

5-2015

# Factors Influencing Treatment Completion of Involuntary Groups

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## Recommended Citation

Kalogo, Charles, "Factors Influencing Treatment Completion of Involuntary Groups" (2015). *Master of Social Work Clinical Research Papers*. Paper 464.  
[http://sophia.stkate.edu/msw\\_papers/464](http://sophia.stkate.edu/msw_papers/464)

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## Factors Influencing Treatment Completion of Involuntary Groups

By

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MSW Clinical Research Paper

Presented to the Faculty of the  
School of Social Work  
St. Catherine University and the University of St. Thomas  
St. Paul, Minnesota  
in Partial fulfillment of the Requirements for the Degree of

Master of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/ University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

### **Abstract**

This qualitative study explores factors that influence treatment completion of involuntary clients. Eight professionals who have substantial experience facilitating groups with domestic abuse, substance abuse, DWI, and general offender rehabilitation programs were recruited for participation. Through semi structured interviews, professionals reflected on the factors they believed contributed to attrition and interventions they implemented to improve retention. Thematic content analysis informed by grounded theory generated several themes associated with treatment completion. Motivation, readiness, stage of change, mental health and chemical dependency were individual factors believed to influence completion. While, housing, employment, transportation, child-care, program cost, program time, program length, closed, and open group formats were noteworthy environmental factors. Engagement and facilitator bias were discussed in terms of the impact on retention. Implications for social work practice suggest the need for pre-group orientation, knowledge of Trans theoretical stages of change, and Motivational Interviewing skills to effectively work with treatment resistant clients.

*Keywords:* treatment completion, retention, attrition, involuntary groups, involuntary clients, mandated clients, domestic abuse, substance abuse.

### Acknowledgements

It is with deep gratitude and sincere appreciation that I thank those whose contributions have made this research project possible.

To Michael G. Chovanec, Ph.D., LICSW, LMFT, my research committee chair, thank you for your ongoing support, guidance, and patience throughout the research process. Your encouragement has helped tremendously from the beginning to the end of this project.

Anna Pederson, MSW, LICSW, Deric Jackson, MSW, LGSW, & James Reilly, MSW, research committee members, thank you for the time you dedicated to attending committee meetings, valuable feedback, and patience throughout the research process.

Roxanne Sanderson, MSW, LICSW, Leon Evans, Tenbit Etafa, MA, and Anna Hewitt, MA, GCMFT, LPCC thank you for the opportunity for experiential learning, support, feedback, and guidance you provided during my field education.

Travis Rooks, B.A. thank you for your support, encouragement and flexibility enabling me to maintain a work/ school/ life balance.

Tim Eiesland, MSW, LICSW, thank you for your encouragement, reassurance, and support throughout my field education.

To the professionals who agreed to participate in this study, thank you for sharing your knowledge, experiences, and making important contributions to the social work knowledge base.

To the faculty at the School of Social Work who I've had the privilege of learning from, Karen T. Carlson, M.S.E, MSSW, Ph.D., LICSW, Teresa M. George, MSW, LICSW, Lisa Kiesel, MSW, Ph.D, LICSW, Lisa Richardson, MSS, LICSW, David Roseborough, MSW, Ph.D, LICSW, ACT, Eva Solomonson, MSW, LICSW Carol, Ashwood, MSW, LGSW, Renee Hepperlen, MSW, LICSW, Carol Schreier, MSW, LICSW, David McGraw-Schuchman, MSW, LICSW, Mary Tinucci, MSW, LICSW and staff Lisa Dalsin, Kelly Fox & Melissa Anderson.

To my family Mom, Dad, Joan & Peace, thank you for your ongoing love, faithfulness, and support.

Proscovia Ojambo, Paul, Peter, Allen, Pauline, Herbert & Liz Sulungaine, Shalom, Israel and Magdeline thank you for your support.

Among others, the classmates, coworkers & friends whom I've had the privilege of knowing.

Thank you.

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### **Introduction**

Social work practice oftentimes requires group work with involuntary clients. Involuntary clients have been defined in social work literature as individuals who feel compelled to receive social services by legal mandate, due to involvement in the juvenile or criminal justice systems (Brodsky, 2011; Rooney & Chovanec, 2006). The term involuntary client may be used more broadly to include individuals who feel pressured to attend otherwise voluntary groups, such as, individuals who are encouraged to complete parenting skills programs, by a child protective service agency, in order to maintain custody of their children (Rooney & Chovanec, 2006). Further involuntary clients may include individuals who feel pressured to attend groups by spouses who threaten to leave, employers threatening dismissal, or parents threatening to disown them (Prochaska, DiClemente, and NorCross, 1992). Group work with involuntary clients may be developed in response to substance abuse, domestic violence, or anger management, and can be conducted in a variety of practice settings including, social service agencies, community mental health centers, probation agencies, and correctional facilities.

Attrition or the discontinuation of treatment has been identified as one of the significant challenges limiting effectiveness of substance abuse and domestic abuse programs (Jewell & Wormith, 2010). More notably, attrition of involuntary clients poses the greatest challenge to successful outcomes, particularly reconviction, as there is accruing evidence that non-completion correlates with recidivism (Hanson & Bussiere, 1998) as cited in (McMurrin & Theodosi, 2007). The former observation has been made in studies indicating that characteristics of treatment non-completers are the same characteristics associated with risk of reoffending (McMurrin & Theodosi, 2007). Also of concern is the observation that treatment non-completion may in fact be detrimental to involuntary clients. For example, in a meta-analysis of

cognitive behavioral treatment outcome studies, McMurrin & Theodosi (2007) discovered that treatment non-completers had higher recidivism rates compared to untreated controls, suggesting that failure to complete treatment is associated with increased risk of reoffending.

Attrition has been reported to occur at three different points in time, post-referral--after the initial referral and prior to the assessment, post-assessment occurring prior to treatment initiation, and in program or premature discontinuation (Jewell & Wormith, 2010). Attrition has been well documented, primarily in the substance abuse, and domestic abuse literature. Additionally, previous studies have identified three distinct categories of treatment non-completion including, administratively based exits (i.e. release or transfer), agency initiated expulsions (removal due to disruptive behavior or rule breaking), and client initiated (withdrawing without staff approval) (Wormith & Olver, 2002). Most individuals who are court ordered to receive substance abuse, and or domestic abuse treatment typically attend publicly funded programming. Therefore, treatment non-completion would further waste services. Generally, domestic violence treatment programs experience high attrition rates with 22 % to 78 % of program participants not completing treatment (Jewell & Wormith, 2010). Meta-analyses of batterer intervention programs have reported modest effect sizes due to 50% of program participants failing to complete treatment regardless of court order (Bennet, Stoops, Call, and Flet, 2007). Respectively, the rate of completion and engagement of individuals participating in substance abuse treatment has been low (Jacobson, 2004). For instance Evans, Li & Hser (2008) noted while 70% of offenders who attended chemical dependency treatment under California's Proposition 36 Drug Rehabilitation Programs, only 36% successfully completed.

Evaluation studies have shown a strong link between treatment duration and post-treatment outcome (Houser, Salvatore, & Welsh, 2012). For example, a one year follow-up study

of adults participating in the DATOS (Drug Abuse Treatment Outcome Study) program, found that those who remained in treatment for 3 months or more experienced a reduction in cocaine use (Hubbard, Creddock, Flynn, Anderson, & Etheridge) as cited in (Houser et al., 2012).

The high rate of attrition in outpatient substance abuse and domestic abuse treatment has motivated researchers to explore demographic, individual, and contextual variables that predict treatment completion. Contextual factors such as program characteristics including, closed or open group formats, group size, cohesion, length, and location of treatment facility have been identified in the literature as having a significant impact on attrition (Schroeder, Bowen, and Twemlow, 1982; Jacobson, 2004). In addition to Risk Need Responsivity assessment tools, identification of demographic, individual, and contextual factors that predict treatment completion, and improve retention of involuntary clients, may provide correctional personnel, and community providers with necessary information on individuals who might benefit most from treatment, and those for whom treatment would be ineffective (Kinlock, Gordon, Schwartz, O'Grady, 2013). As a result providing an ample opportunity to tailor treatment programs to respond directly to the needs of involuntary clients.

Social workers frequently provide services to involuntary clients, in individual and group settings. Social workers practicing with involuntary clients in groups often hold dual roles by, ensuring clients adhere to court ordered conditions, and supporting individual growth (Garvin, Gutierrez, & Galinsky, 2004). Mutual aid and solidarity are important values of social group work that help facilitate change with involuntary clients. Therefore, social workers have an ethical responsibility to assist members develop and maintain mutually supportive relationships (Garvin, Gutierrez, & Galinsky, 2004). Through case planning, social workers can identify factors placing involuntary clients at risk of attrition, thereby maintaining their commitment to

human dignity, community, the common good, and ensuring all individuals are provided access to adequate services (St Catherine University & University of St Thomas School of Social Work, 2006).

The purpose of this study is to contribute to the social work knowledge base by, further exploring the demographic, individual, and contextual factors that influence treatment completion of involuntary groups. The principle research question aims to explore

1. What factors improve retention or contribute to attrition of involuntary clients in offender rehabilitation treatment programs?

To this end, the present study will explore the demographic, individual, and contextual factors associated with attrition of involuntary clients in offender rehabilitation treatment, through qualitative interviews with professionals, who have experience facilitating substance abuse, domestic abuse, and general cognitive skills offender rehabilitation groups.

### **Review of Literature**

The focus of this literature review is to examine contemporary attributions of demographic, individual, and contextual factors contributing to attrition of involuntary clients in offender rehabilitation treatment. First, a definition of the problem will be presented including, the effect on program participants, impact on society, and implications for practice. Secondly, an attempt will be made to compare findings across studies in substance abuse and domestic abuse treatment. Final emphasis will be made on contextual factors that influence attrition of involuntary clients in groups.

### **The Problem of Attrition**

There are several occasions that involve social work practice with involuntary clients in groups. Toseland & Rivas (2012) define involuntary clients as individuals who feel pressured or are required to complete group programming in lieu of legal sanctions such as, the loss of a drivers license, a jail sentence or other conditions of probation. The premature discontinuation of treatment by involuntary and legally mandated clients has been an enduring concern of mental health service providers, public health, community corrections, and public safety officials. There are numerous reasons why individuals may fail to complete treatment. Studies have identified three categories of treatment non-completion, *client initiated* whereby the individual requests to leave a program on their own accord, *agency initiated* in which programs prevent individuals perceived as untreatable from beginning, or completing programming, and *administrative exits* that result from systemic factors such as release from a correctional facility or transfer to another supervising agency (Polaschek, 2010). Nevertheless, involuntary clients who prematurely drop out of offender rehabilitation programs may not receive the full benefits of treatment, placing them at increased risk of reoffending (Olver et al., 2011). For example, studies have shown that

men completing batterer intervention programming are less than 50 % likely to experience re-arrest for domestic abuse than those who fail to complete programming (Bennet, Stoops, Call, and Flet, 2007). Further, with limited resources, attrition may increase the overall program costs per offender, as a result, wait listing those who might otherwise benefit from programming (Polaschek, 2010). The literature suggests that attrition rates of offender rehabilitation programs vary considerably with some studies quoting non-completion rates between 10% and 90 % (Olver et al., 2011). Attrition rates of offender rehabilitation programming in England and Wales have been estimated between 25% and 80%, Whereas, the attrition rate of individuals on parole in the United States has been estimated to be 40% Hollin et al. (2002); Wormith & Olver, (2002) as cited in (Hatcher, McGuire, Bilby, Palmer, & Hollin, 2012). To date several studies have examined client demographic, individual, and psychological variables believed to predict treatment completion of involuntary clients in offender rehabilitation programs (Carney & Buttell, 2004). Despite the availability of research documenting the efficacy of legally mandated treatment, few studies have described client and program characteristics associated with retention (Clark et al., 2014). Moreover, there is a limitation of research describing ways to effectively improve retention in substance abuse and community aftercare programs (Lash, 1998) as cited in (Houser et al., 2012). Retention is characterized by length of time and individual spends in treatment, and is recognized as a reliable indicator of post-treatment outcome (Houser, Salvatore, & Welsh, 2012).

### **Demographic, Individual and Contextual Variables**

A recent study by Clark et al. (2014) sampled 615 individuals on community supervision to identify variables predicting their success in outpatient substance abuse treatment. The researchers predicted that treatment completers would be characterized by having a lower level

of care, an absence of cocaine or heroin use, economic stability, and absence of mental illness (Clark et al., 2014). Participants were required to complete an average of 91 days of treatment in a 12-step group format. Treatment was tailored to meet the needs of program participants including referrals to psychiatric services, transportation and onsite childcare (Clark et al., 2014). Of the 615 participants, 117 (19%) successfully completed treatment whereas 471 (77%) were not successful. 27 (4%) participants had missing data and were not included in the study (Clark et al., 2014). Clark et al. (2014) discovered that successful treatment completion was associated with the following demographic and individual variables. An individual's age, race, post-secondary education, referrals from the lowest level of care, meeting criteria for anxiety disorder, having suicidal ideation, and no history of opioid use (Clark et al., 2014). More notably, this study provided evidence of the linkage between economic stability and successful treatment outcome. Half of the participants in the study were unemployed (Clark et al., 2014). Nevertheless, the researchers cautioned overgeneralization of the results given that the sample consisted of individuals on community supervision, whose crimes are less severe compared to individuals in custody (Clark et al., 2014).

Similar variables have been identified in studies exploring factors associated with attrition in domestic abuse programs. For example, in a meta-analysis Jewell & Wormith (2010) analyzed 30 studies that focused on in-program attrition, in order to identify demographic, violence-related and intrapersonal variables related to treatment attrition. Jewell & Wormith (2010) found that individuals who were employed, were older, and court ordered to attend treatment were more likely to complete than those who were unemployed, younger, and referred from a source other than the court system (Jewell & Wormith, 2010). Notably, it was determined that theoretical orientation moderated the association between age and treatment completion,

evidenced by older individuals being more likely to complete cognitive behavioral programming than younger participants (Jewell & Wormith, 2010). In addition, individuals who were educated and court ordered to attend batterer intervention were more likely to complete feminist psycho educational programs than those who were less educated or referred from a source apart from the court system (Jewell & Wormith, 2010). In response to these findings, researchers recommended practitioners target programming consistent with the principles of Risk Need Responsivity (Andrews et al., 1990) to match the needs of program participants based on age, race, employment, education, and socioeconomic status (Jewell & Wormith, 2010). The Risk Need Responsivity principle is an influential model of offender rehabilitation originally developed by Andrews, Bonta & Hoge in 1990. The three core principles of risk need responsivity suggest that level of service should be matched to individuals based on risk of reoffending (*Risk principle*) (Andrews & Bonta, 2007). Secondly, assessment of criminogenic needs is salient, in order to target treatment accordingly (*Need principle*) (Andrews & Bonta, 2007). Lastly, the provision of treatment should be tailored in response to the individual's motivation, learning style, abilities and strengths (*Responsivity principle*) (Andrews & Bonta, 2007). Given that the meta-analysis by Jewell & Wormith (2010) examined studies that included various definitions of attrition, program length and theoretical orientations, the researchers acknowledged limitations regarding the generalizability of the results.

While the majority of substance abuse programs claim to maintain adherence to gender-neutral treatment models. Male based treatment models assumed to equally benefit female participants are limited and may be a factor influencing treatment completion (Kandall, 1996; Murphy & Rosenbaum, 1987; Reed, 1987; Nelson-Zlipko, Dore, Kauffman, & Kaltenbach, 1996) as cited in Kelly, Blacksin, & Mason, 2001). Consequently, there has been a limitation of

research examining the characteristics of women who successfully complete treatment in comparison to those who do not (Kelly et al., 2001). In an exploratory study conducted at Cook County Hospital, Kelly et al. (2001) compared two groups of women participating in a federally funded prenatal care program known as New Start. Participants were randomized into one of two conditions, prenatal care in Cook County Hospital with subsequent referral to a community based substance abuse treatment, and prenatal care, substance abuse treatment, and case management through New Start (Kelly et al., 2001). Criteria for completion included a yearlong commitment to regularly attend program activities, the absence of relapse throughout the year, and identification of a personal development plan (Kelly et al., 2001). In addition to treatment records, researchers analyzed participant's raw scores from the following standardized instruments, the Addiction Severity Index (ASI), the Maternal Social Support Index (MSSI), and the Sarason Social Support Questionnaire (SSSQ) (Kelly et al., 2001). Together, the analysis helped researchers understand how participants differed, in terms of demographic and social position, relationships, social support, drug use patterns and violence.

Several factors were associated with treatment completion. Participant's education level, job skills, and employment history were important factors, consistent with, studies of male participants exploring factors that influence treatment completion. In addition, limited housing assistance from family members, fewer children, presence of an individual actively supportive of treatment, limited involvement with Child Protective Services (CPS), and the absence of chaotic life situations were associated with treatment completion (Kelly et al., 2001). 80% of treatment completers finished high school in comparison to 32% of non-completers. These findings were comparable to employment statistics indicating that 40% of completers had never been employed compared to 68% of non-completers (Kelly et al., 2001). Therefore, it was suggested that the life

skills and follow through needed to complete high school, and maintain a job provided women with self-efficacy needed to successfully complete treatment (Kelly et al., 2001). In addition to having fewer children, treatment completers had fewer children under age six, 20 % of completers compared to 53% of non-completers. It is believed that pressures involved in caring for young children, particularly, dressing, cleaning, and feeding young children present significant challenges to completion not experienced by mothers of adolescent children (Kelly et al., 2001). It was therefore recommended program development consider on-site childcare as a way to improve retention. The availability of social support, although important, was found to be relatively low for treatment completers and non-completers (Kelly et al., 2001). Unanticipated by the researchers guiding questions, there was an inverse relationship between involvement with CPS and treatment completion, suggesting that participants may have used drugs to cope with loss of children (Kelly et al., 2001). In contrast to the study by Clark et al. (2014), the presence of mental illness was a chaotic factor associated with treatment non-completion (Kelly et al., 2001). Additional chaotic factors included homelessness, and recent incidents of domestic violence (Kelly et al., 2001). Although informative, there are several limitations to the current study including, a small sample size, and the researchers inability to accurately assess the degree of social support, due to the complexity of this variable. In other words, social support may have been confounded by assistance with housing and childcare from family members who were actively using drugs (Kelly et al., 2001).

Bearing similarity to the research design by Clark et al. (2014), Zanis et al. (2009) examined client characteristics that predicted treatment completion in a sample of 380 parolees mandated to complete a comprehensive 12-month substance abuse treatment program in lieu of incarceration. Treatment consisted of four phases that utilized an eclectic approach including,

cognitive behavioral, motivational interviewing, and 12-step facilitation (Zanis et al., 2009). In *Phase one*, participants completed 90 day inpatient programming at a state licensed facility, with the opportunity to participate in five therapeutic groups per week, daily seminars, and individual counseling (Zanis et al., 2009). *Phase 2* consisted of an intensive 90 day outpatient program located in close proximity to program participant's home residence. During *Phase 2*, individuals had the opportunity to participate in four therapeutic groups, and one individual therapy session each week (Zanis et al., 2009). In *Phase 3*, program participants enrolled in a 90 day outpatient program with opportunities to complete two therapeutic drug, and alcohol groups, and one individual therapy session each week. During this phase participants were permitted to obtain employment in the community (Zanis et al., 2009). Similar to *Phases 2* and *3*, in *Phase 4*, participants completed a 90 day outpatient program including, one individual, and one group therapy session per week with an emphasis on community reintegration (Zanis et al., 2009). Treatment completion was dichotomized by grouping program participants into two categories, treatment completers were identified as individuals who completed all four phases, and treatment non-completers were those who did not complete the four phases (Zanis et al., 2009).

Data analysis indicated that of the 380 individuals who participated in the study, 123 (32.4%) successfully completed all four phases (Zanis et al., 2009). Independent variables were selected from a baseline Addiction Severity Index (ASI) which participants completed during intake of the residential component of treatment (Zanis et al., 2009). Utilizing chi square and independent t tests, Zanis et al. (2009) identified five variables independently correlating with treatment completion. Treatment non-completers were individuals who reported significant lifelong problems with their mothers, significant problems with intimate partners, had experienced a recent lengthy incarceration, used heroin in the past 30 days, and were younger in

age (Zanis et al., 2009). To further examine the relationship between the predictor independent variables and the completion dependent variable, Zanis et al. (2009) conducted a multiple regression analysis while controlling for race, education, and marital status. Results indicated that individuals who were older and non-heroin users were more likely to complete treatment (Zanis et al., 2009). It is believed that issues pertaining to community reintegration may explain the relapse of participants who had experienced lengthier prior incarceration (Zanis et al., 2009). Still then, Zanis et al. (2009) identified methodological limitations of the study, one being the absence of post treatment follow up and variability in parole services. For example, parole officers used their discretion to determine whether participant's positive drug screens warranted a parole revocation (Zanis et al., 2009). This may have provided some participants with the opportunity to complete treatment while denying others.

While outcomes from previous studies exploring demographic, and individual variables related to treatment completion have reported high attrition rates. Some studies have documented increased retention of program participants. For example, in a secondary analysis of data from 67 prerelease inmates participating in a prison and community based methadone maintenance treatment program, Kinlock et al. (2013) examined patient and program factors related to retention and successful completion. In this study, program participants were randomly assigned to one of the following treatment conditions, counseling only, counseling and transfer, and counseling and community based Methadone Maintenance Treatment MMT (Kinlock et al., 2013). Participants were assessed at baseline, and at 1, 3, 6, and 12 months following their release. Kinlock et al. (2013) reported a high retention rate, noting that 50 of the 67 participants (74.6%) successfully completed the prison-based component of MMT. Of the 17 participants that discontinued treatment, 15 reported reasons for non-completion varying from questioning the

efficacy of the program, and reporting medication side effects, to institutional rule infractions (Kinlock et al., 2013). Notably, results from the community-based treatment indicated that completion was attributable to participants' previous employment history. For example, those more likely to complete treatment, had reported gainful employment three years prior to their index incarceration (Kinlock et al., 2013). Furthermore, in comparison to treatment non-completers, participants who successfully completed the community-based MMT, had spent more days gainfully employed throughout the 12 month post release period (Kinlock et al., 2013). Despite, the relationship between participant's employment history and treatment completion, employment prior to program entry was not significantly associated with number of days spent in treatment. However, it was determined that the frequency of urine drug screens administered during the community-based treatment was the only variable significantly related to treatment retention (Kinlock et al., 2013). The findings in this study highlighted individual patient and program factors related to prison and community based methadone maintenance treatment completion. Two variables, employment history and frequency of urine drug screens were significantly related to treatment completion and retention. Nevertheless, the results cannot be generalized to other populations due to a relatively small and homogenous sample size.

Despite variability in completion rates reported in offender rehabilitation literature, recurring themes present in most studies have considered the association between participant's education level and employment status relative to treatment completion. In a study examining factors associated with attrition in a correctional sample of 93 offenders, at a specialized treatment facility within the Correctional Service of Canada, Wormith & Olver, (2002) collected descriptive, program participation, and recidivism data on individuals referred to complete a 6 month Aggressive Behavioral Control (ABC) program. The results indicated that thirty five

participants (37.6%) of the initial sample did not successfully complete the program. In other words, more than 1 out of every 3 participants failed to complete ABC treatment (Wormith & Olver, 2002). In light of these results, it was discovered that treatment completers were more likely to have maintained regular and full-time employment in the community prior to their incarceration than non-completers. 80% of treatment completers were employed in the community prior to confinement compared to 57% of non-completers. Additionally, treatment completers reported on average higher levels of academic achievement than non-completers (Wormith & Olver, 2002). Furthermore, results indicated that treatment non-completers were more likely to have a higher security level, and to be of Aboriginal ancestry (Wormith & Olver, 2002). Implications from this study suggest the need for culturally responsive and flexible programming that accommodates program participant's education level, and supports employment readiness skills. The researchers acknowledged difficulty in evaluating the samples completion rate relative to that identified in the correctional literature, due to variability in completion rates across groups of offenders. For example, a high completion rate might be the result of contingencies, specifically early release unique to individuals within a correctional environment (Wormith & Olver, 2002).

Findings from the previous studies suggest that demographic and individual variables such as, an individual's age, employment status, education level, substance use, and relationship status distinguish treatment completers from non-completers. Further providing support for the use of Risk Need Responsivity, principles targeting treatment at involuntary clients most at risk of attrition. However, some studies have reported findings suggesting that few demographic and psychological variables differentiate treatment completers from non-completers (Carney, Buttell, & Muldoon, 2006). For example, Carney, Buttell, & Muldoon, (2006) conducted a secondary

analysis of data from a non-profit, Alternatives to Violence program in South Carolina. The sample consisted of 114 men participating in a cognitive behavioral batterer intervention, which included 56 completers and 58 non-completers (Carney, Buttell, & Muldoon, 2006). Participants were required to complete 16 week group programming that emphasized anger management and skill development. The researchers utilized a logistic regression analysis and determined that, despite results identifying non completers as, more likely to be dating than in marital relationships, and more likely to use minor and severe sexual coercion tactics 12 months prior to beginning treatment; there were no significant differences in demographic and psychological variables between treatment completers and dropouts (Carney, Buttell, & Muldoon, 2006).

In a quasi-experimental design comparing two groups of offenders, analyzing the effect of offender behavior programs on reconviction, Hatcher et al. (2012), matched an experimental group of 173 male offenders, required to attend a general offending behavior program, on a one-to-one basis with a comparison group using selected criminogenic factors. The researchers utilized two analyses to compare the results. An intention to treat (ITT) or treatment allocated design was used to compare a group of treatment completers and dropouts. In addition, a treatment received analysis (TR) was used to compare naturally occurring groups of those who completed treatment and those who did not within the experimental group (Hatcher et al., 2012). The treatment received methodology was intentionally chosen to identify systemic differences between the groups that might be used to increase compliance in offender rehabilitation programming (Hatcher et al., 2012). Utilizing the (ITT) analysis, the results indicated that the comparison group had lower reconviction rates than the experimental group (Hatcher et al., 2012). These findings call into question the effectiveness of offender behavior program under study. Conversely, results from the (TR) analysis suggested that program completers were less

likely than non-completers and those that did not start programming to be reconvicted (Hatcher et al., 2012). A limitation of this study was the failure to account for variables associated with group membership or contextual factors that might otherwise explain the difference between reconviction rates of program completers, non-completers and non-starters.

Other studies have explored the problem of attrition in offender rehabilitation programs utilizing principles of risk, need and responsivity (Andrews & Bonta, 2006; 2010). For example, Olver, Stockdale, & Wormith, (2011) conducted a meta-analysis including 114 studies that examined predictors of offender treatment attrition in relation to recidivism. Data analysis involved the coding of program variables including treatment format (i.e. group or individual), service delivery model (i.e. inpatient or outpatient treatment), setting (hospital, prison, or community), and treatment modality (i.e. Cognitive Behavioral, or Duluth model) (Olver, Stockdale, & Wormith, 2011). Of the 114 studies analyzed, 43 originated from domestic abuse literature, 40 were sex offender specific, 21 assessed correctional programs for offenders, and 10 described programming that included violent nonsexual offenders (Olver, Stockdale, & Wormith, 2011). The results identified an attrition rate of 27.1% across all 96 programs with an increase to 35.8 % when considering pre-program non-completers.

Notably, domestic violence programming experienced the highest attrition rates at 37.8%, and increased by 10% (50.8%) when considering pre-program non-completers (Olver, Stockdale, & Wormith, 2011). This trend was evident in the analysis of attrition rates between treatment modalities. Most programs were Cognitive Behavioral based, an intervention that yielded the lowest attrition rates. Yet, domestic violence offender programming continued to show higher attrition rates than the other offender groups (Olver, Stockdale, & Wormith, 2011). On the contrary, attrition was lowest in institutional programming. For example, prison-based treatment

programs yielded the lowest attrition rates (19.9%) across treatment settings (Olver, Stockdale, & Wormith, 2011). This trend was attributed to the greater incentives perceived for completing institutional programming such as conditional release, compared to those of offenders on community supervision (Olver, Stockdale, & Wormith, 2011). While acknowledging the disadvantages of creating an attrition profile, the researchers identified common predictors of non-completion across all programs. Treatment non completers were noted to be young, single, male, low SES, of ethnic minority background, lacked formal education, and had a history of prior offenses (Olver, Stockdale, & Wormith, 2011). Nonetheless, the researchers suggested that these findings demonstrate the need for responsivity interventions that explore systemic, programmatic and therapeutic factors influencing the retention of involuntary clients in offender rehabilitation programming (Olver, Stockdale, & Wormith, 2011).

### **Motivation & readiness to engage in treatment**

An important factor associated with treatment retention of involuntary clients is motivation and readiness to engage in treatment (McMurrin, 2009). Regardless of treatment approach, involuntary clients need to attend sessions, actively participate by disclosing thoughts and emotions, refrain from problem behavior, explore new behavior, and accept rules imposed by the courts, the program, and correctional administrators (McMurrin, 2009). To this end, the individual's effort to successfully complete treatment requires motivation that is dependent on their problem recognition, perception of legal pressure, outcome expectancy and distress (Drieschner & Verschuur, 2010). Motivational Interviewing is a promising intervention commonly used by community corrections to facilitate behavior change that can increase engagement and subsequently improve treatment outcome (McMurrin, 2009; Drieschner & Verschuur, 2010). Several studies have examined the predictive power of treatment engagement

in relation to premature termination and treatment outcome with correctional samples (Drieschner & Verschuur, 2010).

In a study conducted with a Dutch correctional outpatient sample, N=138, Drieschner & Verschuur (2010) administered the Treatment Engagement Scale (TER) to investigate the relationship between involuntary clients engagement during treatment with premature termination, and treatment outcome, identified as risk of reoffending. In this study participants received treatment in lieu of prosecution and imprisonment. Participants completed 12 to 24 months of Cognitive Behavioral treatment with emphasis on prevention of reoffending (Drieschner & Verschuur, 2010). Treatment comprised of individual and group sessions, non-verbal and partner therapy, social work, and assertive community interventions (Drieschner & Verschuur, 2010). Inclusion criteria limited participation to clients who completed the first 15 weeks of treatment (Drieschner & Verschuur, 2010). Administration of the Treatment Engagement Scale (TER) was completed by therapists and assessed the following eight components of engagement, session attendance, clients willingness to make sacrifices, openness, effort to change problem behavior, goal directedness, effort to improve socio-economic situation, constructive use of therapy sessions, and global rating of treatment engagement (Drieschner & Verschuur, 2010; McMurrin & Ward, 2010). The independent variable, treatment engagement, was defined as client behavior that is desirable and essential for treatment to be effective and measured using the 21 item Treatment Engagement Scale (Drieschner & Verschuur, 2010). There were two dependent variables, treatment completion and non-completion. These variables were coded by the following criteria, dropout, whereby treatment is prematurely terminated by the client without the therapists consent, expulsion, which consisted of termination of treatment by the therapist due to a rule violation, termination in agreement but against advise, occurring

when the therapist accepted the client's decision to end treatment but encouraged its continuation, and full treatment completion, a mutual decision to terminate treatment in accordance with therapists recommendations (Drieschner & Verschuur, 2010). An additional dependent variable, treatment outcome, was operationalized by a reduction in criminogenic needs identified in discharge letters. Altogether, four levels of treatment outcome included, almost no change, unsatisfactory change, satisfactory change, and highly successful (Drieschner & Verschuur, 2010). Data analysis comprised of Spearman correlations to compute the relationship between treatment engagement, premature termination, and treatment outcome. Further, a logistic regression analysis using treatment termination as a dichotomous dependent variable with several predictor variables was conducted, to determine whether risk factors such as, younger age, substance use, and antisocial personality predicted premature termination (Drieschner & Verschuur, 2010). Results indicated that there was a statistically significant correlation between the Treatment Engagement Rating score with treatment termination and outcome (Drieschner & Verschuur, 2010). More notably, the component score, effort to change problem behavior was the strongest predictor of outcome, suggesting that the effectiveness of correctional treatment is to some degree dependent on the effort clients make towards behavior change (Drieschner & Verschuur, 2010). Equally important is the finding that the (TER) predicted treatment expulsion more precisely than dropout. The researchers noted that the link between expulsion and lack of engagement might suggest that the former is a consequence of the latter (Drieschner & Verschuur, 2010). Despite the evidence of the strong correlation between treatment engagement, premature termination and treatment outcome, the researchers identified several limitations of the study. The study does not indicate a causal relationship between

treatment engagement and outcome, likely due to confounding variables such as social networks and job situations not assessed by the researchers (Drieschner & Verschuur, 2010).

Similar contributions exploring treatment readiness, engagement, and assessment have been made in the field of offender rehabilitation in addition to the study by Drieschner & Verschuur (2010). For example, McMurrin & Ward (2010) suggest that research and practice be driven by four main objectives, (1) the development of theoretically and empirically based models of engagement that reinforce assessments, (2) the construction of psychometrically robust assessments of readiness, motivation, and engagement, used to select involuntary clients for treatment and to measure change over time, (3) the development, implementation, and evaluation of pre-treatment preparation procedures used to promote engagement and completion, and (4) the development of strategies to address barriers to engagement (McMurrin & Ward, 2010). In the development of theoretically empirical based models of engagement, the researchers identified strengths of the Multifactor Offender Readiness Model (MORM) developed by Ward et al., (2004). MORM is a multifaceted tool in that it incorporates individual and contextual factors that relate to treatment readiness (McMurrin & Ward, 2010). Individual factors included in the MORM assess cognitive beliefs, strategies and self-efficacy, affective emotions, volitional goals, behavioral skills/competencies, personal and social identity of the client (McMurrin & Ward, 2010). The assumption is that involuntary clients who are ready to begin treatment possess certain psychological features necessary to function in therapeutic environments and benefit from interventions (McMurrin & Ward, 2010). Additionally, the MORM addresses contextual factors such as voluntary or mandated status, treatment location (i.e. prison or community based), program availability, availability of trained and qualified therapists, cultural appropriateness, interpersonal support from individuals who have a genuine

interest in the clients success, and program characteristics such as timing, and program type (McMurrin & Ward, 2010). Accordingly, McMurrin & Ward (2010) suggest individual and contextual factors assessed by the Multifactor Offender Readiness Model, collectively increase the likelihood of involuntary clients engaging and successively benefitting from treatment.

In addition to the MORM, there are several assessments used to measure treatment readiness, motivation and engagement of involuntary clients. One such tool, is the treatment readiness questionnaire by Casey et al. (2007), a self-rated instrument that measures engagement using four scales examining client's attitudes and motivation, emotional reactions, efficacy and offending beliefs (McMurrin & Ward, 2010) Other notable assessments used to assess the motivational structure of involuntary clients include the Personal Concerns Inventory (PCI) (Sellen et al., 2009) and the Treatment Engagement Rating (TER) scale implemented in the Dutch study by Drieschner & Verschuur (2010) (McMurrin & Ward, 2010). Despite increased attention in the assessment of treatment readiness, motivation and engagement regarding involuntary clients. Recently developed psychometric measures have yet to be validated with involuntary clients in a variety of contexts (i.e. institutional, or community based settings) and in different countries (McMurrin & Ward, 2010)

Pre-treatment interventions are another method that can be implemented to augment assessment of involuntary clients prior to initiating treatment. Motivational Interviewing is one such intervention commonly used in correctional settings however, results suggest that it is more effective with substance misusing clients than with domestic violence offenders (McMurrin & Ward, 2010). The development of Motivational Interviewing by Miller, and Rollnick (1991, 2002) was originally intended to assist substance abusers increase motivation to change problematic behavior. Unsurprisingly, most studies exploring the effectiveness of Motivational

Interviewing with involuntary clients pertain to substance use. Nevertheless, the implementation of MI as an evidence-based treatment in the criminal justice system has credibility on the basis of similarities between substance abuse and general offending behavior—both behaviors are valued for short-term rewards, in spite of long-term adverse consequences (McMurrin, 2009).

In a systematic review McMurrin (2009) evaluated 19 applications of Motivational Interviewing with offenders, to determine the impact of Motivational Interviewing (MI) and Motivational Enhancement Therapy (MET) for enhancing engagement and retention in treatment, and motivation for behavior change. The researcher reviewed 13 published studies and 6 dissertations evaluating MI with a diverse sample including, substance abusers, domestic violence perpetrators and individuals convicted of driving while intoxicated (McMurrin, 2009). Inclusion of empirical studies were limited to the following criteria, (1) correlational studies indicating a relationship between intervention and outcome, (2) pre and post-test measures excluding control groups, (3) pre and post-test measures including a target population and comparable control group, (4) a controlled trial with pre and post-test measures of the target population with a comparable control group as in (3) while accounting for confounding variables, and (5) a randomized controlled trial with participants randomly allocated to intervention or control groups (McMurrin, 2009).

In brief, McMurrin (2009) found no conclusive evidence of the effectiveness of MI with offenders due to variability between the target populations (substance abusers, domestic violence, and DWI offenders), and variation in treatment focus (session attendance, engagement, readiness to change, and repeated incidents of driving while intoxicated) (McMurrin, 2009). Nonetheless, McMurrin (2009) suggests that such studies offer some direction for future research and practice. Particularly, with regards to the improvement of treatment retention and

engagement, in community programs, responding to increased recidivism rates of non-completers as opposed to that of untreated offenders (McMurrin, 2009). Grounded in self-determination theory, Motivational Interviewing has the potential to assist clients along the continuum from extrinsic motivation to intrinsic motivation to change behavior (McMurrin, 2009). Secondly, to increase effectiveness, McMurrin (2009) recommends practitioners maintain the integrity of MI through interventions that address offender's motivation for treatment, effect on behavior change or both.

### **Contextual Factors**

Lack of attention to contextual variables is a limitation of the previous studies. The majority of research has discussed factors associated with treatment completion by comparing completers and non-completers based on demographic, individual, and psychological variables. Few studies have identified contextual factors that when presented successively with individual client attributes support or inhibit treatment completion. The shortage of studies emphasizing external factors associated with substance abuse treatment completion has been attributed to the lack of an organized conceptual framework from which to formulate hypotheses (Jacobson, 2004). In a noteworthy report of potential causal mechanisms, Jacobson (2004) argued that contextual factors, such as a client's neighborhood context, the geographic location of treatment, and the interaction between these two systems can influence the decision to voluntarily or involuntarily discontinue treatment. Jacobson (2004) defined transactions that occur within the client's geographic context, during the course of treatment as *treatment ecology*. Comparable to Urie Brofenbrenner's ecological systems framework, (Forte, 2007) *treatment ecology* is concerned primarily with the physical, social, and psychological relationships dependent on one's locale. Specifically, the interrelationships between the client and their home residence,

their neighborhood, the geographic location of the treatment facility, and the effect these interactions have on treatment progress and outcome (Jacobson, 2004). Four key factors associated with treatment retention are identified as: the availability of drugs, neighborhood disadvantage, availability of community resources, and restorative qualities of the neighborhood (Jacobson, 2004).

According to Jacobson (2004) the most apparent variable associated with treatment completion is the visibility of drug markets, dealing, and active users. These audio and visual stimuli serve as environmental cues placing individuals at risk of relapse, and have an inverse relationship with treatment completion (Simpson, Joe, Rowan-Szal et al., 1997) as cited in (Jacobson, 2004). Additionally, market visibility and police drug control tactics predict involuntary attrition, by increasing the likelihood of re-arrest for treatment clients residing in neighborhoods with higher crime rates (Jacobson, 2004).

In considering the impact of neighborhood disadvantage Jacobson (2004) emphasizes the association between geographically concentrated poverty and treatment completion. For example, residents in disadvantaged communities experience stressful conditions such as unemployment, increased mortality, violence, trauma, and social stigmatization due to group membership (Jacobson, 2004). Residents experiencing such psychological stressors are more apt to abuse substances as a coping mechanism to alleviate stress and escape reality (Jacobson, 2004). In addition, psychological stress may cause individuals from disadvantaged neighborhoods to experience lower levels of self-efficacy, reducing expectations of successful completion, thus affecting motivation and readiness to change (Jacobson, 2004). More notably, the absence of local employment opportunities in disadvantaged neighborhoods reduces retention, underscoring the relationship between economic stability and attrition (Jacobson,

2004). In other words, clients who lose jobs while in treatment, or are unable to obtain employment, experience life instability, a common factor associated with treatment non-completion (Rooney & Hanson, 2001) as cited in (Jacobson, 2004). While the importance of social support has been established in the literature, Jacobson (2004) argued that family and friends in disadvantaged neighborhoods are unable to provide supportive networks due to experiencing comparable levels of stress. Tolerance for drug use and the lack of sanctions are two additional aspects of neighborhood disadvantage Jacobson (2004) identified that may encourage discussion of macro level interventions addressing unintended consequences of social policies.

The availability of supportive groups within close proximity to treatment centers has been reported in literature to be correlated with increased enrollment and improved outcome. Therefore, access to self-help and support groups such as NA (Narcotics Anonymous) and AA (Alcoholics Anonymous) may substantially reduce risk of dropout (Jacobson, 2004). Additionally, the shortage of social and economic institutions in disadvantaged neighborhoods increases time cost accessing these resources (Jacobson, 2004). Consequently, the opportunity cost responding to daily hassles diverts time and energy that can be devoted to treatment (Jacobson, 2004).

While discussing the relationship between the client's home residence and the treatment location, Jacobson (2004) described the potential effects of travel burden and the opportunity cost of attendance. Jacobson (2004) defines travel burden not only in terms of the distance between the home residence and treatment location but the accessibility of transit infrastructure connecting the two sites. Observing variability in service utilization as a function of travel

burden, Jacobson (2004) identified studies that found a positive relationship between transportation assistance provided by treatment programs and increased service utilization.

A relative strength of the present study is the development of a framework for classifying treatment ecology's effect on retention including, a methodology for operationalizing contextual factors, such as accessibility and proximity measures (Jacobson, 2004). On the other hand, a limitation of the framework is its inability to account for variability regarding definitions of attrition. For example, Jacobson (2004) suggests travel burden and opportunity cost exert great influence on a client's decision to voluntarily discontinue treatment, yet no mention is made of program characteristics such as, administrative decisions to discharge clients considered untreatable.

### **Summary**

The previous review of literature suggests that there are several reasons why involuntary clients may be unable to successfully complete treatment; many of which are a function of demographic, individual, and contextual factors. With regards to individual factors, the studies under review suggest that treatment non-completers generally are younger, less educated, have more convictions, and experience more community instability (McMurrin & Theodosi, 2007). Additional studies explored the relationship between involuntary client's readiness for treatment, engagement, and motivation indicating a correlation between treatment engagement and treatment non-completion. Also included were studies examining contextual factors impacting involuntary client's efforts to complete treatment. Factors such as neighborhood disadvantage, availability of community resources, and restorative qualities of neighborhoods underscore the person-in-environment interaction. Nonetheless, the inconsistency in attrition rates of substance abuse and domestic abuse treatment emphasize the need for further exploration of demographic,

individual, and contextual factors influencing treatment completion of involuntary clients. The aim of this study is to identify factors that improve retention or hinder progress of involuntary groups, and interventions being implemented to reduce attrition.

### Conceptual Framework

The majority of research concerning treatment completion of involuntary clients has examined demographic, individual, and psychological variables associated with criminogenic risk and needs (i.e. dynamic risk factors highly correlated with criminal conduct, such as antisocial/ pro-criminal attitudes, and associates, education, employment, and substance use (Van der Knaap, Alberda, Oosterveld, & Born, 2011; Hatcher et al., 2012; Polaschek, 2010; Carney, Buttell, & Muldoon, 2006; Carney & Buttell, 2003, 2004) Conversely, other studies have emphasized dynamic contextual factors such as, program characteristics, group composition, dynamics, geographic accessibility of programming, neighborhood disadvantage, and client-therapist alliance (Jacobson, 2004).

Consistent with Jacobson's (2004) concept of *treatment ecology*, this study will apply the ecological systems model as the primary conceptual framework from which to explore the relationship between contextual factors related to attrition of involuntary groups. The concept of *treatment ecology* refers to the relationship between the clients' neighborhood, and a treatment programs geographic location (Jacobson, 2004). It is fitting to utilize an ecological perspective to examine contextual factors that may present barriers to completion, or support retention of involuntary groups.

With application to social work, the ecological theoretical framework enables practitioners to evaluate the consequences of transactions between individuals and their physical and social environments (Forte, 2007). Urie Brofenbrenner a developmental psychologist, and proponent of the ecological theoretical framework conceptualized the *transactions* between individuals and the environment through various system levels including the immediate or *micro system* setting, *mesosystem*, and *macro system* (Forte, 2007).

The immediate setting or *microsystem* includes the physical home, school, and neighborhood environment where individuals participate in activities essential for optimal development (Forte, 2007). At the micro level social workers may utilize bio-psycho-social-spiritual assessments informed by the person-in-environment perspective to identify micro environmental factors such as drug availability, and neighborhood disadvantage (Jacobson, 2004) that present barriers to retention of involuntary clients in offender rehabilitation programming. As a result, social workers in case management roles can refer involuntary clients to complete offender rehabilitation programming in settings with few negative environmental cues.

The *mesosystem* analyzes the relationship between two or more microsystems (i.e. home, school, community center) in order to effectively address conflictual or complementary transactions between the systems (Forte, 2007). At the mesosystem, social workers can assess the linkages between the involuntary client's residential context, and the geographic location of the offender rehabilitation programming. Jacobson (2004) suggested that literature has shown a link between the proximity of treatment facilities, and accessibility of public transportation in improving treatment utilization. Therefore, social workers can provide incentives for involuntary clients to complete offender rehabilitation programming by advocating for transportation assistance to improve access to treatment.

Brofenbrenner defined *macrosystems* as cultural, and ideological, values, laws, and customs that influence individuals in their social environment (Forte, 2007). At the macro level, social workers may advocate for policies that improve community resources and employment opportunities for individuals involved in the juvenile and criminal justice system. As a result, this may contribute to the retention of involuntary clients in offender rehabilitation programming.

One of the limitations of the ecological theoretical framework is that it involves a high level of abstraction, and as a result may not offer specific practice guidelines for working with at risk populations at the micro level (Forte, 2007). The ecological theoretical framework may not adequately explore the linkage between motivation to complete offender rehabilitation programming whereas specific interventions such as the Trans-theoretical stages of change model may be more fitting. As a result, strict adherence to the ecological theoretical framework may avert social workers from exploring alternative interpretations of client problems (Forte, 2007). Another limitation involves time constraints. The ecological theoretical framework requires social workers to collect large volumes of data necessary to assess person-in-environment transactions at the micro, meso, and macro system levels (Forte, 2007). With increased caseloads and limited budgets, social workers may not have the time or available resources to complete comprehensive assessments including micro, meso and macro system variables affecting client functioning (Forte, 2007).

One of the key strengths of the ecological theoretical framework is its emphasis on contextual variables affecting client functioning, which is consistent with the social work value base. More notably, the ecological theoretical perspectives emphasis on the reciprocal relationship between an individual and environmental institutions may prevent practitioners from applying exclusively individualistic or collectivist theoretical frameworks (Forte, 2007) providing a balanced perspective from which to effect change. In the present study, the researcher utilized the ecological framework to develop a qualitative questionnaire that to identify factors involuntary client's experience that present challenges, or contribute to success in offender rehabilitative groups.

**Trans theoretical stages of change model**

The Trans theoretical stage of change (Prochaska, DiClement, & Norcross 1992), is an essential model for conceptualizing modification of addictive and problematic behaviors, and is applicable to social work practice with involuntary clients. The Trans theoretical stage of change model, at its core, proposes that self-initiated and treatment facilitated change progresses through five stages, pre-contemplation, contemplation, preparation, action, and maintenance with individuals cycling through stages several times before sustaining behavior change (Prochaska et al., 1992). Notably, it has been established that individuals stage of change scores are the second most predictive indicators of treatment outcome, even more than age, socioeconomic status, problem severity, duration, outcome expectancy, self-efficacy, and social support (Prochaska et al., 1992).

The initial stage, pre-contemplation is characterized by limited desire to change problematic behavior (Prochaska et al., 1992). During pre-contemplation clients seldom perceive the addictive or problematic behavior as an issue of concern. In other words, as quoted by G. K. Chesterson, *it isn't that they can't see the solution it is that they can't see the problem* (Prochaska et al., 1992). However, family members, friends, employees, and the courts initially notice effects of the problematic behavior. It is through pressure from these social supports and systems that clients usually end up seeking treatment.

Contemplation is the next successive stage of change characterized by clients increased insight of addictive and problematic behavior, although, they have not yet made a commitment to change. A hallmark of contemplation is serious consideration of problem resolution through weighing the pros and cons of problematic behavior, however, contemplators grapple with

positive evaluations of addictive/ problematic behavior and the amount of effort needed to change (Prochaska et al., 1992).

Preparation is the stage directly following contemplation in which clients are intent on taking action to change addictive/ problematic behavior within a month. Individuals contemplating change may have previously unsuccessfully attempted to take action, and often report some behavioral changes such as reduction in alcohol consumption (Prochaska et al., 1992). A distinctive characteristic of individuals at the preparation stage of change is the beginning of behavioral steps that although, essential have not met criteria for effective change (Prochaska et al., 1992).

In action, the fourth stage of change, clients purposefully engage in behavior modification that involves altering their environment to change addictive and problematic behaviors (Prochaska et al., 1992). Therefore, a symbol of action is the overt change noticeable by others enduring between one day and six months.

Individuals who are able to achieve abstinence and refrain from recidivism for a duration exceeding six months are said to have succeeded in reaching maintenance. Despite early conceptualizations of maintenance as a fixed stage, maintenance is believed to be a continuous in that individuals constantly work hard to maintain relapse prevention (Prochaska et al., 1992). A defining characteristic of maintenance is the ability to refrain from addictive and/or abusive behavior for a period lasting more than six months although maintenance has also been observed to span a lifetime (Prochaska et al., 1992).

Previous research has confirmed that treatment outcome is a function of client's pretreatment stage of change. In other words, the amount of progress clients make following an

intervention is associated with their stage of change prior to beginning programming (Prochaska et al., 1992). Additionally, a large majority of clients participating in action oriented treatment programs are believed to be pre-contemplators and contemplators (Abrams, Follick, & Biener, 1988; Gottlieb, Galavotti, McCuan & McAlister, 1990; Pallonen, Fava, Salonen, and Prochaska, in press) as cited in (Prochaska et al., 1992). While action oriented treatment programs may be suitable for individuals at the preparation and actions stages of change, they are ineffective and even harmful for pre-contemplators and contemplators (Prochaska et al., 1992). Such information has important implications for social work practice with involuntary clients, specifically, the need to continuously assess individuals stage of change and tailor treatment accordingly.

A promising approach for practitioners working to facilitate change with involuntary clients is through the integration of stages with processes of change, and interventions geared towards each process of change. Processes are the cognitive, affective and evaluative activities individuals engage in when trying to modify problematic behavior (Prochaska et al., 1992). Processes include consciousness raising, self-reevaluation, self-liberation, counterconditioning, stimulus control, reinforcement management, helping relationships, dramatic relief, environmental re-evaluation, and social liberation (Prochaska et al., 1992). An in depth description of the interventions targeted at each of the aforementioned processes is beyond the scope of this article.

A limitation of the Trans theoretical stage of change model is the lack of attention to social and environmental variables impacting change such as client's socioeconomic status. Another limitation is the ambiguity of criteria used to distinguish clients stage of change and the length of time needed to progress through the stages. A relative strength of the stages and

processes of change model is its ability predict treatment outcome with accuracy, despite client demographics, socio economic status, problem history and severity.

## **Methodology**

### **Research Design**

The present research utilized an exploratory qualitative survey, with audio taped interviews of professionals who facilitated offender rehabilitative groups with involuntary clients in Hennepin, Ramsey and Sherburne County. This design was intended to explore professional's perspectives of individual and environmental factors, influencing treatment completion of involuntary clients court ordered to complete substance use, domestic abuse, and/ or general offender rehabilitation programs. The researcher administered a semi-structured interview to 8 professionals who facilitated groups with the target population. Berg and Lune (2012) describe the semi-standardized interview as a process of obtaining information whereby the researcher uses a set of predetermined questions to structure the interview, yet allows flexibility to probe for additional information.

### **Sampling**

A non-probability and purposive sampling technique was implemented in order to recruit participants for this study. Purposive sampling is the process whereby researchers use prior knowledge of the targeted population to select subjects who possess unique qualities, or experiences of value to the research goals (Monette, Sullivan, and DeJong, 2011). In this case, the researcher intended to interview professionals who had a minimum of three years of experience facilitating groups with involuntary clients, within community corrections, and human service agencies. Participants who provided offender rehabilitation services to juveniles and adults in domestic abuse, chemical dependency, anger management, and cognitive skills programming were preferred. The researcher recruited subjects from human service agencies, and, community corrections departments in Ramsey, Hennepin, and Sherburne County.

Following consultation with committee members, an invitation to participate in the research study was sent via email to professionals who facilitated groups with individual's court ordered to complete substance abuse, domestic abuse, and general offender rehabilitation cognitive skills programming. The sample included N=8 professionals. One Family Intervention Specialist, a Family Violence Program Coordinator, Correctional Facility School Instructor, School Social Worker, Licensed Alcohol & Drug Counselor, and three County Probation Officers.

### **Protection of Human Subjects**

In adherence to the values articulated in the Belmont Report (Monette et al., 2011), the study maintained *Respect for Persons*, *Beneficence*, and *Justice* by, providing subjects with information regarding any potential risks and benefits of participation. An effort was made to ensure participants received a clear and comprehensible description of the study, in order to make an informed decision about participation. This was implemented by providing the participants with detailed information in the invitation letter, as well as a copy of the research questions to review before the actual study was conducted. Details pertaining to all elements of the study were communicated in an informed consent form including, who to contact in the event that a participant needed to report misconduct or a violation of the Code of Ethics. Additionally, participants were informed that their choice to withdraw from the study would not result in penalty, or damage their relationship with the School of Social Work. Most importantly, an effort was made to protect the privacy of participants, and maintain confidentiality of the data by de-identifying interviews, withholding participant identifiable information from administrators at participant's agency of employment, and destroying audio recordings, and text transcripts upon completion of the study.

**Research Setting**

The researcher conducted the qualitative interviews at locations agreed upon by the study participants. The locations included participant's agency of employment, and public library study rooms.

**Instrument**

The interview questions were divided into two sections. Section one included demographic questions which provided a brief description of the sample, in terms of their qualifications and experience working with involuntary clients. Section two of the questionnaire explored the extent professionals believed individual and contextual variables affected retention of involuntary groups. In addition, participants were asked to what extent their respective agencies responded to individual and environmental factors impacting their clients. All together the questionnaire comprised of 14 questions. The first 6 questions asked participants to identify their, race, gender, education level, title, certification, preferred treatment modality, and, years of experience facilitating groups with involuntary clients. The subsequent eight questions were open ended and qualitative in nature. These questions explored participant's perceptions of the extent they believed, individual factors, contextual variables, and program characteristics such as, treatment modality influenced treatment completion. Further, questions explored interventions professionals used to increase engagement, and the impact facilitator bias had on retention.

### **Data Collection**

1.) The researcher consulted with committee members who had knowledge of facilitators providing services to involuntary clients in Ramsey, Hennepin, Dakota, Washington, and Sherburne County. 2.) A list of potential candidates was generated, and emailed to the researcher by a committee member. 3.) The researcher then sent emails to potential participants inviting them to participate in the study. Included in the email was a letter of invitation, consent form and sample research questions. In the body of the email, the researcher requested individuals interested in participating to provide confirmation by responding to the email, or calling to schedule an interview. 4.) The researcher scheduled appointments with participants at an agreed upon location and conducted the interviews. Locations included public library study rooms, and participant's offices. 5.) The data was collected by audiotaping the interviews with professionals responding to the research questions in a semi-standardized format. The length of the semi-structured interviews averaged between 30 and 50 minutes. 6.) Upon completion of the interview, participants were debriefed, and provided with gift cards in the amount of \$5 to a local coffee shop, as a token of appreciation for their willingness to participate in the study.

### **Data Analysis**

The researcher transcribed verbatim each recorded interview into a text document using Express Scribe transcription software. The text transcripts were then amenable to content analysis. The qualitative methodology used for data analysis in the present study applied thematic content analysis, through careful, and detailed systematic examination, and interpretation of data, in order to develop themes emerging from the raw data (Berg, 2012). The unit of analysis included paragraphs, phrases, and sentences that identified themes reflecting factors influencing treatment completion of involuntary groups. Berg (2012) suggests that

themes are the most useful units to count based on the frequency in which they appear in a written document. Consistent with the Stage Model of Qualitative Content Analysis (Berg, 2012), Initial interpretation began by identifying the research question under consideration. The first question asked for example, to what extent do you believe individual factors affect positive outcomes of involuntary groups? How does your agency respond to address these factors? After identifying the research question, the researcher developed an analytic category, in this case, individual factors. A procedure known as open coding (Berg, 2012) was then implemented to review the data minutely, line by line for words, or concepts that reflected each analytic category. Identified categories were then revised and selected based on frequency that they appeared across interview transcripts in response to a given question. While analyzing the data, the researcher relied on grounded theory to accurately discern the perceptions of interviewees. Monette et al., (2011) described grounded theory as an inductive approach of developing themes from emergent concepts in the raw data.

### **Researcher Bias**

The potential for bias in this study may result from the researcher's experiences working with involuntary clients within community corrections. Additional bias may result from the researchers increased awareness of racial and class disparities experienced by minority clients in the criminal justice system. Restricted access to community resources, economic instability, and substandard education (Garvin, Gutierrez, & Galinsky, 2004) experienced by minority populations increases the risk of becoming an involuntary client. Prior knowledge of group membership, and what constitutes being at risk may impact the analysis of demographic, individual, and contextual factors associated with treatment completion of involuntary groups. At the same time increased sensitivity to racial and class disparities may enable the researcher

identify culturally responsive interventions that improve retention of involuntary clients most at risk of attrition. The researcher addressed the potential for bias through guidance and feedback from committee members on the development of the research questions.

## Findings

### Sample

The participants interviewed in the present study included 8 professionals who had on average of 9.6 years experience working with involuntary groups comprised of clients mandated to attend, domestic violence, substance use, and general offender cognitive skills programs. All eight professionals who were invited to participate in this study consented to the questionnaire and completed audiotape recorded interviews. The sample consisted of a multidisciplinary group of professionals including, a Family Intervention Specialist, Family Violence Program Coordinator, Correctional Facility School Instructor, School Social Worker, Licensed Alcohol & Drug Counselor, and three County Probation Officers. Two of the participants held a Bachelor of Arts Degree and five held a Master's Degree in their respective fields. The majority of participants worked in Ramsey and Hennepin County with the exception of one who had gained experience from work in Washington and Sherburne County. Six participants were Caucasian and two were African American. Of the eight participants interviewed, five were women who worked primarily with domestic abuse clients, and the remaining three males worked with substance abuse clients, domestic abuse clients, DWI offenders, and facilitated groups with a variety of treatment modalities.

The researcher conducted interviews with participants during the months of February, March and April of 2015. The following results are themes identified by three or more participants describing factors they believe influence treatment completion of involuntary groups. The quotations that support identified themes are italicized.

## Individual Factors

### Motivation & Readiness

The first qualitative question in the survey explored the extent participants believed individual factors affected positive outcomes of involuntary groups. Four themes, client motivation and readiness, stage of change, mental health and chemical dependency were identified as having a significant impact on client progress and retention of involuntary groups. Irrespective of client demographics five of the eight (5/8) participants identified motivation and readiness as the single most important factor, and asserted that individuals who recognize the personal benefit of programming usually make an effort to complete groups. In addition to client motivation and readiness was the stage of change in which clients were identified to be in. Participants commented on how stage of change in effect preceded an involuntary client's motivation and readiness to complete programming. This was most clearly articulated by one respondent, a probation officer who facilitated domestic abuse groups.

*That's probably the biggest thing motivation and readiness of involuntary clients. The demographic stuff I really don't think is as much of an issue honestly. I mean it doesn't matter. In some respects the age, the racial background, anything like that really is about that individual, and are they motivated to attend a group. Do they see a need for it and if they are not motivated, if they have been court ordered to do it, can you build that motivation for them. So if you look at the stages of Motivational Interviewing, if you have a client who is absolutely in the pre-contemplative stage and they are not ready to go to group. That is going to impact them more than anything I think. (Interview #1, p1. Lines3-10).*

A family intervention specialist who facilitated domestic abuse groups provided a similar response, with an example from her experience facilitating groups with involuntary clients who successfully were able to complete programming, only after developing intrinsic motivation and readiness to change. As reflected in the following quote:

*I think just the want to do this and complete this is something. I have a couple of guys that it's their 3<sup>rd</sup> time back in the program. They never completed the first two, and they've stated that they are in that point in their life that they want it. You know they are ready to kinda get through this and get their act together, and get their life back on track. So I think that's a huge one. So you are going to have to want it. (Interview #2, p.1, lines 9-13).*

Another respondent, a probation officer who provided services primarily to DWI offenders also identified motivation, readiness, and stages of change as a necessary precondition for client engagement and successful completion of court ordered programming. This participant commented,

*I think a key role of participation and completion of groups is where the offender is at in the stages of change process. Individuals can be at pre-contemplation, contemplation, and then move into the other stages of change. So based on where they are at in regards to their mindset is to whether or not they see this as beneficial. (Interview #4, p.1, lines 3-6).*

Reasonably, the Licensed Alcohol and Drug Counselor perceived client motivation and readiness to a large extent a predictive individual factor influencing involuntary client's progress and successful outcome in court-ordered programming. This respondent explained:

*Every individual decision to change that is in per case to quit drinking and stay quit is an individual decision. It can't be made for them. We can send them to treatment but we cannot*

*individually mandate that they will quit. We can only make them jump through the hoops.*

*(Interview #5, p.1, lines 4-7).*

### **Mental Health & Chemical Dependency**

Mental health and chemical dependency were two factors oftentimes identified separately by participants, and as such, would not establish a strong theme. However, it is common for these disorders to appear co-morbidly in clinical samples, and when considering the dual nature, presented significant challenges for involuntary clients. Three out of the eight (3/8) participants interviewed discussed the impact a client's untreated mental health and active substance use had on their motivation to attend programs, and/or ability to engage with others and successfully complete group. Additionally, professionals believed untreated mental health and active substance use made it difficult for clients to gain insight of symptoms limiting their capacity to integrate material from group and apply it to their lives. One participant, a school social worker facilitating groups predominantly with domestic abuse clients commented:

*I think that those factors like mental health chemical dependency that's tuff. That's what I see as being big factors in whether or not a client is successful. Like if a person is dealing with a pretty severe mental illness, or is actively using um they are not going to be as willing, or able and probably as able to I think get as much out of the program. That's obviously a sweeping statement but um I think that if someone is dealing with a significant mental illness. Like I have a client who is pretty depressed right now and he is not going to complete the program on time because he is so entrenched in his own mental health stuff and in alcoholism. (Interview #6, p. 1, lines 16-23).*

Agency's responded to address mental health and chemical dependency through multidisciplinary collaboration with other professionals and making referrals for clients to receive psychological or substance use evaluations, in order to identify disorders affecting motivation and readiness for programming. Two out of the five (2/5) professionals who worked primarily with domestic abuse groups advocated that involuntary clients address mental health and chemical dependency before returning to group. Treating co-occurring disorders was perceived as crucial to client success. The premise being clients would be able to focus on the material and more ready to engage in programming. Participants discussed the process of coordinating with other professionals to ensure clients had access to MI/CD resources, or were nearing completion of substance use programming before beginning domestic abuse groups. A family intervention specialist emphasized the importance of treating client's mental health and chemical dependency, and the need to communicate with referral sources, in most cases, probation officers and child protection workers by referring clients for psychological evaluations, after being terminated from group, and/ or prior to beginning domestic abuse programming. As indicated by the following quote:

*We have also been recommending a lot of psych evals, or updated psych evals. I feel that a lot of the clients that have been coming through have obvious mental health issues that are not being addressed, which could factor into them not being ready to be here. (Interview #2, p. 6, lines 253-255). So those are the things that we would talk with their probation officers, child protection workers um and again recommendations. If someone was terminated from the program for something we would recommend that these things be done before they come back whether it is a psych eval, and then they follow the recommendations of that psych eval, or just*

*those certain things that they need to address before they can come here and be completely focused on what they need here. (Interview #2, p.6, lines 258-263).*

An additional factor increasing client's vulnerability to mental health and substance use disorders, and potentially impacting their ability to complete programming were individual crises. Three out of the eight professionals (3/8) identified crisis and its capacity to exacerbate client's mental health. Crisis was described in terms of emergency situations affecting clients such as housing, food insecurity, relationship problems, and unemployment. One participant described the events that constitute being in crisis and the impact it can have on the client's ability to focus in a group setting. For example:

*A lot of guys kind of come to our group and are in crisis whether it be housing, food you know tokens, having to get here and employment resources. You know separated from partners you know those individual factors kind of overtake the thought process, which can distract them from group. (Interview #3, p 1., lines 4-7).*

Consistent with the ecological systems conceptual framework, each participant was asked to identify how their agency responded to address individual factors at the individual/ familial level (micro), community level, (meso) agency and social policy levels (macro). At the individual level, three out of the eight participants (3/8) advocated for facilitators to engage clients during group, or one on one meetings finding topics in the curriculum that they could connect to personally, and getting that buy in for programming. Some professionals discussed individualizing programming to help make it more responsive to the client's needs while others discussed the importance of meeting with clients on a one to one basis after group, to determine

their interests and tailor programming accordingly. This individual level intervention was echoed by a probation officer who facilitated groups with domestic abuse clients.

*You have to somehow connect it to them so that it means something to them. So that it is something that court ordered or not, or ordered to do it by their PO, whatever their conditions are that if they can find some reason that it's going to be important to them, to improve their life, to keep them from coming back here, you know whatever that is. You help build that motivation. That I think is the key to helping clients succeed. (Interview #1, p.1, lines 13-18).*

One of the crucial themes identified by three of the eight (3/8) participants articulating their agency's response to address individual factors was active participation in the referral process. By interviewing potential clients prior to running groups, facilitators ensured that clients were directed to the appropriate programs. This practice was viewed as important for assessing client readiness for programming by, providing an opportunity for facilitators to increase an individual's motivation through communicating necessary information about programming and how it could benefit them. One participant who worked with domestic abuse clients described her involvement in the referral process with the following quote:

*So I think when you match the right client with the right program. That in and of itself is going to be a good place to start. (Interview #1, p 1., 23-24) So sitting down with them, explaining the program to them, kind of talking through, trying you know building that motivation before you even start the group. So figuring out where they are at, what their interest level is and then what conversations can you have to kind of build that up before they actually come to the group (Interview #1, p 1., 25-29).*

Similarly, the referral process was viewed as important by professionals who worked with substance use clients. A professional working with DWI offenders commented on the referral process providing facilitators with an opportunity to explain why the court had ordered a particular program. This had the potential of clarifying any ambiguity clients had about group and how it can help resolve issues contributing to their involvement in the legal system. This participant stated.

*The other important piece is what is the probation officer doing on the front end with these individuals prior to them going to group. Are they educating that individual about why the court sentenced them to this group? Are they giving them the basic information about the class? (Interview # 4, p. 1, lines 40-44).*

### **Environmental factors**

In order to further explore the influence contextual variables had on client outcomes in group, professionals were asked to what extent they believed environmental factors affected positive outcomes of involuntary clients, and how their respective agency's responded to address each factor at the individual/ familial level, community level, agency and social policy levels. Participants provided a variety of answers that included support for programming, prevalence of substance use in the community, housing insecurity, transportation and employment. Of the themes identified *three* were cited by four of the eight participants (4/8), as significantly impacting retention of involuntary groups. *Housing, employment, and transportation* were considered for their impact on client's ability to attend and successfully complete groups.

Housing was perceived as a critical factor for substance use clients not only for the stability it provided by increasing the likelihood that clients would complete groups. Rather it

was viewed as a necessary component for maintaining sobriety. For example, a Licensed Alcohol and Drug Counselor advocated for supportive living housing arrangements whereby clients resided in therapeutic communities that encouraged sobriety. In addition to housing, employment was identified as a predictive factor of treatment completion. A probation officer, described his role apart from facilitating groups, in terms of working with clients to resolve barriers to employment, so that they could successfully complete programming. Transportation was another common factor identified by professionals that presented significant challenges for clients who attended groups in the community. Lack of transportation was attributable to limited finances for bus fare, in which case professionals provided clients with bus tokens, in order to reduce this barrier. An additional component of transportation was the availability and access to transit lines experienced by clients who were geographically isolated from program locations, such as individuals who lived outside of the metropolitan area. As a result, transportation was identified as differentially impacting clients residing in rural settings where there was limited access to public transportation. Also notable was the account that environmental factors were perceived to have a more profound effect on client retention than individual factors. This finding was indicated by a school social worker reflecting on factors she perceived presented challenges for clients attending a domestic abuse group facilitated in the community.

*I think that environmental factors are what we see more often than the individual stuff. So like homelessness, unemployment, um...kind of other like job related stuff or transportation. All of that stuff preventing clients from making it to group (Interview #6, p. 2., lines 50-53).*

In light of the present findings, there was a noticeable difference in the environmental factors influencing treatment completion for involuntary clients attending groups in the community and those who participated in programming within a correctional institution. For

instance, *three* of the eight professionals (3/8) who worked with involuntary clients in correctional facilities cited group dynamics and length of sentencing as environmental factors impacting client's ability to complete programming. While professionals working with involuntary groups in the community identified factors such as housing instability, employment and transportation that significantly affected retention. Additionally, professionals working within correctional settings believed to an extent that it was easier for clients in custody to complete programming than for those on community supervision. Despite acknowledging the benefits programming offered, professionals who facilitated groups within institutional settings advocated for limited access to clients whose sentence length would interfere with completion of programming. This was agency policy influenced by evidence-based research directing practice with involuntary clients. A probation officer who facilitated domestic abuse groups in a correctional facility provided a compelling argument as to why partial programming is ineffective.

*You can't do partial programming here. There's actually a lot of research to show that if you start somebody in a program and they don't finish. It actually has a worse effect on recidivism they are more likely to recidivate. (Transcript 1, p.5, lines 203-205).*

With adherence to the ecological systems framework, the researcher encouraged participants to identify how their agencies responded to address environmental factors impacting client outcomes at the individual/ familial level, community level, agency and social policy level. At the individual/ familial level for example, *two* of the eight participants (2/8) reported their agency encouraged clients to share curriculum, or practice skills with family members, provided there were no legal conditions preventing contact. This was a micro level intervention that has potential to increase support for programming. A probation officer facilitating groups within a

correctional facility described how she encouraged familial support for programming to assist with skill acquisition.

*We do encourage clients as long as there is not a legal reason why they can't have contact to. I've had clients mail out like copies of the homework that they're doing to family members. I've had them have phone conversations. I've had them try to use some of the skills when they can on visits. (Transcript 1, p. 2, lines 69-72).*

At the agency level, three participants described how their agencies responded to address environmental factors through the provision of financial assistance to individuals and families experiencing crises. The availability of crisis funds was supported by donations and eligibility based on need, and as a result, not every client benefited. Nonetheless, this service appeared to be a promising intervention that had potential to reduce the impact of three primary environmental factors, housing, employment, and transportation. One respondent described how her agency utilized crisis funds.

*Our program has some crisis funding through a donor so we can look to see who is eligible for services based on their circumstance. You know if they fit the group criteria. So sometimes we pay it for a deposit or a month's rent, or car repair so that they can keep going to work. Or a storage unit so that they don't lose all of their items in storage before they move into their new place, or the work boots they need for their new job because they need steel toe and they couldn't afford it on their own. So, it gives us a lot of diversity of ways that we can help clients, and with that funding being able to purchase bus tokens, so that we can give our clients a bus token to get back, so that transportation is not a barrier for them to get the services here. (Transcript #3, p.1, lines 15-23).*

In addition to crisis funding some agencies made an effort to geographically situate programs closer to communities where clients resided, in an attempt to reduce barriers to transportation. A Probation Officer, who worked outside of the metropolitan area described an intervention implemented by his agency, to reposition groups in parts of the county that were underserved due to limited access to transportation.

*What we have done in the past is have the group in different areas of the county, so let's just say the main hub is in this major city, well um if the county is pretty large we will move our group so to speak. We will have facilitators go to a different part of the county, to offer that program to capture those who just live in other parts of the county. We'll do a group and those individuals that are around that area will go to that group, and then a different part of the county we will have a different group start, and you know again scheduling calendars and things of that nature. (Interview #4, p. 3, lines 128-134).*

At the social policy level, one professional, a Licensed Alcohol and Drug Counselor, who worked with substance abuse clients in a correctional setting and in the community advocated for increased funding to improve prevention programs targeting individuals at risk of addiction. He emphasized that...

*A lot more could be done but we don't do it. We throw our money at the after the fact program. Once the addiction has occurred we try to fix the problem. That's where 90% of our money goes. What it should be is 10% of our money going there and 90% going in the front end so for prevention. (Interview #5, p. 3, lines 100-104).*

Further analysis of the individual and environmental factors influencing treatment completion prompted the researcher to ask professionals to identify reasons clients reported

regarding inability to complete programming. This question generated several themes some of which were similar to environmental factors identified by professionals and others differed in terms of strength. *Employment, child-care, transportation, and cost of programming* were four themes reported by clients as having a relatively significant effect on retention. *Four* out of the eight (4/8) participants interviewed identified employment as a significant barrier to completing programming. Child-care was identified as an important factor by *three* of the eight (3/8) participants who worked primarily with domestic abuse clients. These professionals considered the impact access to quality child-care had on retention. Transportation was a salient factor reported by clients as having a significant effect on treatment completion. *Five* of the eight (5/8) professionals interviewed considered the impact access to transportation had on their clients' ability to attend and subsequently complete programming. As one respondent, a family violence program coordinator reported.

*A lot of times it is um... jobs, it's you know I work and you want me to come in from 2 to 4 in the afternoon. For more women than men it's family issues, daycare, childcare, those kinds of things. Transportation can be the other big factor for clients in the community Just being able to get to whatever location the group is at. (Interview #1, p. 3, 104-107).*

Perhaps most intriguing finding was the reported impact of program cost on retention. The cost of programming was identified as a significant barrier for domestic abuse clients, but not so profound for substance abusers. Of the eight participants interviewed, *six* (6/8) identified cost as a significant barrier to completing programming. Four of the six participants worked primarily with domestic abuse clients and one participant facilitated groups with DWI offenders. Identification of program cost as a significant barrier was attributed to the fact that insurance companies do not recognize domestic abuse programming as a billable service under the

umbrella of adult mental health. A probation officer who facilitated groups with domestic abuse offenders provided a probable explanation for the reason clients experienced challenges due to the cost of programming.

*One of the hardest things for domestic abuse programs especially. A lot of those programs cost a significant amount. Insurance won't cover for them. (Interview #1, p.4, lines 159-160). When you think about medical insurance domestic abuse programming doesn't...you know it doesn't connect to any medical need I think would be the argument. You know I mean mental health issues can get billed under you know that kind of cost but domestic abuse programming isn't typically considered a mental health issue or a physical health issue so that insurance there's no insurance to cover for that. (Interview #1, p. 4, lines 163-167).*

In response to this barrier, few agencies attempted to reduce the financial burden by contracting with the County to provide scholarships for programming, or making payment arrangements with clients who could not afford to pay for groups, but demonstrated motivation to complete programming, by frequent attendance and engagement during group. Scholarships were needs based, and eligibility determined through proof of income, participation in public assistance programs, and household size. A family intervention specialist who worked with domestic abuse groups described how her agency responded to address this need.

*Our program is \$300 total. We have a contract with Hennepin County where if you are a Hennepin County client then they can fill out a scholarship form, and we base that off of income. So that is either income from their current job or any assistance that they get, and then we factor in household size, and then household income. So we put that into our computer and it generates*

*a percentage, so if they are under a hundred percent which is extremely low poverty they get a full scholarship. (Interview # 2, p. 3, lines 123-129).*

Additionally, two participants described how they would oftentimes make payment arrangements with clients, who could not afford the full cost of programming. This occurred when clients had made initial payments, and were nearing completion, but could not pay the remaining balance due to unexpected circumstances. A school social worker described how she negotiated with a client who was not eligible for the scholarship and, yet experienced difficulty paying the program fees.

*I had a client who had paid, and completed like two weeks ago, and he had paid like \$25. So far he was on week like 22 and he is like I don't know how much money I'm going to be able to get and, I'm like well how much can you get for me to get out of here? I said can you get me like \$75 more dollars? He is like yeah I think I can do that. So I was like yeah okay I will take it. Like it's almost like we try to be real systematic but at the same time it's like I'll just wheel and deal you. (Interview # 6, p. 6, lines 257-263).*

### **Program Characteristics**

Further exploration of environmental factors, prompted the researcher to ask participants what program characteristics they believed presented challenges to client's successful completion of treatment? Notably, some program characteristics reported by, professionals were environmental factors previously identified as having an effect on treatment completion. Four program characteristics were identified for their significance, and provided a better understanding of challenges clients encountered that are directly related to the group experience.

The four program characteristics identified were *program time*, *program length*, *closed or open group formats*, and *program cost*.

Program time was identified by *five* out of eight (5/8) participants as having an insignificant effect on client's ability to complete programming whereas, *three* professionals believed it had a more profound effect, in that programming would interrupt client work schedules and family life. Additionally, program time was found to be more of a challenge for clients who attended community based programs, yet this was not an issue for groups within correctional settings. Some agencies made an effort to accommodate clients whose changing work schedules occasionally conflicted with programming. Agencies effectively did this by offering groups at different times of the day. A school social worker reflected on her agencies response to address this need.

*Time of day we've tried to respond to that by offering groups at a couple of different times so we have two nights of men's groups that are evenings. Then we have one morning group on a different day so like hopefully that kind of gets people who have different work schedules, or like issues with scheduling and stuff. I don't think anything can ever be perfect in terms of scheduling because everyone is going to have something but...you try your best to accommodate them for working so that people that have to work in the day. (Interview # 6, p.5, lines 214-221).*

Program length was a group characteristic often identified by clients as being a significant challenge to completing programming. However, *three* professionals believed that the duration of programs was reasonable, and even necessary to facilitate change in clients. One professional, a family intervention specialist stated....

*I don't think program length. They might say, the clients may think it's an issue but, we go to monthly meetings with other agencies in the state that do similar work as us. We call it PW meetings. People Who Work With People Who Batter. All of our programs are very similar in length, and the last meeting I was at it was talked about that programs used to be longer than 18 weeks, and has since been shortened, and my thought and their thought is that the 18 weeks is probably that pivotal point in the process of kind of you know gaining what they need to kind of take it out into their real life. (Interview # 2, p.4, lines 141-148).*

Program length was identified as impactful by, professionals working with domestic abusers, and DWI offenders alike. While they acknowledged the benefits of longer programs, professionals understood the drawback extended programs had on retention of involuntary clients. One professional who facilitated cognitive skills groups with DWI offenders discussed the unintended consequence of program length.

*The longer the program the likelihood that they will not complete so that's a pretty big factor. So there are cognitive skills programs out there, domestic abuse programs that are, basically 24 weeks long... 24 sections. So if you do that twice a week if you do that once a week you are looking at a 12-week commitment or, a 24-week commitment. Um so that's a huge... It's huge for somebody that's not in the criminal justice system to make that happen um....and then you compound that with all the barriers that folks that are in the criminal justice system have...I mean it's a huge responsibility for them to complete such a program. (Interview # 4, p. 5, lines 216-224).*

When asked about the effectiveness of group formats, participants discussed the advantages and disadvantages of facilitating open or closed groups. The basis for facilitating

open groups was that new members would be exposed to members who were further along in the change process, and could therefore serve as mentors, or peer counselors. One participant believed open groups might improve the likelihood that involuntary clients would complete programming having the opportunity to see others who have worked through the initial resistance, and imagine where they can be. One participant however strongly believed facilitating closed groups would be more effective, citing stages of group development and, the need to maintain a level of trust in the group, especially with domestic abuse clients. A probation officer who advocated for closed group formats provided her reasoning.

*Closed groups I do think tend to be more successful because you build that sense of community within a group. You look at the stages of group development and kinda what they go through when you are constantly bringing new people in that you are almost always at that stage of forming that group dynamic so um... Not to say that you can't have open groups and that can't work. I think particularly when you are looking at the domestic abuse programs at least ours is always going to be closed. (Interview # 1, p. 5, lines 225-231).*

Further exploring the advantages and disadvantages of open or closed groups, one participant provided an explanation for why he felt closed groups were more of a challenge for agencies than for individual clients. He reported that...

*When it comes to closed and open group formats, that's one of the major issues that we still struggle with ten years after presenting in programs. I don't know if it is as much of a challenge for clients as it is a challenge for agencies because a lot of these programs that are offered are closed groups so you can offer a group in January and you might not have another group until June. So what's going on with the individuals that need a group but the group isn't offered*

*because they are only doing a closed group and it's going for 6 months. So I think there is a barrier maybe for the agency not so much for the client because the client is just going to hang out and say well I don't want to go to group (Interview # 4, p. 6, lines 238-245).*

In addition to identification of program fees as a significant environmental factor impacting positive outcomes by clients and professionals, the cost of programming was frequently cited as a program characteristic presenting continuous challenges to retention. As previously noted, the impact of program cost was overwhelmingly experienced by domestic abuse clients whose, program fees ranged between \$300 and \$500 and, were not covered under insurance. Whereas the majority of substance abuse clients were eligible for Rule 25 chemical dependency treatment funded by the county. Nonetheless, some agencies made efforts to reduce financial barriers to programming by implementing community work service arrangements to offset the cost. One participant who worked with DWI offenders described how his agency responded to ensure clients completed programs.

*Cost of programming is a challenge how we kinda address that in my county is you are allowed to do community work service at \$10 an hour prior to programming and that community work service will go towards your programming fees. Um so we kind of you know if you are unemployed and can't find a job the program is \$300. You can work for 30 hours prior to the program beginning to work off the program fee. (Interview # 4, p. 6, lines 246-249).*

## **Engagement**

In order to develop a better understanding of engagement and its effect on retention, professionals were asked how they engaged participants to make treatment more responsive to their needs. Three themes were noted by professionals as essential mechanisms, for engaging

clients, the application of Motivational Interviewing, one on one time with clients, and contracting for completion. One professional described how she used plenty of reflections and open-ended questions to get input from members rather than being the primary source of information. Another participant described how he facilitated group by encouraging collaboration through round table discussions, as opposed to providing information in a dyadic format. Further supporting implementation of Motivational Interviewing, one professional, a probation officer who worked with DWI clients reported that the key to engagement was being knowledgeable of Motivational Interviewing skills.

Facilitators provided one on one time to clients in order to identify treatment readiness and resistance to change. One professional, who facilitated groups with substance abusers in a correctional facility, described how he used one on one time after groups to assess whether clients were invested in the material, and what conditions within the group were keeping them from full participation. Still other professionals used one on one time as an opportunity to review client's goals and expectations for programming and to determine whether they were congruent with what clients had identified during the intake.

One on one time also provided facilitators the opportunity to contract for completion with clients. Contracting was a method used to engage resistant and disengaged clients. One professional offered that after four or five weeks if clients were uncooperative and communicated they were not willing to participate, eventually facilitators would contract with them, informing clients of what needed to be accomplished in order to continue programming. A family intervention specialist described contracting with clients at her agency.

*I think that those type of clients are on my radar and I watch them more closely maybe meet with them one on one to discuss things to say this is what I need to see from you um we have been contracting a lot of clients um that aren't maybe at that point and saying this is what we need from you and if we don't see it by this week then you are going to be done in our program*  
*(Interview #2, p.6, lines 248-253)*

### **Facilitator Bias**

A central issue raised in the present study was the effect of facilitator bias on treatment completion of involuntary groups. To better understand the extent that personal biases had on client outcome, professionals were asked specifically what impact they believed the personal bias of a facilitator had on retention of involuntary clients. Six professionals perceived the personal bias of facilitators having a marked and direct impact on retention of involuntary groups. One professional discussed bias in terms of professional use of self. They suggested that professionals use themselves to facilitate change in clients. Therefore, if a facilitator has a conscious or unconscious bias towards a certain group of people, it may surface during group and eventually hinder the client's progress. This perspective was supported by yet another professional who advocated that facilitators remain neutral otherwise members will disengage if their bias became known. Two participants suggested that effective facilitators were those who are able to recognize their own personal biases and prevent them from surfacing in groups. Regardless of offense type, personal bias was considered to have a negative effect on client outcome due to self-fulfilling prophecies that diminished client's self-efficacy. Professionals noted that involuntary clients and, particularly domestic abuse clients, expected to be judged, and expected to be shamed, which made it even more difficult for them to change. Additionally, some participants discussed how they addressed personal bias through self-awareness, and

communication. The recognition of personal biases emerging during group compelled participants to debrief after group and, seek feedback during supervision. One participant, a probation officer described the process of debriefing.

*We always try to have our co-facilitators debrief after group so sit down and talk through it cause you know guys will say things that trigger you and vice versa. Group members will say things that will trigger things for facilitators. I mean it's just. It's going to happen and so that debrief process is really important and sometimes you may not even know it and have that co-facilitator say you know he said this and you seemed really, you seemed really like you were struggling with it. (Interview #1, p.8, lines 343-348).*

As with the previous interviewee, another participant discussed the importance of setting time aside after group to process, in order to gain insight and a different perspective on group interactions. This participant stated.

*When it's a challenge having our process time after group is really important because we glean a lot of really important information because of that in group out of group information may get, but also um people kind of have this is where I think this could be coming from and that kind of staff insight or staff reflection of the interactions is really helpful (Interview #3, p. 7, lines 293-297).*

Countertransference was a key issue on the subject of facilitator bias discussed by interviewees. One participant provided an insightful description of how positive and negative countertransference can be impactful. A family intervention specialist explained that her agency's policy delineated the number of groups an individual could miss before they would be at risk of termination. However, under certain circumstances, clients who were doing very well

were allowed to continue through group. In this case, the facilitator's willingness to make an exemption for a client demonstrated positive countertransference. Nonetheless, professionals cautioned about the negative effect of positive countertransference on other group members. A probation officer who worked with domestic abuse clients provided a convincing explanation of the unintended consequence of positive countertransference.

*I think if we get too attached to that one client doing so well we neglect other clients in group or we may focus you know what topics we talk about first for one particular client versus the rest. (Interview # 2, p. 7, lines 316-318).*

To limit the occurrence of countertransference both positive and negative, professionals emphasized the need for consistency in policy implementation with involuntary clients by limiting the amount of leniency towards certain clients. It is believed that such a practice would eventually decrease the amount triangulation occurring in client/staff interactions.

## **Discussion**

### **Description of the Sample**

The present study sought to explore factors that influence treatment completion of involuntary groups. Through interviews with professionals who facilitated domestic abuse, substance use, and general offender cognitive skills programs, the researcher hoped to develop a better understanding of individual and environmental factors contributing to attrition, and agencies responses to improve retention. Eight professionals who had on average 9.6 years of experience working with involuntary clients were invited to interview. All eight accepted the invitation to participate in the study. The sample consisted of a multidisciplinary group of professionals including, a Family Intervention Specialist, Family Violence Program Coordinator, Correctional Facility School Instructor, School Social Worker, Licensed Alcohol & Drug Counselor, and three County Probation Officers. Two of the participants held a Bachelor of Arts Degree and five held a Master's Degree in their respective fields. The majority of participants worked in Ramsey and Hennepin County with the exception of one professional who served Sherburne County. Six participants were Caucasian and two were African American. Of the eight participants, five were women who worked primarily with domestic abuse clients, and the remaining three males worked with substance abuse clients, domestic abuse clients, DWI offenders, and general offender populations.

### **Comparison of Findings to Literature Review**

The themes that emerged from the data regarding factors influencing treatment completion of involuntary groups indicated that completion was a function of both individual and environmental factors and, professionals believed that environmental factors were more profound for clients mandated to complete programming in the community compared to those

who attended groups in correctional environments. In contrast to the literature reviewed concerning individual and demographic variables effect on retention, five professionals identified motivation, treatment readiness, and stage of change, as the single most important factors influencing treatment completion regardless of client demographics, and/or offense type (i.e. domestic abuse, substance use). This finding was consistent with research by Drieschner & Verschuur (2010) which identified effort to change problem behavior as the strongest predictor of outcome, suggesting that the effectiveness of correctional treatment is to some degree dependent on the effort clients make towards behavior change.

Secondly, mental health and chemical dependency were important individual factors identified by three professionals as having a significant impact on treatment readiness, and believed to impede client's ability to engage in treatment, and successfully complete programming. Professionals noted that clients who experienced mental and chemical health issues were also vulnerable to experiencing crises, which presented challenges to completing treatment. These individual factors, although, important, were infrequently discussed in the literature. A seminal study by Cadsky, Hanson, Crawford, & Lalonde (1996) further supports the association between lifestyle instability and treatment completion.

Equally important were individual/familial and agency level interventions being implemented to address these factors. Three professionals discussed micro level interventions they utilized such as, actively engaging clients during group, finding topics in the curriculum that connected to them personally, individualizing programming making it more responsive to client needs, providing one on one time after group to determine interest level, reinforcing motivation for programming, and engaging in multidisciplinary collaboration by making recommendations for clients to receive psych evals, in order to address mental and chemical health issues

impacting functioning in group. Most importantly, was the need for facilitators active participation in the referral process, in which they had an opportunity to assess client readiness for programming and ensure individuals were directed to the appropriate groups. The implementation of brief pre-treatment orientation groups to engage resistant clients, and improve readiness for programming has been shown to be highly successful in decreasing attrition with a group of men who batter (Brekke, 1989). Further, the use of Motivational Interviewing, and the need for training facilitators who are skilled in Motivational Interviewing was identified as a necessary intervention to improve retention. Consistent with McMurrin & Ward (2010), these results suggested that professional's and, administrative officials supported pre-treatment preparation, especially the use of Motivational Interviewing to increase engagement and subsequently improve retention of involuntary clients.

Environmental factors were perceived to have more of an impact on client's who were mandated to complete programs in the community, as opposed to individuals in custody. Professionals attributed this finding to the absence of certain barriers in correctional environments and incentives to complete programming such as conditional release. This finding was supported by Olver et al., (2011) whose research demonstrated that prison based treatment programs yielded the lowest attrition rates at (19.9%). For individuals who attended community based groups, professionals identified several environmental factors they believed presented challenges to completion of treatment, namely, housing instability, employment, transportation, program time & location, child-care, and cost of programming. Four of the aforementioned factors were consistent with literature exploring demographic and individual factors influencing completion, whereas two were infrequently mentioned. For example, employment (Clark et al., 2014; Jewell & Wormith, 2010; Kinlock et al., 2013) housing, availability of quality child-care

(Kelly et al., 2001) and geographic location of treatment facilities including transportation (Jacobson, 2004) were considered for their impact on domestic abuse, and substance abuse clients alike.

A cardinal issue identified in this study was the cost of programming. Surprisingly, program cost and the effect on retention of involuntary clients was absent from the literature under review. The cost of programming deserves mention as it was identified by six participants as one of the primary factors presenting barriers to completion for domestic abuse clients. Despite micro and meso level interventions geared towards the improvement of retention in domestic abuse groups, including the provision of scholarships, payment arrangements, and community work service. Professionals reported that domestic abuse clients frequently attributed the challenges they experienced completing group to program fees. This finding may offer an explanation of a meta-analysis by Olver, Stockdale, & Wormith, (2011) whose research indicated that domestic violence programs experienced the highest rates of attrition when compared to other involuntary groups. Taking in consideration, conversations with professionals regarding lack of insurance coverage for domestic abuse programming, these results have important implications for social policy needed to improve retention of involuntary groups.

Facilitator bias was an important factor identified by professionals as influencing retention, although, it received limited attention in the literature reviewed. Six professionals believed bias had a marked and direct impact on retention of involuntary clients. Bias was discussed in terms of use of self, and facilitators encouraged to, increase self-awareness of personal biases and its negative impact on involuntary groups. Lastly, bias was noted to reinforce self-fulfilling prophecies particularly with domestic abuse clients who enter therapy expecting to be judged and shamed.

### **Limitations & Recommendations for Future Research**

A limitation of this study is that it included a small sample size  $N=8$ , comprised primarily of professionals who work within the metropolitan area. Therefore generalizability of the results may be limited due to the geographic location from which the majority of participants were employed. A recommendation for future research would be to increase the sample size by conducting a quantitative online survey. Another limitation of this study was the fact that the sample included a disproportionate number of participants who worked with domestic abuse clients,  $N=5$ , compared to those who served substance users and general offender populations,  $N=3$ . Consequently, the results emphasized treatment completion of clients mandated to attend domestic abuse programming, and interventions to improve retention with this population. Despite the prevalence of substance use amongst domestic abuse offenders. The results in this study found that these two populations often experienced slightly different barriers to completion. One recommendation for future research would be to conduct a study focusing separately on domestic abuse clients or substance users. While the majority of the professionals interviewed were women, few facilitated involuntary groups comprised of female clients. As such, recommendations for gender responsive programming were limited to the provision of onsite childcare or scheduling programming at times to accommodate for women with school age children. Future research is needed to explore gender specific programming from women who batter. A final limitation of this study was the potential for confirmation bias during the data analysis. Future research would benefit from the addition of a second reviewer to evaluate themes generated from the data analysis.

**Researcher reaction**

While the researcher had certain knowledge of factors that influence treatment completion of involuntary clients from prior internship experience. The extent that the results supported or contradicted the extant literature was limited due to the fact that participants were a multidisciplinary group of professionals with education, and training experience in different settings. As such, factors identified by professionals as salient varied in terms of strength while others were less pronounced.

**Implications for Social Work Practice**

As an increasing number of social workers continue to provide the majority of mental health services in the United States, 60% according to NASW (2014), it is likely that practitioners will work with involuntary clients. Therefore, it is important to understand how to effectively work with individuals who may be resistant to change. One of the key themes identified in this study was motivation, readiness, and stages of change. These findings suggest that social workers need to continue seeking education and training to develop an awareness of the Trans theoretical stages of change to inform practice and improve Motivational Interviewing skills, needed to effectively work with treatment resistant and/ or disengaged clients.

In addition, social workers can intervene to improve retention of involuntary groups by assessing client's readiness and motivation for programming prior to treatment initiation. This can be implemented in pre-treatment orientation with the application of psychometrically robust assessments, such as the Treatment Engagement Scale (TER) by Dreischner & Verschuur (2010) and empirically based models of engagement such as the Multifactor Offender Readiness Model (MORM) developed by (Ward et al., 2004). Furthermore, social workers can reinforce

motivation by individualizing programming, identifying topics that relate to clients personally, and tailoring curriculum to be more responsive to client needs.

Although some programs provide funding to improve retention of domestic abuse groups, this population continues to experience the highest attrition rates compared to other offender groups. Social workers can advocate for funding to increase scholarship programs for domestic abuse groups at the national, state, or local level, through writing grant proposals to the Office of Justice Programs. Increased funding for scholarships to attend domestic abuse groups may have the potential to improve retention and reduce recidivism in our community.

Facilitator bias was a central issue identified in the present study believed to have a significant effect on treatment completion of involuntary clients. In order to increase self-awareness of personal biases affecting client outcomes, social workers need to continuously seek supervision and allot time to process difficult client interactions that surface during groups.

### **Conclusion**

Treatment completion of involuntary clients is important social issue impacting individuals, families and communities. The purpose of this study was to explore factors that influence treatment completion of involuntary clients and interventions being implemented to improve retention. Through interviewing a group of multidisciplinary professionals working with domestic abuse and substance use clients, treatment completion was determined to be a function of both individual and environmental factors. Additionally, environmental factors were perceived to have a more profound effect on clients mandated to attend community based groups, opposed to individuals attending programming within a correctional setting. Professionals identified motivation & readiness, stage of change, mental health & substance use as key individual factors

influencing completion. While, housing, employment, transportation, childcare, program cost, time, length, and group formats were notable environmental factors believed to influence completion. A cardinal issue was the financial burden experienced by domestic abuse clients due to program cost. A notable strength of this study was the multidisciplinary perspective offered from professionals who had considerable experience facilitating involuntary groups in the community and within a correctional environment. Therefore, the information obtained provided a deeper understanding of individual and environmental factors affecting client outcomes. An additional strength of this study was consistency with the ecological systems conceptual framework which guided questions and provided information on agency's response to address factors at the individual level, community level, and agency policy levels. Nonetheless, further exploration and research is needed to improve retention of involuntary clients through identification of factors that differentially impact individuals mandated to attend programming whether in the community or within a correctional institution. Additional, research is needed to explore the association between program cost and attrition from domestic abuse groups.

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## Appendix A

### Factors Influencing Treatment Completion of Involuntary Groups

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**Part I: The following participant demographic information is needed to provide a description of the sample. Please complete Part I of this questionnaire before meeting for the interview.**

1. Race & Ethnicity

Hispanic or Latino  Not Hispanic or Latino

American Indian or Alaskan Native  Asian  Caucasian

Black or African American  Native Hawaiian or Pacific Islander  Other

2. Gender: Male  Female

3. Education Level: Associates  Bachelors  Masters  Doctorate

4. Job title\_\_\_\_\_

5. Certification\_\_\_\_\_

6. Years of experience facilitating groups with involuntary clients\_\_\_\_\_

7. What type of group(s) do you facilitate?

Domestic Abuse  Substance Abuse  Cognitive skills  Other

8. What modality of treatment do you utilize?

Cognitive Behavioral  Motivational Interviewing  12-step

Duluth Model  Solution Focused  Psychodynamic  Other

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### Part II: Interview Questionnaire

**Please review the questions below and identify key ideas prior to meeting.**



13. How do you engage group members to make treatment more responsive to their needs?

14. What impact do you believe the personal bias of a facilitator has on the retention of involuntary clients?

15. What recommendations do you have for facilitators working to improve retention of involuntary groups at the individual/familial level, community level, agency and social policy level?

16. Is there anything else that you believe would be helpful for me to know regarding work with involuntary clients?

Thank you for taking the time to share your knowledge and experience. It is greatly appreciated.

## **Appendix B**

### **INFORMATION AND CONSENT FORM**

#### **Introduction:**

You are invited to participate in a research study exploring the factors influencing treatment completion of involuntary groups. This study is being conducted by Charles Kalogo, a graduate student at St. Catherine University and University of St Thomas, School of Social Work. The study will be completed under the supervision of Michael G. Chovanec, Ph. D, a faculty member in the Department of Social Work. Through consultation with a research committee, you were selected as a possible participant in this study because of your experience facilitating groups with involuntary clients. Please read this form thoroughly, and ask questions before you agree to participate.

#### **Background Information:**

The purpose of this study is to explore factors that influence treatment completion of involuntary client groups. In this capacity, involuntary clients are individuals who feel pressured to receive social services as a result of their involvement in the juvenile or criminal justice system. The main goal of this research is to contribute to the social work knowledge base by identifying factors that support or create barriers to successful completion of treatment by involuntary clients. Approximately eight people are expected to be recruited for participation this study.

#### **Procedures:**

If you decide to participate in this study, you will be invited via email to schedule an appointment, to complete an audio taped interview. Attached in the email will be information describing the nature of the study, a sample of the interview questions, and this informed consent form. You will be instructed to complete Part I of the interview questionnaire prior to meeting with the researcher. The interview is expected to last between 50 to 60 minutes in length. It will be conducted in a semi-structured format, meaning it will utilize a set of predetermined questions, but will allow for flexibility to discuss specific questions in more detail. Upon completion of the interview you will be debriefed, provided information regarding how the data will be analyzed, published, and the date you can expect it to be destroyed.

#### **Risks and Benefits of being in the study:**

The potential for risks as a result of your participation in this study are minimal. However, please be advised that the potential risk involves the effect on participant's employment, if data

including attitudes and beliefs that are perceived as critical of the agency, or effectiveness of programming, were accidentally lost and made public. One way the researcher intends to minimize the potential of risk occurring in this study is by maintaining confidentiality of the data set. The researcher plans to ensure data remains confidential by removing all direct identifiers as soon as possible, substituting codes for identifiers, and protecting personal identifiable information by using pseudonyms or reporting data in aggregate format.

There are no direct benefits resulting from your participation in this study. However, your decision to participate will be beneficial to the profession of social work. Information you provide will make important contributions to the social work knowledge base of, factors that improve treatment completion of involuntary groups. As a result, providers will be able to tailor programming that is responsive to the needs of involuntary clients, and decrease recidivism rates in the community.

**Compensation:**

You will be provided with a gift card to a local coffee shop as a token of appreciation for your willingness to participate in this study, regardless of whether you decide to answer a few or all of the questions during the interview.

**Confidentiality:**

Any information obtained in connection with this research study that can be identified with you will be disclosed only with your permission; your results will be kept confidential. In any written reports or publications, no one will be identified or identifiable and only group data will be presented. The researcher plans to ensure data remains confidential by removing all direct identifiers, substituting codes for identifiers, and protecting personal identifiable information by using pseudonyms. No one within your agency will be able to identify your responses to the interview questions.

The research results will be locked in a file cabinet located in the office of the advisor. The researcher and the advisor will have access to the records while the study is being conducted. The audio tape recording from the interview will be accessible to the researcher and an assistant for the purpose of content analysis. It is estimated that data analysis will be completed by May 2015. At that time, all original reports will be destroyed and identifying information that can be linked back to you.

**Voluntary nature of the study:**

Participation in this research study is voluntary. Your decision whether or not to participate will not affect your future relations with St. Catherine University & University of St Thomas, School of Social Work in any way. If you decide to participate, you are free to stop at any time without affecting these relationships.

**Contacts and questions:**

If you have any questions, please feel free to contact me, at ###-###-####, and [cokalogo@stkate.edu](mailto:cokalogo@stkate.edu) , or [kalo5851@stthomas.edu](mailto:kalo5851@stthomas.edu) . You may ask questions now, or if you have any additional questions later, the faculty advisor, Michael G. Chovanec, will be happy to answer them. You can contact him at 651-690-8722, or [mgchovanec@stkate.edu](mailto:mgchovanec@stkate.edu) . If you have other questions or concerns regarding the study and would like to talk to someone other than the researcher and advisor, you may also contact Dr. John Schmitt, Chair of the St. Catherine University Institutional Review Board, at (651) 690-7739 or [jsschmitt@stkate.edu](mailto:jsschmitt@stkate.edu) .

You may keep a copy of this form for your records.

**Statement of Consent:**

You are making a decision whether or not to participate. Your signature indicates that you have read this information and your questions have been answered. Even after signing this form, please know that you may withdraw from the study. Please note that once your data has been aggregated, it becomes a permanent part of the study.

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I consent to participate in the study. \*Your signature on this form also indicates that you are agreeing to have your responses audio taped.

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Signature of Participant

Date

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Signature of Researcher

Date

### Appendix C

Dear participant,

My name is Charles Kalogo and I am a graduate student at St Catherine University & University of St Thomas School of Social Work. To fulfill a research requirement, I will be conducting a study exploring professional's perspectives of factors that influence treatment completion of involuntary groups. The study will be supervised by Michael G. Chovanec, a faculty member at the School of Social Work. Through consultation with a research committee, you were selected as a potential candidate because of the experience you have facilitating groups with involuntary clients.

I invite you to participate in this study, and encourage you to contact me and schedule an appointment for an interview at your convenience. The interview will be audio taped and is expected to last approximately 50 – 60 minutes in length. I have included a sample of the questions, and the informed consent form for you to review prior to our meeting.

Your decision whether or not to participate in this study will not affect your current or future relationship with the School of Social Work.

If you choose to participate, please contact me by phone at ###-###-####, or via email at [kalo5851@stthomas.edu](mailto:kalo5851@stthomas.edu), or [cokalogo@stkate.edu](mailto:cokalogo@stkate.edu). If I am unable to answer the phone when you call, please leave a message and I will call you back. If you have additional questions about the nature of the study, feel free to contact my advisor Michael G. Chovanec Ph.D. at 651-690-8722 or [mgchovanec@stkate.edu](mailto:mgchovanec@stkate.edu)

Thank you

Charles O. Kalogo, MSW Candidate