensuring successful outcomes is shared between both participants*" (p.330). In the absence of consistently available staff, the extent to which a reciprocal relationship can be established may be hindered. Whilst staff absences cannot always be avoided, alternative provisions should be made available, in order to ensure young people feel supported on such occasions.

Participants' relationships with their family and peers were also noted to influence decisions regarding attendance, providing further evidence for the support factor of the MORM (Ward et al., 2004). For example some participants reported attending sessions on the request of a family member, whilst others found engaging in group work with peers to be beneficial. With research highlighting positive therapeutic outcomes associated with engaging young people in family based treatments, including reductions in psychiatric symptoms and recidivism, provision of such intervention should be strongly considered by practitioners (Henggeler & Sheidow, 2011). As well as being cost effective, group programmes, particularly those adopting a cognitive behavioural therapy approach, are also reported to be effective in reducing recidivism amongst an adolescent population (Wikstrom & Treiber, 2008).

In addition to this however, a larger number of participants reported attending sessions simply to socialise with peers and maintain relationships with others (including family members). Whilst linked to the original support factor of the MORM, this finding is less about feeling supported by their family and friends to engage in treatment and overcome their problems, but rather a need to ensure relatedness more generally, indicating a variation of this factor, specific to adolescents. In reference to peer relationships specifically, research suggests that adolescents generally (a) spend more time with their peers, (b) attach more importance to such relationships in comparison to those with adults and (c) are more influenced by their peer relationships (Agnew, 2003). This finding would therefore appear to reflect the natural trajectory of adolescent development, emphasising the importance of helping young people establish a sense of normality which, as suggested by the current research, is considered important among young people engaged in rehabilitative services.

Whilst peer and family relationships have commonly been implicated within theories of youth offending as risk factors, the extent to which they present as protective factors has also been highlighted, particularly amongst resiliency theorists (Carr & Vandiver, 2001). For example, the presence of a supportive relationship with at least one caregiver has been noted to mitigate young people's experience of stress when faced with adversities (Werner, 1989). Amongst forensic adult populations, contact with one's family has been found to be associated with a shorter stay in hospital (Castro et al., 2002). Particularly amongst those young people residing in custody, peer relationships have been found to play a critical role in maintaining young people's wellbeing (Cesaroni & Peterson-Badali, 2005), supporting the current research. Providing young people with the opportunity to achieve their need for relatedness

during their detention is therefore likely to increase their wellbeing as well as feelings of support, increasing their willingness to engage in treatment.

Circumstances & Location. Perceived coercion to attend treatment was noted by a large number of participants as reason for attending treatment in the current study. Whilst already discussed in the context of internal factors, this finding would also appear to provide some support for the external, circumstances factor of the MORM (Ward et al., 2004). Specifically, according to the MORM, the extent to which treatment is mandated or voluntary often depends on whether attendance is precipitated by social pressure or personal choice (Ward et al., 2004). Whilst not mandated by the courts, participants are admitted into hospital on the basis that they will engage in rehabilitation; the fact that non-attendance was also associated with negative consequences would suggest a level of actual coercion, particularly with regards to those sessions participants reported not wanting to attend. In comparison to adults, research has suggested that adolescents are less internally motivated for treatment and therefore more likely to enter treatment for external reasons (Battjes, Gordon, O'Grady, Kinlock & Carswell, 2003). As a result, Battjes et al. (2003) concluded external pressure to enter treatment to be important when working with young people as it "*brings them into treatment*" (p.230), providing professionals with the opportunity to increase clients insight into the need for treatment and motivate engagement in meaningful rehabilitation. Although considered to be challenging, interventions aimed at increasing young people's intrinsic motivation, for example motivational interviewing, have been advised as one way to overcome this barrier and prevent treatment resistance (Baer & Peterson, 2002; Battjes et al., 2003). As highlighted in the

current study, the use of incentives is also likely to increase a positive perception of treatment and thus motivation to attend amongst young people.

An inability to attend scheduled sessions due to other commitments, including mandatory appointments, visits and accessing community leave, were articulated by a number of participants, providing further support for the circumstances factor of the MORM (Ward et al., 2004). Out of the young person's control, this finding would appear to support the presence of external barriers to engagement. Due to the perception that attendance at such appointments was (a) more important than their timetables sessions and (b) not going to result in any negative repercussions, participants did not report experiencing any negative affect as a result of being unable to comply with their treatment timetable. When considering the nature of these appointments, this finding would appear to highlight the importance with which young people place on achieving relatedness, autonomy and to a lesser extent competence (Ryan & Deci, 2000). Similarly to this, issues with participants' timetables were also noted to prevent attendance, further highlighting the impact of external circumstances upon their engagement. Thus, in addition to responsivity, consideration should be given to the logistics of young people's treatment pathway and the extent to which this is achievable within the context of their current circumstances.

Other Factors

Overall the majority of factors appeared to mirror those outlined in the MORM (Ward et al., 2004), providing support for this model. However there were several findings which did not appear to fit exactly with this model, suggesting variations of

some of the factors is required to ensure the models applicability to this population, some of which have already been discussed above.

Similar to both Long et al. (2012) and Sheldon et al. (2010) however, an additional factor was also found. Specifically, participants commonly reported being unable to attend due to the level of risk they were considered to pose by professionals. Although not excluded from treatment as was the case with both Long et al. (2012) and Sheldon et al. (2010), participants were temporally suspended from attending sessions until they had demonstrated a period of settled behaviour. In addition to staff availability, suspension accounted for the slight reduction in attendance, particularly amongst those on the medium secure wards, during the interview stage. Whilst on the whole this method appeared to facilitate engagement, once unable to attend, participants often perceived themselves as having nothing left to lose, precipitating a state of helplessness and treatment resistance. Organisations could therefore consider engaging such young people in alternative activities in order to try and maintain their motivation to engage in their treatment pathway during this time.

Limitations

The present study has several limitations which warrant consideration. Firstly, the current study focused solely on those young people residing in secure hospital settings and so the extent to which the findings can be generalised outside of this population is limited. Therefore, future research should aim to explore reasons for and against attending treatment amongst adolescent offenders residing in both prison and community settings in order to further the existing research and allow for the comparison of findings. Furthermore, due to the fact that participation in the current

study was voluntary, it is possible that those who agreed to take part were more complaint with remediation attempts, potentially biasing the sample towards those deemed more treatment ready. For some participants, refusal to participate may have reflected their resistance towards treatment generally and so it is likely that for this subgroup, treatment readiness may have been lower. The findings of the current study may have differed somewhat had these participants been included.

Secondly, not all participants included within the current sample had received a conviction, limiting the extent to which the sample could be considered purely forensic. All participants had however engaged in antisocial behaviour towards others and/or property which, when combined with their mental health, meant that they were considered too high a risk, be it to themselves or others, to be managed on general inpatient wards or in the community (Centre for Mental Health, 2011). As a result, it was not deemed necessary to exclude those who had not been formally convicted for their behaviour. In order to prevent any inaccurate assumptions however, the author remained vigilant as to which participants endorsed each theme, highlighting any differences between those with and without a conviction, as to ensure accurate interpretation of the results. Only one subtheme, "*attend to reduce risk*" was noted to be more frequently endorsed by participants with a conviction, suggesting all other findings were of similar importance to those with and without a conviction.

Intended specifically for adult offenders, the extent to which CVTRQ can be accurately applied to an adolescent population is unknown, preventing accurate conclusions regarding the outcome of this measure from being drawn. As with Long et al. (2012), in order to improve the suitability of the measure to the intended population,

the wording of some of the items was adapted. Whilst efforts were made to ensure the content and overall meaning of the items was not changed, the extent to which the adapted version directly mirrors the original measure is still unknown. Whilst this is a limitation of the current research, the lack of a suitable alternative would appear to reflect a limitation of the field more generally and the consequences this then has for practice. Future research should therefore aim to establish a measure specific to assessing treatment readiness amongst young people, residing in a variety of settings to ensure responsivity. When considering the support found for the MORM in the current study, validation of the CVTRQ amongst adolescent offenders would seem appropriate (Casey et al., 2007; Ward et al., 2004).

Furthermore, the current study adopted a very broad approach to the exploration of treatment readiness amongst young people and included a range of different sessions which is likely to have influenced the results found. This approach was deemed necessary due to the absence of research in the current area. However, with research indicating high dropout rates amongst explicit types of young offenders referred for targeted treatment (i.e. sexual offences, Edwards et al., 2005; drug offences, Stein et al., 2013), exploration of young peoples' reasons for completion/non-completion of specific interventions is required in order to guide clinical practice in the development of more responsive interventions.

Finally, in reference to the qualitative data analysis, despite TA being a content driven method, the assigning of codes may have been influenced by subjective bias, although this cannot be concluded with certainty. It is possible that the authors existing knowledge of the MORM and reasons for and against attending sessions amongst adult offenders, may have influenced the themes derived. However, aware of this risk prior to

conducting the analysis, several strategies were put in place to prevent this from occurring, for example via the development and implementation of a codebook, in addition to conducting both face validity and inter-rater reliability. Whilst the author had an existing knowledge of the MORM, the individual involved in establishing the validity and reliability of the research did not, increasing the likelihood with which such bias would have been detected before deciding upon the finalised themes. The seven step produce to TA as put forth by Braun & Clarke (2013) was also executed to ensure analysis was of optimal quality and accuracy.

Conclusions

Despite the limitations discussed, the current study provides a novel understanding of treatment engagement among young people from their own perspectives. The findings sought support the notion that treatment readiness is as much the responsibility of the organisation in which an individual resides as it is the individual themselves, highlighting the need for a collaborative and flexible approach to treatment (Day et al., 2010; Ward et al., 2004). With this in mind, poor treatment engagement should not automatically be interpreted to mean a lack of motivation to change, but potentially an issue with the organisation which provides such services. At the very least organisations should ensure they are adequately resourced and thus able to support rehabilitation as intended. Developing upon this, the incorporation of rewards and varied activities provided by supportive and caring staff is likely to maintain young people's interest, and thus motivation to comply with remediation attempts. Efforts to minimise feelings of coercion, through the collaborative development of prosocial goals supportive of rehabilitation, should also be made in an attempt to precipitate intrinsic motivation to attend and thus prevent further resistance. Providing young people who

are detained in secure settings with the opportunity to engage in recreational and fun activities away from the ward environment with their peers, is likely to maintain client wellbeing and in turn support their ability to engage in more challenging treatment. In ensuring the above, psychological needs of competence, relatedness and autonomy are likely to be supported, encouraging feelings empowerment, self-motivation and psychological wellbeing (Ryan & Deci, 2000).

Overall the themes identified in the current study would appear to support both the internal and external factors of the MORM, thus evidencing the models applicability to young people detained within secure hospital settings. However, not all factors included in the model accurately reflected an adolescent population. As a result variations amongst some of the factors were highlighted, as was an additional factor. An adapted version of the MORM specific to this population is therefore required to ensure the model is implemented accurately in practice. Interestingly, the additional factor identified reflected that found amongst adults, suggesting a more general revision of this model is required (Long et al., 2012; Sheldon et al., 2010).

Chapter 4:

The Corrections Victoria Treatment Readiness Questionnaire:

Critique of a Psychometric Assessment

Background

As already highlighted, high rates of treatment non-completion have been found for both adult and young offenders (Daly & Pelowski, 2000; Lockwood, 2012; McMurran, Huband & Duggan, 2008; Wormth & Olver, 2002). When considering the aforementioned negative consequences associated with non-completion, there is certainly a need amongst practitioners to reliably predict those individuals who may experience difficulties engaging in treatment and consequently pose an increased risk of treatment dropout (Day et al., 2010; McMurran & Theodosi, 2007).

Assessing Offender Suitability for Treatment: Treatment Readiness

One possible approach to evaluating an offender's suitability for intervention is to assess the extent to which they present as *ready* to engage. In order to be ready for treatment an individual must be both motivated to engage (e.g. wants to, has the will to) and view the treatment being offered as relevant and meaningful in addressing their needs (Day et al., 2010; Ward et al., 2004). They must also perceive themselves as able to successfully enter, and respond appropriately to treatment (Day et al., 2010; Ward et al., 2004).

Assessing an individual's treatment readiness prior to engaging them in treatment is reported to improve the treatment selection process by reducing the number of inappropriate referrals made, ensuring treatment resources are used more effectively (Burrows & Needs, 2009; Casey et al., 2005; Day et al., 2010). As suggested in Chapter 2, in terms of those deemed to lack treatment readiness, preparatory treatment could be offered in an attempt to promote future engagement and thus prevent attrition (Day et al. 2010). Whilst not always feasible due to a lack of resources, information gleamed from

such assessments could also be used to develop individually responsive intervention packages (Day et al., 2010). When considering the overall goals of rehabilitation, the better the fit between the needs of the individual and the intervention being offered, the more likely risk of recidivism is to be reduced (Day et al., 2010).

Treatment Readiness Assessment Measures

Whilst clearly related, failure to distinguish between the concepts of treatment motivation, responsivity and readiness, presents as a limitation amongst psychometric tests claiming to measure the extent to which an individual is "*treatment ready*" (Day et al., 2010). Specifically, due to the lack of clarity amongst these concepts, few measures have been developed solely based on a framework of treatment readiness (Day et al., 2010).   For example, common measures including the Readiness to Change Questionnaire (RCQ; Rollnick, Heather, Gold & Hall, 1992), the University Rhode Island Change Assessment (URICA; McConnaughy, Prochaska & Velicer, 1983) and the Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES; Miller & Tonigan, 1996) were each developed based on the transtheoretical model of behaviour change (Prochaska & DiClemente, 1984, 1986). Despite the debated suitability of such measures amongst offender populations due to the model which they are derived from, each presents as a measure of treatment motivation as opposed to readiness (Casey et al., 2005; Little & Girvin, 2002) which, as previously discussed, is considered to be a more robust construct in comparison (Day et al., 2010).

Developed on a general premise of treatment readiness both the Serin Treatment Readiness Scale (STRS; Serin & Kennedy, 1997; Williamson, Day, Howells, Bubner & Jauncey, 2003) and the Treatment Readiness Clinical Rating Scale (TRCRS; Serin, Mailoux & Kennedy, 2007) are thought to provide practitioners with more specific

measures of treatment readiness. However, further information regarding the psychometric properties of both measures is required (Day et al., 2010). Specifically, whilst research has shown the STRS to be moderately correlated with other measures indicating concurrent validity, other psychometric properties of the measure are yet to be reported (Day et al., 2010). Regarding the TRCRS, whilst the measure is reported to be reliable and sensitive to change, inter-rater reliability, concurrent and predictive validity are still required (Serin et al., 2007), as is test re-test reliability. Information regarding how the scores on the measure might be calculated and thus used to assess levels of treatment readiness is also yet to be articulated by the authors (Day et al., 2010). Subsequently there is a need for both a reliable and valid measure of treatment readiness.

Developed using the MORM model, Casey et al. (2007) devised a general screening measure of internal treatment readiness termed the Corrections Victoria Treatment Readiness Questionnaire (CVTRQ). Whilst still limited, information regarding its psychometric properties is available. Furthermore, unlike the TRCRS, not only has information been provided as to how the scores of the CVTRQ can be used to assess treatment readiness, but the authors also discuss how the scores can be used to develop intervention responsive to the needs of those with low readiness (Casey et al., 2007).

Considering the above, this chapter aims to outline the psychometric properties of the CVTRQ in detail and evaluate its use in accurately providing information pertaining to an offender's treatment readiness (Casey et al., 2007). According to Kline (1993), a psychological test may only be deemed to be a "*good*" test if it is reliable,

valid and has appropriate norms. The extent which the CVTRQ complies with these
vital characteristic will therefore be explored.

Overview of the CVTRQ

The CVTRQ is a 20 item, self-report screening measure of treatment readiness.
Item responses are made on a 5-point Likert scale, utilising a numerical scale approach;
possible answers include 1 "*strongly disagree*", 2 "*disagree*", 3 "*undecided*", 4 "*agree*"
and 5 "*strongly agree*". With scores ranging from 20 to 100, higher score indicate
higher levels of treatment readiness (Day et al., 2010). A cut-off score of 72 and above
is recommended (Day et al., 2010). Each item maps onto one of four subscales (See
Table 8).

Table 8

Description of CVTRQ subscales (Day et al., 2010).

Subscale of the CVTRQ	Description
Attitudes and Motivation	Refers to the individuals' attitudes and beliefs about programmes and the desire to change, e.g. "*treatment programmes are rubbish*" and "*I want to change*" respectively. Comprises six items in total.
Emotional Reactions	Refers to the emotional responses to the individuals offending behaviour, e.g. "*when I think about my last offence I feel angry with myself*" and "*I feel guilty about my offending*". Comprises six items in total.
Offending Beliefs	Refers to an individuals' beliefs about personal responsibility for offending behaviour, e.g. "*I am to blame for my offending*" and "*when I think about my sentence I feel angry with other people*". Comprises of four items in total.
Efficacy	Refers to the individual's perceived ability to participate in treatment programmes, e.g. "*I am well organised*". Comprises of four items in total.

Development

Originally developed as a 40-item measure, factor analysis resulted in a reformulated 20-item measure (King, 2014). Specifically, principal components analysis (PCA) originally produced a 12-component solution by eigenvalue (Kaiser, 1960), however exploration of the scree criteria (Cattell, 1966) revealed a four factor solution to be a more appropriate fit for the data, resulting in the version described in this critique (Casey et al., 2007). Given the differences between the number of factors identified by the different methods, it is possible that more factors could have been identified. Furthermore, researchers have advised against using both Cattell's Scree test (Cattell, 1966) and the K1 method (Kaiser, 1960) due to their limitations in determining the number of factors required (See Ledesma & Pedro, 2007). Reported to be a superior method to those above, Velicer (1976) suggests the minimum average partial (MAP) method should be utilised instead.

Clinical Utility

Regarding the measures utility, the CVTRQ is reported to be a quick and easy measure to administer by individuals with limited training (Day et al., 2010). When considering both the limited resources and time constraints often faced by organisations offering rehabilitative services to offenders, such qualities are often of value when conducting assessments.

In terms of its clinical utility, the CVTRQ has been found to significantly predict levels of treatment engagement (Casey et al., 2007), supporting the measures use both as a screening measure to inform formulation and treatment planning, and for the purpose of treatment monitoring and evaluation (Day et al., 2010). Regarding the

former, treatment readiness has been found to predict engagement in treatment; therefore when used in conjunction with information regarding the individual's risk and specific needs, the outcome of the CVTRQ can be used to help practitioners make evidence based decisions about the suitability of treatment referrals (Day et al., 2010). In reference to those deemed to lack treatment readiness, low scores on the individual subscales are thought to highlight specific deficits in an individual's treatment readiness, highlighting targets for preparatory treatment aimed at increasing readiness (Day et al., 2010). Once complete, treatment readiness can be reassessed and used to inform further treatment decisions, allowing practitioners to not only evaluate treatment, but adjust the treatment approach accordingly, as to ensure responsivity (Weisz, Chu & Polo, 2004).

Regarding monitoring treatment progress, it has been argued that changes in criminogenic need can only take place once engagement in treatment has been established; suggesting engagement is an intermediate goal of treatment (Ward et al., 2004). Administering the CVTRQ part way through treatment would allow the relationship between treatment readiness and engagement to be assessed allowing practitioners to reach conclusions regarding the effectiveness of treatment as it is carried out (Day et al. 2010). Reductions in treatment readiness amongst those already referred onto a treatment programme can then be addressed in an attempt to prevent dropout.

Reliability

According to Kline (1993), reliability has two distinct meanings, internal consistency and test-retest reliability. These are discussed both generally and in relation to the CVTRQ below.

Test-Retest Reliability. To the author's knowledge test-retest reliability is yet to be established for the CVTRQ. Test-retest reliability refers to the stability of a test over time (Kline, 1993). Specifically, in order for a measure to have good test-retest reliability, an individual should score similarly on the same test administered on two separate occasions, assuming no substantial change in the construct under investigation at the time (Kline, 1993). In order to measure the level of agreement in scores across the two occasions, both sets of scores are correlated to produce a correlation coefficient. Ranging between -1 to +1, the higher the correlation coefficient, the higher the level of similarity in scores across the two separate time points (Kline, 1993). Whilst a correlation of .7 is reported to be the minimum figure for a good test, the closer to 1 the test-retest reliability is, the better the test is considered to be (Kline, 2014). However, in order for this statistic to be considered trustworthy, a large sample size is required in order to reduce the standard error. According to Kline (1993) a minimum sample size of 100 is required to produce reliable results.

When establishing and/or interpreting test-retest reliability however, there are several caveats that must be taken into consideration. Firstly, the time between administering the measure should be at least three months as to prevent the outcome from being influenced by temporal factors, such as practice effects (Kline, 1993). Secondly, changes in an individual's mood, mental state and physical health can also influence performance on the measure across the two time points (Kline, 1993). Measurement error such as that described above is likely to negatively impact upon test-retest reliability by lowering the correlation coefficient (Kline, 1993).

Thirdly, some constructs, for example state-like variables, are *expected* to show change over time and so temporal stability is not expected (Day et al., 2010; Kline

1993). This is particularly true if an individual has received intervention targeting the construct in question prior to the measure being administered for the second time. On such occasions not only would low test-retest reliability be expected, but desired if the intervention is to be concluded as successful. Regarding the CVTRQ, treatment readiness is influenced by both internal and external factors, reflecting a transient state liable to change (Ward et al., 2004). For this reason test-retest reliability for the CVTRQ is likely to be low. Whilst this should not prevent adequate testing, this would provide a plausible explanation as to why test-retest reliability has not been determined for this measure.

Internal Consistency. Internal consistency refers to the extent to which all items not only measure the same intended construct, but contribute to the data obtained by the measure in a consistent way (Day et al., 2010). According to Kline (1993), in order for a measure to be considered valid, it must attain high internal consistency. A minimum reliability of .7 is considered to reflect a good test however, similar to test-retest reliability, this score must be derived from a minimum representative sample of 100 individuals for the outcome to be considered statistically reliable (Kline, 1993; Nunnally, 1978).

Based on a population of convicted male offenders (n=177) referred to a cognitive skills programme, Casey et al. (2007) found an overall alpha coefficient of .83 for the CVTRQ, indicative of a good test (Kline, 1993; Nunnally, 1978). This would suggest that all 20 items are well correlated for treatment readiness. However, upon analysis of the individual subscales, only three out of four yielded alpha coefficients above the desired .7 level, including attitudes and motivation (α = .84), emotional reactions (α = .79) and offending beliefs (α = .73). Regarding the efficacy subscale, an

alpha coefficient of .6 was obtained, indicating poor reliability (Nunnally & Bernstein, 1994).

In another study by Day et al. (2011), the CVTRQ was administered to 134 prisoners as part of a wider study aimed at assessing the social climate of prisons. Participants were recruited from both a therapeutically focused medium security institution and a minimum to medium security prison, both in Australia. Although not as high as Casey et al. (2007), Day et al. (2011) found an overall alpha coefficient of .74 for the CVTRQ. Analysis of the individual subscales however revealed only the emotional reactions ($\alpha = .72$) subscale to produce an alpha coefficient above the desired level for a good test (Kline, 1993; Nunnally, 1978). Whilst reported as "*acceptable*" alpha coefficients for the attitudes and motivation ($\alpha = .68$) and offending beliefs ($\alpha = .62$) subscales fell below the minimum acceptable level as reported by Kline (1993), thus suggesting poor reliability. Even further reductions in reliability were noted for the efficacy scale which produced an alpha coefficient of .45, again indicating poor reliability.

Considering the above, despite the test appearing reliable overall, there are problems with the subscales that require further development; this would appear particularly true for the efficacy subscale which yielded alpha coefficients below the desired level across both studies (Casey et al., 2007; Day et al., 2011). Also it should be noted that it may not be valid to combine the various subscales into a total score given that each construct is conceptually distinct. Doing so is likely to result in the test being misrepresented in terms of its reliability.

Furthermore, research has suggested that in order to accurately compute and thus interpret alpha, a scale should be comprised of at least 10 to 15 items (Cudeck, as cited in Iacobucci, 2001). Scales made up of less than 10 items, for example those included in the CVTRQ, are considered less likely to incorporate the variability that exists within the domain and are consequently considered to lack sufficient bandwidth (Cronbach & Gleser, 1965; Cudeck, as cited in Iacobucci, 2001). Whilst it is likely research has found the total score of the CVTRQ to be more reliable than any of the subscales individually due to the number of overall items, interpretation of the total score alone is restrictive. As highlighted by the MORM, treatment readiness is a multifaceted construct and so even if individuals do achieve the same overall score, they cannot be considered homogenous in terms of their treatment readiness.

Validity

In order for a psychometric to be considered valid, it must (a) be reliable and (b) measure what it is it claims to measure (Kline, 1993). Unlike reliability, there is no single validity coefficient (Kline, 1993). According to the Standards for Educational and Psychological Testing there are three main methods in establishing the validity of a test, including content, criterion and construct validity, each of which are discussed below (American Educational Research Association, American Psychological Association, & National Council for Measurement in Education, 1999; Groth-Marnat, 2003).

Content Validity. Content validity refers to the extent to which a measure is both relevant and representative of the construct it claims to assess (Groth-Marnat, 2003). In order to establish content validity, experts in the field make judgements regarding the extent to which the test items accurately represent the construct under

investigation (Groth-Marnat, 2003; Kline, 2003). To the authors knowledge content validity is yet to be established for the CVTRQ. Nevertheless, positive attitudes towards treatment (Long et al., 2012), a desire to change (McMurran, 2002), emotional reactions towards offending behaviour (particularly guilt and shame; Marshall, Marshall, Serran & O'Brien, 2009) and a perceived ability to participate in treatment (Viets, Walker & Miller, 2002) are all associated with treatment engagement within the wider literature, providing some support for three out of the four subscales, and thus the measures content validity. Offence supportive beliefs however, are perhaps better considered as treatment targets as opposed to a barrier treatment readiness.

Nevertheless, it should be noted that the CVTRQ fails to take account of the volitional and identity factors of internal readiness as highlighted by the MORM (Casey et al., 2007). Assuming the factors of the MORM accurately reflect the construct of treatment readiness, by excluding these factors the extent to which the items of CVTRQ can be considered to accurately represent, and thus measure, internal treatment readiness in its entirety is subsequently questioned.

Face Validity. Similar to content validity, face validity refers to the extent to which a test appears to measure what it claims to measure (Kline, 1993). What distinguishes this from that of content validity is that such conclusions are drawn from test users as opposed to experts in the given field (Groth-Marnat, 2003). Whilst the presence of face validity is thought to increase participant motivation to complete the measure accurately, it is also thought to increase the risk of response bias for some measures as individuals are considered likely to distort their answers in the direction of a desired outcome (Kline, 2003).

Upon review of the CVTRQ, items relating to the emotional reactions subscale would appear to measure what it is intended to, for example, "*I feel guilty about my offending*". However, with regards to the other subscales there would appear to be several issues. Firstly, in reference to the attitude and motivation subscale, the following statements would appear overly similar: "*treatment programmes are rubbish*", "*treatment programmes don't work*" and "*treatment programmes are for wimps*". The reliability of this subscale, and in turn the overall measure, is likely to be inflated by the repetition of the items. Secondly, in reference to the offending beliefs subscale, it would appear limited to beliefs regarding blame (*n*=3). Other attitudes and beliefs regarding offending behaviour are not explored. Furthermore, one item within this subscale would appear to be assessing participant's emotional reaction to their offending behaviour as opposed to their beliefs as stipulated. Consequently, the extent to which these subscales measure what they intend to should be considered somewhat tentative.

Finally, items comprising the efficacy scale appear very heterogeneous and consequently poorly reflect the concept (See Table 9.). For example, good organisation whilst desirable would not appear to be a necessary requirement for treatment engagement, nor would a lack of aversion with regards to being told what to do. Many individuals who are ready to engage in treatment may present as disorganised and dislike being told what to do, however this does not stop them from being willing and able to engage and benefit from treatment. A similar position can be taken from the item regarding recidivism ("*I have not offended for some time now*"); whilst the outcome of offence focused treatment is to reduce risk and thus prevent recidivism, desistance is not a necessary prerequisite to being ready for treatment, but rather a desired outcome.

Table 9

Questions relating to the specific subscales of the CVTRQ

Subscale	Questions relating to specific subscale
Attitudes & Motivation	• Treatment programmes are rubbish
	• I want to change
	• I am not able to do treatment programmes
	• Treatment programmes don't work
	• Stopping offending is really important to me
	• Treatment programmes are for wimps
Emotional Reactions	• When I think about my last offence I feel angry with myself
	• I am upset about being a corrections client
	• I feel guilty about my offending
	• Being seen as an offender upsets me
	• I regret the offence that led to my last sentence
	• I feel ashamed about my offending
Offending Beliefs	• I am to blame for my offending
	• Others are to blame for my offending
	• I don't deserve to be doing a sentence
	• When I think about my sentence I feel angry with other people
Efficacy	• Generally I can trust other people
	• I am well organised
	• I have not offended for some time now
	• I hate being told what to do

Construct Validity. Construct validity refers to the extent to which a test measures a specified theoretical construct or trait, such as treatment readiness (Casey et al., 2007; Groth-Marnat, 2003). One way to establish a measures construct validity is to

assess the extent to which the construct correlates (a) positively with other variables which are theoretically similar to it (convergent validity) and (b) negatively with those unrelated to it (discriminate validity; Groth-Marnat, 2003). Convergent and discriminant validity for the CVTRQ are subsequently discussed below.

Convergent Validity. In order to establish the convergent validity of the CVTRQ, Casey et al. (2007) correlated male offenders scores obtained on the CVTRQ (including total and subscale scores) with their scores on various other measures which they reported to be reliably associated with treatment readiness; including the RCQ (Rollnick et al., 1992), STRS (Serin & Kennedy, 1997), processes of change questionnaire (PCQ) and Loza-Fanous Self-Efficacy Questionnaire (SEQ; Loza-Fanous, 2004). Overall the CVTRQ was found to correlate positively with all measures, although not all reached statistical significance. Of those which were deemed statistical significant ($p < .05$), correlation coefficients ranged from .21 to .70 across all variables.

A very weak correlation was found between the SEQ and the efficacy subscale of the CVTRQ (r = .21; Casey et al., 2007). This would suggest that both the SEQ and the CVTRQ are measuring different theoretical aspects of efficacy, making it difficult to conclude what aspects of this construct are most relevant to treatment readiness. Self-efficacy is a multifaceted entity and therefore it is unlikely that it can be fully captured in the four questions comprising this subscale. However, this relationship may also suggest that CVTRQ is in fact measuring some other construct, weakly related to efficacy, as opposed to efficacy itself. This would support the lack of face validity and internal consistency for this subscale.

Apart from the SEQ, moderate relationships between each measure (PCQ, r = .48; RCQ, r = .56; STRS, r = .56) and the total treatment readiness scale of the CVTRQ were found, suggesting the CVTRQ is in fact measuring constructs relevant to treatment readiness (Casey et al., 2007). Overall, the attitudes and motivation scale was noted to correlate most strongly with the other measures, especially the STRS (r = .70), suggesting the items within this subscale measure a pertinent component of internal treatment readiness (Casey et al., 2007).

Using the CVTRQ, Day et al. (2011) assessed the convergent validity of the Essen Climate Evaluation Schema (EssenCES), a measure of perceived social climate, by correlating the total score with that of the CVTRQ amongst a group of male prisoners. Whilst the EssenCES would appear to compile items associated more so with external treatment readiness, some of the items regarding the individual's attitude towards treatment and their perceived efficacy to engage in treatment, could be considered reflective of aspects of internal readiness. Despite this however, the two measures are intended to measure different constructs raising questions regarding the suitability of this comparison. A very small yet significant positive correlation was found between the scores on both these measures (r (111) = .23, $p < .05$), suggesting higher levels of treatment readiness to be very weakly associated with a more positive perception of one's social climate. The small correlation found is likely to reflect the lack of homogeneity between the two measures and so further exploration with more appropriate measures is required.

Discriminant Validity. Using the Paulhus Deception Scale (PDS; Paulhus, 1998) and the MacArthur Perceived Coercion Scale (PCS; Gardner et al., 1993; Monahan et

al., 1995), Casey et al. (2007) correlated participants' scores with those attained on the CVTRQ in order to establish discriminant validity. Both these measures were considered to assess conceptually dissimilar constructs to that of treatment readiness, hence their suitability for such analysis (Casey et al., 2007). Specifically, scores on the PDS were not significantly associated with those on the CVTRQ (r (94) = .18, $p > .05$) suggesting the measures are assessing theoretically different constructs, indicating discriminant validity. A significant ($p < 0.001$) weak negative correlation was found between the MacArthur PCS and (a) the total CVTRQ score ($r = -.29$), (b) the attitudes and motivation ($r = -30$) and (c) the emotional reactions subscales ($r = -.27$). This suggests that as treatment readiness increases, perceived coercion decreases. A non-significant relationship between the PCS and offending beliefs and efficacy ($p > 0.05$) was also found, suggesting that for these subscales, the construct of coercion is not related. These results would appear to provide some support the measures discriminant validity.

Criterion Validity. Commonly divided into concurrent and predictive validity, criterion validity refers to the relationship between the score of a particular test measure and some sort of performance on a theoretically related outcome measure (Drost, 2011; Groth-Marnat, 2003). What differentiates concurrent validity from predictive is the time in which the two measurements are taken (Groth-Marnat, 2003). For example, whilst concurrent validity refers to when both measurements are taken at approximately the same time, predictive validity refers to when performance is measured sometime after obtaining scores from the initial test measure (Groth-Marnat, 2003). Whilst concurrent validity is often preferred if a measure is to communicate information about the current status of an individual (i.e. determining whether or not an individual currently presents

as treatment ready), predictive validity is often sought for those measures which aim to predict a future outcome (i.e. determining those individuals likely to engage and thus complete treatment; Groth-Marnat, 2003). Whilst concurrent validity is yet to be established for the CVTRQ, the measures predictive validity has been reported.

Predictive Validity. In order to establish the predictive validity of the CVTRQ, Casey et al. (2007) compared scores on the CVTRQ as administered prior to engagement in a cognitive skills programme, with scores on a measure of engagement, administered halfway through the programme. Defined as "*a multifaceted construct that incorporates client perceptions of and confidence in the treatment process and the extent to which the therapeutic alliance is established*" (p. 1433), the authors argued that no existing measure accurately assessed the construct of engagement in its entirety and so efforts were made to devise a more encompassing measure for analysis (Casey et al., 2007). Specifically, three separate measures of engagement including the Penn Helping Alliance Rating Scale (PHA; Luborsky, Crits-Christoph, Alexander, Margolis & Cohen, 1983), working alliance inventory-client short form (WAI-C SF; Horvath & Greenberg, 1989; Tracey & Koktovic, 1989) and the group cohesion scale (GCS; adapted from Riggs, Warka, Babasa, Betancourt & Hooker, 1994) were administered to each participant at the mid programme stage. Items of each of the measures were subsequently combined and subject to a PCA which suggested a three factor solution by both eigenvalue and scree test criteria; a total score was devised by calculating each of the scores in the three subscales (See Table 10.). Overall the measure indicated high internal consistency ($\alpha = .9$).

Table 10

Description of engagement measure (Casey et al., (2007)

Treatment Engagement Measure	Description
Treatment Engagement: Total	Sum of the three subscales (α = .9)
Treatment Engagement: Alliance subscale	Comprises 8 items which describes the participant-facilitator relationship (α = .89)
Treatment Engagement: Group cohesion subscale	Comprises 4 items which describes the participants beliefs about the efficacy of the group in terms of achieving treatment goals (α = .83)
Treatment Engagement: Confidence subscale	Comprises 5 items that reflect the participants self-confidence in terms of changing their offending behaviour (α = .85)

Including subscales, statistically significant correlations ranged from between .17 to .53 for internal treatment readiness and treatment engagement (Casey et al., 2007). Both the emotional reactions and offending beliefs subscales were weakly correlated with engagement, suggesting these subscales performed poorly when predicting engagement. The total treatment readiness score of the CVTRQ however, was found to be moderately correlated with total treatment engagement (r = .45) at the mid programme stage. Regarding the subscales of the CVTRQ, total engagement was noted to be most strongly related to the attitudes and motivation subscale (r = .43) suggesting engagement was positively associated with a positive perception of treatment, as well as a desire to change and refrain from offending. The strongest

correlation overall was found between total treatment readiness (CVTRQ) and the confidence subscale of the engagement measure (r = .53), suggesting that being ready for treatment was positively associated with the perception that engaging in treatment would address offending behaviour (Casey et al., 2007). Overall, the CVTRQ would appear to have some predictive validity however, both the emotional reactions and offending beliefs subscales require development.

Standardisation

In order to standardise a test, norms need to be established (Kline, 1993). Defined as a set of scores obtained from defined samples, norms make interpretation of the measure possible by ascribing meaning to the test scores (Kline, 1993). Regarding those measures which facilitate practitioners to make decisions about an individual (i.e. treatment suitability) standardisation has been highlighted as particularly important (Kline, 1993).

To date the CVTRQ has only been standardised on 177 male offenders referred onto a cognitive skills programme delivered in both community and prison settings in Victoria, Australia, thus limiting is application to this population only (Casey et al., 2007). In reference to this population specifically, the authors identified a preliminary cut off score of $\geq$ 72 which subsequently provided a sensitivity of 69.49 and a specificity of 59.38, representative of a positive predictive value of 61.2% and a negative predictive value of 67.9%. However, in the absence of a large scale study, cut-off scores between 68 and 74 were also suggested to be appropriate, depending on the desired outcome of administration (Casey et al., 2007; Day et al., 2010). For example, if the intention was to increase the number of individuals ready for treatment, then

utilising a cutoff score that increases the measure's sensitivity would help achieve this; however in doing so, the risk of including individuals not ready for treatment is increased (Casey et al., 2007). If the intention however was to try and ensure all individuals referred to treatment were in fact ready to engage, then increasing the specificity of the measure would be preferable; the risk of excluding some individuals who are in fact ready to engage however is increased with this approach (Casey et al., 2007). In order to more accurately inform cut off scores, and thus the measure's clinical utility, further research into different populations, adopting a larger sample size is required.

Limitations

Self-report measures, such as the CVTRQ, are vulnerable to response biases and social desirability, due to their reliance on the individual to provide honest and accurate answers to the questions asked (Moskowitz, 1996; Paulhus, 1991). Specifically to the CVTRQ for example, due to external pressures to engage in treatment (i.e. parole directions), some offenders may intentionally distort their answers in order to create an image of themselves which they view as pertinent to achieving this goal, indicating social desirability or "*faking good*" response (Furnham, 1986; van de Mortel, 2008). Considering the aim of treatment is to reduce risk, similar patterns in responding may occur when evaluating the outcome of intervention, again in attempt to present themselves in a more positive manner. Considering the positive correlation found between self-report measures of social desirability and treatment readiness, response bias would appear a prominent concern (Serin & Kennedy, 1997).

Self-report measures utilising Likert scales have also been found to be vulnerable to both acquiescence and mid-point response set bias (Kline, 1993). In reference to the former, regardless of the question, this bias reflects the tendency to agree to the majority of items, whereas the latter reflects the tendency to choose the middle answer (Furnham, 1986; Kline, 1993). Answers provided by individuals adhering to this style of responding do not reflect the true opinion of the individual, resulting in inaccurate results. Potentially due to a lack of motivation to engage in treatment and thus the assessment process, such response styles may be endorsed by those low in treatment readiness.

Other sources of error impacting on both validity and reliability of self-report measures include those relating to individual differences (Kline, 1993). Specifically, Likert scales commonly do not define what constitutes each answer, thus leaving the measure vulnerable to individual interpretation (Kline, 1993). As highlighted by Kline (1993), one person's "*strongly disagree*" may be another's "*agree*". In reference to the CVTRQ, answers to the items, such as "*I regret the offence that led to my last sentence*", is strongly dependent on how the individual defines the five possible answers. Furthermore, answers to the item such as "*I have not offended for some time now*", will not only be influenced by how the individual defines the five possible answers, but also how they define the ambiguous concept of "*some time*". Such answers are also likely to be influenced by whether or not the individual the individual has had the opportunity to offend, which if they are detained is unlikely. The extent to which generic cut-off scores can be applied is subsequently dependant on whether the definition used by one individual accurately reflects that endorsed by others.

Conclusion

The aim of the current critique was to explore the psychometric properties of the CVTRQ, a measure of offender internal treatment readiness, and evaluate its clinical utility. Developed from the theoretical model of treatment readiness put forth by Ward et al. (2004), the CVTRQ is reported to provide both practitioners and researchers with a suitable screening measure to inform formulation as well as a method in which to monitor and evaluate treatment (Day et al., 2010). Whilst defined as a measure of internal treatment readiness, the CVTRQ does not account for all person centred factors of the MORM, limiting the extent to which the measure can be considered truly reflective of the model (Casey et al., 2007). Although not yet established for the CVTRQ, the measures content validity is likely to be negatively impacted upon as a result. Developing the measure to take account of such factors may therefore improve its psychometric properties.

To date very limited research is available regarding the psychometric properties of the CVTRQ, highlighting the need for future research to help accurately evaluate the tool. However, based on what is available, the CVTRQ would appear to present with adequate psychometric properties. Overall the measure is internally consistent and attains adequate convergent and discriminate validity (Casey et al., 2007; Day et al., 2010), however further development of the individual subscales would be beneficial. Regarding treatment engagement, research has also supported the measures overall predictive validity (Casey et al., 2007), although again there are issues regarding the individual subscales. Therefore, the measure would not appear without its flaws. Specifically, the efficacy subscale would appear problematic as indicated by the subscales lack of face validity, convergent validity and low levels of internal

consistency (Casey et al., 2007; Day et al., 2011). Future research should therefore aim to explore and thus improve both the reliability and validity of this subscale in particular and the CVTRQ more generally.

Additionally, future research should aim to establish the CVTRQ's content and concurrent validity as doing so would allow more accurate conclusions to be drawn regarding the measures overall psychometric properties. As stated previously, validation of the CVTRQ 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 males and females in varying offender groups in different countries, as well as with different types of intervention is required before it can be accurately used to assess suitability for treatment more generally (Casey et al., 2007).

Chapter 5: Discussion

Overall the current thesis aimed to gain a more detailed understanding of treatment engagement amongst a forensic population. As highlighted in Chapter 1, guidance as to how professionals can encourage and thus support offender engagement in treatment has not been clearly articulated (Day et al., 2010; Polaschek, 2012; Porporino, 2010; Ward et al., 2004). This would appear particularly true when taking in to consideration high rates of treatment dropout commonly reported amongst offending populations (see Chapter 2 & 3). Of those consequences associated with non-completion of treatment, increased risk of recidivism is by far the most concerning (McMurran & Theodosi, 2007). Developing an understanding of how to promote engagement through to completion is therefore imperative. Argued to be a more robust construct of greater clinical utility is that of treatment readiness (see Chapter 1 for a definition; Ward et al., 2004). Encapsulated within the Multifactor Offender Readiness Model (MORM; Ward et al., 2004) as described in Chapter 1, this model proposes a number of factors, internal and external to an individual, which are required to promote successful engagement in treatment (Day et al., 2004; Ward et al., 2004).

In order to achieve the above, several aims were identified. Firstly, this thesis aimed to identify existing empirical literature, exploring offenders' reasons for completion and/or non-completion of treatment, in an attempt to gain a detailed understanding of the factors influencing engagement, and in turn identify areas for future research. As highlighted in Chapter 2, research into static factors, fails to provide information as to how interventions should be adapted to increase treatment responsivity, and therefore engagement (McMurran et al., 2010). Consequently, research aimed at understanding clients overall experience of treatment is argued to be more informative when preventing attrition (McMurran et al., 2010).

A systematic literature review was therefore presented in Chapter 2. Having conducted searchers for relevant research across six databases, thirteen papers were retained after applying PICO inclusion and exclusion criteria, suggesting research in this area is limited. Overall, six papers recruited participants residing in secure hospital settings, whilst seven included those in prison settings. Findings from these papers were presented where possible within the structure of the MORM in order to demonstrate the extent to which the research reflected the current theoretical thinking on treatment readiness. Overall, consensus regarding participants' reasons for completion/non-completion of treatment was found, the majority of which were consistent with the factors of the MORM, providing support for this model. With regards to internal factors for example, negative perceptions of treatment, staff and/or peers, was found to be associated with poor engagement and non-completion of treatment, whilst the opposite tended to be true for those completing treatment. Denial/minimisation of offending behaviour, as well as a lack of self-efficacy to engage was also noted to prevent engagement. Acknowledging the need to engage in treatment and perceiving this as congruent with one's goals was noted to facilitate engagement, whereas a perceived lack of choice and control over one's therapeutic involvement was found to prevent this, as did an inability to disengage from one's identity as an offender. Fluctuations in mental health, as well as an inability to effectively regulate emotions presented as a further barrier. Regarding external factors, feeling safe and supported by staff, both inside and outside of treatment was reported to facilitate engagement and thus completion, as did the opportunity to engage in treatment run by professional and experienced staff. Additional factors were also identified, highlighting the need for an adapted, more comprehensive version of this model. Nevertheless, in accordance with

the MORM, the findings of the review appeared to highlight the interaction between both person centred and contextual factors upon an adult offender's readiness to engage in treatment (Ward et al., 2004).

Chapter 3 comprised a research study which aimed to further existing knowledge in the area by being the first to explore adolescents' reasons for and against attending treatment. It was hoped that the findings from this study would help inform professionals working with this population on ways to increase treatment responsivity, contributing towards successful rehabilitation. Similar to the review, in order to explore the extent to which the findings reflected the current theoretical thinking on treatment readiness, findings were discussed where possible, within the context of the MORM (Ward et al., 2004).

Implementing an embedded mixed methods design, where possible the study intended to replicate the research of Long et al. (2012). However, in an attempt to improve upon this research, reasons for *and* against attending sessions was explored, in order to inform practitioners on both barriers and facilitators to engagement amongst this population. Utilising a purposive sampling strategy, 19 young people were interviewed on two separate occasions regarding their attendance at sessions over a two week period. As indicated by the CVTRQ, 58% of participants were classified as treatment ready (Casey et al., 2007). Whilst treatment readiness scores were not found to differ by gender, convicted participants achieved significantly higher treatment readiness scores than their un-convicted counterparts, suggesting the former were more treatment ready. Adhering to the seven step procedure advised by Braun and Clarke (2013), qualitative data was analysed using thematic analysis. Results of this analysis revealed a number of themes, most of which were consistent with the factors of the

MORM (Ward et al., 2004). A number of variations to the original factors specific to adolescents, as well as an additional factor were also identified. As a result, a model specific to this population was concluded to be necessary in order to ensure clinical practice is accurately guided.

Consistent with the self-determination theory of motivation (SDT; Ryan & Deci, 2000), outlined in Chapter 1, the need for competence, relatedness and autonomy appeared to underlie a number of themes, particularly those relating to reasons for attending treatment. Through meeting these needs participants were able to develop their skills, increase their feelings of self-efficacy and in turn establish sound therapeutic alliances with professionals which appeared to promote engagement (Howells and Day 2003). The incorporation of personally valued rewards also appeared to encourage attendance amongst the majority of participants, and so was concluded to be an additional overarching theme within the data set. The use of behavioural reinforcement was subsequently considered to be particularly useful in promoting engagement amongst this population. As with the review, a number of factors external to the individual were also highlighted in the research, for example lack of available staff and issues with participants timetable, highlighted the importance of the interaction between person centred and contextual factors on client's engagement in treatment.

Finally, as implemented in the research, Chapter 4 examined the psychometric properties and clinical utility of the CVTRQ, a measure of internal treatment readiness developed using the factors of the MORM (Casey et al., 2007). The need to reliably predict those individuals low in treatment readiness and therefore at risk of dropout, was concluded to be important in facilitating treatment engagement and thus preventing recidivism. Overall, very few papers commenting on the measures psychometric

properties were identified, highlighting the need for further research in order to accurately evaluate this tool. Despite this however, the CVTRQ was concluded to present with adequate psychometric properties. Specifically, research demonstrated the *overall* measure to be internally consistent and of acceptable convergent, discriminate and predictive validity. However, despite being a measure of internal treatment readiness, the CVTRQ fails to take account of the volitional and identity factors of the MORM, highlighting potential issues regarding its content validity, although this is yet to be formally assessed. Several issues regarding the reliability and validity of the individual subscales were also highlighted. For example, problems regarding some of the subscales face validity were identified, raising questions regarding the extent to they measured what they intend to. This was particularly true of the efficacy which was also reported to demonstrate poor internal consistency as well as a lack of convergent validity (Casey et al., 2007; Day et al., 2011), preventing the findings from this measure from accurately informing practice. The critique further highlighted that the measures test-retest reliability and concurrent validity is yet to be established, as is the validation of this tool beyond male offenders residing in Australia, highlighting areas for development.

Limitations & Directions for Future Research

Whilst contributing to the lack of research in the area, the current thesis is not without its limitations, highlighting areas for future research, some of which have already been highlighted above. Firstly, in reference to the systematic literature review (see Chapter 2), concerns were raised regarding the heterogeneity of both the studies design and implemented definition of engagement. This, paired with the lack of research identified in the current area, made it difficult to draw affirmative conclusions regarding

the factors that influence offender treatment readiness. This also prevented the results of the review from being accurately compared with the findings identified in the research, highlighting a broader limitation of the current thesis. As research in the area of treatment readiness amongst both adults and adolescents develops, comparisons of studies utilising similar designs will be possible. However, in order for research in this area to meaningfully progress, a more consistent definition of engagement needs to be adopted within the literature in order to allow for the accurate generalisation of findings. In an attempt to contribute towards the progression of future research, a potential definition of engagement was provided in Chapter 2 (Tetley, Jinks, Huband & Howells, 2011, p.927).

Due to the anticipated influence of location on participants' reasons for/against engaging in treatment, offenders residing in the community were excluded from both the review and the research, preventing the findings of the current thesis from being generalised amongst this population. Whilst efforts have been made to understand treatment engagement amongst adult offenders participating in community treatment, this research is limited and tends to focus on factors preventing completion, as opposed to promoting it (Britton, 2012; Evans, Li & Hser, 2008; 2009; Sung, Mahoney & Mellow, 2011). To the author's knowledge, research amongst forensic adolescent populations residing in the community is yet to be established. When considering a large proportion of offenders are required to engage in community programmes upon release, future research should aim to qualitatively explore clients' perceptions of what *facilitates* engagement in such treatment as well as what prevents it, in order to inform relevant professionals as to how best to support this population upon their release. It should be noted that participants residing in prison settings were also excluded from the

research, further limiting the generalisation of findings. Research exploring adolescent prisoners' reasons for and against engaging in treatment is therefore warranted also. Whilst some variation in reasons for engagement between those adolescents residing in secure hospital and prison settings is to be expected, as was the case with adults in the review, significant differences between these populations are not anticipated.

Due to the lack of research in the area, the current thesis explored clients' perspectives on engagement in a range of interventions provided by various disciplines, in order to gain an initial understanding of some of the influential factors amongst both adult and adolescent populations. As noted in Chapter 3, certain themes/subthemes were commonly endorsed for certain types of intervention (i.e. OT vs. Psychology), and so further exploration into what factors influence readiness to engage in specific interventions should be explored, in order to help further the research in this area and thus guide practice.

Specific to Chapter 3, due to the lack of research exploring treatment readiness amongst adolescents, a very broad inclusion criterion was implemented when recruiting participants. This resulted in a fairly heterogeneous sample particularly regarding participants diagnosis. For example, the sample included those participants diagnosed with LD, ASD and/or complex mental health needs. As highlighted in the Chapter 2, factors regarding the impact of intellectual disabilities were noted to specifically influence treatment engagement, particularly participants understanding of the importance of therapy. It is possible that similar subtle differences in reasons for and against attending treatment, specific to diagnosis, may have been found had these populations been investigated separately. As research in this area develops, exploration

of such differences, as well similarities would be beneficial in order to improve the responsivity of services providing specialised care to such individuals.

Despite all participants in the research having engaged in aggressive and antisocial behaviour, not all of them had received a formal conviction, preventing the extent to which the sample could be considered purely forensic. As highlighted in Chapter 2, the degree to which participants perceived themselves as an offender, or a patient, may have been influenced by the presence or absence of a conviction respectively, influencing their motivation to attend sessions and therefore the current findings. Whilst analysis only revealed the subtheme, "*attend to reduce risk*", to be more readily endorsed amongst those with a conviction, it is possible other more subtle variations may have been highlighted had these populations been explored separately. In order to validate the findings of this research, replication of this study using only those formally convicted of an offence is required.

Furthermore, in the absence of a measure of treatment readiness suitable for use amongst adolescents, the CVTRQ (Casey et al., 2007) was administered in the current research. As this measure is only validated amongst male, adult offenders, the extent to which it is applicable to adolescent participants is unknown, preventing accurate conclusions regarding participant's treatment readiness from being drawn. Whilst a limitation of the current study and the thesis as a whole, this would appear to reflect a limitation of the research area more generally, demonstrating the need for a measure suitable for use within an adolescent population specifically. With the research study supporting the internal factors of the MORM in particular, one possible option may be to validate the CVTRQ amongst an adolescent population. When developing this tool however, consideration should be given to its limitations. For example, as previously

discussed, not all factors of the MORM are included within the CVTRQ. With the current research highlighting the importance of volitional factors, in particular amongst young people and their decisions to engage in treatment, there would certainly appear a need to include this within any measure of treatment readiness targeting this population. More generally, the subscales of the measure require development, particularly the internal consistency and convergent validity of the efficacy subscale, in order to improve its overall clinical utility, not only with adolescents but adults also. Furthermore, due to external pressures to engage in treatment perceived or actual, as reported by both adult and adolescent offenders (see chapter 2 & 3), the CVTRQ is vulnerable to both response bias and social desirability; this should subsequently be taken into consideration when interpreting the findings and using them to inform clinical practice.

Implications for Practice

In accordance with the MORM, the findings of the current thesis have found treatment readiness to be influenced by various factors relating to the (a) client, (b) treatment (including the content and therapeutic relationship) and (c) setting. As a result several implications for practise have been highlighted, each of which involve modifying some, or all, of these factors.

The client. Common to both adult and adolescent participants, insight into ones needs, as well as a willingness to pursue a more prosocial lifestyle, was found to increase motivation to change and therefore engagement in treatment (see Chapter 2 & 3), supporting the wider literature. Congruence between the goals of the client and therapist appeared to increase participant's positive perceptions of treatment, further

perpetuating their engagement. With this in mind, working collaboratively with clients to establish mutually endorsed goals, supportive of desistance, prior to engaging them in treatment is likely to increase willingness to change. Through the provision of clear and concise information regarding the aims of treatment, professionals can successfully guide offenders to the realisation that their goals can be achieved via such means (McMurran, 2010). Not only is this realisation likely to promote engagement in treatment, it is likely to protect against the negative impact of perceived coercion which as highlighted in Chapter 2 and 3, is commonly present amongst this population. Having a clear understanding of what treatment entails and what is to be expected as a recipient prior to engagement, is also likely lessen any negative misconceptions about treatment and/or professionals which are likely to prevent engagement (Kozar, 2010; Ward et al., 2004). By creating realistic expectations of the treatment process, clients are less likely to feel as though treatment has been miss-sold to them, preventing the development of attitudes discouraging of engagement. Engaging adult clients in motivational interviewing as a means of preparatory work, has been found to increase readiness to change (McMurran, 2002), prevent attrition and thus reduce risk of recidivism (McMurran, 2009). With similar results being reported amongst adolescent populations (Naar-King & Suarez, 2011), this would appear to be an effective strategy in promoting treatment completion across the ages.

Specific to adolescents, the opportunity to socialise with peers whilst engaging in recreational activities away from the ward environment precipitated feelings of enjoyment and normality amongst participants in Chapter 3. As low mood was found to prevent attendance at sessions, supporting young people's psychological and emotional wellbeing through the provision of such activities would appear effective in preventing

affective factors from hindering engagement. As discussed in Chapter 1, an over emphasis on risk reduction through the use of avoidance based goals is considered to be demotivating for individuals, increasing the risk of treatment non-completion, hostility and more generally a lack of rehabilitative success (Ward et al., 2007; 2012). With research highlighting the provision of leisure activities to result in reductions in antisocial behaviour (Sigafoos & Kerr, 1994), the need to establish a balance between direct risk reduction work and more leisurely, yet meaningful intervention is required in order to maintain young people's wellbeing, and consequently their motivation to comply with treatment. When considering the principles of the Good Lives Model of offender rehabilitation (Ward et al., 2007), this is also likely to be the case with adult offenders detained within rehabilitative services.

Treatment. More commonly reported amongst adolescent participants (see Chapter 3), the inclusion of incentives within the treatment session itself was noted to encourage engagement directly via positive reinforcement, as well as indirectly by precipitating participant's positive perceptions of treatment and staff. This was in comparison to the reward of community leave for example, which despite encouraging attendance, precipitated feelings of coercion and negative attitudes towards rehabilitation as a whole. In relation to achieving parole, similar findings were reported amongst adult participants in Chapter 2. Whilst successful in encouraging attendance, perceived coercion was found to be less successful in promoting actual therapeutic engagement across both populations. With this in mind, the provision of personally meaningful incentives is likely to be one strategy which professionals can use to help improve attitudes towards treatment and encourage engagement. Exactly what these incentives should be, as well as what a client has to do to achieve them should be

established collaboratively with the client in order to promote feelings of choice and control over their rehabilitation.

Supporting existing literature, the current thesis further highlighted the importance of the therapeutic alliance in promoting motivation to engage amongst both adult and adolescent clients (Kozar, 2010). Regardless of age, feeling supported by caring, professional and competent staff was found to facilitate engagement, emphasising the importance of the interaction between a therapist's professional qualities and personal characteristics in developing this relationship (Ross, Polaschek & Ward, 2008). According to Kozar (2010) difficulties in establishing a therapeutic alliance in the early stages of treatment, is considered more likely to occur amongst those individuals presenting with low levels of treatment readiness. As suggested in Chapter 2, attempts should be made early on in a client's therapeutic pathway to establish a sound therapeutic alliance, so that this can be used not only to increase client's motivation to change, but willingness to engage in treatment (Polascheck & Ross, 2010). As previously mentioned, establishing collaborative goals supportive of rehabilitation (McMurran, 2010), as well as the provision of rewards or incentives for attending sessions (Kozar, 2010), has been found to foster the development of this relationship both in the wider literature and in the current study.

The setting. In relation to the setting, both the review and the research highlighted issues relating to the social climate of the setting as preventing optimal engagement in treatment (i.e. not feeling safe, to avoid conflict). When considering the competing demands of offender rehabilitation and security found in forensic settings (Hodge & Renwick, 2002), it would appear important that all professionals working

with offenders remain mindful of the therapeutic climate in which they work and how this might be impacting upon rehabilitation. For example, Howells et al. (2009) found when assessing the social climate of a high security setting, that in comparison to patients, staff perceived the climate of the setting as more therapeutic and positive. Accurately assessing the social climate is therefore important when trying to identify how to modify the setting to better support engagement. Ensuring clients feel safe and able to express their thoughts and feelings openly in treatment is imperative if rehabilitation is to be achieved.

Finally, issues regarding resources, as highlighted in Chapters 2 and 3, were found to impact upon engagement. Whilst for adults the unavailability of immediate treatment negatively impacted upon participants' motivation to engage, for adolescents, such consequences were more commonly precipitated by the lack of available staff to facilitate sessions. At an organisational level, the need to ensure settings are adequately resourced and therefore able to provide effective rehabilitative services is paramount in facilitating change, particularly amongst those motivated to do so.

Conclusions

This thesis has highlighted both the barriers and facilitators to treatment engagement from a client's perspective, furthering what has been identified to be a very limited research area. Through the completion of a systematic literature review (Chapter 2) and research project (Chapter 3), the perspectives of both adult and adolescent client groups have been explored respectively, as has the extent to which these reflect current theoretical thinking in the area.

Overall, this thesis has found engagement in treatment to be influenced by factors relating to the client, the treatment and the setting also, supporting the principles of the MORM and its subsequent application amongst both adult and adolescent populations. However, as some additional factors were also identified, the findings would appear to suggest that at present the model is somewhat limited. Furthermore, whilst additional factors such as being unable to attend treatment due to risk were found to overlap across both populations, a small number of differences were also noted, for example, wanting to spend time with peers (adolescents) and issues relating to personality traits (adults), highlighting the need for age specific models. In order to ensure such models are accurately informed, further research adopting a similar design and definition of engagement, particularly amongst adolescents, is needed in order to ensure all subtle differences between these populations are accurately identified and articulated clearly.

As much as there is a need to identify those ready for treatment so that efforts at risk reduction can be appropriately targeted, there is also a need to identify those low in treatment readiness so that efforts can be made to modify this in preparation for later therapeutic involvement. However, as highlighted in Chapter 4, existing measures of treatment readiness require development before they can be accurately used to inform clinical practice, highlighting an area for future research.

As raised in Chapter 1, despite its importance, details regarding how treatment should be adapted to ensure responsivity to the client's needs to date, has not been clearly articulated. It is hoped that the findings from this thesis will contribute towards a more detailed understanding of this principle within the wider context of treatment

readiness, and its subsequent application within clinical practice among both adult and adolescent forensic populations.

References

Agnew, R. (2003). An integrated theory of the adolescent peak in offending. *Youth & Society, 34*, 263-299. doi: 10.1177/0044118X02250094

American Educational Research Association, American Psychological Association, & National Council on Measurement in Education. (1999*). Standards for educational and psychological testing.* Washington, DC: American Educational Research Association.

Andrews, D.A. (2001). Principles of effective correctional programs. In L.L. Motiuk., & R.C. Serin (Eds.), *Compendium 2000 on effective correctional programming, vol. 1.* Canada: Ministry of Supply Services.

Andrews, D.A., & Bonta, J. (2007). *The psychology of criminal conduct* (4th ed.). Cincinnati,
    OH: Anderson Publishing.

Arnetz, J.E., & Arnetz, B.B. (2001). Violence towards health care staff and possible effects on the quality of patient care. Social Science and Medicine, 52, 417-427. doi:10.1016/S0277-9536(00)00146-5

Baer, J.S., & Peterson, P.L. (2002). Motivational interviewing with adolescents and young adults. In W.R.Miller & Rollnick, S. (Eds.). Motivational interviewing: Preparing people for change (p.320-332). New York: Guildford. doi: 10.1002/casp.2450020410

Battjes, R.J., Gordon, M.S., O'Grady, .K.E., Kinlock, T.W., & Carswell, M.A. (2003). Factors that predict adolescent motivation for substance abuse treatment. *Journal of Substance Abuse Treatment, 24*, 221-232. doi: http://dx.doi.org/10.1016/S0740-5472(03)00022-9

Beecham, J., Chisholm, D., O'Herlihy, A., & Astin, J. (2003). Variations in the costs of child and adolescent psychiatric in-patient units psychiatric in-patient units. *British Journal of Psychiatry, 183*, 220-225. doi: 10.1192/bjp.183.3.220

Berkowitz, L. (1989). Frustration-aggression hypothesis: Examination and reformulation. *Psychological Bulletin, 106*, 59-73. doi: 10.1037/0033-2909.106.1.59

Block, A. M., & Greeno, C. G. (2011). Examining outpatient treatment dropout in adolescents: A literature review. *Child and Adolescent Social Work Journal, 28,* 393-420. doi: 10.1007/s10560-011-0237-x

Borduin, C. M., & Schaeffer, C. M. (1998). Violent Offending in Adolescence: Epidemiology, Correlates, Outcomes, and Treatment. In T.P.Gullotta, G. R.

Adams, & R. Montemayor (Eds.), *Delinquent Violent Youth. Theory and Interventions* (pp. 144-174). USA: SAGE Publications, Inc. doi: 10.4135/9781483328256

Braun, V., & Clarke, V. (2013). *Successful qualitative research a practical guide for beginners*. London: SAGE Publications Ltd.

Breckon, S. E., Smith, I. C., & Daiches, A. (2013). What makes offenders with an intellectual disability ready to engage with psychological therapy? A qualitative study. *Research inDevelopmental Disabilities*, *34*, 1408-1416.

Britton, T. (2012). *Mandated treatment, 12-step support groups, and criminal recidivism policy implications and perspective.* (Unpublished doctoral thesis). University of North Carolina, Chapel Hill, America.

Brooks, M., & Khan, R. (2015). Psychosocial influences that motivate young offenders to engage in a non-custodial community intervention. *The Journal of Forensic Psychiatry & Psychology, 26,* 351-367. doi: 10.1080/14789949.2015.1013973

Brusca R.M., Nieminen G.S., Carter R., & Repp, A.C. (1989). The relationship of staff contact and activity to the stereotypy of children with multiple disabilities. *Journal of the Association for Persons with Severe Handicaps 14,* 127–136. doi: 10.1177/154079699602100204

Bui, K. V. T., Ellickson, P. L., & Bell, R. M. (2000). Cross-lagged relationships among adolescent problem drug use, delinquent behavior, and emotional distress. *Journal of Drug Issues, 30,* 283-304. Retrieved from: http://search.proquest.com/openview/4df268a202f24dbd556e968bd4176be1/1?pq-origsite=gscholar

Burnett, R. (2004) 'One-to-one ways of promoting desistance: in search of an evidence base', in Burnett, R. and Roberts, C. (eds.). *What Works in Probation and Youth Justice: Developing evidence-based practice*. Cullompton: Willan Publishing. doi: 10.1177/1057567705284584

Burrowes, N., & Needs, A. (2009). Time to contemplate change? A framework for assessing readiness to change with offenders. *Aggression and Violent Behavior, 14,* 39-49. doi:10.1016/j.avb.2008.08.003

Cann, J., Falshaw, L., Nugent, F., & Friendship, C. (2003). *Understanding what works: Accredited cognitive skills programmes for adult men and young offenders (Home Office Research Study 226)* London: Home Office. Retrieved from: http://webarchive.nationalarchives.gov.uk/20110218135832/rds.homeoffice.gov.uk/rds/pdfs2/r226.pdf

Carr, M.B., & Vandiver, T.A. (2001). Risk and protective factors among youth offenders. *Adolescence, 26,* 409-426. Retrieved from http://search.proquest.com/openview/e693ed0ab3292dc6d65ecccc2b13cc7d/1?pq-origsite=gscholar

Casey, S., Day, A., & Howells, K. (2005). The application of the transtheoretical model to offender populations: Some critical issues. *Legal and Criminology Psychology, 10,* 157-171. doi:10.1348/135532505X36714

Casey, S., Day, A., Howells, K., & Ward, T. (2007). Assessing suitability for offender rehabilitation - Development and validation of the treatment readiness questionnaire. *Criminal Justice and Behavior, 34,* 1427-1440. doi: 10.1177/0093854807305827

Castro, M., Cockerton, T., & Birke, S. (2002). From discharge to follow-up: a small-scale study of medium secure provision in the independent sector. *The British Journal of Forensic Practice, 4,* 31 – 39. doi: 10.1108/14636646200200019

Cattell, R. B. (1966). The scree test for the number of factors. *Multivariate Behavioral Research, 1,* 245-276. doi: 10.1207/s15327906mbr0102_10

Centre for Mental Health (2011). Pathways to unlocking secure mental health care. National Mental Health Development Unit. Retrieved from http://www.centreformentalhealth.org.uk/pathways-to-unlocking-secure-mental-health-care

Cesaroni, C., & Peterson-Badali, M. (2005). Young offenders in custody: Risk and adjustment. *Criminal Justice and Behavior, 32,* 251-277. doi: 10.1177/0093854804274370

Chambers, J.C., Eccleston, L., Day, A., Ward, T., & Howells, K. (2008). Treatment readiness in violent offenders: The influence of cognitive factors on engagement in violence programs. *Aggression and Violent Behavior, 13,* 276-284. doi:10.1016/j.avb.2008.04.003

Cooper, C. (2001). *Juvenile drug court programs.* Washington, D.C: U.S Department of Justice. doi: 10.1037/e516232006-001

Cronbach, L. J., & Gleser, G. C. (1965) *Psychological tests and personnel decisions.* Urbana, IL: University of Illinois Press.

Cullen, A. E., Soria, C., Clarke, A. Y., Dean, K., & Fahy, T. (2011). Factors predicting dropout from the Reasoning and Rehabilitation program with mentally disordered offenders. *Criminal Justice and Behavior, 38,* 217-230. doi: 10.1177/0093854810393659

Daly, J. E., & Pelowski, S. (2000). Predictors of dropout among men who batter: A review of studies with implications for research and practice. *Violence and Victims, 15,* 137-60. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/11108498

Day, A., Casey, S., Vess, J., & Huisy, G. (2011). Assessing the social climate of Australian prisons. *Trends and issues in crime and criminal justice, 427,* 1836-2206. doi: http://dx.doi.org/10.1037/e620432012-001

Day, A., Casey, S., Ward, T., Howells, K., & Vess, J. (2010). *Transitions to better lives: Offender readiness and rehabilitation*. Cullompton, UK: Willan. doi: 10.1111/j.1468-2311.2011.00661.x

Diener, E., Sandvik, E., & Larsen, R.J. (1985). Age and sex effects for emotional intensity. *Developmental Psychology, 21*, 1253-1265. doi: 10.1037/0012-1649.21.3.542

Domes, G., Mense, J., Vohs, K., & Habermeyer, E. (2013). Offenders with antisocial personality disorder show attentional bias for violence-related stimuli. *Psychiatry Research, 209,* 78-84. doi: 10.1016/j.psychres.2012.11.005

Drost, E.A. (2011). Validity and Reliability in Social Science Research. *Education Research and Perspectives, 38*, 105-123. Retrieved from http://www.erpjournal.net/wp-content/uploads/2012/07/ERPV38-1.-Drost-E.-2011.-Validity-and-Reliability-in-Social-Science-Research.pdf

Durkin, R. P., & Durkin, A. B. (1975). Evaluating residential programs for disturbed children. In M.Guttentag & E. Strevening (Eds.), *Handbook of evaluation research* (eds. ed., pp. 275-339). Beverly Hills, CA: SAGE.

Edwards, R., Beech, A., Bishopp, D., Erikson, M., Friendship, C., & Charlesworth, L. (2005). Predicting dropout from a residential programme for adolescent sexual abusers using pre-treatment variables and implications for recidivism. *Journal of Sexual Aggression, 2,* 139-155. doi: 10.1080/13552600500063641

Evans, E., Li, L., & Hser, Y. (2008). Treatment barriers among Califormia's Proposition 36 offenders. *Journal of Substance Abuse Treatment, 35*, 410-418. doi: 10.1016/j.jsat.2008.03.003

Farrington, D. P. (1990). Implications of criminal career research for the prevention of offending. *Journal of Adolescence, 13,* 93-113. doi:10.1016/0140-1971(90)90001-N

Farrington, D. P., Ditchfield, J., Hancock, G., Howard, P., Jolliffe, D., Livingston, M. S., & Painter, K.A. (2002). *Evaluation of two intensive regimes for young offenders. (Home Office Research Study No. 239)*. London: Home Office. Retrieved from: http://www.crim.cam.ac.uk/people/academic_research/david_farrington/hors239.pdf

Florsheim, P., Shotorbani, S., Guest-Warnick, G. & Barratt, T. (2000). Role of the working alliance in the treatment of delinquent boys in community-based programs. *Journal of clinical child psychology, 29*, 94-107. doi: 10.1207/S15374424jccp2901_10

Ford, J. (1978). Therapeutic relationship in behavior therapy: an empirical analysis. *Journal of Consulting and Clinical Psychology, 46*, 1302 – 1314. doi: 10.1037/0022-006X.46.6.1302

French, R., Reardon, M., & Smith, P. (2003). Engaging with a mental health service: Perspectives of at-risk youth. *Child and Adolescent Social Work Journal, 20,* 529-548. doi: 10.1023/B:CASW.0000003142.13457.0a

Furnham, A. (1986). Response bias, social desirability and dissimulation. *Personality and Individual Differences, 7,* 385-400. doi:10.1016/0191-8869(86)90014-0

Gardner, W., Hoge, S.K., Bennett, N., Roth, L.H., Lidz, C.W., Monahan, J., & Mulvey, E.P. (1993). Two scales for measuring patients' perceptions for coercion during mental hospital admission. *Behavioural Science and the Law, 11*, 307-321. doi: 10.1002/bsl.2370110308

Grietens, H., & Hellinckx, W. (2004). Evaluating effects of residential treatment for juvenile offenders by statistical metaanalysis: A review. *Aggression and Violent Behavior, 9,* 401-415. doi: 10.1016/S1359-1789(03)00043-0

Grossman, M., & Wood, W. (1993). Sex differences in intensity of emotional experience: A social role interpretation. *Journal of Personality and Social Psychology, 65*, 1010-1022. doi: 10.1037/0022-3514.65.5.1010

Groth-Marnat, G. (2003). *Handbook of Psychological Assessment.* New Jersey: John Wiley & Sons, Inc.

Guest, G., MacQueen, K. M., & Namey, E. E. (2012). *Applied Thematic Analysis*. Thousand Oaks: SAGE.

Henggeler, S. W. (1996). Treatment of violent juvenile offenders: we have the knowledge. *Journal of Family Psychology, 10,* 137-141. doi: 10.1037/0893-3200.10.2.137

Henggeler, S.W., & Sheidow, A.J. (2012). Empirically supported family-based treatments for conduct disorder and delinquency in adolescents. *Journal of marital and family therapy, 38,* 30-58. doi: *10.1111/j.1752-0606.2011.00244.x*

Hodge. J. E., & Renwick, S. J. (2002) Motivating mentally disordered offenders. In M. McMurran (ed.) *Motivating Offenders to Change: A Guide to Enhancing Engagement in Therapy* (p. 221-234). Chichester: Wiley.

Hornsveld, R. H. J. (2005). Evaluation of aggression control therapy for violent forensic psychiatric patients. *Psychology, crime and law, 11,* 403-410. doi: 10.1080/10683160500255596

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counselling Psychology, 36*, 223-233. doi: 10.1037/0022-0167.36.2.223

Howells, K., & Day, A. (2003). Readiness for anger management: clinical and theoretical issues. *Clinical Psychology Review, 23*, 319-337. doi:10.1016/S0272-7358(02)00228-3

Howells, K., & Day, A. (2007). Readiness for treatment in high risk offenders with personality disorders. *Psychology, Crime & Law, 13,* 47-56. doi: 10.1080/10683160600869767

Howells, K., Tonkin, M., Milburn, C., Lewis, J., Draycot, S., Cordwell, J., Price, M., Davies, S., & Schalast, N. (2009) The EssenCES measure of social climate: A preliminary validation and normative data in a UK high secure hospital setting. *Criminal Behavioural Mental Health,* 19, 308–320. doi: 10.1002/cbm.745

Iacobucci, D. (2001). Measurement. *Journal of Consumer Psychology's Special Issue on Methodological and Statistical Concerns of the Experimental Behavioral Researcher*, 10, 55-69. Retrieved from http://ww2.owen.vanderbilt.edu/dawn.iacobucci/JCPmethodsIssue/III-meas-coef-alpha.pdf

Kaiser, H.F. (1960). The application of electronic computers to factor analysis. *Educational and Psychological Measurement, 20*, 141-151. doi: 10.1177/001316446002000116

Karoly, P. (1999). A goal systems self-regulatory perspective framework for clinical assessment and treatment planning. *Psychological Assessment, 5,* 273-280. doi: 10.1037/1040-3590.5.3.273

Kennedy, S.M. (2001). Treatment responsivity: Reducing recidivism by enhancing treatment effectiveness. In L.L.Motiuk., & R.C. Serin (Eds.), *Compendium 2000 on effective correctional programming, vol. 1.* Canada: Ministry of Supply Services.

Kim, H., Munson, M., & McKay, M. (2012). Engagement in mental health treatment among adolescents and young adults: A systematic review. *Child and Adolescent Social Work Journal, 29*, 241-266. doi: 10.1007/s10560-012-0256-2

King, C.M. (2014). *RNR-Based Assessment Feedback: Reception by Offenders and Impact on Self-Perceived Risk and Needs, Motivation for Change, and Treatment Readiness*. (Unpublished Doctoral Dissertation). Drexel University, United States.

Kline, P. (1993). *The Handbook of Psychological Testing*. London: Routledge.

Kline, P. (2014). *The new psychometrics: Science, psychology and measurement.* London: Routledge

Kozar, C. (2010). Treatment readiness and the therapeutic alliance. In A. Day, S. Casey, T. Ward, K. Howells, & J. Vess (Eds.), *Transitions to better lives: Offender readiness and rehabilitation* (pp. 195-213). Cullompton, UK: Willan. doi: 10.4324/9781843927204

Kraemer, B. D., Salisbury, S. B., & Spielman, C. R. (1998). Pretreatment variables associated with treatment failure in a residential juvenile sex-offender program.

Criminal Justice and Behavior, 25, 190-202.
doi: 10.1177/0093854898025002003

Larochelle, S., Diguer, L., & Laverdiere, O. (2011). Predictors of psychological treatment noncompletion among sexual offenders. *Clinical Psychology Review, 31*, 554-562. doi: 10.1016/j.cpr.2010.12.004

Ledesma, R.D., & Pedro, V.M. (2007). Determining the Number of Factors to Retain in EFA: An easy-to-use computer program for carrying out Parallel Analysis. *Practical Assessment Research & Evaluation, 12*, 1-11. Retrieved from http://pareonline.net/pdf/v12n2.pdf

Lipsey, M. W., & Wilson, D. B. (1993). The efficacy of psychological, educational, and behavioral treatment. *American Psychologist, 48,* 1209. doi: 10.1037//0003-066x.48.12.1181

Little, J.H., & Girvin, H. (2002). Stages of change: A critique. *Behavior Modification, 26,* 223-272. doi: 10.1177/0145445502026002006

Lloyd, C., Mair, G., & Hough, M. (1994). *Explaining reconviction rates: A critical analysis.* London: HMSO.

Lockwood, B. (2012). The influence of travel distance on treatment noncompletion for juvenile offenders. *Journal of Research in Crime and Delinquency, 49*, 572-600. doi:10.1177/0022427811414198

Loeber, R. (1990). Development and risk factors of juvenile antisocial behavior and delinquency. *Clinical Psychology Review, 10,* 41. doi:10.1016/0272-7358(90)90105-J

Long, C. G., Banyard, E., Fox, E., Somers, J., Poynter, D., & Chapman, R. (2012). Barriers to treatment: reasons for non-attendance in women's secure settings. *Advances in Dual Diagnosis, 5,* 154-163. doi: 10.1108/17570971211281657

Long, C., Dolley, O., & Hollin, C. (2013). Engagement in psychosocial treatment: Its relationship to outcome and care pathway progress for women in medium-secure settings. *Criminal Behaviour & Mental Health, 22,* 336-349. doi: 10.1002/cbm.1824

Loza-Fanous, A. (2004). Motivation, self-efficacy, problem recognition and locu of control as offender treatment responsivity factors. *Dissertation Abstracts International: Section B: The Sciences and Engineering, 64,* (9-B). Retrieved from http://www.collectionscanada.gc.ca/obj/s4/f2/dsk4/etd/NQ83521.PDF

Luborsky, L., Crits-Christoph, P., Alexander, L., Margolis, M., & Cohen, M. (1983). Two helping alliance methods for predicting outcome of psychotherapy: A counting signs vs. a global rating method. *Journal of Nervous and Mental Disease*, 171, 480-492. doi: 10.1097/00005053-198308000-00005

Marshall, .WL., Marshall, L.E., Serran, G.A., & O'Brien, M.D. (2009) Self-esteem, shame, cognitive distortions and empathy in sexual offenders: their integration and treatment implications, *Psychology, Crime & Law, 15*, 217-234. doi: 0.1080/10683160802190947

Marshall., W.L., Serran, G.A., Fernandez, Y.M., Mulloy, R., Mann, R.E., & Thornton, D. (2003). Therapist characteristics in the treatment of sexual offenders: Tentative data on their relationship with indices of behaviour change. *Journal of Sexual Aggression, 9,* 25-30. doi: 10.1080/355260031000137940

Martinson, R. (1974). What Works: Questions and answers about prison reform. *The Public Interest, 35*, 22-54. Retrieved from: http://www.nationalaffairs.com/doclib/20080527_197403502whatworksquestion sandanswersaboutprisonreformrobertmartinson.pdf

Mason, P., & Prior, D. (2008). Engaging young people who offend. Retrieved 6th June 2015, from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/356204/Final_EYP_source.pdf

Matson J.L., & Boisjoli J.A. (2007) Multiple versus single maintaining factors of challenging behaviours as assessed by the QABF for adults with intellectual disabilities. *Journal of Intellectual and Developmental Disability 32,* 39–44. doi:10.1080/13668250601184689

McConnaughy, E.A., Prochaska, J.O., & Velicer, W.F. (1983). Stages of change in psychotherapy: Measurement and sample profiles. *Psychotherapy: Theory, Research and Practice, 20*, 368-375. doi: 10.1037/h0090198

McGrain, P. N. (2006). An examination of therapeutic engagement in a prison-based drug treatment therapeutic community. *Dissertation Abstracts International Section A: Humanities and Social Sciences, 67,* 1-314. doi: 10.1177/0032885503262459

McGuire, J. (2012). Crime and Punishment: 'What works'?. In Davies, G. & Beech, A. (2nd Eds.). *Forensic Psychology Crime, Justice, Law, Interventions*. West Sussex, UK: BPS Blackwell.

McGuire, J., & Hatcher, R. (2001). Offence focused problem solving: Preliminary evaluation of a cognitive skills program. *Criminal Justice and Behaviour, 28,* 564-587. doi: 10.1177/009385480102800502

McLeod, J. (1990). The client's experience of counselling and psychotherapy: a review of the research literature. In: D. Mearns, & W. Dryden (Eds.), Experiences of counselling in action (pp. 66 – 79). London: Sage Publications.

McMurran, M. (2002). *Motivating offenders to change: A guide to enhancing engagement in therapy*. Chichester, UK: John Wiley.

McMurran, M. (2009). Motivational Interviewing with offenders: A systematic review. *Legal and Criminological Psychology*, *14*, 83-100.

McMurran, M. (2010). Goal-focused interventions with offenders. In A. Day, S. Casey, T. Ward, K. Howells, & J. Vess (Eds.), *Transitions to better lives: Offender readiness and rehabilitation* (pp. 180-213). Cullompton, UK: Willan.

McMurran, M., Huband, N., & Duggan, C. (2008). A comparison of treatment completers and non-completers of an in-patient treatment programme for male personality-disordered offenders. *Psychology and Psychotherapy: Theory, Research and Practice, 81,* 193-198. doi: 10.1348/147608308X288762

McMurran, M., Huband, N., & Overton, E. (2010). Non-completion of personality disorder treatments: A systematic review of correlates, consequences and interventions. *Clinical Psychology Review, 30,* 277-287. doi:10.1016/j.cpr.2009.12.002

McMurran, M. & Theodosi, E. (2007). Is treatment non-completion associated with increased reconviction over no treatment? *Psychology Crime & Law, 13,* 333-343. doi: 10.1080/10683160601060374

McMurran, M. & Ward, T. (2004). Motivating offenders to change in therapy: An organizing framework. *Legal and Criminological Psychology, 9,* 295-311. doi: 10.1348/1355325041719365

McMurran, M. & Ward, T. (2010). Treatment readiness, treatment engagement and behaviour change. *Criminal Behaviour and Mental Health, 20,* 85. doi: 10.1002/cbm.762

Miller, L. (2014). Juvenile crime and juvenile justice: Patterns, models, and implications for clinical and legal practice. *Aggression and Violent Behavior, 19,* 122-137. doi:10.1016/j.avb.2014.01.005

Miller, W.R., & Tonigan, J.S. (1996). Assessing drinkers' motivation for change: The stages of change readiness and treatment eagerness scale (SOCRATES). *Psychology of Addictive Behaviour, 10,* 81-89. doi 10.1037/0893-164X.10.2.81

Ministry of Justice Information Release (2013). Costs per place and cost per prisoner. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/251272/prison-costs-summary-12-13.pdf [Electronic version].

Ministry of Justice (2014). Youth Justice Statistics 2012/13 England and Wales. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/278549/youth-justice-stats-2013.pdf [Electronic version].

Ministry of Justice (2015). Criminal Justice Statistics Quarterly Update to September 2014 England and Wales Ministry of Justice Statistics bulletin. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/405301/cjs-quarterly-update-september-2014.pdf

Mitchell, O., Mackenzie, D. L., Styve, G. J., & Gover, A. R. (2006). The impact of individual, organizational, and environmental attributes on voluntary turnover among juvenile correctional staff members. *Justice Quarterly, 17,* 333-357. doi: 10.1080/07418820000096351

Moffitt, T. E. (1993). Adolescence-limited and life-course-persistent antisocial behaviour: A developmental taxonomy. *Psychological Review, 100,* 674-701. doi: 10.1037/0033-295x.100.4.674

Moffitt, T. E. & Caspi, A. (1999). Findings about partner violence from the dunedin multidisciplinary health and development study. *National Institute of Justice: Research in Brief,* 1-12. Retrieved from: https://www.ncjrs.gov/pdffiles1/170018.pdf

Monahan, J., Hoge, S.K., Lidz, C.., Roth, L.H., Bennett, N., Gardner, W., & Mulvey, E. (1995). Coercion and commitment: understanding involuntary mental hospital admission. *International Journal of Law and Psychiatry, 18*, 249-263. doi:10.1016/0160-2527(95)00010-F

Morse, J. M. (2000). Determining Sample Size. *Qualitative Health Research, 10,* 3-5. doi: 10.1177/104973200129118183

Moskowitz, D. S. (1996). Comparison of self-reports, reports by knowledgeable informants, and behavioural observation data. *Journal of Personality, 54*, 294-317. doi: 10.1111/j.1467-6494.1986.tb00396.x

Munson, R. F., & LaPaille, K. (1984). Personality tests as a predictor of success in a residential treatment center. *Adolescence, 19,* 679-701. Retrieved from: http://www.ncbi.nlm.nih.gov/pubmed/6507151

Naar-King, S. & Suarez, M. (2011). *Motivational Interviewing with Adolescents and Young Adults*. New York: The Guildford Press.

Neighbors, B., Kempton, T., & Forehand, R. (1992). Co-occurrence of substance use with conduct, anxiety, and depression disorders in juvenile delinquents. *Addictive Behaviors, 17,* 379-386. doi:10.1016/0306-4603(92)90043-U

Newcomb, M. D., & McGee, L. (1989). Adolescent alcohol use and other delinquent behaviors: A one-year longitudinal analysis controlling for sensation seeking. *Psychological Review, 100,* 674-701. doi: 10.1177/0093854889016003006

Nunnally, J.C. (1978). *Psychometric Theory.* (2nd. Ed.). New York: McGraw-Hill.

Nunnally, J.C. & Bernstein, I. (1994). *Psychometric theory*. (3rd ed.). New York; McGraw-Hill.

Palmer, E.J., McGuire, J., Hounsome, J.C., Hatcher, R.M., Bilby, C.A., & Hollin, C.R.(2007). Offending behaviour programmes in the community: The effects on reconviction of three programmes with adult male offenders. *Legal and Criminological Psychology, 12*, 251–264. doi: 10.1348/135532506X138873

Paulhus, D.P. (1991). Measurement and control of response bias. In Robinson, J.P., Shaver, P.R. & Wrightsman, L.S. (Eds.). *Measures of personality and social psychological attitudes*. San Diego: Academic Press

Paulhus, D.L. (1998). *Manual for the balanced inventory of desirable responding: Version 7*. Buffalo, NY: Mutli-Health Systems.

Polaschek, D. L.L. (2012). An appraisal of the risk-need-responsivity (RNR) model of offender rehabilitation and its application in correctional treatment. *Legal and Criminological Psychology, 17*, 1-17.doi: 10.1111/j.2044-83333.2011.02038.x

Polaschek, D. L. L., & Ross, E. (2010). Do early therapeutic alliance, motivation, and stages of change predict therapy change for high-risk, psychopathic violent prisoners? *Criminal Behaviour and Mental Health, 20*, 100-111. doi: 10.1002/cbm.759.

Porporino, F.J. (2010). Bringing sense and sensitivity to corrections: From programmes to fix offenders to services support desistance. In Brayford, J., Cowe, F. & Deering, J. (Eds.), *What else works? Creative work with offenders*. UK: Willan.

Prochaska, J. O., & DiClemente, C. C. (1984). *The transtheoretical approach: Crossing traditional boundaries of therapy*. Homewood, IL: Dow Jones-Irwin.

Prochaska, J. O., & DiClemente, C. C. (1986). Toward a comprehensive model of change.
In W. R. Miller & N. Heather (Eds.), *Treating addictive behaviours: Process of change* (pp. 3–27). New York: Plenum Press.

Prochaska, J.O., Redding, C.A., & Evers, K.E. (2008). The transtheoretical model and stages of change. In K. Glanz., B.K. Rimer., & K. Viswanath (Eds.). *Health behaviour and health education: Theory, research and practice* (4th eds., p. 97-122). San Francisco: John Wiley & Sons, Inc.

Rollnick, S., Heather, N., Gold, R., & Hall, W. (1992). Development of a short readiness to change questionnaire for use in brief opportunistic interventions amongst excessive drinkers. *British Journal of Addiction, 87,* 743-754. doi: 10.1111/j.1360-0443.1992.tb02720.

Riggs, M. L., Warka, J., Babasa, B., Betancourt, R., & Hooker, S. (1994). Development and validation of self-efficacy and outcome expectancy scales for job-related applications. *Educational and Psychological Measurement, 54,* 793-802. doi: 10.1177/0013164494054003026

Ross, E.C., Polaschek, D.L.L., & Ward, T. (2008). The therapeutic alliance: A theoretical revision for offender rehabilitation. *Aggression and Violent Behavior,13,* 462-480. doi: 10.1016/j.avb.2008.07.003.

Rubin, D. C., Schrauf, R. W., & Greenberg, D. L. (2003). Belief and recollection of autobiographical memories. *Memory & Cognition, 31,* 887-901. doi: 10.3758/BF03196443

Ryan, R.M., & Deci, E.L. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development and well-being. *American Psychologist, 55,* 68-78. doi: 10.1037110003-066X.55.1.68

Ryan, V. L., & Gizynski, M. N. (1971). Behavior therapy in retrospect: patients' feelings and their behavior therapies. *Journal of Consulting and Clinical Psychology, 37,* 1 – 9. doi: 10.1037/h0031293

Ryan, R.M., Plant, R.W., & O'Malley, S. (1995). Initial motivations for alcohol treatment: Relations with patient characteristics, treatment involvement and dropout. *Addictive Bheaviors, 20,* 279-297. doi:10.1016/0306-4603(94)00072-7

Saunders, M. (1999). Clients' assessments of the affective environment of the psychotherapy session: relationship to session quality and treatment effectiveness. *Journal of Clinical Psychology, 55,* 597 – 605. doi: 10.1002/(SICI)1097-4679(199905)55:5<597::AID-JCLP7>3.0.CO;2-M

Serin, R., & Kennedy, S. (1997). *Treatment readiness and responsivity: Contributing to effective correctional programming.* Canada: Correctional Services.

Serin, R., Mailloux, D.L., & Kennedy, S. (2007). Development of a clinical rating scale for offender readiness: Implications for assessment and offender change. *Issues in Forensic Psychology, 7,* 70-80. Retrieved from http://www.bps.org.uk/content/issues-forensic-psychology-no-7-readiness-treatment

Sheldon, K., Howells, K., & Patel, G. (2010). An empirical evaluation of reasons for non-completion of treatment in a dangerous and severe personality disorder unit. *Criminal Behaviour and Mental Health, 20,* 129-143. doi: 10.1002/cbm.760

Sigafoos, J., & Keer, M. (1994). Provision of leisure activities for the reduction of challenging behaviour. *Behavioural Intention, 1, 43-*53. doi: 10.1002/bin.2360090105

Skinner, B. F. (1953). *Science and human behaviour.* New York: Macmillan.

Solway, A. & Botvinick, M. (2012). Goal-Directed Decision Making as Probabilistic Inference: A Computational Framework and Potential Neural Correlates. *Psychological Review, 119,* 120-154. doi: 10.1037/a0026435

Stein, L.A.R. (2011). The juvenile justice system. In S. Naar-King & M. Suarez. *Motivational Interviewing with Adolescents and Young Adults (p. 100-105)*. New York: The Guildford Press.

Stein, D. M., Deberard, S., & Homan, K. (2013). Predicting success and failure in juvenile drug treatment court: A meta-analytic review. *Journal of Substance Abuse Treatment, 44,* 159-168. doi: 10.1016/j.jsat.2012.07.002

Stinchfield, R. D., Niforopulos, L., & Feder, S. H. (1994). Follow-up contact bias in adolescent substance abuse treatment outcome research. *Journal of Studies on Alcohol, 55,* 285-289. doi: 10.15288/jsa.1994.55.285

Storbeck, J., & Clore, G.L. (2008). Affective Arousal as Information: How Affective Arousal Influences Judgments, Learning, and Memory. *Social and personality psychology compass, 2,* 1824-1843. doi: 10.1111/j.1751-9004.2008.00138.

Sung, H., Mahoney, A.M. & Mellow, J. (2011). Substance abuse treatment gap among adult parolees: Prevalence, correlates, and barriers. *Criminal Justice Review, 36,* 40-57. doi: 10.1177/0734016810389808.

Sweeten, G. (2006). Who will graduate? Disruption of high school education by arrest and court involvement. *Justice Quarterly, 23,* 462-480. doi: 10.1080/0741882060098531

Tanner, J., Davies, S., & O'Grady, B. (1999). Whatever happened to yesterday's rebels? Longitudinal effects of youth delinquency on education and employment. *Social Problems, 46,* 250-274. doi: 10.2307/3097255

Tarolla, S. M., Wagner, E. F., Rabinowitz, J., & Tubman, J. G. (2002). Understanding and treating juvenile offenders: A review of current knowledge and future directions. *Aggression and Violent Behavior, 7,* 125-143. doi:10.1016/S1359-1789(00)00041-0

Tetley, A., Jinks, M., Huband, N., & Howells, K. (2011). A systematic review of measures of therapeutic engagement in psychosocial and psychological treatment. *Journal of Clinical Psychology, 67,* 927-941. doi: 10.1002/jclp.20811.

Tracey, T. J., & Kokotovic, A. M. (1989). Factor structure of the Working Alliance Inventory. *Psychological Assessment, 1,* 207-210. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3330646/pdf/173.pdf

Truax, C.B., & Carkhuff, R.R. (1967). *Toward Effective Counselling and Psychotherapy*. Chicago: Aldine.

Trupin, E. W., Turner, A. P., Stewart, D., & Wood, P. (2004). Transition planning and recidivism among mentally ill juvenile offenders. *Behavioural Sciences and the Law, 22,* 599-610. doi: 10.1002/bsl.596

Tulving, E. (1984). Precis of elements of episodic memory. *The Behavioral and Brain Sciences, 7,* 223-268. doi: 10.1017/S0140525X0004440X

Ulin, P., Robinson, E., & Trolley, E. (2005). *Qualitative methods in public health: A field guide for applied research.* San Fransisco, CA: Jossey-Bass.

Van de Mortel, T.F. (2008). Faking it: social desirability response bias in self-report research. *Australian Journal of Advanced Nursing, 25,* 40-48.Retrieved from http://epubs.scu.edu.au/cgi/viewcontent.cgi?article=1001&context=hahs_pubs

Velicer, W. F. (1976). Determining the number of components from the matrix of partial correlations. *Psychometrika, 41,* 321-327. doi: 10.1007/BF02293557

Viera, A.J., & Garrett, J.M. (2005). Understanding interobserver agreement: The kappa statistic. *Family Medicine, 37,* 360-363. Retrieved from: http://www.stfm.org/fmhub/fm2005/May/Anthony360.pdf

Viets, V.L., Walker, D.D. & Miller, W.R. (2010). What is motivation to change? A scientific analysis. In M.McMurran (Eds.), *Motivating offenders to change: A guide to enhancing engagement in therapy (p.15-30).* Chichester, UK: John Wiley.

Walborn, F. S. (1996). *Process variables: four common elements of counselling and psychotherapy.* Pacific Grove, CA: Brooks/Cole.

Ward, T., & Brown, M. (2004). The Good Lives Model and conceptual issues in offender rehabilitation. *Psychology, Crime & Law, 10,* 243-257. doi: 10.1080/10683160410001662744

Ward, T., Day, A., Howells, K., & Birgden, A. (2004). The multifactor offender readiness model. *Aggression and Violent Behavior, 9,* 645-673. doi:10.1016/j.avb.2003.08.001

Ward, T., Mann, R.E., & Gannon, T.A. (2007). The good lives model of offender rehabilitation: Clinical implications. *Aggression and violent behaviour, 12,* 87-107. doi:10.1016/j.avb.2006.03.004

Ward, T., Melser, J., & Yates, P.M. (2007). Reconstructing the Risk-Need-Responsivity model: A theoretical elaboration and evaluation. *Aggression and Violent Behaviour, 12,* 208-228. doi: 10.1016/j.avb.2009.01.007.

Ward, T., Yates, P.M. & Willis, G.M. (2012), The good lives model and the risk need responsivity model. A critical response to Andrews, Bonta and Wormith (2011). *Criminal Justice and Behaviour, 39,* 94-110. doi: 10.1177/0093854811426085

Weisz, J.R., Chu, B.C., & Polo, A.J. (2004). Treatment dissemination and evidence-based practice: Strengthening intervention through clinician-researcher collaboration. *Clinical Psychology: Science and Practice, 11,* 300-307. doi: 10.1093/clipsy.bph085

Werner, E. E. (1989). High-risk children in young adulthood: A longitudinal study from birth to 32 years. *American Journal of Orthopsychiatry, 59,* 72–81. doi: 10.1111/j.1939-0025.1989.tb01636.x

Westbrook, D., Kennerley, H., & Kirk, J. (2011). *An introduction to cognitive behavioural therapy. Skills and applications* (2nd Ed.). London, UK: SAGE Publications Ltd

Wikstrom, P.O., & Treiber, K. (2008). Offender Behaviour Programmes. South Document Youth Justice Board. Retried from http://yjbpublications.justice.gov.uk/Resources/Downloads/Final%20OBP%20source.pdf

Wild, T.C., Cunningham, J.A., & Ryan, R.M. (2006). Social pressure, coercion and client engagement at treatment entry: A self-determination theory and perspective. *Addictive Behaviours, 31,* 1858-1872. doi:10.1016/j.addbeh.2006.01.002

Williams, R. J., & Chang, S. Y. (2000). A comprehensive and comparative review of adolescent substance abuse treatment outcome. *American Psychological Association, 7,* 166. doi: 10.1093/clipsy.7.2.138

Williamson, P., Day, A., Howells, K., Bubner, S., & Jauncey, S. (2003). Assessing offender readiness to change problems with anger. *Psychology, Crime and Law, 9,* 295-307. doi: 10.1080/1068316031000073371

Wilson, R.J., & Yates, P.M. (2009). Effective interventions and the Good Lives Model: Maximising treatment gains for sexual offenders. *Aggression and Violent Behaviour, 14,* 157, 161.doi: 10.1016/j.avb.2009.01.007.

Wormith, J. S., & Olver, M. E. (2002). Offender treatment attrition and its relationship with risk, responsivity, and recidivism. *Criminal Justice and Behavior, 29,* 447-471. doi: 10.1177/0093854802029004006

Appendices

Online Appendix

Table 1.

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

Readiness Factor	Description
Internal Factors:	
Cognitive Factors	**Self-efficacy**: 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.
	Attitudes & Beliefs: 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.
Affective Factors	**Emotional dysregulation**: 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.
	Guilt & Shame: 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.

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 an 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 identify 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 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 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.

Table 2.

Summary of Included Studies (n=13)

Author & Date	Study Design	Treatment Type	Definition of non-completion/ Engagement	Research Question	Sample Size	Main Findings	Quality Assessment score
Breckon et al. (2013)	Qualitative	Psychological Intervention	None stated.	Factors associated with readiness to engage in treatment.	6 male forensic inpatients & 6 professionals	Factors that were identified as contributing to treatment readiness *Internal Factors:* 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	75%

Author & Date	Study Design	Treatment Type	Definition of non-completion/ Engagement	Research Question	Sample Size	Main Findings	Quality Assessment score
						External Factors: 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.	
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%

Author & Date	Study Design	Treatment Type	Definition of non-completion/ Engagement	Research Question	Sample Size	Main Findings	Quality Assessment score
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	*Internal Factors:* Cognitive factors (i.e. negative appraisal of treatment/self-efficacy) were common reasons for non-attendance. Affective and volitional factors were also identified. *External Factors:* 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%
Mann et	Mixed-	Sex Offender	*Treatment*	Factors associated	121 male	Six themes were identified as impacting upon	50%

Author & Date	Study Design	Treatment Type	Definition of non-completion/ Engagement	Research Question	Sample Size	Main Findings	Quality Assessment score
al. (2012)	methods	Treatment	*accepters*: those who had admitted their offence and had accepted a place on the programme. *Treatment refusers:* those who had refused to participate in the programme.	with treatment refusal. Also explored barriers to treatment as perceived by both treatment accepters and refusers.	prisoners *Phase 1 (n =11)* *Phase 2 (n = 101)*	an offender's decision to refuse treatment. *Internal Factors:* 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".	

Author & Date	Study Design	Treatment Type	Definition of non-completion/ Engagement	Research Question	Sample Size	Main Findings	Quality Assessment score
Mason & Adler (2012)	Qualitative	Therapeutic group work	Active participation in treatment and not just 'obedience' and 'attendance'.	Reasons for engagement	11 male service users	Identified 6 themes associated with engagement in therapeutic group work: motivation, content of group work, choice, expected outcomes, external locus of control and relationships. *Internal Factors:* The following hindered engagement: the notion of detention within a high secure hospital results in 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.	75%

Author & Date	Study Design	Treatment Type	Definition of non-completion/ Engagement	Research Question	Sample Size	Main Findings	Quality Assessment score
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: *Internal Factors*: 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%

Author & Date	Study Design	Treatment Type	Definition of non-completion/ Engagement	Research Question	Sample Size	Main Findings	Quality Assessment score
McGrain (2006)	Qualitative	Therapeutic Community (TC)	In reference to treatment engagement the following was stated: "Clients who are engaged in treatment are actively involved in treatment and recovery"	Factors which influence engagement	30 male prisoners	Identified several areas associated with treatment engagement. *Internal Factors:* Negative perceptions of treatment structure/delivery (i.e. the inclusion of small/large groups, 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. *External Factors:* Family/friends were external motivators to engage in treatment. Rapport with staff maintained engagement.	100%

Author & Date	Study Design	Treatment Type	Definition of non-completion/ Engagement	Research Question	Sample Size	Main Findings	Quality Assessment score
						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, prevent recidivism, learn new skills, learn to manage anger, increase confidence/improve self as a person.	25%

Author & Date	Study Design	Treatment Type	Definition of non-completion/ Engagement	Research Question	Sample Size	Main Findings	Quality Assessment score
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	75%

Author & Date	Study Design	Treatment Type	Definition of non-completion/ Engagement	Research Question	Sample Size	Main Findings	Quality Assessment score
						programme; removed due to engaging in offending behaviours; unknown reason.	
Sainsbury et al. (2004)	Qualitative	Not specified	None stated.	Factors which influence engagement in treatment.	6 male forensic inpatients	*Internal Factors:* 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). *External Factors:* 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	75%

Author & Date	Study Design	Treatment Type	Definition of non-completion/ Engagement	Research Question	Sample Size	Main Findings	Quality Assessment score
						therapeutic relationship was found to increase motivation to engage. The sudden loss of this relationship was associated with reductions in engagement.	
Sheldon et al. (2010)	Quantitative	Various psychological therapies.	Non-completion: Referred to any participant who had failed to attend the required number of sessions, either	Rate of non-completion Participant reasons for non-engagement	28 male forensic patients	*Internal Factors:* 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 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	50%

Author & Date	Study Design	Treatment Type	Definition of non-completion/ Engagement	Research Question	Sample Size	Main Findings	Quality Assessment score
			through patient withdrawal or failure to meet attendance requirements. Did not include treatment refusers or those excluded from participation.			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. *External Factors:* 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.	

Author & Date	Study Design	Treatment Type	Definition of non-completion/ Engagement	Research Question	Sample Size	Main Findings	Quality Assessment score
Strauss & Falkin (2000)	Mixed-methods	Drug user treatment	Non-completers included those who quite the programme or received an administrative discharge.	Explored reasons for and against completion of a drug user treatment programme.	101female prisoners (completers=55; non-completers=46)	*Internal Factors:* A desire to be sober, acknowledgment of a 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 *External factor:* Positive relationships with	75%

Author & Date	Study Design	Treatment Type	Definition of non-completion/ Engagement	Research Question	Sample Size	Main Findings	Quality Assessment score
						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.	
Tetley et al. (2012)[a]	Mixed-methods	Psychosocial Therapy	None stated.	Barriers to and facilitators to treatment engagement Validate and Extend the MORM	19 non-forensic community outpatients 41 male and 16 female forensic inpatients	Barriers & Facilitators to treatment engagement as identified by the MORM: *Internal Factors:* Cognitive factors i.e. denying/minimising offending, feeling inappropriately detained, low self-efficacy regarding ability to change/engage in treatment, negative perceptions of	50%

Author & Date	Study Design	Treatment Type	Definition of non-completion/ Engagement	Research Question	Sample Size	Main Findings	Quality Assessment score
				within a forensic and non-forensic PD population.	(Detained) 55 Professionals	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	

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

[a]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.

APPENDIX A: Step by Step process for data treatment

Justification regarding the method of data analysis selected

Selecting an appropriate method of qualitative data analysis is imperative to producing robust research. The qualitative method selected should map directly onto the derived research question, in order to ensure this is appropriately addressed. In reference to the current research, having reviewed a variety of analytic methods, thematic analysis (TA) was deemed appropriate.

Considered to be the most widely used qualitative approach, thematic analysis (TA) aims to identify, analyse and communicate themes across a particular data set (Braun & Clarke, 2006). Reported by Guest et al. (2012) to be "*the most useful in capturing the complexities of meaning within a textual data set*" (p. 11), TA is considered to be a comprehensive yet flexible approach to data analysis (Braun & Clarke, 2006). For example, unlike conversational analysis or interpretive phenomenological analysis (IPA), TA is not tied to a specific theoretical or epistemological standpoint, allowing theoretical freedom (Braun & Clarke, 2006). This subsequently benefitted the current research in which adopted a realist, as opposed to a relativist/constructivist, interpretation of the data set (Braun & Clarke, 2006; 2013). Specifically, realism assumes a "*knowledgeable world*" in which the truth can be discovered and accurately understood via the application of appropriate research techniques (Braun & Clarke, 2013). This is in comparison to relativist/constructivist position which denies a single truth, and instead perceives there to be a number of realities, each of which are socially produced, constructed as a result of human interpretation and knowledge (Braun & Clarke, 2006; 2013).

As a result of the above, TA can also be used to answer a wide variety of research questions (Braun & Clarke, 2013). In reference to the current research, TA was deemed suitable as it allowed the researcher to derive themes regarding reasons for/against engaging in treatment from the data, addressing the primary research question (Braun & Clarke, 2013). According to Braun & Clarke (2006), themes can be identified via one of two approaches in TA, including inductive (bottom-up) or theoretical analysis (top down). Inductive analysis is considered to be data driven, in that the themes derived are not developed as a result of the researchers own knowledge and theoretical interests, but rather the data itself. Whilst it is acknowledged such analysis cannot go entirely uninfluenced by an individuals' interests and epistemological stance, where possible this should be avoided. This approach is in stark contrast to the more analyst driven theoretical method, whereby themes are heavily influenced by the researchers theoretical thinking and interests (Braun & Clarke, 2008). Taking into consideration the above, whilst the current research also aimed to explore the extent to which the MORM could be applied to an adolescent population, it was felt important that the data were analysed independent of this model, via an inductive approach, rather than using the MORM to guide the analysis. It was anticipated that this may cause bias in the analysis and identification of themes (Theoretical TA; Braun & Clarke, 2013).

In accordance with the aims of the research, TA allowed for the exploration of factors which influenced participant's attendance or non-attendance at treatment sessions. According to Braun and Clarke (2013), the most suitable methods for exploring influencing factors are TA and grounded theory. As the intention of this research was to explore whether the reasons identified for/against attending treatment

were applicable to the MORM, rather than constructing a new theory from the data, TA was deemed the more appropriate method (Braun & Clarke, 2013). Furthermore, it is advised when conducting grounded theory that researchers avoid engaging with the relevant literature before conducting the analysis, in order to prevent the analysis from being influenced by existing research. Due to the author's prior knowledge of the MORM, this method was not deemed possible.

TA is also suited to larger data sets, such as that implemented in the current research (Braun & Clarke, 2006; Guest et al., 2012). The inclusion of quantitative analysis is also considered to add analytic breadth to TA (Guest et al., 2012). As a result, TA was considered to compliment the mixed method design adopted in the current research.

Despite the above, TA is not without its limitations and it is important that these are acknowledged. For example it has been argued that TA often fails to account for any continuity and/or contradictions within a single individual account, due to its emphasis on identifying themes across the entire data set (Braun & Clarke, 2013). As a result, particularly when working with large data sets, findings from individual participants are more likely to be overlooked. Furthermore, whilst the methods flexibility is considered by most to be a benefit of TA, due to the lack of specific guidance, specifically with regards to more interpretive analysis, it has also been highlighted as a weakness (Braun & Clarke, 2013). Finally, although not necessary in the current research, unlike discourse or conversational analysis, TA does not allow claims regarding the language used to be made by the researcher(s). These weaknesses were subsequently taken into consideration when conducting the analysis, and accounted for where possible.

Overall, despite the limitations discussed, TA was deemed the most suitable method of analysis for answering the questions posed in the current research. Due to the methods flexibility in terms of its sample size, research question and theoretical framework, it was anticipated that this method would result in comprehensive findings which could subsequently be used to help further the limited field.

Details regarding the analytic process

Transcription. All interviews were transcribed by the author. Orthographic transcription (verbatim) was used in order to ensure a thorough transcription of all verbal utterances (and others sounds) was achieved (Braun & Clarke, 2013). Orthographic transcription focuses on what was said and not how it was said, which is more commonly incorporated within discursive or conversational analysis (Braun & Clarke (2013). In order to ensure all audio files were transcribed consistently, enhancing the overall validity of the data analysis stage, an orthographic notation system and key was used (See Table 1; Guest et al., 2012). In accordance with ethical practice, participant, staff and ward names were removed from the transcripts to ensure the anonymity of others (See Table 1). All audio recordings were transcribed verbatim into a Microsoft Word document and uploaded on to NVivo10, a qualitative data analysis (QAD) computer software package. Sufficient time was allocated to this stage to ensure thorough and high quality transcripts were produced.

Table 1.

Orthographic notation system taken from Braun and Clarke (2013)

Feature	Notation and explanation of use
The identity of the speaker; turn-taking in talk	The interviewees allocated ID number followed by a colon (e.g. 101:) signals it is them that is speaking. The followed represents that the interviewer is speaking - Int: NB. Start a new line every time a new speaker enters the conversation, and start the first word of each new turn of talk with a capital letter.
Names	Replace with [staff member] or [other patient] or [name of ward]
Laughing, coughing etc	((laughs)) and ((coughs)) signals a speaker laughing or coughing during a turn of talk; ((general laughing)) signals multiple speakers laughing at once and should appear on a separate line (signals that no-one owns the laughter)
Pausing	((pause)) signals a significant pause (i.e. a few seconds or more) (.) signals a short pause ((long pause)) signals a very long pause (over 10 seconds)
Spoken abbreviations/vernacular usage	Abbreviations will only be used if said by one of the speakers. Ensure vernacular usage is reported (i.e. 'cos' instead of 'because'
Overlapping	Type ((in overlap)) before the start of overlapping speech.

speech/inaudible speech	Use ((inaudible)) for speech and sounds that are completely inaudible. When unsure but a best guess at what has been said has been made, use a single parenthesis to signal this a best guess i.e. (I like it/slighted)
Non-verbal utterances	'erm', 'er', 'mm', 'mm-hm' – non-verbal utterances must be recorded where possible.
Spoken numbers	Spell out all numbers
Cut off speech and speech-sounds	Type out sounds you can hear followed by a dash (i.e. wa-, wor-)
Emphasis on particular words	<u>Word</u> – underlining a word signals the word has been said with emphasis.
Reported speech	Use inverted commas around reported speech (includes a verbatim account of someone else's speech or someone else's thoughts) – (i.e. and he said 'I think you need to attend this session')

Reading and familiarisation. Braun & Clarke (2006; 2013) advise individuals conducting TA immerse themselves in the data set in order to facilitate later analysis. Whilst this is likely to have been achieved to an extent during transcription, the author read and reread the entire data set before coding, in order to further increase familiarity with the data as a whole. During this stage, initial ideas and impressions were recorded directly onto hard copies of the transcript for two reasons. Firstly, such notes are considered useful when moving onto the next stage of analysis. Secondly, as highlighted by Braun & Clarke (2013), ideas about the data generated at this stage,

whilst useful, are likely to reflect issues of personal significance and thus theoretical interests. This stage subsequently increased the author's awareness of potential bias when interpreting the data in preparation for later analysis.

Coding. Overall, this stage involved coding all aspects of the data which may be relevant to the research question. Braun & Clarke (2013) put forth two methods to coding, including selective and complete coding. In reference to the former, this involves selecting particular instances of the data which are of particular interest to the research questions and coding these only. The latter approach on the other hand involves coding the entire data set. Unlike selective coding, complete coding is not influenced by existing theories or frameworks and instead aims to identify all data relevant to answering the research question (Braun & Clarke, 2013). Complete coding was subsequently used in the current research as, in accordance with the aims of the research, it allowed the author to explore influencing factors on session attendance, independent of existing theory.

In reference to the above, on the whole, data-derived (semantic) codes were utilised as opposed to researcher derived codes. Data-derived codes depict the sematic meaning of the dat,a and are often derived using the participant's language as to avoid inaccurate interpretation (Braun & Clarke, 2013). Researcher derived codes (latent codes) go beyond the semantic content and reflect the implicit meanings within the data, as influenced by the researchers knowledge of conceptual and theoretical frameworks (Braun & Clarke, 2013). Whilst Braun and Clarke (2013) state that neither method is superior, data-derived codes was considered more suitable in the current research in

ensuring the participants voice was accurately heard and interpreted during later stages of analysis.

Each transcript was coding thoroughly using the QAD software package NVivo10, which allowed the author to both code and collate extracts of text which appeared similar in nature, contributing to the later development of themes. This subsequently contributed towards the development of a code book in order to help the author organise codes into themes and subthemes during the latter stages of analysis. As advised by Braun & Clarke (2006) data was coded inclusively (i.e. some text surrounding the extract was included in the code) in order to provide context to the code. Furthermore, all extracts were coded in as many ways as possible in order to ensure inclusivity. Once the entire data set had been coded, each transcript was then revisited in order to ensure all derived codes were applied to the relevant extracts. Each code was then reviewed, and subsequently refined to ensure the title given clearly reflected the data selected. Furthermore, codes which appeared to reflect similar concepts were merged into a single code where necessary, in order to prevent duplication.

Searching for themes. Once all the data had been coded, the author started to provisionally organise the codes into candidate themes, supported by corresponding extracts from the transcripts. Rather than using NVivo during this stage, all codes were exported into a Microsoft Word document and organised accordingly in order to produce a codebook.

Unlike a code which reflects a single idea, a theme is comprised of many ideas (or codes), all of which relate to what is termed a "*central organising concept*" or *theme*

(p.224, Braun & Clarke, 2013). Subsequently themes are considered to reflect broad patterns of responses across a data set. In terms of the current research, each code was first sorted into two overarching themes, reasons for attending treatment or reasons against attending treatment. These codes were then further organised into subsequent themes, subthemes and where necessary subordinate themes, resulting in a hierarchical structure with four layers (overarching themes, themes, subthemes and subordinate themes). In order to ensure all codes were appropriately organised, a temporary "*miscellaneous*" category was created for any codes which did not appear to fit within the candidate themes. Once all codes had been allocated to provisional themes, this category was then reviewed to see if any of the included codes could be more appropriately placed elsewhere.

Reviewing themes. On completion of the above, the author moved onto the next stage of analysis, reviewing themes. Primarily this stage involved reviewing the candidate themes, and how well these reflected both the coded data and the data set as a whole. Braun & Clarke (2006) advise this stage of analysis be split into two levels each of which is described below.

Firstly, extracts supporting each candidate theme were reviewed in order to assess (a) whether each theme encapsulated what it intended and thus, contributed towards answering the research question, (b) whether each theme was independent of others or whether some needed to be combined, and (c) whether some themes needed to be separated further into additional themes/subthemes or (d) discarded (Braun & Clarke, 2006). Secondly, once satisfied each candidate theme was conceptually independent and

contributed towards answering the research question posed, the entire data set was reviewed to ensure the themes fully captured the participants' responses.

Throughout this stage, themes were continuously reviewed and refined until the author had established a sound understanding of the themes developed, and felt confident that they fully encapsulated the contents of the entire data set, addressing the overall research question. Once satisfied the themes contributed towards telling the overall story of the data, a copy of the code book was provided to another Forensic Psychologist in Training for review in order to establish face validity. The aim of this task was to ascertain whether on face value, both the codes, and in turn themes they had been assigned to, made sense to individual's independent from the research. Feedback regarding the wording of codes, themes and subthemes was provided, as were comments regarding the extent to which the codes appeared to fit within the allocated theme. Feedback was discussed and the code book was revised as necessary.

Defining and naming themes. During this stage of analysis, the author provided a detailed description of each theme, in order to ensure a clear understanding of the theme and its wider contribution in answering the research question. Specifically, this stage encouraged the author to ensure that each theme had a clear focus, scope, purpose and was in turn, independent from other themes (Braun & Clarke, 2013). As a result of engaging in this process, some themes/subthemes were collapsed whilst others were separated further, reflecting the ongoing analytic process in which Braun and Clarke (2013) suggest produces comprehensive results. Names of themes were also reviewed in order to ensure they reflected the intended content.

On completion of the above, in order to ensure all aspects of the data set were encapsulated within the themes, inter-rater reliability was established before moving onto analysis.

Writing and finalising analysis. This stage refers to the final write up of the data which can be found within the results section of Chapter 3. It should be noted that when writing up the analysis, the author decided to use an illustrative approach as this was considered beneficial in providing a more descriptive account of the analysis in which closely reflected the overall story of the data.

APPENDIX B: Participant Information sheet

Participant Information Sheet

Danielle Sturgess is a student at the University of Birmingham and is doing a research project as part of her course. Danielle would like to invite you to take part in her research.

Before you decide if you want to join in, it is important to understand why the research is being done and what it will involve for you. Information about the research is provided in this information sheet. If after reading this information you have any questions then please ask a member of staff to contact Danielle on her email address. Danielle will return to the ward in 1 week to see if you would like to take part in the research or not.

What is the research about?

The research is about young people in secure hospitals, like yourself, and your treatment. Your treatment includes any work you do with psychology, occupational therapy, education or any other therapies you have agreed to do in your care plan.

This research looks at the reasons why you decide to go and do your treatment sessions, and the reasons you sometimes might decide not to go to your sessions.

What would I have to do if I took part?

If you decide you would like to take part in this research, then you would need to sign what is called a consent form saying you are happy to take part in the research and that you understand what is being asked of you as a participant. You will also need to fill in a short questionnaire. The questionnaire is called the "Corrections Victoria Treatment Readiness Questionnaire" or CVTRQ for short. It looks at your motivation to take part in treatment. There are 20 questions in total and it should only take 5 to 10 minutes to do.

After you have done this, you will be asked to meet once a week for 2 weeks with Danielle for a short chat about your treatment sessions you had planned for that week. This will take about 20 minutes or so. Danielle will ask you if you went to all your planned sessions, and the reasons you decided to go or decided not to go. If you didn't go to your sessions, you won't get into trouble. Danielle will just ask why you didn't go.

During these interviews Danielle will be recording what you are saying. After the interview, Danielle will listen to the recording and write down what you said. She will then delete the recording so that no one else can listen to it. Only Danielle will listen to the recording. No one else will be allowed to listen to the recording. Danielle needs to record the interview so she can accurately write down what you said.

Danielle will also need to look at the notes staff write about you for 6 weeks. Danielle will be looking at these notes to see what treatment sessions you did

or didn't go to and the reasons why you did or didn't go. Danielle will also need to look at your personal information. There is a list below which tells you exactly what information Danielle would need to look at if you decided to take part in the research. Danielle will only be able to look at this information if you say it is ok. She will not look at this information if you do not want her to.

Danielle would need to see the following:
- Your medical records – this will include looking at information about your age and diagnosis.
- The date you arrived at [*name of hospital*]
- Your offence, if you have one
- Your legal status
- Your electronic notes written by staff on a daily basis
- Your treatment care plans

If you decide to take part in the research, anything you say when you talk to Danielle will be kept confidential, which means that no-one, apart from Danielle, will know that the information you provided was about you. In order to make sure your information is confidential, Danielle will give you a made up number, which will be used instead of your name. So that Danielle knows which number is yours, she will need to keep a list, but this list will be kept very safe and no-one apart from Danielle will be able to see it. Danielle needs this list, so that if you decide at any point that you don't want to take part in the research anymore, Danielle can find all the information you gave and get rid of it for you.

As well as Danielle, [*staff name*], a psychologist at [*name of hospital*], will need to look at the information from your clinical notes and the answers you gave Danielle during the interviews to help Danielle with the research. [*staff name*] will not listen to the recording of the interview but will read a written version of what you said which will not have your name on it so she won't know it is you she is reading about. [*staff name*] will not discuss this information with anyone else.

Although Danielle will do everything to make sure your information is always kept confidential, if you tell Danielle something about you or another person being at risk or in danger, then Danielle will need to tell a member of staff to make sure that you and

everyone else stays safe. If at any point in the research you think Danielle has not kept your information confidential or you would like to make a complaint about the research, then please either speak to Danielle or a member of staff you feel comfortable talking to and we will deal with your problem appropriately.

Do I have to take part?

It is up to you if you would like to take part or not. If you would like to take part, you will be asked to sign a form saying that you agree to take part. A member of staff will need to be there when you sign the consent form to make sure that you are happy to take part. Your responsible clinician will also need to confirm that are able to make an informed decision to

take part in the research. Unfortunately, if your responsible clinician does not think you can make the decision to take part in the research then you will not be able to take part for your own safety.

If you are under 16 years old, then your legal guardian will need to say that they are happy for you to take part. If your legal guardian does not think you should take part, then for your own safety, you will not be able to.

What if I change my mind and decide I don't want to take part anymore?

If you do decide to take part in the research, but then change your mind later on and decide you don't want to do it anymore, then that is ok, you can just stop taking part. You don't even have to give a reason for why you don't want to do it anymore. Nothing will happen to you if you decide you don't want to take part and your care will not be affected in any way.

If you decide not to take part, then any information about you that Danielle has will be destroyed and it won't be used in the research. No-one will be angry if you decide you don't want to do it anymore, so don't worry if you change your mind.

If you decide to stop taking part at any point, either tell Danielle, [*staff name]* or another member of staff you feel comfortable talking to so that they can pass on the message to Danielle, and she will stop arranging to meet with you and make sure all your information is destroyed and not used in the research. It is likely that Danielle, [*staff name*] or another member of staff will ask why you don't want to take part anymore, just to make sure you are ok, but you don't have to say if you do not want to.

What happens after the 6 weeks is over?

If you decide to take part in the research, then after the research has finished, Danielle will come to see you for the last time to talk to you about how you found taking part in the research. At this meeting, you will be able to ask her any questions you have.

Danielle has given staff her email address so if you have any questions after Danielle has left that you forgot to ask, you can ask staff to email Danielle for you and she will get back to you as soon as possible.

Danielle will also ask you if you would like to be sent a short summary of the findings of the research once she has finished all the interviews. If you don't want to that's fine, but if you change your mind you can always ask a member of staff to email Danielle and ask her to send you one.

After this visit, you will no longer need to meet with Danielle, and she will stop looking at your notes. Your care will carry on as usual.

What will Danielle do with my information?

As mentioned, Danielle is doing a research project as part of her course at the University of Birmingham. Danielle will include the information you gave her in her research but your name will not be used, so no-one will know the information is about you. Danielle will mention [*name of hospital*] in her research but again, anything that could be used to identify you, will NOT be included. Danielle might also want to publish her research in the future, which means that other people outside of the University would be able to see it. Again, Danielle will not include any information which could be used to identify you, and therefore people will not know it is you Danielle is talking about.

What are the possible benefits of taking part?

This research is not guaranteed to help you but the information gained from the research might help other young people who are attending treatment in the future.

Who has reviewed the study?

Before any research goes ahead it has to be checked by a Research Ethics Committee. They make sure that the research is fair. This research has been checked by the Black Country Research Ethics Committee.

Thank-you!

Thank you very much for reading this information sheet. If you would like to take part in this research, or have any other questions then please either talk to Danielle or ask a member of staff to contact Danielle directly. If you would like independent advice on your participation then you may want to contact VoiceAbility who will put you in contact with an independent mental health advocate or you could speak to your friends/staff.

Danielle will visit the ward next week to ask if you would like to take part in the research or not.

Many Thanks

Danielle Sturgess

APPENDIX C: Participant Consent Form

(To be printed on official letter headed paper)

Participant Consent Form

Research Title: Treatment Readiness from the Perspective of Adolescents Residing in Forensic Services: Reasons for and Against Engagement.

Research Summary: This research is looking at the sessions you have agreed to do in your care plan and the reasons why sometimes you decide to go to them, and the reasons why sometimes you decide not to go to them. For more information, see your information sheet or ask Danielle.

Please initial the box if you agree:

- I have read and understood the participant information sheet (Version 4, dated 16.01.14). I have also been given the opportunity to ask Danielle questions about the research and my role as a participant.

- I understand that I do not have to take part in the research if I do not want to and that I can change my mind at any time.

- I understand that whatever decision I make (take part or not), it won't change how I am treated by others.

- I agree to be interviewed once a week, for 2 weeks, to talk about my treatment sessions.

- I consent to the interview being audio recorded as long as what I say remains confidential (I understand this means that no one will know it's about me).

- I agree to let the research team read my clinical notes during the time of the research (6 weeks in total)

- I agree to let the research team read the anonymous transcript of what I said during the interview. I understand that this means that no-one will know it is my transcript they are reading.

- I agree to let the research team look at my personal information including my medical records (including my name, age, diagnosis and ethnicity), my admission date, my index offence, my legal status, my treatment timetable and my treatment care plans.

- I agree to let Danielle use my information for her University project as long as my information remains confidential.

- I am aware that Danielle may want to publish her research in the future. I give permission for Danielle to publish the information I tell her as long as it remains confidential.

- I understand that relevant data collected during the study, may be looked at by individuals from [*name of hospital*], from regulatory authorities or from the NHS trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to this data.

- I agree to take part in the above research.

Your Name:………………………………………………………………………Date: ……/……/……

Signature:……………………………………………………………………………………………………….

Witness: I confirm that the participant has been informed about the research, has been provided with an information sheet and has been offered the opportunity to ask any questions regarding the research and their role as a participant. I agree that he/she not in any way been coerced or manipulated into taking part.

Witness Name:…………………………………………………………………Date: ……/……/……

Signature:………………………………………………………………………………………………………

Researcher's Name:……………………………………………………………Date: ……/……/……

Signature:……………………………………………………………………………………………………….

APPENDIX D: Participant Assent Form

Participant Assent Form

Research Title: Treatment Readiness from the Perspective of Adolescents Residing in Forensic Services: Reasons for and Against Engagement.

Research Summary: This research is looking at the sessions you have agreed to do in your care plan and the reasons why sometimes you decide to go to them, and the reasons why sometimes you decide not to go to them. For more information, see your information sheet or ask Danielle.

*Please initial
the box if
you agree:*

- I have read and understood the participant information sheet (Version 4, dated 16.01.14). I have also been given the opportunity to ask Danielle questions about the research and my role as a participant.

- I understand that I do not have to take part in the research if I do not want to and that I can change my mind at any time.

- I understand that whatever decision I make (take part or not), it won't change how I am treated by others.

- I agree to be interviewed once a week, for 2 weeks, to talk about my treatment sessions.

- I consent to the interview being audio recorded as long as what I say remains confidential (I understand this means that no one will know it's about me).

- I agree to let the research team read my clinical notes during the time of the research (6 weeks in total)

- I agree to let the research team read the anonymous transcript of what I said during the interview. I understand that this means that no-one will know it is my transcript they are reading.

- I agree to let the research team look at my personal information including my medical records (including my name, age, diagnosis and ethnicity), my admission date, my index offence, my legal status, my treatment timetable and my treatment care plans.

- I agree to let Danielle use my information for her University project as long as my information remains confidential.

- I am aware that Danielle may want to publish her research in the future. I give permission for Danielle to publish the information I tell her as long as it remains confidential.

- I understand that relevant data collected during the study, may be looked at by individuals from [*name of hospital*], from regulatory authorities or from the NHS trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to this data.

- I agree to take part in the above research.

Your Name:…………………………………………………………………Date: ....../……/……

Signature:……………………………………………………………………………………………

Witness: I confirm that the participant has been informed about the research, has been provided with an information sheet and has been offered the opportunity to ask any questions regarding the research and their role as a participant. I agree that he/she not in any way been coerced or manipulated into taking part.

Witness Name:…………………………………………………………Date: ....../……/……

Signature:…………………………………………………………………………………………

Researcher's Name:……………………………………………………Date: ....../……/……

Signature:………………………………………………………………………………………….

APPENDIX E: Correction Victoria Treatment Readiness Questionnaire (CVTRQ)

(to be printed on official letter headed paper)

Corrections Victoria Treatment Readiness Questionnaire

Instructions: Please read each statement below carefully and then decide whether you agree or disagree with each statement. Circle the number that best represents how you feel. Please circle one and only one number for every statement.

	Strongly disagree	Disagree	Undecided	Agree	Strongly Agree
1. Treatment programmes are rubbish.	1	2	3	4	5
2. I want to change.	1	2	3	4	5
3. Generally I can trust other people.	1	2	3	4	5
4. I am not able to do treatment programmes.	1	2	3	4	5
5. I am to blame for my offences.	1	2	3	4	5
6. Treatment programmes don't work.	1	2	3	4	5
7. When I think about my last offence I feel angry with myself.	1	2	3	4	5
8. Others are to blame for my offences.	1	2	3	4	5
9. I am upset about being a secure unit patient.	1	2	3	4	5
10. Stopping offending is really important to me.	1	2	3	4	5
11. I am well organized.	1	2	3	4	5
12. I feel guilty about my offending.	1	2	3	4	5

13.	I have not offended for some time now.	1	2	3	4	5
14.	I don't deserve to be on a section at [*name of hospital*].	1	2	3	4	5
15.	Being seen as a secure unit patient upsets me.	1	2	3	4	5
16.	When I think about my section at [*name of hospital*] feel angry with other people.	1	2	3	4	5
17.	I regret the offence that led to my section to [*name of hospital*]	1	2	3	4	5
18.	I feel ashamed about my offending.	1	2	3	4	5
19.	I hate being told what to do.	1	2	3	4	5
20.	Treatment programmes are for wimps.	1	2	3	4	5

Completed by: **Date:**   /   /

Clinician: **Date:**   /   /

APPENDIX F – CVTRQ Answer Sheet

| Strongly Disagree | Disagree | Undecided/ Not sure | Agree | Strongly Agree |

APPENDIX G: NRES Ethical Approval

A Research Ethics Committee established by the Health Research Authority

Evidence of insurance or indemnity	University of Birmingham	03 December 2013
GP/Consultant Information Sheets	Staff Letter & Information Sheet	14 October 2013
Interview Schedules/Topic Guides	1	16 October 2013
Investigator CV	Miss Danielle Sturgess	
Investigator CV	Dr Jessica Woodhams	
Letter from Sponsor	University of Birmingham	03 December 2013
Other: St Andres Letter of Research Approval		05 December 2013
Other: MORM Rating Manual	2	06 November 2013
Other: Coding Sheet	1	05 November 2013
Other: Email Correspondence between sponsor and REC		05 December 2013
Other: Parent Letter	2	20 January 2014
Other: Legal Guardian Letter	1	20 January 2014
Other: Staff Letter	3	18 January 2014
Other: Responsible Clinician Capacity Declaration Form	2	16 January 2014
Participant Consent Form: Parent Consent Form	2	20 January 2014
Participant Consent Form: Legal Guardian Consent Form	1	20 January 2014
Participant Consent Form	4	16 January 2014
Participant Consent Form: Assent Form	1	20 January 2014
Participant Information Sheet	4	16 January 2014
Participant Information Sheet: Parent Information Sheet	2	20 January 2014
Participant Information Sheet: Legal Guardian Information Sheet	1	20 January 2014
Participant Information Sheet: Staff Information Sheet	3	18 January 2014
Protocol	4	20 January 2014
Questionnaire: Corrections Victoria Treatment Readiness Questionnaire	Validated	
REC application	3.5	05 December 2013
Response to Request for Further Information	Email outlining response to Provisional Opinion	20 January 2014

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

<u>Reporting requirements</u>

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments

- Adding new sites and investigators

- Notification of serious breaches of the protocol

- Progress and safety reports

APPENDIX H: Responsible Clinician Capacity Declaration Form

(to be printed on official letter headed paper)

Responsible Clinician Capacity Declaration Form

Research: Treatment Readiness from the Perspective of Adolescents Residing in Forensic Services: Reasons For and Against Engaging in Treatment.

To be filled in by the patient's responsible clinician:

Name of Patient:………………………………………………D.O.B: ………………………….

Please initial the box if you agree:

- I confirm that the above patient has capacity to make an informed decision regarding their involvement in the research stated above.

- I agree that the patient is suitable for inclusion in this research.

Please sign below:

Name:………………………………………………………………………………………………..

Relationship to patient: ……………………………………………………………………….

Signature:…………………………………………………………………………………………..

Date: ……/……/……

Researcher's Name:…………………………………………………………………………..

Signature:……………………………………………………………………………………….

Date: ……/……/……

APPENDIX I: Legal Guardian Information Pack & Consent Form

(to be printed on official letter headed paper)

Danielle Sturgess
Centre for Forensic and Criminological Psychology (CFCP)
Frankland Building
School of Psychology
University of Birmingham
Edgbaston
Birmingham
B15 2TT
E-mail: ⬛⬛⬛⬛⬛⬛⬛⬛⬛   Date: [insert date]

Dear [*insert name*]

I (Danielle Sturgess) am a Forensic Psychology Doctorate student at the University of Birmingham and I am currently conducting a research project at [*name of hospital*]. My research is about young people's treatment and the reasons they decide to attend some sessions and the reason why they decide not to attend others. More specifically, I am looking at what makes young people ready to take part in treatment, and whether these are factors relating to the young person themselves, the treatment being offered or a mixture of both.

I have recently attended [*name of the ward*] at [*name of hospital*] to inform the patients there of my research. I am contacting you as [*insert participant name*] has expressed an interest in taking part in the research project, however due to his/her age, [*insert participant name*] requires consent from you as his/her legal guardian to take part. I have enclosed an information sheet outlining the research and what would be required of [*insert participant name*] as a participant if they were to take part in the research. I have also enclosed a copy of the information sheet given to [*insert participant name*] for your information. Additionally, I have enclosed a copy of the assent form [*insert participant name*] will be required to sign should you consent to their participation.

If after reading the information sheet you are happy for [*insert participant name*] to take part in the research, then please could you complete the enclosed Legal Guardian consent form and return to [*name of hospital*] using the enclosed addressed stamped envelope within 7 working days. Please note that your decision regarding [*insert participant name*] participation will in no way affect the standard of care they currently receive.

If after reading the information sheet you still have any questions about the research, or [*insert participant name*] role as a potential participant then please contact me on the above email address. If you do not have access to the internet then please forward your questions onto the [*name of hospital*] (xxxxx xxxxxx), who can then contact Danielle on your behalf. Please ensure you provide the team with a telephone number and a suitable time for Danielle to contact you regarding your questions. I am happy to answer any questions you may have. You may contact me at any point prior to, or during the research regarding your concerns should you have any.

Thank you for taking the time to read this letter.

Yours Sincerely

[*Sign here*]

Danielle Sturgess

Forensic Psychologist in Training

Legal Guardian Information Sheet

Research: Treatment Readiness from the Perspective of Adolescents Residing in Forensic Services: Reasons For and Against Engaging in Treatment

As stated in the enclosed letter, [*insert participant name*] has expressed an interest in taking part in the above research. The patient has received a brief presentation about the research by the main researcher, Danielle Sturgess, and has been provided with a participant information sheet which he/she has either read/or had read to him/her. As stated in the enclosed letter the child cannot take part in the research without your consent.

Before you decide whether you consent to their participation in this research, please read this information sheet. If you have any questions after reading this information sheet please feel free to contract contact Danielle via email). If you do not have access to the internet then please forward your questions onto the [*name of hospital*] , who can then contact Danielle on your behalf. Please ensure you provide the team with a telephone number and a suitable time for Danielle to contact you regarding your questions.

What is the research about?

The research aims to explore the reasons why adolescents residing in secure services either choose to attend or not attend the treatment sessions they have agreed to in their care plan (for example psychology sessions, occupational therapy sessions etc). Such knowledge will allow practitioners to tailor treatment to better meet the needs of the patients and as a result increase attendance rates.

To date, research exploring reasons for and against attending treatment has focused on adults and therefore research regarding adolescents is needed.

Why has the child been asked to take part?

As mentioned above, the research is exploring reasons, for and against attending treatment, amongst adolescent residing in secure services. As a result all patients residing on the adolescent wards of [*name of hospital*], between and including the ages of 13 to 18 years have been invited to take part in this research.

Does the child have to take part?

No. Participation in the research is completely voluntary. Participants who decide they would like to take part will be required to sign an assent form stating that they agree to take part. A copy of the participant assent form has been enclosed for your information. As the child is under the age of 16 years, they also require your consent as their legal guardian to take part. If you decide you do not consent to the child's participation, that

is fine, you do not need to provide a reason for your decision and your decision will not affect the standard of care the child receives.

Should you consent to the child's participation but later change your mind this is fine. Both you and the child have the right to withdraw consent at any time during the research, again without having to provide reason for doing so. If you or the child decides to withdraw consent at any point, then any information the child has contributed to the research will be suitably destroyed and under no circumstances included in the research. Withdrawing consent to take part in the research will not affect the standard of care the child receives in any way.

What will happen to the child if they take part in the research?

If you consent to the child's participation in the research, the child would be required to sign an assent form which states they agree to take part in the research. They will then be asked to complete a short questionnaire called the Corrections Victoria Treatment Readiness Questionnaire (CVTRQ). The CVTRQ is made up of 20 questions and takes around 5 to 10 minutes to complete. The questionnaire looks at an individual's motivation to take part in treatment. If you would like a copy of the questionnaire, please contact Danielle on the email address provided and a copy will be sent to you.

The child will then be required to meet with Danielle once a week for two weeks, at a time suitable for them for a short interview about their treatment sessions that week. Specifically, participants will be asked whether or not they attended their sessions and the reasons why they attended or perhaps did not attend their sessions. They will also be asked about how important they perceive their sessions to be. It is expected that this interview will take around 20 minutes. Interviews will take place in a quiet room on the ward where possible.

It should be noted that these interviews will be audio recorded. All participants will have been made aware of this prior to them providing their consent. The purpose of recording the interviews is to ensure that the participant's responses to the questions are recorded accurately. After each interview, Danielle will transcribe the interview onto an electronic word document on the computer. This document will be made fully anonymous and therefore no one will be able to identify the participant from the word document. The audio recording will then be deleted. No-one other than Danielle will listen to the audio recording.

In addition to the above, Danielle will also need to look at participants clinical notes, as written by staff, once a week for 6 weeks in order to record how many sessions they attended and how many they did not attend. Danielle will also need access to the following information during the research:

- Participant medical records – including information regarding participants age, diagnosis, ethnicity
- Date of admission to [*name of hospital*]
- Details regarding participants offence/offending behaviour if applicable
- Participants legal status/section
- Participants treatment careplans

Under no circumstances will Danielle access this information without both your and the child's consent to do so.

What happens when the research is over?

Once all the data has been collected, the participant will be given a full debrief about the research. During this debrief, the participant will be asked if they would like to receive a summary of the findings once the analysis of data has been completed. Danielle's email address will again be provided in case the participant has any questions in the future. After this debrief, the participant will no longer be required to meet with Danielle and she will no longer access their notes.

If you would like a summary of the findings please contact Danielle and she will ensure you are sent a copy on completion of the research.

What if there is a problem?

It is hoped that neither you nor the child will experience any problems during the course of the research, however, if you or the child does have a complaint about the research, the researcher or any other matter, please inform Danielle Sturgess by addressing your complaint to the email address provided and she will deal with your complaint appropriately and professionally. Alternatively, you should contact [*staff name*], Research Manager at [*name of hospital*], who again will ensure your complaint is dealt with. Contact details for both are provided below:

[*name of hospital*]: xxxxx xxxxxx

[*staff name*]: xxxx@xxxxx.co.uk

Will the child's information be kept confidential?

All data collected during the course of the research will be made anonymous in order to ensure confidentiality. Specifically, participants will be allocated a unique identification number which will be used instead of their name. A list of participant names and corresponding identification numbers will be saved on a [*name of hospital*] password protected computer in order to allow Danielle to identify participant information should you or the child choose to withdraw consent. Only Danielle will have access to this list. Only data which has been made fully anonymous will leave the hospital site.

As mentioned, interviews will be audio recorded. Under no circumstances will the audio files be taken outside of the hospital at any point during the research and no one other than Danielle will have access to the audio files. The audio recording device will be kept in a lockable cupboard at [*name of hospital*] at all times when not in use on site by Danielle. All audio files will be transcribed onto an electronic word document and made anonymous as soon as possible, after which the audio file will be deleted immediately. This document will be password protected and saved onto a password protected computer at [*name of hospital*]. Only the password protected, anonymous transcripts will be transferred off site and on to a University computer.

Dr [*staff name*] will require access to the information collected during the interviews in order to help Danielle analyse the data collected. Please note that [*staff name*] will not have access to the audio files. [*staff name*] will only have access to the anonymous interview transcripts.

It should be noted that all the data collected throughout the research will be stored securely at all times. If at any point the participant feels confidentiality has been breached they will be urged to contact Danielle (as stated in the participant information sheet). If participants do not feel comfortable contacting Danielle regarding this, they will be urged to speak to the psychologist working on the adolescent wards of [*name of hospital*], [*staff name*].

On completion of the research, Danielle will write about her research and the subsequent findings and submit this to the University of Birmingham. It should be noted that whilst Danielle will not include any information which could be used to identify any of the participants included in the research, she will make reference to [*name of hospital*].

Also, Danielle may also seek to publish the findings of this research which would mean that the data will be stored for a minimum of five years (in accordance with the Data Protection Act, 1998). After which it will be suitably destroyed. It should be noted that only anonymous data will be stored for this length of time.

What are the possible disadvantages and risks of taking part?

Although unlikely, it is possible that some participants may find being asked questions about their treatment distressing. At the start of each interview, all participants will be reminded of their right to withdraw from the research at any time, without having to provide a reason for their decision to do so should they not want to. Participants will also be reminded that if they feel distressed at any point in the interview they can have a break from the interview or terminate the interview completely. Participants will be reminded that they don't have to answer any questions they do not want to. After each interview, participants will be asked if they have any questions or concerns they would like to discuss with either the researcher or a familiar member of staff. After each

interview, a handover regarding the participant's level of engagement and presentation will be handed over to all necessary staff in order to enable them to provide the participant with any additional support and ensure they are safe. Participants will be made aware at the start of each interview that a handover of the interview will be provided to staff and that the researcher is obligated to handover any information indicative of risk either to themselves or others.

What are the possible benefits of taking part?

Taking part in the research will provide the participants with the opportunity to reflect on their involvement in treatment and their reasons for engaging/not engaging in treatment. The interviews may provide an opportunity for the participant to disclose any concerns about their treatment and/or themselves in general which they may have previously felt unable to do with a familiar member of staff. If this is the case, necessary action can be taken to address the participant's concerns.

Furthermore, the data collected will be shared directly with the hospital. The findings generated from the research would provide specific guidance for the hospital on what factors, both internal and external to the participant, would improve the patients' perception and experience of the treatment being offered and therefore reduce attrition rates.

Who has reviewed this study?

This research has been reviewed by an independent group of people, called a Research Ethics Committee in order to protect the interests of the child. This research has been given a favourable opinion by NRES Committee West Midlands – The Black Country Research Ethics Committee on the [insert date here].

Thank you!

Thank you for taking the time to read this information sheet. If you still have any questions regarding the research then please contact Danielle directly on the email provided.

If you consent to the child's participation, please could you now complete the enclosed Legal Guardian consent form and return to [*name of hospital*], using the enclosed addressed stamped envelope within 7 working days. Please note, two copies of the Legal Guardian consent form have been included, you should keep one copy for your records. Please also keep the Legal Guardian information sheet, participant information sheet and participant assent form for your own records.

If after reading this information sheet you do not consent to the child's participation in the research then there is no need to return this form.

Legal Guardian Informed Consent Form

Research Title: Treatment Readiness from the Perspective of Adolescents Residing in Forensic Services: Reasons for and Against Engagement.

Please initial if you agree:

- I confirm that I have read and understood the Legal Guardian Information Sheet. I have been provided with contact details for the researcher should I have any concerns or questions regarding [*insert participant name here*] role in the research.

- I consent for [*insert participant name*] to meet with Danielle Sturgess once a week for two weeks to briefly discuss his/her treatment.

- I agree to allow Danielle Sturgess to look at [*insert participant name*] clinical notes throughout the 6 weeks of the research.

- I understand that the research is being done as part of a university project and that Danielle eventually aims to publish her research.

- I understand that all information regarding [*insert participant name*] will be kept confidential.

- I understand that relevant data collected during the study, may be looked at by individuals from [*name of hospital*], from regulatory authorities or from the NHS Trust, where it is relevant to [*insert participant name*] taking part in this research. I give permission for these individuals to have access to this data.

- I consent for [*insert participant name*] to take part in this research.

I agree to all the above and consent for [*insert participant name*] to take part in this research.

Name:……

Relationship with the participant:………………………………………………………………………………..

Signature:………………………………………………………………………………………Date: …..../……/……

Appendix J: Percentage attendance during each stage of data collection.

	Percentage attendance during each stage of data collection (%)		
Participant	Baseline	Interview	Follow up
101	96.43	58.33	90.32
102	76.74	72.73	85.71
103	83.05	54.72	83.33
104	80.39	76.09	76
105	84.31	72.73	77.08
106	90.9	51.22	70
107	88	64	86.27
108	81.03	94.64	96.49
110	75	67.57	75.56
111	69.7	68.75	75.61
113	62.86	78.79	63.16
114	61.82	54.9	26.09
117	74.07	68.89	68.18
118	72.97	65.85	69.57
119	25	34.15	36.17
120	63.46	28.57	23.53
121	41.86	56.1	59.46
122	57.45	38.24	26.32
123	65.45	73.91	38.89

Percentage attendance during each stage of data collection for individual participants.