MOTIVATING OFFENDERS TO CHANGE

A Guide to Enhancing Engagement in Therapy

Edited by

Mary McMurran

School of Psychology, Cardiff University, UK

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MOTIVATING OFFENDERS TO CHANGE

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Library of Congress Cataloging-in-Publication Data

British Library Cataloguing in Publication Data

A catalogue record for this book is available from the British Library

ISBN 0-470-84510-4 (cased)
ISBN 0-471-49755-X (paper)

Typeset in 10/12pt Palatino by TechBooks, New Delhi, India
Printed and bound in Great Britain by Antony Rowe Ltd, Chippenham, Wiltshire
This book is printed on acid-free paper responsibly manufactured from sustainable forestry
in which at least two trees are planted for each one used for paper production.

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SERIES EDITORS' PREFACE

ABOUT THE SERIES

At the time of writing it is clear that we live in a time, certainly in the UK and other parts of Europe, if perhaps less so in other parts of the world, when there is renewed enthusiasm for constructive approaches to working with offenders to prevent crime. What do we mean by this statement and what basis do we have for making it?

First, by "constructive approaches to working with offenders" we mean bringing the use of effective methods and techniques of behaviour change into work with offenders. Indeed, this might pass as a definition of forensic clinical psychology. Thus, our focus is application of theory and research in order to develop practice aimed at bringing about a change in the offender's functioning. The word *constructive* is important and can be set against approaches to behaviour change that seek to operate by destructive means. Such destructive approaches are typically based on the principles of deterrence and punishment, seeking to suppress the offender's actions through fear and intimidation. A constructive approach, on the other hand, seeks to bring about changes in an offender's functioning that will produce, say, enhanced possibilities of employment, greater levels of self-control, better family functioning or increased awareness of the pain of victims.

A constructive approach faces the criticism of being a "soft" response to damage caused by offenders, neither inflicting pain and punishment nor delivering retribution. This point raises a serious question for those involved in working with offenders. Should advocates of constructive approaches oppose retribution as a goal of the criminal justice systems as incompatible with treatment and rehabilitation? Alternatively, should constructive work with offenders take place within a system given to retribution? We believe that this issue merits serious debate.

However, to return to our starting point, history shows that criminal justice systems are littered with many attempts at constructive work with offenders, not all of which have been successful. In raising the spectre of success, the second part of our opening sentence now merits attention: that is, "constructive approaches to working with offenders to *prevent crime*". In order to achieve the goal of preventing crime, interventions must focus on the right targets for behaviour change. In addressing this crucial point, Andrews and Bonta (1994) have formulated the *need principle*:

> Many offenders, especially high-risk offenders, have a variety of needs. They need places to live and work and/or they need to stop taking drugs. Some have poor self-esteem, chronic headaches or cavities in their teeth. These are all "needs". The need principle draws our attention to the distinction between *criminogenic* and *noncriminogenic* needs. Criminogenic needs are a subset of an offender's risk level. They are dynamic attributes of an offender that, when changed, are associated with changes in the probability of recidivism. Noncriminogenic needs are also dynamic and changeable, but these changes are not necessarily associated with the probability of recidivism. (p. 176).

Thus, successful work with offenders can be judged in terms of bringing about change in noncriminogenic need *or* in terms of bringing about change in criminogenic need. While the former is important and, indeed, may be a necessary precursor to offence-focused work, it is changing criminogenic need that, we argue, should be the touchstone of working with offenders.

While, as noted above, the history of work with offenders is not replete with success, the research base developed since the early 1990's, particularly the meta-analyses (e.g. Lösel, 1995), now strongly supports the position that effective work with offenders to prevent further offending is possible. The parameters of such evidence-based practice have become well established and widely disseminated under the banner of *What Works* (McGuire, 1995).

It is important to state that we are not advocating that there is only one approach to preventing crime. Clearly there are many approaches, with different theoretical underpinnings, that can be applied. Nonetheless, a tangible momentum has grown in the wake of the *What Works* movement as academics, practitioners and policy makers seek to capitalize on the possibilities that this research raises for preventing crime. The task now facing many service agencies lies in turing the research into effective practice.

Our aim in developing this Series in Forensic Clinical Psychology is to produce texts that review research and draw on clinical expertise to advance effective work with offenders. We are both committed to the ideal of evidence-based practice and we will encourage contributors to the Series to follow this approach. Thus, the books published in the Series will not be practice manuals or "cook books": they will offer readers authoritative and critical information through which forensic clinical practice can develop. We are both enthusiastic about the contribution to effective practice that this Series can make and look forward to it developing in the years to come.

ABOUT THIS BOOK

In the early 1990s, Don Andrews identified three key aspects of effective offender treatment—risk, needs and responsivity. Since then, the practice of assessment of risk and the identification of criminogenic needs has advanced apace. The notion of responsivity has, however, received considerably less attention from academics and practitioners. The concept of responsivity is a complex one that incorporates, among other things, an understanding of and a response to the strength (or weakness) of an offender's motivation to change. Motivating offenders to consider change, engage

fully in treatment and maintain gains over time is one of the greatest challenges facing the forensic practitioner. Despite this, very little has been written on the topic of motivating offenders to change.

Political support for offender treatment programmes continues to grow, but practitioners and academics must watch that they do not become complacent in the absence of a struggle to promote offender rehabilitation. Work to improve the effectiveness of treatment is a constant endeavour, and it is, perhaps, time to concentrate upon issues of responsivity, including motivation to change. We hope, then, that this book will be a timely prompt to researchers and practitioners in this field.

August 2001 Mary McMurran and Clive Hollin

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PREFACE

Encouraging offenders to stop offending is a major facet of the role of many professionals in forensic mental health and criminal justice settings. (Mental health professionals may say that their business is to treat the patient's mental disorder, and whether or not that patient offends is nothing to do with them, but this is clearly not the opinion of the public, the media, and the judiciary.) Although not all change is inspired by treatment, this is certainly one way to tackle offending. Interventions of the highest calibre may be on offer, but offenders have to be persuaded to sign up for treatment, be reliable in their attendance, engage in the process, and put into practice the skills and strategies that they are taught.

Some offenders may deny the need for change or resist attempts to help them change. Others may admit the need to change and accept offers of help, but fall short when it comes to putting promises into action. There can be few treatment professionals who have not whiled away an hour when the client did not attend for the session. Indeed, defaulting is so common that the abbreviation "DNA" is widely understood in the world of clinical record keeping to stand for "did not attend". Many professionals actually factor DNA time into their schedules, relying on it for the opportunity to read or clear paperwork. There are also many group workers who have started with a sensible number of clients, only to find somewhere down the line that the number of people turning up scarcely permits the use of the word "group". There are certainly professionals who have asked clients to keep diaries, practise skills, or try new ways of doing things, only to be faced at the next session with blank sheets of paper or excuses.

Recruitment, attendance and compliance are all issues that may be investigated in terms of a client's motivation to change. As soon as we start to think more closely about this, it becomes clear that we need to know what motivation to change is all about, how it may be measured and how therapists can enhance it. Do we know what motivation to change is? If we know what motivation is, can we measure it? If so, should we set a level of motivation that warrants acceptance into treatment? Can we increase a person's level of motivation to change? The notion of altering motivation comes with a warning signal; do we have the right to work on changing people's minds about what they do? These questions are the substance of this text.

The contributing authors are all eminent academics and clinicians, but not all in the same field. Matters relating to motivation to change have been the subject of considerable academic and applied research in the treatment of addictions, and so the expertise of addictions specialists was sought. Many addictions concepts and

treatments have been poached and adapted for the understanding and treatment of offenders. The intention here is to continue this useful tradition. Professionals working with offenders, in both mental health services and in prisons, have also been active in working on motivational problems, and here we have the benefit of their wisdom from research and practice.

I am deeply indebted to all authors for their contributions. That so many world-renowned experts have generously made the time to write is gratifying. While editing this book and writing my own chapters, I was employed on a grant from the Department of Health's National Programme for Forensic Mental Health Research and Development, whose support I wish to acknowledge. Thanks also to my host institution—Cardiff University.

As editor, I was in need of a reader to cast a critical eye over my own chapters. I am grateful to Dr Harold Rosenberg of Bowling Green State University, Ohio for tackling this job with all his trademark qualities: intelligence, sensitivity and great good humour.

My hope is that this text will make a difference in practice, helping professionals who work with offenders to develop their treatment programmes. I know for a fact that the book has already succeeded in fulfilling this hope to a degree; it has changed my own thinking and practice. I hope it makes a similar welcome difference to yours.

Mary McMurran

August 2001

Part I

UNDERSTANDING MOTIVATION TO CHANGE

Chapter 1

MOTIVATION TO CHANGE: SELECTION CRITERION OR TREATMENT NEED?

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INTRODUCTION

Crime is a matter of perennial public interest and concern, with vast resources poured into the range of activities that contribute to the administration of justice. One aspect of the criminal justice process is dealing with convicted offenders. Broadly speaking, retribution and rehabilitation approaches co-exist in an uncomfortable alliance, while vying with each other for dominance. In recent times, there has been an unprecedented growth in the popularity of offender treatments, with prison and probation services in many countries promoting the development of offender treatment programmes.

In the UK, for example, the Home Office's Crime Reduction Strategy commits considerable financial resources towards developing evidence-based treatment programmes for use in prisons and probation services, ensuring that these programmes are delivered to high standards and evaluating their impact (Colledge et al., 1999; Home Office, 1999a). These programmes tackle offending behaviour per se, as well as mediators of offending, such as sexual deviance, poor problem-solving skills, antisocial beliefs and attitudes, anger problems and substance misuse. The design, implementation and evaluation of programmes is a multidisciplinary endeavour, involving psychologists, probation officers, prison officers, prison managers and researchers.

Treatment no doubt suits the current political and ideological Zeitgeist, but this recent growth in offender treatment is also in large part attributable to the results of meta-analytic studies, commonly called the "What Works" literature. These studies have provided strong evidence that treatment lowers recidivism by at least 10%, which is a modest degree of change but by no means a negligible one (Lipsey, 1995; Lösel, 1995). Meta-analyses have also taught us that the most effective treatments are structured cognitive-behavioural programmes which address offending

Motivating Offenders to Change: A Guide to Enhancing Engagement in Therapy. Edited by M. McMurran.

or mediators of offending, and the greatest effects are with high-risk offenders (Andrews et al., 1990; Lipsey, 1992). Such programmes work best when they are designed to suit offenders' learning styles, operate to high standards of practice, and are conducted in community settings. As a consequence of this knowledge, structured cognitive-behavioural treatment programmes for offenders now abound, targeting a wide range of offending behaviours and mediators of offending. Not only are these programmes used with prisoners and probationers, but professionals working with mentally disordered offenders are also taking them up (Hughes et al., 1997; McMurran et al., 2001).

Despite the apparent effectiveness of structured cognitive-behavioural programmes, not all offenders can be given the advantage of these treatments. Prison and probation personnel do not have the capacity to provide programmes for all offenders within the criminal justice system, even if programmes are reserved only for high-risk offenders, who respond best according to the findings of the meta-analyses. The limited number of programme places has, therefore, to be filled by a selected subgroup of offenders. One common criterion for selecting offenders for such programmes is on their level of motivation to change.

The Scottish Prison Service's programme accreditation criteria, for example, contain the suggestion that programme effectiveness will be ensured if prisoners with the "appropriate" motivation to change are selected, although there is also acknowledgement of the need to take steps to enhance the motivation to change of those who are ambivalent (Scottish Prison Service, 1998). Similarly, guidelines for accreditation of prison and probation offender treatment programmes in England and Wales specify that the offender should be "adequately" motivated to change in order to benefit from the programme (Home Office, 1999b). The possession of "adequate" motivation is a suggested selection criterion, and at the same time motivational enhancement is recommended as an essential component of the treatment.

These criteria reveal that motivation to change is treated partly as a selection criterion and partly as a treatment need. "Appropriate" or "adequate" motivation to change is required for entry to a programme, but thereafter aspects of programme design and delivery ensure that motivation is nurtured, using methods that encourage motivation to flourish. These criteria leave programme designers to judge what "appropriate" or "adequate" motivation might be: the terms come with no definitions or calibrations. The questions that arise are: what kind of motivation is "appropriate" for treatment entry, and how much motivation is deemed "adequate" for treatment entry?

WHAT KIND OF MOTIVATION?

In relation to psychological treatments, Miller (1985) shrewdly observed that "A client tends to be judged as motivated if he or she accepts the therapist's view of the problem (including the need for help and the diagnosis), is distressed, and complies with treatment prescriptions. A client showing the opposite behaviors—disagreement, refusal to accept diagnosis, lack of distress, and rejection of treatment prescriptions—is likely to be perceived as unmotivated, denying, and resistant" (pp. 87–8). Where offenders are concerned, in order to be deemed motivated to

change, the professional wants to hear the offender admit to the offence, accept full responsibility for the offence, admit that offending is shameful, express a wish to refrain from offending in future, and own up to needing help from a professional person in order to learn how to refrain from offending. If offenders do not fully admit to the offence, they are denying or minimising culpability; if they do not admit that offending is shameful and express a wish to desist, they are at best anti-social and at worst psychopathic; and if they do not own up to needing the help of a professional, they are considered either arrogant or lacking in insight. In short, an offender is deemed motivated to change as long as he or she agrees with the professional's point of view. A different and potentially more useful perspective is to look at motivation to change from the offender's point of view.

Most human behaviours are considered to be motivated, whether those behaviours are energetic and appetitive (e.g. running a race to win), or lethargic and avoidant (e.g. watching television because you are too tired for anything else). There are several theories of motivation, with goal-systems or goal-setting theory being one well-founded approach (Karoly, 1993; Locke, 1996). Motivation for most actions can be construed in terms of rational, goal-directed behaviour, and the notion of goals is important in understanding human motivation (Karoly, 1993; Locke, 1996). Commitment to a goal is influenced by internal motivators such as values, beliefs and intrinsic rewards, and by external contingencies, such as material or social rewards and sanctions. Commitment is also influenced by goal attainability, part of which is environmentally determined, but much of which is attributable to the individual's abilities in planning, self-regulation, problem-solving and self-efficacy beliefs. Any volitional behaviour may be examined within this framework, including motivation to change in therapy (Klinger et al., 1981), and motivation to change offending. Motivation to change offending and motivation to stay the same—that is, to continue offending—are both revealed as positions that represent rational goal choices, based on the individual's characteristics and circumstances.

Motivation to change, defined as commitment to the goal of change, has to be inferred from the person's pre-change behaviours. If one accepts the rational, goal-choice perspective, then the most obvious way to discover what goal the offender intends to pursue is to ask him or her. Does the offender intend to change or not? The problem that now presents itself to the practitioner is how to determine whether an offender's expressed motivation to change is "genuine" or not. Expressed intentions are the most readily accessible indicators of motivation to change, and are hence the most commonly used means of assessment.

Although professionals are taught to ask offenders about their motivation to change, they are simultaneously taught to be sceptical about what offenders say, believing them to agree to whatever will have the best outcome for them. An offender may, for example, express a willingness to enter treatment for offending because to do so is likely to attract a more lenient or a non-custodial sentence, rather than because of a genuine desire to change his or her behaviour. In terms of a rational model of motivation, this is a sensible perspective, and if the situational demands are such that promising to change for the better is likely to have a desirable outcome for the offender, then the expressed intention to change must be treated with caution.

However, such scepticism often cuts only one way. When an offender says he or she is *not* motivated to change, this tends to be all too readily believed. Why should

professionals, who are so suspicious of an admission of willingness to change, accept unquestioningly the veracity of a statement of lack of motivation to change? There may indeed be reason for an offender to fake willing, and this ought to be checked out, but so may there be reason for an offender to deny any need for or desire to change and this should also be examined more closely.

In addition to what the offender says about his or her intention to change, another commonly used indicator of motivation is previous engagement in and successful response to treatment (Berry et al., 1999). If an offender has taken up offers of treatment in the past, complied with instructions, and shown some improvement, then this is taken as evidence of motivation to change. The return of the compliant offender to the professional offering treatment is not seen as a lack of motivation to change, but more as a temporary lapse or setback in a generally laudable change endeavour. Conversely, if an offender has refused offers of treatment, failed to adhere to treatment protocols, or not improved in treatment, this is taken as an indication of lack of motivation to change. Indeed, as Miller (1985) pointed out, therapists seem inclined to interpret such behaviour not as therapist failure, but as an unmotivated client.

An offender may show no eagerness for treatment, be summarily labelled unmotivated to change, and consequently treatment may be withheld. This is an important decision, often with long-term repercussions, since this assessment of motivation to change may well be taken into account in future assessments, or may even preclude future assessment. It is crucial, then, to consider that perceived motivational failures may, in fact, be failures of the professional, who, in terms of a rational, goal-directed behaviour framework, fails to understand the individual in terms of his or her other life-goals (Karoly, 1993). Looking at some possible alternative interpretations of an offender's denial of culpability, minimisation of harm, unwillingness to stop offending and refusal of help illustrates that there may be rational explanations for apparent lack of motivation to change. Some examples are presented in Table 1.1.

In respect of failure to engage in or respond to treatment, here too there are possible alternative explanations, other than lack of motivation to change. A person who did not attend therapy may have been unable to surmount practical obstacles, or unable to organise his or her chaotic lifestyle sufficiently to attend sessions. There is a logical inconsistency in expecting people with problems to accept help, and

Table 1.1 Alternative interpretations of apparent lack of motivation

"Unmotivated" statement or behaviour	Alternative interpretations
"I didn't do it."	"I'm too ashamed to admit it." "I can't face what will happen next if I admit it."
"It wasn't such a bad thing to do."	"It's the only way I know how to get rewards." "If I admit it was bad, that makes me a bad person."
"I don't want to stop."	"I can't imagine life without this pleasure." "I'd have to change my whole way of life."
"I don't need help."	"I'm scared of what you will ask me to do." "I'll fail and make matters worse."

also expecting them to be capable of overcoming the very problems that besiege them in the first place in order to access that help. If they do not manage to solve this conundrum, they are seen as lacking in motivation to change. A good example of this is in alcohol treatment. A person who has difficulty controlling his or her drinking is deemed to need help. Therapy is offered, but a rule is set that the person should abstain from alcohol in order to access the treatment. If this rule is not adhered to, the offer of therapy is withdrawn. The client's failure to desist from drinking is evidence of a lack of motivation to change his or her drinking problem! Other reasons for failure to comply with therapies are that people may not understand or agree with the goals or methods of treatment, and furthermore, treatment can be a negative experience, apparently aimed at taking away the client's joys in life without constructively building in new sources of rewards.

In short, offenders are mostly rational people, and will therefore sometimes be reluctant to own up to their offending and resistant to admitting the need to change, for a variety of reasons: the desire to keep on with a rewarding behaviour, the desire to avoid feeling ashamed, the fear of embarrassment at being unable to change, and an inability to see how to lead a different life. They may not attend therapy because they experience therapy as aversive, confusing or incomprehensible, or because the very problems for which they have been referred make attendance difficult.

Motivation to change may be understood in the same terms. Offenders want to change for a variety of reasons: they may want to avoid the sanctions and disapproval consequent upon being caught offending, because they feel guilty or ashamed about their behaviour, or because they have acquired or recognised good reasons for leading a different kind of life. They may attend therapy because they agree with the treatment goals, understand the treatment process and because it is convenient to do so. Motivation to change, and lack of it, are rational responses to circumstances. Motivation to change is not a trait that one is born with, to a fixed degree.

These motivational factors may be classified as either: (1) internal—for example, the achievement of a valued goal, or the avoidance of or escape from aversive emotions such as guilt and shame—or (2) external—for example, gaining social acceptance and the avoidance of sanctions and disapproval. It is generally assumed that motivation driven by internal factors is a more reliable predictor of change than motivation that is driven by external factors, and there may be some truth in this, particularly in respect of long-term maintenance of change (Wild et al., 1998). It is also true that goal-directed behaviour is influenced variously by many interacting factors relating to the nature and value of the goal to the individual, the "topography" of the goal (e.g. specificity or ambiguity; ease or difficulty; attainability or otherwise), the cognitive and behavioural skills of the individual in relation to achieving the goal, and the person's perceptions of his or her performance and efficacy (Karoly, 1993; Locke, 1996). In any individual, the number of motivational variables that may be present in various degrees is incalculable, and the effects on motivation to change of treatments targeting any or all of these factors is a question that can only be answered by further research.

In answer to the original question, "What kind of motivation is 'appropriate' for treatment entry?", it might seem that the motivational ideal is for the person to be internally motivated to change, have made a robust decision to change, and have a belief in his or her ability to change. In respect of this ideal, to what degree would a

professional expect the offender to be in this state of grace at the first interview? This leads to the second question posed earlier: "How much motivation is 'adequate' for treatment entry?".

HOW MUCH MOTIVATION?

The view that the client must be robustly motivated to change to benefit from treatment is called into question by evidence that compulsory treatment can work. Regarding drug-abuse treatment, Farabee and colleagues (1998) reviewed eleven treatment outcome studies and found that criminal justice referrals did as well as, or better than, voluntary participants in nine of these studies. Similarly, Chick (1998) reviewed mandatory treatments for offenders with alcohol problems, and found that criminal justice referrals had fewer convictions after treatment than did voluntary referrals. Compulsory clients are generally more likely to complete treatment, with completion being a predictor of successful outcome.

Some people believe that those mandated to treatment by the criminal justice system do not have "genuine" motivation to change and hence will do worse than those with autonomous motivation to change (Wild et al., 1998). This view ignores the evidence that many people enter treatment because of external pressure, and even apparent volunteers are there because of ultimatums from family, friends or employers (Polcin & Weisner, 1999). There are, perhaps, fewer differences between volunteers and those mandated to treatment than most people assume. A legal mandate may be an important external motivator for a client to enter treatment and, once there, internal motivation may be enhanced as part of the treatment programme. That is, sanctions and a mandate for treatment may present the opportunity for "softer" approaches to encouraging a client to change his or her goals, such as persuasion, encouragement, enlightenment, empowerment and treatment. Better research is needed, however, to determine whether those who change in mandated treatment intended to change anyway, regardless of the treatment mandate, or if treatment programmes successfully enhance motivation to change in the previously unmotivated—in other words, change a person's goal choice (Farabee et al., 1998).

The issue of compulsory treatment, regardless of intention to change, is likely to become an increasingly important issue in England and Wales, as in other jurisdictions (e.g. LaFond, 2001). Currently, personality disordered offenders can only be compulsorily detained in hospital under mental health legislation if they are considered treatable, with the offender's motivation to change being one key aspect of the determination of treatability or otherwise (Berry et al., 1999; Blackburn, 1993). This is almost certain to change in the near future with a proposed revision of the law to permit the detention, regardless of treatability, of people with severe personality disorder who are deemed dangerous (Department of Health/Home Office, 2000).

Whether in compulsory or voluntary treatment, it seems that the most reliable way to influence behaviour change is through an empathic, empowering approach. In his review of why people change addictive behaviour, Miller (1998) summarised the characteristics of therapists who have most success in changing