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Offender engagement in group programs and associations with offender characteristics and
treatment factors: A review

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Abstract

The aim of this review is to establish how offender engagement within group programs has been conceptualized, defined or assessed, and the factors that are associated with it. Existing models describe determinants of engagement and the process of behavioral change, but there is little in the way of theory explaining the process of engagement in treatment and change. Forty-seven studies were reviewed and revealed inconsistent definitions and assessments of engagement as well as inconsistent use of measures which contributes to confusion about the scope of engagement and reflects the lack of theory. Attendance, completion or dropout rates were frequently relied upon, but may not reliably infer engagement. Participation and out of session behaviors in conjunction with one another, reflecting a series of active responses to treatment, may more reliably reflect engagement in treatment and change. A model for offender engagement is presented which might help clarify the role of engagement variables. Offender demographics appeared to be of little value in predicting engagement, with only a small number of psychosocial factors (hostility, impulsivity) predicting low levels of engagement and most others (anger, anxiety) having little influence. Treatment factors (therapeutic relationship, program objectives) were more consistently related to engagement, but are under-researched.

Key words: Offender, engagement, group, treatment, program, change

1. Introduction

There is a consensus that successful outcomes of offender rehabilitation programs are dependent on offenders engaging with treatment (McMurran & Ward, 2010; Scott & King, 2007), regardless of the type of program, offenders' criminogenic needs, or the treatment setting (Drieschner & Verschuur, 2010). One suggested type of evidence of non-engagement is non-completion of treatment (Wormith & Olver, 2002), which leads to poor treatment outcomes. Non-completion of treatment has been related to recidivism among domestic violence offenders (Gondolf, 2002), sexual offenders (Miner & Dwyer, 1995) and parents perpetrating child abuse (Harder, 2005). Furthermore non-completers of cognitive skills programs have been identified as at higher risk of re-offending than untreated offenders (McMurran & McCulloch, 2007). High non-completion rates across different offending behavior programs have therefore given cause for concern. In a review of 16 studies of treatment non-completers across a range of cognitive skills programs, McMurran and Theodosi (2007) found that, on average, 15% of institutional samples and 45% of community samples did not complete treatment. In a review of 16 domestic violence intervention studies, Daly and Pelowski (2000) reported dropout rates of between 50% and 70%. While non-completion may evidence non-engagement, how either relates to recidivism has yet to be explained. However, in a meta-analytic review of 114 studies, Olver, Stockdale and Wormith (2011) found attrition rates of over 27% for sexual offenders and over 37% for domestic violence offenders were predicted by a range of demographic, historic, and personality factors. These factors may shed some light on who is more or less likely to complete treatment and potentially who is more or less likely to reoffend, but this knowledge may be of little benefit to helping practitioners influence engagement in treatment and the subsequent influence this may have on recidivism. What may be of greater benefit to practitioners is to know what to look for in order to reliably infer that engagement is, or is not, occurring over the course of treatment, and how to enhance it.

While enhancing offender engagement in any intervention program appears to be relevant to improving treatment outcomes, there appears to be an absence of any common definition or theoretical model explaining what the process of engagement in treatment constitutes. Researchers have proposed models explaining determinants of offender engagement, such as the integral model of treatment motivation (Drieschner, Lammers, & van der Staak, 2004) and the Multifactor Offender Readiness Model (MORM: Ward, Day, Howells, & Birgden, 2004). The integral model of treatment motivation includes internal

determinants of motivation including problem recognition (denial and responsibility for behavior), perceived external pressure (partner, legal system), and perceived suitability of treatment (treatment satisfaction, perception of therapeutic relationship). Internal determinants also moderate the influence of external factors, such as the treatment process and circumstances (available resources, peers). The resulting motivation is then argued to dictate engagement (Drieschner & Boomsma, 2008), although Scott and King (2007: 407) have argued that there is a lack of evidence that internal determinants of motivation precede engagement, and that there may be more of an iterative process at play. The MORM includes a broader spectrum of individual factors (cognitive strategies, self-efficacy and motivation) and contextual factors (mandated/self-referred, prison/community) that comprise treatment readiness, which is argued to facilitate engagement (McMurran & Ward, 2010). The integral model of treatment motivation and the MORM reflect an important emphasis on what determines engagement but there is comparatively less emphasis on the process of engagement with treatment and the change that follows.

The transtheoretical model of change (Prochaska & DiClemente, 1982; Prochaska & DiClemente, 2002) incorporates stages of behavioral change and the progress of individuals through each stage. The importance of matching treatment interventions to individuals' stages of change is highlighted by the authors of this model. The model has widespread use across clinical and health settings, and is used to describe change both with *and* without therapy (Prochaska & DiClemente, 1982: 282); however, it does not include the role and coordinated process of treatment engagement. Therefore while there are theoretical models that offer explanations of the factors and processes surrounding engagement, there appears little in the way of a clear theoretical explanation of the process of treatment engagement itself.

The apparent anomaly in the literature between the importance of engagement and a lack of engagement theory suggests that the construct has yet to be fully and clearly conceptualized and explained, although it might have previously been defined and interpreted in a number of different ways by researchers. In response to the problems associated with client resistance and reluctance in treatment, Scott and King (2007: 401) have argued that there has been a proliferation and inconsistent application of terms and theories that have hindered research on useful treatment strategies. However, it might be assumed that the type of engagement that is typically referred to within the context of treatment programs is the type of engagement that leads to behavioral change. Drieschner et al. (2004: 1121) argued that 'engagement in the process of change is *almost* the same as engagement in the treatment process' [emphasis added]. However, offenders may potentially 'engage' in the process of

treatment but not in the process of change. Given the importance of offender engagement in relation to behavioral change but lack of theory, it is important to establish how it has been defined or assessed and to what extent these definitions and assessments reflect the behavioral change it is associated with. It is also important to draw together the factors (e.g. offender characteristics and treatment factors) that have been evidenced as associated with engagement and equally those that have been investigated but that do not appear to be associated with engagement. There were consequently two aims of this review: first, to establish the various ways offender engagement within group programs has been operationally defined and assessed; second, to establish the offender characteristics and treatment factors associated with engagement as it has thus far been defined and assessed.

2. Method

A search of PsycINFO, Medline, and Academic Research Complete was undertaken for peer-reviewed empirical studies published in English excluding dissertations. The search terms including all their potential derivatives and spellings were: [offender (and) engagement (and) group (and) treatment (or) program (or) intervention]. This search returned 128 studies, none of which were dated before 1980. Studies were included if offender ‘engagement’ had been operationally defined or assessed, or defined by participants in qualitative studies, in relation to any offender characteristics or treatment factors within treatment that comprised or at least included group work. Studies involving adolescent participants were excluded on the basis that the focus was on adult engagement. There may be distinct features of engagement that are attributable to development in adolescents such as higher levels of impulsivity and negative peer relationships (Smallbone, Crissman, & Rayment-McHugh, 2009), making a synthesis of these two bodies of literature problematic. Twenty-one studies met the review criteria and are henceforth referred to as the ‘engagement-defined’ studies.

The principle variables underpinning the definitions and assessments for engagement in these studies were then used in a second search. This search was identical to the first, but the term ‘engagement’ was replaced with: [attendance (or) completion (or) dropout] (returning 175 studies) and participation (returning 99 studies). Other variables employed to define or assess engagement in the first 21 studies included homework, counselor rapport, peer- support, and self-disclosure but searches using these terms returned few studies, mainly relating to treatment outcomes rather than offender characteristics or treatment factors. In line with the same inclusion criteria for the first search, 25 studies met the review criteria and are henceforth referred to as the ‘non-engagement defined’ studies. The purpose of the

second search was to capture an extended view of the offender characteristics and treatment factors associated with the variables underpinning definitions and assessments of engagement. Consequently a total of 46 studies (indicated by an asterisk in the references section) were included in this review.

3. Results

The results are divided into two sections with corresponding tables. The first section (3.1) clarifies the various operational definitions and assessments of engagement in the 21 engagement-defined studies. The second section (3.2) then comprises a summary of the offender characteristics and treatment factors investigated in all 46 studies reviewed that are associated with the variables underpinning the definitions and assessments employed in the 21 engagement-defined studies.

3.1 Operational Definitions and Assessments of Offender Engagement

A brief summary of the 21 engagement-defined studies including how engagement was operationally defined or assessed along with details of samples, design and other factors assessed is presented in Table 1.

Table 1. Summary of samples, research design, how engagement was defined or assessed in addition to other factors in the engagement-defined studies

Authors	Sample and group program	Research design	How engagement was operationally defined or assessed	Other factors assessed
		Engagement as attendance, completion, or drop-out		
Cook et al.(1991)	55 non-violent male sexual offenders attending long-term group therapy outpatient program	Comparison between program completion group; default group and non-engagement group on type and number of offences on record	Completion: fulfillment of program aims according to the satisfaction of group leaders Non-engagement: attendance to up to three sessions	Type and number of offences committed prior to and following attendance to group program
Marinelli-Casey et al. (2007)	57 male substance-using offenders and 230 substance-using males volunteering or probation referred for treatment	Comparison of drug court participants' and non-drug court participants' response to matrix-model treatment (multi-component) within the Methamphetamine Treatment Project	Immediate treatment dropout: dropout within the first 30 days of admission into treatment	Socio-demographic characteristics, psychosocial assessments, nature, number, and severity of seven life domains: drugs, alcohol, employment, family/social, legal, medical, and psychiatric, urinalysis
McCarthy and Duggan (2010)	81 Male personality disordered offenders	Psychosocial factors relating to completion and non-completion, and frequency, severity and time taken to re-offend after discharge	Non-engagement: regularly missing groups	Intelligence, psychopathy, personality disorder, anxiety, anger expression, impulsivity, post-discharge offending data
Sowards et al. (2007)	117 female substance-using offenders attending an outpatient drug-treatment program	Mixed methods: 11 interviews and program evaluation surveys exploring factors relating to program completion	Program success: program completion	Dimensions of motivation and readiness at intake, self-reported drug use; background factors; program exist status
Ting et al. (2001)	145 male offenders attending domestic violence program	Examination of predictive associations of substance abuse with engagement variables and partner abuse outcomes	Session attendance	Alcohol and drug use, working alliance, group cohesion and task orientation, relationship abuse

Vallentine et al. (2010)	42 male mentally-disordered offenders detained in high security hospital attending UMI ^a	Mixed methods to explore the effectiveness of psycho-educational material in their engagement with other group therapies	Completion, refusal, or dropout of other group therapies	Relapse: changes in medication, level of care: high versus low dependency wards, number of violent incidents; subjective wellbeing, symptoms, social functioning, risk to self/others
Authors	Sample and group program	Research design	How engagement was operationally defined or assessed	Other factors assessed
Engagement as participation				
Harkins et al. (2010)	55 male and 21 female imprisoned offenders attending Geese Theatre's 'Re-Connect'	Mixed methods during and post to evaluate the impact of program for offenders due for release	Researcher/member of Geese Theatre's daily ratings of offenders' behavior in the group ^b pre-program and post program	Self-efficacy: motivation to change, confidence in skills
McCarthy and Duggan (2010)	81 Male personality disordered offenders	Psychosocial factors relating to completion and non-completion, and frequency, severity and time taken to re-offend after discharge	Non-engagement: not actively participating in group work	Intelligence, psychopathy, personality disorder, anxiety, anger expression, impulsivity, post-discharge offending data
Sowards et al. (2007)	117 female substance-using offenders attending an outpatient drug-treatment program	Mixed methods: 11 interviews and program evaluation surveys exploring factors relating to program completion	Program success: participation in activities	Dimensions of motivation and readiness at intake, self-reported drug use; background factors; program exist status
Authors	Sample and group program	Research design	How engagement was operationally defined or assessed	Other factors assessed
Engagement as homework or out of session behaviors				
Frost and Connelly (2004)	16 imprisoned male sexual offenders	Qualitative method (grounded theory) to examine the significance	Out of session behavior Stages of engagement: recall from	

^a Understanding Mental Illness

^b Evaluation of behavior in the group form, Geese Theatre Handbook (Baim, Brookes, & Mountford, 2002)

Levesque et al. (2010)	attending a relapse prevention group program 248 male domestic violence offenders mandated to usual care and 244 male domestic violence offenders mandated to usual care plus Journey to Change	of out of session behavior on therapeutic engagement Comparison of outcomes of Usual Care to usual care plus Journey to Change	session; issue identification; rumination; consultation; reflection Assessment of 13 strategies to stay violence-free: talking to partner, friends, family, priest, pastor, rabbi, medical health professional; attending one-on-one, couple, or other group counseling; reading self-help books; leaving the relationship for a short while; leaving the relationship permanently; reducing stress; managing anger; and using any other strategies – at baseline and at 5 months follow-up	Stages of change for staying violence free, condom use, program completion, police involvement
McCarthy and Duggan (2010)	81 Male personality disordered offenders	Psychosocial factors relating to completion and non-completion, and frequency, severity and time taken to re-offend after discharge	Non-engagement: not completing homework	Intelligence, psychopathy, personality disorder, anxiety, anger expression, impulsivity, post-discharge offending data
Sowards et al. (2007)	117 female substance-using offenders attending an outpatient drug-treatment program	Mixed methods: 11 interviews and program evaluation surveys exploring factors relating to program completion	Program success: sustained period of sobriety, cooperation with court mandates	Dimensions of motivation and readiness at intake, self-reported drug use; background factors; program exist status
Ting et al. (2001)	145 male offenders attending domestic violence program	Examination of predictive associations of substance abuse with engagement variables and partner abuse outcomes	Homework compliance: ACRS ^c	Alcohol and drug use, working alliance, group cohesion and task orientation, relationship abuse
Authors	Sample and group program	Research design	How engagement was operationally defined or assessed	Other factors assessed

^c Assignment Compliance Rating Scale (Bryant, Simons, & Thase, 1999)

Measures of engagement & treatment satisfaction

Chovanec (2012)	95 domestic violence offenders and 4 facilitators of domestic violence perpetrator program	Mixed methods assessing engagement and offenders' and facilitators' perspectives of engagement	Interviews of offenders and facilitators about factors affecting offenders' engagement, GEM ^d (therapist's version)	Arrest history, employment, chemical dependency treatment, mental illness, experience of family trauma (physical abuse, witnessing abuse)
Greaves et al. (2008)	23 male and 13 female young non-dependent drug-using offenders attending a Community based Drug Intervention Program (DIP)	Mixed methods as clients attended clinic to examine offenders' attitudes about substance use to determine appropriateness of DIP	Treatment Motivation: Desire for Help, Treatment Readiness, and Treatment Needs subscales of the TCU-CEST during treatment	Substance use over last 30 days, criminal history, severity of dependence
Levenson and Macgowan 2004	61 male sexual offenders attending group therapy outpatient program based on cognitive behavioral relapse prevention model (purposive)	Correlations between engagement, denial, and treatment progress	GEM (client's and therapist's version) during treatment	Treatment progress, denial
Levenson et al. (2009)	336 male sexual offenders attending three outpatient counseling centers (subsample of 88 completed the GEM)	Correlation between treatment satisfaction and engagement	GEM (client's version) during treatment	Treatment satisfaction and treatment importance
Levenson et al. (2010)	88 male sexual offenders attending an outpatient counseling center (purposive)	Correlations between treatment satisfaction and treatment importance, and between treatment satisfaction and engagement (concurrent validity for treatment satisfaction measure)	GEM (client's version) during treatment	Treatment satisfaction and treatment importance
MacGowan and Levenson	61 male sexual offenders attending group therapy	Investigation of the psychometric properties of the GEM	GEM (therapist's version) during treatment	Group attitude, treatment progress, denial

^d Group Engagement Measure (Macgowan, 2000)

(2003)	outpatient program based on a cognitive behavioral relapse prevention model			
Pankow and Knight (2012)	521 male substance-using offenders from six prison-based therapeutic community programs	Establish a model for asociality and determine its relationship with engagement	Treatment participation and peer support: CJ-CEST during treatment	Treatment motivation, psychological and social functioning, criminal thinking
Raney et al. (2005)	87 Male imprisoned offenders at different stages of participating in RDAP ^e	Mixed methods to explore participants' perceptions of helpfulness of RDAP and the influence of an early release incentive	Participants' hopes for treatment topics, perception of helpfulness of program, program satisfaction, what participants liked most either one month, three months, or six months into treatment	Ratings of treatment topics: cognitive skills, living with others, criminal lifestyles, transition, relapse-prevention, personal change plan, and wellness
Rowan-Szal et al. (2009)	359 female imprisoned substance-using offenders attending CLIFF ^f or OTP ^g	Differences between groups in, and effects of treatment on, motivation, psychosocial functioning, criminal thinking and treatment engagement	Treatment participation, treatment satisfaction, counselor rapport, peer and social support subscales of the CJ CEST ^h	Demographics, psychosocial functioning, drug use, motivation, psychosocial functioning, criminal thinking
Roy et al. (2012)	40 male offenders attending domestic violence groups	Interviews and focus groups to explore factors influencing engagement	Conceptual framework including seven dimensions of the GEM	
Simpson et al. (2012)	3025 male and 1997 female imprisoned substance-using offenders attending eight residential therapeutic-community programs	Psychometric validity of the CEST ^h and TCU CTS short forms	Treatment participation, treatment satisfaction, counselor rapport, and peer support: TCU ENG ⁱ form	Drug Screening, criminal thinking, motivation, psychological functioning, social functioning

^e Residential Drug Abuse Program

^f Clean Lifestyle is Freedom Forever

^g Standard Outpatient Treatment Program

^h Criminal Justice version of the Client Evaluation of Self and Treatment (Joe, Broome, Rowan-Szal, & Simpson, 2002)

ⁱ Texas Christian University Engagement form adapted from the Client Evaluation of Self and Treatment (Joe et al., 2002)

Staton-Tindall et al. (2007)	1950 male imprisoned offenders and 824 female imprisoned offenders attending drug abuse programs as part of CJ-DATS ^j	Differences between males and females in engagement, psychosocial functioning, and criminal thinking, and relationships between engagement and psychosocial functioning, and engagement and criminal thinking in relation to gender	Treatment participation and counselor rapport subscales of the CJ CEST	Psychosocial functioning, criminal thinking
Authors	Sample and group program	Research design	How engagement was operationally defined or assessed	Other factors assessed
Engagement as self-disclosure				
Frost (2004)	16 imprisoned male sexual offenders attending a relapse prevention group program	Qualitative method (grounded theory) to establish offence pattern disclosures	Self-disclosure demonstrating a willingness to take part in therapy	

^j Criminal Justice Drug Abuse Treatment Studies project

3.1.1 Engagement as attendance, completion, or drop-out. Attendance, completion, or drop-out was central to the definitions of engagement in six of the studies (Cook, Fox, Weaver, & Rooth, 1991; Marinelli-Casey et al., 2008; McCarthy & Duggan, 2010; Sowards, O'Boyle, & Weissman, 2006; Ting, Jordan-Green, Murphy, & Pitts, 2009; Vallentine, Tapp, Dudley, Wilson, & Moore, 2010). Attendance is also one of seven subscales of the Group Engagement Measure (GEM: Macgowan, 1997) employed in six further studies (Levenson & Macgowan, 2004; Levenson, Macgowan, Morin, & Cotter, 2009; Levenson, Prescott, & D'Amora, 2010; Macgowan & Levenson, 2003). The GEM is used to assess engagement as a multidimensional construct and is therefore discussed separately (measures of engagement, below).

Dropouts appear to have been conceptualized as a proxy for non-engagement, defined as attendance to less than three sessions (Cook et al., 1991), dropping out within the first 30 days (Marinelli-Casey et al., 2008), or regularly missing sessions (McCarthy & Duggan, 2010). The converse, treatment retention and completion, were also assessed (Cook et al., 1991; Sowards et al., 2006; Valentine & Maras, 2011), but not always as a proxy for engagement (Cook et al., 1991; Sowards et al., 2006; Vallentine et al., 2010), and not always with a clear description of what program completion constituted (Sowards et al., 2006; Valentine & Maras, 2011), making the findings of these studies difficult to compare. Cook et al. (1991), Sowards et al. (2006) and Vallentine et al. (2010) defined completers as offenders who fulfilled the aims of the program (e.g. victim awareness) according to the satisfaction of group leaders, but without defining the criteria for fulfilling these aims.

Attendance or dropout may be misleading if employed in isolation to infer engagement. Offenders may be present without investing in the therapeutic component (Contrino, Dermen, Nochajski, Wiczorek, & Navratil, 2007). Arguably a minimum amount of attendance (depending on program length) may be required to provide sufficient opportunity for engagement, but beyond which any quantification of treatment may be of little value in assessing engagement. If engagement in treatment leads to behavioral change, it should arguably be characterized by more active components on the offenders' part (e.g. cognitive, discursive, active responses within treatment) than simply being present.

Completion may be more indicative that engagement in treatment has occurred, but it can only be considered retrospectively, and is hence an engagement outcome, not a characteristic of engagement per se. Furthermore if completion is used to infer that engagement not just in treatment but also in the process of change has occurred, it should be

assessed in relation to explicit qualitative criteria i.e. cognitive and behavioral changes that are directly linked to the program objectives, rather than attending a number of sessions.

3.1.2 Engagement as participation. Participation was central to the definitions of engagement in three studies (Harkins, Pritchard, Haskayne, Watson, & Beech, 2011; McCarthy & Duggan, 2010; Sowards et al., 2006). Participation is also one of the subscales of the Client Evaluation of Self and Treatment (CEST: Joe et al., 2002), while ‘contributing’ is one of the subscales of the GEM (Macgowan, 1997). Because both the CEST and GEM are multidimensional assessments of engagement, they warrant a separate discussion (section 3.1.4), but taking the studies employing these measures into account, only 14 of the 21 engagement-defined studies incorporated participation within the definitions or assessments of engagement.

Participation in treatment may account for offenders’ active efforts within sessions, and should be clearly defined. Non-engagement has been defined as a ‘lack of active participation in group work’ (McCarthy & Duggan, 2010: 116). Similarly, ‘participation in activities’ has been employed to define engagement (Sowards et al., 2006: 61). In both papers there were no operational definitions of active participation (or lack of) or the activities referred to, therefore it cannot be deduced what was a satisfactory level of participation, or in what activity, to conclude that participants were engaged (or not) with the treatment process. How much participation, the type of participation expected to be evidenced during treatment, and how it is assessed as indicators of engagement are likely to be determined by the objectives and nature of the program. Harkins et al. (2011) assessed the behaviors of imprisoned offenders with a measure designed specifically to evaluate ‘Re-Connect’. Re-Connect uses theatre performance and role-play to elicit discussion, different types of involvement, co-operation and disclosure (Baim et al., 2002). Daily observational ratings of whether offenders engaged without prompting, maintained concentration, and showed a willingness to do personally-focused work were conducted (Harkins et al., 2011). Thus program engagement was conceptualized as behaviorally indicated, with a concentration on a variety of participatory behaviors during sessions.

It might be argued that programs such as Re-Connect and measures designed to assess their effectiveness are specified to the extent that indices of engagement can only be program-specific. Measures may therefore suffer problems in terms of establishing validity and reliability if the programs to which they relate are not in common use (e.g. there is no available reliability for the Re-Connect measures). Consequently, participatory behaviors

reflecting engagement with the process of treatment may only be adequately assessed within the confines of the philosophy and scope of the program to which the behavior relates. It is therefore important that practitioners are clear about what types of participatory behaviors should be expected to be in evidence, in accordance with the objectives and nature of the programs they are delivering. From a generic perspective, participation in any group program is intuitively a key component of the engagement process, and a multidimensional construct requiring taxonomy for assessment. However, as participation refers to the active efforts offenders make within treatment, it may be confined to reflecting engagement with the treatment process, not necessarily with the process of change.

3.1.3 Engagement as homework or out of session behaviors. Homework (McCarthy & Duggan, 2010; Ting et al., 2009), or out of session behaviors (Frost & Connolly, 2004; Levesque, Ciavatta, Castle, Prochaska, & Prochaska, 2012; Sowards et al., 2006) were incorporated within the definitions of engagement in five studies. Homework is a feature of many offending behavior programs and has been found to relate to positive treatment outcomes (Morgan & Flora, 2002); therefore, it is odd that few studies examined homework as a proxy for engagement. The active efforts offenders make between sessions may indicate their engagement with the process of change, unlike participation within sessions that confines inferences of engagement to the treatment process.

Homework completion may, however, reflect an aspect of treatment compliance more than engagement, two constructs that may in some cases (e.g. Sowards et al., 2006) be conceptually conflated. Sowards et al. (2006) assessed engagement as a period of sobriety and compliance with court mandates. This compliance may reflect engagement in treatment and change to an extent, but compliance may not always reflect the underlying internal determinants (e.g. genuine motivation to enter treatment) comprising offenders' readiness to change (Ward et al., 2004). Instead, compliance may stem from coercion, or offenders' perceptions of coercion (e.g. in substance abuse treatment) that predict treatment retention (Young & Belenko, 2002) but sometimes with short-term positive treatment outcomes (Zhang, Roberts, & Lansing, 2013). Engagement, on the other hand, may be a broader construct that accounts for a variety of change behaviors between sessions because of treatment, not just those that are dictated by treatment (i.e. treatment compliance behaviors). However, offenders' readiness to change and perceptions of coercion versus volition to enter treatment should not be considered mandatory requirements for engagement; rather they should be considered as targets for enhancing engagement. Therefore, in order to distinguish

between compliance and engagement, any treatment-related behaviors indicating change should be considered as evidence of engagement in the process of change and explored within sessions as part of the treatment process.

The behaviors between sessions evidencing engagement in the process of change are likely to be dictated by offenders' environments. Violence-avoidance strategies by offenders in the community were assessed by Levesque et al. (2012) as a measure of engagement, including: talking to partner, friends, family or professionals; attending counseling; and reading self-help books (see Table 1 for a full list of the strategies). On the other hand, Frost and Connelly (2004) identified a 'social reality testing' employed by imprisoned offenders between sessions, who consulted with one another following their in-session personal disclosures. The environment for offenders in the community may be less predictable and harness dynamic risk factors for offending behavior, but on the other hand it provides greater opportunities for practicing and applying strategies acquired in treatment to change their behavior. Conversely prisoners' environments are arguably more predictable but provide less opportunity to apply such strategies. However greater contact with other group members between sessions provides opportunities for greater group cohesion, which is important for therapeutic gains (Serran & Marshall, 2010), and which may also improve engagement in the process of treatment and change. Consequently, both types of environments offer different strengths and challenges in relation to out of session behaviors that need to be considered when inferring and enhancing engagement.

Homework activities, or more broadly, out of session behaviors are likely to be equally as important as participation within treatment, if not more so, as this is when experiences from formal sessions are likely to be processed (Frost & Connolly, 2004). Offenders' applications of treatment concepts to real-life relationships and situations, or any behaviors that indicate the integration of treatment concepts reflects engagement in the process of change and therefore, as Drieschner and colleagues have argued (2004), engagement in the process of treatment. Participation within treatment and out of session behaviors might be considered as two sides of the same coin and should be assessed in conjunction with one another, in order to measure engagement not only with the process of treatment, but also with the process of change.

3.1.4 Measures of engagement and treatment satisfaction. Two different measures of engagement were utilized in the studies reviewed. The Client Evaluation of Self and Treatment (CEST: Joe et al., 2002) was used in five studies (Greaves, Best, Day, & Foster,

2009; Pankow & Knight, 2012; Rowan-Szal, Joe, Simpson, Greener, & Vance, 2009; Simpson, Joe, Knight, Rowan-Szal, & Gray, 2012; Staton-Tindall et al., 2007) and the Group Engagement Measure (GEM: Macgowan, 1997) in six studies to assess engagement (Chovanec, 2012; Levenson & Macgowan, 2004; Levenson et al., 2009; Levenson et al., 2010; Macgowan & Levenson, 2003) or incorporate it within a conceptual framework (Roy, Châteauevert, & Richard, 2013). Each measure is discussed in turn.

3.1.4.1 *Client Evaluation of Self and Treatment (CEST)*. The CEST was developed to assess the Texas Christian University (TCU) Treatment Process model (Simpson, 2001) and is used to assess participation (cognitive and behavioral involvement and progress), treatment satisfaction (e.g. ‘the program is organized and run well’) and counselor rapport (e.g. ‘you are motivated and encouraged by your counselor’) as variables that represent engagement in substance abuse treatment (Joe et al., 2002: 184). An analysis of the CEST subscales reported by Joe et al. (2002: 191) brought the homogeneity of the participation subscale into doubt, supporting an argument that participation in treatment should be considered a multidimensional construct requiring taxonomy for assessment.

Treatment satisfaction has been considered by other researchers as a component of the group environment (Wilson et al., 2008), an aspect of treatment suitability (an internal determinant of treatment motivation according to Drieschner et al., 2004), related to engagement (Levenson et al., 2009), but not a component of engagement according to the GEM (discussed below). Therefore, treatment satisfaction is construed differently by researchers, but there is no clear rationale as to why satisfaction with treatment should reliably reflect engagement. Raney, Magaletta and Hubbert (2005) did not employ the CEST, but measured engagement as program satisfaction, participants’ hopes for treatment topics, perceptions of treatment helpfulness and what participants liked most. This broader assessment captures offenders’ perceptions of the relevance of the program that is likely to be of importance to engagement, but what offenders *like* the most about programs (e.g. empathy training) may not always translate to engagement or positive treatment outcomes (Brown, Harkins, & Beech, 2012). In fact, engagement in the process of treatment that may also involve behavioral change may, at some point during the course of treatment, reflect some level of discomfort (particularly in programs that require self-disclosure). Consequently, treatment satisfaction is therefore likely to fluctuate during the course of treatment, as will how it associates with engagement, meaning the two variables may not always correlate.

However, while treatment satisfaction does not constitute clients' active efforts within and between treatment sessions, it may reflect an outcome of these efforts.

Counselor rapport, the therapeutic relationship or working alliance (Horvath & Greenberg, 1994) has been argued to have a greater influence than techniques (Duncan, Miller, Wampold, & Hubble, 2010; Lambert & Barley, 2001), and therefore likely to be important in relation to offenders' engagement, but not necessarily part of the engagement process. Perceptions of the therapeutic relationship, according to Drieschner et al. (2004) in their integral model of treatment motivation, are components of treatment suitability, an internal determinant of motivation, and hence not considered an aspect of the engagement process that follows. However, as Scott and King (2007) have argued, the process between motivational determinants and engagement may well be iterative. Therefore, there may be a diffuse influence of the therapeutic relationship on engagement with the process of treatment and the process of change i.e. it influences participation in treatment as well as guiding and encouraging offenders through the process of change. Yet given the considerable literature on the subject (see Taxman & Ainsworth, 2009 for a review), it is surprising that it was only investigated by researchers employing the CEST or the GEM, and in the case of the former, the use of the counselor rapport subscale was inconsistent.

There has been a lack of consistency in the use of all but the participation subscale of the CEST to measure engagement, generating confusion as to which of these variables are determinants of engagement, and which comprise engagement with the process of treatment and the process of change. Some researchers assessed treatment satisfaction (Rowan-Szal et al., 2009; Simpson et al., 2012), counseling rapport (Rowan-Szal et al., 2009; Simpson et al., 2012; Staton-Tindall et al., 2007), peer support (Pankow & Knight, 2012; Rowan-Szal et al., 2009; Simpson et al., 2012), social support (Rowan-Szal et al., 2009), or motivation (Greaves et al., 2009) as engagement. Social support (Broome, Simpson, & Joe, 2002) and motivation (Olver et al., 2011) have been found to predict treatment outcomes and are therefore likely to be important to engagement. However, as with the therapeutic relationship, they do not comprise the active efforts clients make towards treatment or change, and therefore should be considered determinants rather than constituents of engagement.

3.1.4.2 Group Engagement Measure (GEM). The GEM has a therapists' and a clients' version, the former of which has demonstrated good reliability and validity (Macgowan, 1997; Macgowan, 2000; Macgowan & Levenson, 2003). Macgowan and Levenson (2003) established good convergent validity between the GEM and the Group

Attitude Scale (GAS: Evans, Jarvis, & Dawson, 1986), the Sex Offender Treatment Rating Scale (SOTRS: Anderson, Gibeau, & D'Amora, 1995) and divergent validity between the GEM and Facets of Sexual Offender Denial (FoSOD: Schneider & Wright, 2001).

The GEM consists of five dimensions: attendance; contributing (verbally or by participating in group activities); relating (to the facilitator and to other members); contracting (agreeing with the policies and activities of the group); and working (on own problems and on others' problems). Contracting is not assessed by the other measures of engagement, and along with attendance correlated weakly with group attitude and treatment satisfaction (Macgowan & Levenson, 2003). These findings suggest that attendance is not the most reliable assessment of engagement and that contracting may indicate treatment compliance, rather than the broader construct of engagement in treatment and change. Conversely, relating with members, and working on problems were strongly correlated with group attitude and treatment satisfaction (Macgowan & Levenson, 2003) and may reflect group cohesion, which facilitates greater self-understanding among offenders (Reimer & Mathieu, 2006) and may encourage offenders to work on their problems. In turn, working on problems within sessions reflects engagement in the treatment process.

Both the CEST and the GEM draw attention to the multidimensional nature of engagement, but both have their limitations. The CEST was developed to help reduce drop-out and relapse among drug-users (Simpson, Joe, Dansereau, & Chatham, 1997) and therefore was not designed for the assessment of engagement among non-drug using offenders. Furthermore, the inconsistent use of CEST subscales might be because it was designed to assess treatment processes and outcomes, of which offenders' engagement only forms a part. Conversely, the GEM is focused only on engagement, and offers a more generic purpose for assessment, as it was theoretically derived from a review of the literature on social group work (Macgowan & Levenson, 2003). It therefore represents a combination of the different indices employed by other researchers to infer engagement such as attendance, contributing, and the therapeutic relationship. However, these studies were conducted among students (Tryon, 1985), pre-adolescent boys (Mallery & Navas, 1982) and clients in counseling (Horvath & Greenberg, 1989), and not always in group settings. Therefore, these measures may reliably assess indices of engagement but this might not always readily translate across different groups of offenders and different intervention settings. An important limitation common to both measures, is that neither includes assessments of offenders' efforts between sessions. Assessments using these tools are

therefore confined measures of engagement with the process of treatment, not necessarily behavioral change.

3.1.5 Engagement as self-disclosure. One of two studies (Frost, 2004; Frost & Connolly, 2004) where qualitative methodology was employed examined self-disclosure. Frost (Frost, 2004: 203) argued that self-disclosure management styles of sexual offenders in treatment are a key indicator of engagement. Participants were required to nominate the three most personally meaningful events from a disclosure session because of how these events maximally engaged the offenders' attention. Establishing which particular events during the process of self-disclosure of offending behavior are the most meaningful from offenders' perspectives is powerful to understanding their engagement, but not all programs foster a need for self-disclosure of offending behavior (e.g. solution-focused brief interventions - see Lee, Uken, & Sebold, 2007). A concentration on offenders' disclosure management styles may reveal engagement in the treatment process, but in some cases may confine what is revealed to indices of compliance. Offenders who comply with treatment requirements as dictated by the treatment philosophy may not necessarily be engaging in the process of change. For strengths-based approaches, establishing the most meaningful events from the process of self-disclosure of efforts towards change i.e. the efforts offenders are making between sessions to change their behavior, may offer more insight into the extent to which offenders' are engaged in the process of change. Consequently self-disclosure may represent a type of in-treatment participation that may link with offenders' efforts in-between sessions towards change, representing an important engagement process variable.

3.1.6 Summary. In the 21 engagement-defined studies, engagement has been variously quantitatively (mainly) and qualitatively defined or assessed. Although a set quantity or 'dose' of treatment is associated with treatment outcomes (Hansen, Lambert, & Forman, 2002) and attendance may be a necessity for engagement opportunities to exist, it should not be relied upon to infer engagement on the basis that it only reflects offenders' minimum active efforts towards treatment. Completion may be a more suitable outcome proxy for engagement, if it is assessed in relation to criteria that are program objectives-based, but it cannot be used to assess the process of engagement itself. Participation (specified in accordance with the treatment program) and out of session behaviors (any treatment-related efforts, not just those pre-defined) both reflect active responses to treatment and should ideally be assessed in conjunction to both engagement in the process of treatment

and change, with due consideration to offenders' out of session environments. Measures of engagement such as the CEST and GEM may reliably be used to assess engagement in the treatment process in specific treatment settings, but may not be reliable in other settings. Self-disclosure linking treatment details and offence details may represent a form of participation, but links with change details may reflect engagement in the process of change as well as treatment, and thereby represent an important engagement process variable.

3.2 Associated Offender Characteristics and Treatment Factors

This section of the review comprises a summary of the offender characteristics and treatment factors investigated in all 46 studies reviewed that are associated with the variables underpinning the engagement definitions and assessments in the 21 engagement-defined studies. This includes 20 studies investigating factors associated with attendance, completion and dropout, four studies focusing on participation, and one study focusing on both attendance and participation. A summary of the 25 non-engagement defined studies can be found in Table 2, listed in alphabetical order under two different subheadings corresponding to the variables assessed. Tables 3 and 4 present the findings in relation to associations (or lack of) between each variable and the offender characteristics and treatment factors respectively. A lack of any significant association is indicated by a strike through the engagement variable (e.g. ~~Participation~~), with citations for the authors of the studies indicated by superscript footnotes.

Table 2. Summary of the samples, research design, and how variables were assessed in the non-engagement-defined studies

Attendance, Completion, and Dropout				
Authors	Sample and group	Research design	How attendance/completion/dropout was operationally defined or assessed	Other factors assessed
Bowen (2010)	77 male domestic violence offenders attending a domestic violence program and 31 probation tutors	Examination of perceptions of the therapeutic environment and associations with attendance, psychological change, alleged reoffending	Attendance: number of hours attended	Therapeutic environment, pro-domestic violence attitudes, anger, interpersonal dependency, emotional reliance on others, Locus of Control, desirable responding
Buttell et al. (2011)	485 female offenders mandated to a domestic violence program	Comparison of completers and dropouts using mixed methods	Dropout: clients who had completed intake interview but failed to complete entire program	Demographic interviews, desirable responding, propensity for abusiveness,
Clegg et al. (2010)	156 imprisoned sexual offenders offered group cognitive behavioral treatment program: refusals, dropouts, compliant	Comparison of refusals, dropouts, and compliant offenders on demographic, offence-related, clinical, and psychological assessment data	Dropouts: attended at least one session but dropped out of expelled for non-compliance Currently compliant: those compliant with second or third phase of treatment and no history of treatment noncompliance	Personality, intelligence, academic skills, neuropsychological functioning
Daly et al. (2001)	220 male domestic violence offenders referred to a domestic violence program	Examination of predictors of attendance	Attendance: total number of sessions attended	Referral source, physical violence, exposure to family violence, alcohol use, psychopathology, partners' prediction of attendance
Derks (1996)	52 imprisoned male personality disordered offenders referred to a relapse prevention program	Completers, currently completing, dropouts	Completers: those who had already completed or were still attending the program Dropouts: those who dropped out at any	Demographics, personality, symptoms, hostility, anxiety, anger

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Deschenes et al. (2009)	477 male and 273 female drug-court participants	Evaluation of the impact of enhancing drug- court services	Completion: graduation – 180 consecutive days of sobriety, find employment and housing, develop aftercare plan, complete community service, complete vocational program and other activities required by judge	Data on residential treatment, specialty groups, vocational referrals
DeVall and Lanier (2012)	526 male drug-court participants	Examination of influence of demographics and legal factors on program completion	Completion: graduation – completion of three phrases of treatment resulting in a final disposition	Demographics, age at first arrest, age at substance-use onset, number of misdemeanors and offences prior to program entry, sentencing guidelines, mode of entry, and drug of choice
Evans et al. (2009)	926 male offenders assessed for substance abuse treatment across 30 sites	Examination of records in relation to characteristics of completers and dropouts	Completion/dropout: self-reported discharge status at 3 month follow-up or CADDs ^a discharge status	Addiction severity, treatment motivation, treatment process
Ghodse et al. (2002)	50 male and 29 female offenders admitted to inpatient drug treatment	Examination of characteristics of non-completers, completers with no after-care, and completers with after-care of a tri-stage drug-use treatment program	Non-completion: discharged for noncompliance or self- discharge against medical advice before completion of detoxification Completion with no aftercare: completed detoxification program but received less than 6 weeks aftercare Completion with aftercare: completed detoxification program and received at least 6 weeks aftercare	Socio-demographic background, history of and current drug and alcohol use, physical health, mental health, offending behavior, and interpersonal relationships with substance abusers
Hadley et al. (2001)	1,185 female and 5,114 male	Examination of attendance records	Attendance: number of absences	Age

^a California Alcohol and Drug Data System

	forensic psychiatric outpatients	in relation to age and gender		
Hollin et al. (2008)	2,186 male offenders: completers, non-completers, non-starters and 2,749 controls in relation to general offending behavior programs	Program evaluation	Completion: of all sessions, non-completion: failed to finish because of own volition or expulsion	Demographic information, criminal history, risk scores
McGuire et al. (2008)	929 male offenders: completers, non-completers, non-starters, controls in relation to general offending behavior programs	Program evaluation	Completion: of all sessions, non-completion: failed to finish because of own volition or expulsion	Demographic information, criminal history, risk scores
McMurrin et al. (2008)	56 male offenders attending a personality disorder treatment program	Comparison of characteristics between completers, those expelled for rule-breaking, and non-engagers	Completion and non-engagement grouping criteria not specified	Psychopathy, intelligence, social problem-solving, anxiety
McMurrin and McCulloch (2007)	24 male prisoners: completers and non-completers of a general offending behavior program	Exploratory study of what interferes with program completion	Completion of all sessions	Reasons for non-completion: Semi-structured interviews, motivation: ratings of intrinsic and extrinsic motivation
Nunes and Cortoni (2008)	100 imprisoned male sexual offenders who completed or dropped out of sexual offender treatment programs	Differences between completers and dropouts in sexual deviance and general criminality	Dropout/expulsion: dropped out or expelled for unacceptable behavior or performance	Sexual deviance, general criminality
Polaschek (2010)	132 male high-risk violent prisoners attending intensive cognitive behavioral therapy program	Comparison of completers and non-completers on a range of demographic and psychosocial variables	Non-completion: criminal justice system withdrawal (exists determination not related to program involvement), therapist-initiated withdrawal (staff-based exclusion), and prisoner-initiated withdrawal (clients' request to leave) ^b	Risk of serious reconviction, anger, aggression, empathy, anxiety, depression, alcoholism, rape beliefs, attitudes to women, attitudes to violence, level of service, psychopathy, intellectual functioning
Roque and Lurigio (2009)	Male probationers attending a substance abuse treatment	Characteristics of offenders attending a treatment readiness	Attendance to one or more sessions	Drug and alcohol use, family and living conditions, employment,

^b Categories adapted from Wormith and Olver (2002)

		group		education, income, criminal justice status, mental and physical health problems
Rosenbaum et al. (2002)	326 male offenders either self-referred or court-ordered to domestic violence program	Evaluation of programs of three different lengths, based on associations between referral source, demographics, intra-personal, experiential factors and completion, recidivism	Completion: attendance to six out of seven session, eight out of 10 sessions, or 17 out of 20 sessions	Data on demographics, violence and family history, type of referral, relationship to victim, history of aggression, interpersonal aggression between parents, education, employment, history of depression, history of head injury
Schweitzer and Dwyer (2003)	445 imprisoned male sexual offenders: completers, non-completers and controls in relation to sex offender treatment program	Evaluation of program: examination of recidivism rates over 5 years	Completion: completion of program prior to release, non-completers: dropped out at any point before the end	Data on demographics and offence history prior and post program
Shaw et al. (1995)	114 imprisoned male sexual offenders: completers and non-completers of sex offender treatment program	Investigation of the predictors of treatment completion	Completion: completion of all or most of the treatment modules Non-completion: failure to complete all or most of the treatment modules or display of inappropriate behavior	Demographic, offence history, reading level, antisocial personality disorder
Tapp et al. (2009)	83 male offenders within a high security hospital attending a general offending behavior program	Evaluate the impact of the Enhanced Thinking Skills program	Dropout: completion of 10 or less sessions	Demographics, clinical outcomes, criminal thinking style, social problem solving

Participation

Authors	Sample and group	Research design	How participation was operationally defined or assessed	Other factors assessed
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Daly et al. (2001)	220 male offenders referred to a domestic violence abuse program	Examination of predictors of attendance	Staff member ratings on sobriety during sessions, use of techniques, self-disclosure, non-sexist language, attentive body posture	Referral source, physical violence, exposure to family violence, alcohol use, psychopathology, partners' prediction of attendance
Jackson and Innes (2000)	178 imprisoned male offenders attending self-development training program	Logistic regression of the predictors of program participation using demographics and prison factors	Self-reported participation in at least one type of program: vocational training classes, college courses, anger/stress management and/or values programs	Attitudes and behavioral styles, demographics, previous offence history, time served, visits from friends or family
Kalichman et al. (1990)	55 imprisoned male rapists attending a sex offender treatment program	Prediction of treatment participation using personality profiles	Participation: attendance rates and clinician ratings of participation	Personality profile, criminal history, psychosocial history
Roque and Lurigio (2009)	Male probationers attending a substance abuse treatment program	Evaluation of the impact of treatment readiness program on participation in substance abuse treatment	Length of stay and completion of substance abuse treatment	Drug and alcohol use, family and living conditions, employment, education, income, criminal justice status, mental and physical health problems
Shearer and Ogun (2002)	49 male inpatients in a substance abuse treatment program, 51 male inpatients in a pre-release therapeutic community, 60 male inpatients in a therapeutic community substance abuse treatment facility	Comparison of treatment resistance between three groups	Voluntary participation/forced participation: coerced treatment, court-ordered treatment, mandated treatment, involuntary treatment, or compulsory treatment	Resistance

Table 3. Offender characteristics associated with variables underlying operational definitions and assessments of engagement

Offender characteristics	Engagement variables (no. of studies finding an association) and engagement variables (no. of studies finding no association)
<u>Demographics</u>	
Age (older)	>Attendance (1 ^a) Attendance (2 ^{b, c}) Completion (3 ^{d, e, f}) Completion/dropout (4 ^{g, h, i, j}) Participation (2 ^{c, k})
Education/reading ability	>Attendance (1) Attendance (1) Completion (3 ^{l, m}) >Participation (1) Participation (1)
Educated (white only)	Completion (1)
Education (court-referred only)	Completion (1 ⁿ)
Employment	>Attendance (1) <Attendance (1) Completion (4 ^{f, g, l, m}) Completion/dropout (2 ^{i, m}) >Participation (2 ^{c, k})
Gender (male)	>Attendance (1) Attendance (1) Completion/dropout (1) <Participation (1 ^o)
Married (white only)	Completion (1)
No dependent children at home	Completion (1) Completion (1)
Race	Attendance (1) Completion/dropout (2 ^{g, l}) Participation (2 ^{c, k})

^a Roque and Lurigio (2009)

^b Hadley et al. (2001)

^c Daly et al. (2001)

^d Hollin et al. (2008)

^e Derks (1996)

^f DeVall and Lanier (2012)

^g Evans et al. (2009)

^h Tapp et al. (2009)

ⁱ Ghodse et al. (2002)

^j Shaw et al. (1995)

^k Jackson and Innes (2000)

^l Buttell et al. (2012)

^m Deschenes et al. (2009)

ⁿ Rosenbaum et al. (2002)

^o Staton-Tindall et al. (2007)

Race (white)	<Attendance (1) Completion (1)
<u>Historic factors</u>	
Age at first arrest/conviction (younger)	Dropout (2 ^{f, g}) Completion/dropout (1^p)
CJS involvement (less)	Completion (1)
History of violence/aggression (greater)	Attendance (1) Dropout (3^{k, f, m}) Completion/dropout (3^{g, l, n}) Participation (1)
Longer period of admission/previous incarceration	>Attendance (1 ^q) Completion/dropout (2^{r, s}) >Participation (1)
Number of previous arrests/convictions (lower)	Attendance (1) Completion (3^{d, f, q}) Completion/dropout (2^{s, t}) Participation (2^{c, t}) Homework/out of session behavior (1)
Older at onset of drug use (non-white only)	Completion (1)
<u>Offence-related factors</u>	
Entering a not guilty plea	Dropout (1 ^u)
Index offence: child sexual offending	Completion (1)
Index offence: property crime	Dropout (1)
<u>Psychosocial factors</u>	
Anger	Completion/dropout (3^{e, a, t}) Participation (1^t) Homework/out of session behavior (1^t)
Antisocial (lower)	Completion (2 ^v) Completion/dropout (1) >Participation (3 ^{cc, t, w}) >Peer support (1)
Anxiety	Completion/dropout (3^{e, l, t}) <Participation (2^{o, x}) Participation (2^{t, x}) Homework/out of session behavior (1^t) <Counselor rapport (1^x) <Treatment satisfaction (1^x)
Attitudes towards women	Completion/dropout (1)
Attitudes towards violence/rape	Completion/dropout (1)
Cluster B - Histrionic/borderline/narcissistic (higher)	Dropout (1) <Participation (1)
Cold-heartedness	<Participation (1) <Counselor rapport (1 ^o)
Confidence/self-esteem/self-efficacy	>Participation (2 ^y) Participation (1^x) Counselor rapport (1^x) Treatment satisfaction (1^x) >Peer support (1^x)

^p Polaschek (2012)

^q Cook et al. (1991)

^r Tapp et al. (2009)

^s Schweitzer and Dwyer (2003)

^t McCarthy and Duggan (2010)

^u Clegg et al. (2010)

^v Nunes and Cortoni (2008)

^w Pankow and Knight (2012)

^x Simpson et al. (2012)

^y Harkins et al. (2010)

Crack-cocaine dependency	Motivation (1)
Criminal thinking style	<Participation (2 ^{o, x}) <Counselor rapport (2 ^{o, x}) <Treatment satisfaction (1 ^x) <Peer support (1 ^x)
Decision making (higher)	>Participation (2 ^{o, x}) >Counselor rapport (1) >Counselor rapport (1) >Treatment satisfaction (1 ^x) Peer support (1^x)
Denial (lower)	>Participation (1 ^z) >Counselor rapport (1)
Depression (higher)	Dropout (2 ^{s, n}) Completion/dropout (2^{e, p}) <Participation (2 ^{o, x}) Participation (1^x) <Counselor rapport (2 ^{o, x}) Counselor rapport (1^x) Treatment satisfaction (1 ^x)
Heroin dependency	>Motivation (1 ^{aa})
Hostility (higher)	Dropout (1) <Participation (2 ^{o, x}) <Counselor rapport (2 ^{o, x}) <Treatment satisfaction (1 ^x) <Peer support (1 ^x)
Impulsivity (lower)	Completion (1 ^t) >Participation (1 ^t) >Homework/out of session behavior (1 ^t)
Impulsive/careless social problem solving (lower)	Completion (1 ^{bb})
Intelligence	Completion/dropout (2^{p, t}) Participation (1^t) Homework/out of session behavior (1^t)
MMPI subscales: F(distress, alienation), K (guarded, defensive)	>Participation (1 ^{cc})
Passive social problem solving (lower)	Completion (1)
Psychiatric issues	Dropout (1)
Psychopathy (lower)	Completion (2 ^{bb, t}) >Participation (1 ^t) >Homework/out of session behavior (1 ^t)
Rational social problem solving (higher)	Completion (1)
Risk-taking (higher)	<Participation (2 ^{o, x}) <Counselor rapport (2 ^{oo, x}) <Treatment satisfaction (1 ^x) Peer support (1 ^x) Peer support (1^x)
Social support (higher)	>Participation (1 ^x)
Substance addiction severity	Completion/dropout (1^s)
Use of alcohol/substances	<Attendance (2 ^{c, dd}) Attendance (1^a) Completion/dropout (1^p)
<u>Approach to treatment</u>	
Defensive/opposed to treatment	<Homework/out of session behaviors (1 ^{ee})
Emotional response to personal issues identified in treatment	>/<Homework/out of session behaviors (1 ^{ee})
Evasive/ambivalent to treatment	>Homework/out of session behaviors (1 ^{ee}) <Self-disclosure (1 ^{ff})
Exploratory	>Self-disclosure (1 ^{ff})
Motivation (higher)	Completion (2 ^g) Completion/dropout (1^{hh}) >Participation (2 ^{x, y}) Participation (1^{hh}) , Homework/out of session behavior (1^{hh}) >Counselor rapport (1 ^x) >Treatment satisfaction (1 ^x) >Peer support (1 ^x)

^z Macgowan and Levenson (2003)

^{aa} Greaves et al. (2009)

^{bb} McMurrin et al. (2008)

^{cc} Kalichman et al. (1990)

^{dd} Ting et al. (2001)

^{ee} Frost and Connelly (2004)

^{ff} Frost (2004)

^{gg} McMurrin and McCulloch (2007)

^{hh} Sowards et al. (2007)

Oppositional/placatory	<Self-disclosure (1 ^{fff})
Positive outlook	Completion (1 ^{hh}) > Participation (1 ^{hh}) Homework/out of session behavior (1 ^{hh})
Treatment readiness	Completion (1 ^{hh}) Participation (1 ^{hh}) Homework/out of session behavior (1 ^{hh}) > Counselor rapport (1 ^x) > Treatment satisfaction (1 ^x) > Peer support (1 ^x)

Table 4 . Treatment factors associated with variables underlying operational definitions and assessments of engagement

Treatment factors	Engagement variables (no. of studies finding an association) and engagement variables (no. of studies finding no association)
<u>Treatment referral</u>	
Court ordered/drug court	>Attendance (1 ⁱⁱ) Completion (3 ^{jj, kk, ll}) >Participation (1 ^{mmm})
<u>Perceptions of treatment</u>	
Program organization/policies	>Attendance (1 ⁿⁿ) Completion (1 ^{oo}) Completion/dropout (1ⁿⁿ) >Participation (1 ^{pp})
Treatment satisfaction	Attendance (1^{pp}) >Participation (2 ^{pp, qq}) >Counselor rapport (2 ^{qq, pp})
Therapeutic relationship/counselor rapport	Attendance (1^{pp}) Completion (1 ^{oo}) >Homework/out of session behaviors (1 ^{rr}) >Treatment satisfaction (1 ^{pp})
<u>Treatment progress/length</u>	
Treatment progress (therapist ratings)	>Participation (1 ^{ss})
Length of time in treatment (longer)	>Treatment satisfaction (1 ^{tt})

ii Chovanec (2012)
 jj Buttell et al. (2011)
 kk Marinelli-Casey et al. (2007)
 ll Rosenbaum et al. (2002)
 mmm Shearer and Ogun (2002)
 nn Bowen (2010)
 oo McMurrin and McCulloch (2007)
 pp Levenson et al. (2009)
 qq MacGowan and Levenson (2003)
 rr Frost and Connelly (2004)
 ss MacGowan and Levenson (2003)
 tt Raney et al. (2005)

Program content/objectives/environment

Content importance	Attendance (1 ^{pp})
Learning new skills/psycho-educational material	>Attendance (1 ⁱⁱ) Completion (2 ^{oo, uu}) >Participation (1 ⁱⁱ) Counselor rapport (1 ⁱⁱ)
Controlling anger and aggression	Completion (1 ^{oo})
Increasing confidence and self-improvement	Completion (1 ^{oo})
Matched to stages of change	>Homework/out of session behavior (1 ^{vv})
Drama/role-play	>Participation (1 ^{ww})
Specialty groups (alcohol and addiction counseling)	Completion (1 ^{xx})
Pre-trial program/pre-treatment program	Completion (1 ^{jj}) >Participation (1 ^{yy})
Therapeutic community program	Participation (1 ^{zz}) Counselor rapport (1 ^{zz}) Treatment satisfaction (1 ^{zz}) Peer support (1 ^{zz})
<u>Group dynamics</u>	
Group members not taking program seriously	Dropout (1 ^{oo})
Identifying with others who had changed	>Attendance (1 ⁱⁱ) >Participation (1 ⁱⁱ) > Homework/out of session behavior (1 ^{aaa})
Attitude towards the group (positive)	>Participation (1 ^{qq}) >Counselor rapport (1 ^{qq})

^{uu} Vallentine et al. (2010)

^{vv} Levesque et al. (2010)

^{ww} Harkins et al. (2010)

^{xx} Deschenes et al. (2009)

^{yy} Roque and Lurigio (2009)

^{zz} Rowan-Szal et al. (2009)

^{aaa} Sowards et al. (2007)

3.2.1 Offender characteristics and treatment factors associated with attendance, completion, or drop-out. In terms of the offender demographics associated with attendance, completion or drop-out, the findings were equivocal for every factor assessed. Age was associated with attendance in one study (Roque & Lurigio, 2009) but not others (Daly, Power, & Gondolf, 2001; Hadley, Reddon, & Reddick, 2001). Equally being older differentiated completers from dropouts in three studies (Derks, 1996; DeVall & Lanier, 2012; Hollin et al., 2008), but not others (Evans, Li, & Hser, 2009; Ghodse et al., 2002; Shaw, Herkov, & Greer, 1995; Tapp, Fellowes, Wallis, Blud, & Moore, 2009). More women completed treatment than men in one study (Hadley et al., 2001), but other studies found no gender differences in completion rates (Ghodse et al., 2002; Roque & Lurigio, 2009). White participants were more likely than non-whites to complete drug-court treatment (DeVall & Lanier, 2012), less likely to attend a treatment readiness group (Roque & Lurigio, 2009), but other studies found no associations between race and completion rates (Buttelli, Powers, & Wong, 2012; Evans et al., 2009). Being employed was associated with higher rates of completion (Buttelli et al., 2012; Daly et al., 2001; Deschenes, Ireland, & Kleinpeter, 2009; DeVall & Lanier, 2012; Evans et al., 2009) but also non-attendance (Roque & Lurigio, 2009). As with gender and race, other studies found no associations between employment and completion (Ghodse et al., 2002; Rosenbaum, Gearan, & Ondovic, 2002). Similarly inconsistent findings were evident for relationship status and attendance (please refer to Table 3), but the most consistent finding was that higher levels of educational attainment and reading ability were associated with completion among sexual offenders (Shaw, Herkov, & Greer, 1995), drug-court participants (Deschenes et al., 2009; DeVall & Lanier, 2012), female (Buttelli et al., 2012) and male (Daly et al., 2001) domestic violent offenders. These findings suggest that demographic factors are likely to be generally unreliable predictors of engagement, but that offenders with a better education may more easily engage.

Historical factors relating to program completion also produced equivocal findings, most of which appear to be related to whether samples were in the community, or within an institution. Age at first conviction failed to differentiate prisoners completing or dropping out of treatment (Polaschek, 2012), but being younger at first conviction predicted outpatients dropping out of treatment (DeVall & Lanier, 2012; Evans et al., 2009). History of violence was not associated with completion of programs in prison or institutions (McMurrin, Huband, & Duggan, 2008; Polaschek, 2012), but a greater history of violence was associated with offenders in the community dropping out of treatment (Buttelli et al., 2012; Evans et al.,

2009; Rosenbaum et al., 2002). A greater number of previous convictions was not associated with completion of programs in prison or institutions (McCarthy & Duggan, 2010; Schweitzer & Dwyer, 2003), but offenders in the community with a greater number of previous convictions were significantly more likely to drop out of treatment than those with fewer convictions (Cook et al., 1991; DeVall & Lanier, 2012; Hollin et al., 2008). The period of admission in prison or hospital prior to treatment failed to differentiate completers in prison (Schweitzer & Dwyer, 2003; Tapp et al., 2009) but sexual offenders in the community failing to attend treatment were significantly more likely than those that attended to have no previous imprisonments (Cook et al., 1991). These findings indicate that historical factors have a greater, negative influence on offenders' engagement if they are in the community than if they are in prison or an institution, possibly because in the community they may still be exposed to historical factors relating to their offending behavior.

Among the offence-related factors, only risk produced equivocal findings. Non-completers had a significantly higher risk of reoffending compared to completers (Hollin et al., 2008; McGuire et al., 2008), whereas risk failed to discriminate completers in the study by Polaschek (2012). Dropouts were significantly more likely than completers to have entered a plea of not guilty (Clegg, Fremouw, Horacek, Cole, & Schwartz, 2011), and be convicted of a property crime rather than a sexual offence (Derks, 1996). Offenders' denial, risk of reoffending, and the nature of their offences and how these factors influence treatment completion are likely to reflect varying levels of underlying psychosocial factors impacting on their ability to engage in treatment.

There were a few inconsistent findings in relation to substance abuse (Daly et al., 2001; Evans et al., 2009; Roque & Lurigio, 2009; Ting et al., 2009), depression (Derks, 1996; Evans et al., 2009; Polaschek, 2012), motivation (Evans et al., 2009; McMurrin & McCulloch, 2007; Sowards et al., 2006) and antisocial behavior (Derks, 1996; McCarthy & Duggan, 2010; Nunes & Cortoni, 2008; Shaw, Herkov, & Greer, 1995), which suggests that these factors may not always reliably predict treatment completion (please refer to Table 3). These factors are likely to be particularly prone to fluctuation necessitating multiple assessments over the course of treatment in order to reliably predict completion. However, most of the 20 psychosocial factors investigated in relation to attendance, completion or dropout were consistent. Completers had significantly lower scores for hostility (Derks, 1996), psychopathy (McCarthy & Duggan, 2010; McMurrin et al., 2008), impulsivity (McCarthy & Duggan, 2010; McMurrin & McCulloch, 2007), and were more rational (McMurrin & McCulloch, 2007) than non-completers. However, anger, anxiety, intelligence

(Derks, 1996; McCarthy & Duggan, 2010; Polaschek, 2012), attitudes towards women, and attitudes towards violence (Polaschek, 2012) were all found to be unrelated to completion or dropout.

Among the 33 studies where attendance was assessed, only nine investigated associated treatment factors. As can be seen in Table 4, the findings were generally consistent, but most factors were examined within only one or two studies. Female offenders (Buttell et al., 2012) and male offenders (Marinelli-Casey et al., 2008; Rosenbaum et al., 2002) were more motivated to attend (Chovanec, 2012) or complete treatment (Buttell et al., 2012). Deschenes et al. (2009) found that drug-court offenders were more likely to complete treatment if they completed group counseling for alcohol and addiction (Deschenes et al., 2009)(2009). 'Learning new things' was cited by participants as important to offenders' engagement (Chovanec, 2012), which supports the earlier findings of McMurrin and McCulloch (2007) whereby prisoners completing a thinking skills program cited learning new skills as an important factor. Vallentine et al. (2010) also found that psycho-education encouraged offenders to complete other relevant treatments.

Group dynamics are clearly of importance in relation to attendance and completion. Being able to identify with other group members undergoing change motivated offenders to attend (Chovanec, 2012) and complete treatment (Sowards et al., 2006). On the other hand, in the study by McMurrin and McCulloch (2007), non-completers cited group dynamics and group members not taking the program seriously as reasons for non-completion. Completers in the same study cited increasing confidence and self-improvement as reasons for completion (McMurrin & McCulloch, 2007). Therefore, while the MORM (Ward et al., 2004) includes self-esteem as a treatment readiness factor facilitating engagement, a desire to enhance it may also play a part in the engagement process.

Apart from typical research limitations such as a reliance on self-report data (Evans et al., 2009), non-random allocation to groups (Marinelli-Casey et al., 2008), small samples (Derks, 1996; Vallentine et al., 2010) and lack of control groups in therapeutic evaluations (Cook et al., 1991; Shaw, Herkov, & Greer, 1995; Vallentine et al., 2010), the main limitation of the completion research was that few of the offender characteristics or treatment factors relating to completion or dropout were investigated in more than one study. Furthermore, the program type and setting varied across the studies. This leads to a broad but indeterminate profile of the characteristics of offenders who are likely to complete, or dropout of, treatment. However, they collectively indicate greater inconsistencies than consistencies in terms of offender demographics associated with completion, and that the influence of historic factors

on completion appears to be mediated by offenders' environments. Psychosocial factors were generally more consistent, as were treatment factors, but further research is required to support the findings.

3.2.2 Offender characteristics and treatment factors associated with participation. Unlike the attendance, completion and dropout literature, findings from the participation studies in relation to offender demographics appear consistent, although this may well be due to fewer studies investigating this engagement variable. Age and race were not associated with participation (Daly et al., 2001; Jackson & Innes, 2000) but employment (Jackson & Innes, 2000), being female (Staton-Tindall et al., 2007) and education (Jackson & Innes, 2000) were. Education was also the only characteristic consistently related to attendance, indicating this to be an important factor in relation to offenders' engagement. In terms of historic factors, a longer time served predicted greater participation (Jackson & Innes, 2000) but the number of previous offences was not related to participation (Daly et al., 2001; McCarthy & Duggan, 2010), indicating that offenders anticipating release, irrespective of their offence histories, may see greater benefits from participating in treatment.

The findings of associations between psychosocial factors and participation were mixed. In the study by Kalichman, Shealy and Craig (1990) offenders' participation in treatment was positively correlated with being guarded and defensive, but in the study by Macgowan and Levenson (2003) participation was negatively correlated with denial; hence there may be a subtle but important distinction between defensiveness and denial in relation to offenders' participation. Lower levels of depression and anxiety (Simpson et al., 2012; Staton-Tindall et al., 2007) at the treatment phase were associated with participation but not at a later (prior to release) phase (Simpson et al., 2012). There were similar inconsistencies among the findings from the completion studies, indicating that these factors may be prone to fluctuation requiring multiple assessments, but their association with participation may also be moderated by gender. Staton-Tindall et al. (2007) found a stronger negative relationship between depression, anxiety, poor decision-making, hostility and participation among female offenders than male offenders. On the other hand, there was a stronger negative association between participation and cold-heartedness among male offenders than female offenders (Staton-Tindall et al., 2007). Cold-heartedness may reflect antisocial tendencies more common among males (Staton-Tindall et al., 2007: 1153), which were also associated with lower participation (Daly et al., 2001; Pankow & Knight, 2012). However, for both male and female offenders, lower levels of hostility, risk taking and criminal thinking (Simpson et al.,

2012), and higher levels of self-esteem (Staton-Tindall et al., 2007), expectancy (Simpson et al., 2012), decision making (Simpson et al., 2012; Staton-Tindall et al., 2007), self-efficacy, and motivation to change (Harkins et al., 2011) were associated with participation.

Offenders' motivations to change and perceptions of volition to enter treatment are identified as change readiness factors in the MORM (Ward et al., 2004) but these factors can also be targeted within treatment to enhance participation. Following active participation in a three-day drama-based program to help prisoners address issues related to release, participants evidenced significant improvements in motivation to change, as well as self-efficacy and confidence in skills (Harkins et al., 2011). Participants described the program as enlightening and enjoyable compared to other courses (Harkins et al., 2011: 558), indicating the benefits of active participation over more didactic approaches that can also create problems for offenders with learning difficulties. Offenders' who perceived that they had voluntarily participated in substance abuse treatment were significantly lower in treatment resistance than those who perceived they were forced to participate (Shearer & Ogan, 2002). However in some cases, actual coercion may be needed as Buttell et al. (2012) found that females court ordered to treatment were more likely to complete than those who were not. These findings indicate that perceptions of coercion (or volition) rather than coercion itself are more important to change-readiness, and ultimately treatment participation. Offenders participating in one or more treatment readiness sessions were five times more likely to enter substance abuse treatment than those who did not participate, and were also more likely to complete treatment (Roque & Lurigio, 2009). These findings advocate the use of pre-treatment sessions (even just one) to enhance offenders' change readiness, by encouraging offenders' to perceive autonomy in their rehabilitation as a means of enhancing the likelihood of treatment participation.

Participation also depends on offenders' perceptions of other group members. Sowards et al. (2006) interviewed female offenders and found a theme of connecting with peer "role models" for fostering program engagement. Similarly, Chovanec (2012) interviewed male offenders and reported men identifying the importance of learning from other men's stories as relevant to their engagement. Being able to personally identify and connect with others embarking on change was also a motivational factor that doubled the likelihood of female offenders succeeding in treatment (Sowards et al., 2006) and enhanced the overall engagement of male offenders (Roy et al., 2013). Sexual offenders' attitudes towards the group were also associated with participation and treatment progress (Macgowan

& Levenson, 2003), demonstrating the importance of group members' perceptions of one another on both treatment participation and treatment outcomes.

The limitations of the participation studies included small sample sizes (Kalichman et al., 1990), a reliance on self-report assessments of participation (Simpson et al., 2012; Staton-Tindall et al., 2007), quasi-experimental research design (Roque & Lurigio, 2009), a lack of control groups and the selection of already motivated participants (Harkins et al., 2011: 553). Apart from the mixed findings in relation to depression, anxiety, denial, and defensiveness, the findings were less equivocal than in the completion studies, although there were fewer studies investigating participation. Offenders who were educated, previously employed, with lower scores for psychopathy, impulsivity and hostility, and who had served a longer sentence were more likely to participate in treatment. Offenders' motivation and self-esteem were enhanced through active participation in drama and role-play. Perceptions of coercion rather than coercion itself appear to be of greater importance to participation, but can be addressed through pre-treatment change readiness sessions which have a significant, positive impact on participation. Identifying with peer-role models within the group enhanced participation and ultimately treatment progress.

Offender characteristics and treatment factors associated with homework and out of session behaviors. Homework completion was associated with lower psychopathy and impulsivity scores (McCarthy & Duggan, 2010) and fewer substance-use problems (Ting et al., 2009), but not with motivation or treatment readiness (Sowards et al., 2006), suggesting that in some cases homework completion may reflect a basic treatment compliance. The remaining findings were in relation to offenders' treatment attitudes and treatment factors. Levesque et al. (2012) found that offenders attending an extra three sessions of treatment matched to their stages of change were more likely to engage in out of session strategies to avoid violence (e.g. talking to friends, family, professionals, attending counseling) than offenders not attending the extra sessions. Talking to other prisoners in the group and reflecting on treatment feedback was an activity undertaken by offenders who were more evasive or ambivalent towards treatment than those who were defensive or opposed to treatment in the study by Frost and Connelly (2004). Their study also revealed that the therapeutic relationship was what progressed offenders through the engagement process (Frost, 2004), indicating the important and pervasive influence this relationship has on offenders' engagement in treatment and change.

Some of the findings might be considered limited by a sample that was either small (Frost, 2004) or limited to treatment completers (Levesque et al., 2012). However, they indicate the importance of matching offenders' change readiness to treatment, ideally with the use of pre-treatment sessions such as motivational interviewing (Miller & Rollnick, 2002). This may help to reduce diversity in offenders' stages of change but there may be an argument for retaining *some* variation in readiness as the findings of McMurrin and McCulloch (2007) indicated that being able to identify with group members at a more advanced stage of change was associated with completion. Furthermore, the findings underscore the importance of the therapeutic relationship on engagement in the process of treatment and change.

Offender characteristics and treatment factors associated with counselor rapport and treatment satisfaction. The three studies employing the CEST to assess treatment satisfaction and counselor rapport (Rowan-Szal et al., 2009; Simpson et al., 2012; Staton-Tindall et al., 2007) generated similar findings to the psychosocial factors associated with participation as measured by the CEST. Female offenders' higher scores for depression, anxiety, poor decision-making and male offenders' higher scores for criminal thinking and cold heartedness were negatively related to their ratings of counselor rapport (Staton-Tindall et al., 2007). Hostility and risk-taking were also negatively related to both treatment satisfaction and counselor rapport (Simpson et al., 2012). Depression and anxiety related differently to treatment satisfaction compared to counselor rapport in the study by Simpson et al. (2012). Counselor rapport was only related to depression scores at the treatment phase and not the pre-release phase, whereas treatment satisfaction was related to low scores for depression and anxiety at both time points (Simpson et al., 2012). This indicates that treatment satisfaction may be more susceptible to the influence of these psychosocial factors and fluctuate along with them than counselor rapport, which may be more stable although further research would be required to support this. A potential for treatment satisfaction to fluctuate might also be because it takes longer to become established as Raney et al. (2005) found that prisoners who had been in treatment for six months reported significantly higher levels of treatment satisfaction than prisoners who had been in treatment for three months or less.

Although treatment satisfaction may fluctuate during the course of treatment, it is likely to reflect offenders' perception of the therapeutic relationship; therefore, it is not surprising that associations between the two have been established (Levenson et al., 2009;

Macgowan & Levenson, 2003). However, both treatment satisfaction and counselor rapport appear to be unrelated to the therapeutic environment. Rowan-Szal et al. (2009) found no differences between female prisoners attending either a therapeutic community program or a standard outpatient treatment program in their ratings of treatment satisfaction or counselor rapport. However the ratings for both engagement variables were high, which may reflect the fact that females tend to be more engaged than males (Staton-Tindall et al., 2007).

The findings of the counselor rapport and treatment satisfaction studies might be limited through a reliance on self-reporting evidencing impression management (Levenson et al., 2009; Macgowan & Levenson, 2003), or 'early release participants' (Raney et al. 2005, p. 32) that may have resulted in a biased reporting. Limitations notwithstanding, the findings tentatively indicate there are gender-based differences in how treatment satisfaction and counselor rapport are related to psychosocial factors, that treatment satisfaction may be more prone to fluctuation than counselor rapport, and that the therapeutic environment has little impact on either.

Offender characteristics and treatment factors associated with motivation, peer/social support, and self-disclosure. The engagement determinants of motivation and peer support were positively correlated (Simpson et al., 2012). Interviews with offenders revealed that pleasing loved ones and receiving their encouragement were significant influences on their motivation and engagement (Greaves et al., 2009; Roy et al., 2013). Although findings may be limited by small opportunistic samples (Greaves et al., 2009), they demonstrate the importance of positive peer influence (or lack of) on engagement. However, the desire to please others or receive encouragement may cause problems for the motivation of offenders who have anti-social tendencies. High anti-social scores predicted low participation in treatment and low peer support (Pankow & Knight, 2012). Pankow and Knight (2012: 381) suggested orientation classes might be beneficial to prepare anti-social offenders for treatment on the basis that their mechanisms for engagement are likely to be different. This certainly warrants further research, but practitioners may in some cases consider one-to-one treatment more suitable for particularly anti-social offenders who may not benefit from group work or who may have a negative influence on other group members.

The way in which offenders self-disclose in groups may reflect the nature of their engagement. Frost (2004) classified the disclosures of sexual offenders into four management styles: exploratory (prefers self-validation and open discussion); oppositional (prefers validation of others and open discussion); evasive (prefers validation of others and

circumspection); and, placatory (prefers validation of others and open discussion). Oppositional-style offenders were the most resistant while exploratory-style offenders were considered the most engaged (Frost, 2004: 201). Although the findings are restricted to a small sample of sexual offenders, they provide an insight into how offenders manage uncomfortable situations in treatment. As a certain amount of discomfort may be unavoidable for some offenders to engage in any meaningful change, practitioners may need to consider developing ways of reducing sources of discomfort within treatment (e.g. rolling with resistance: Lee, Uken and Sebold 2007) as a means of enhancing engagement.

4. Discussion

4.1 Operational Definitions and Assessments of Offender Engagement

The various operational definitions and assessments of engagement employed in the studies reviewed reflect a lack of clarity in the role of engagement-related variables. Prior to a discussion of each of these variables, a brief model is proposed (please see Figure 1) that characterizes the role of the engagement variables. Engagement determinant variables comprise inter-related variables that are either cognitively-based (offender motivation), treatment-based (program responsivity, counselor rapport, peer support) or dependent on offenders' living situations (social support, out of session environments). Although offenders' out of session environments were not employed as a proxy for engagement in the studies reviewed, they appeared to differentiate the influence of offenders' historical factors on completion rates. Furthermore, environmental factors are likely to be of significant influence on offenders' out of session behaviors, which potentially represent the most important proxies for engagement in the process of change. The engagement determinant variables influence offenders' engagement within treatment and the process of change, but they do not reflect what offenders 'do' in relation to treatment. In contrast, engagement process variables: attendance; participation; out of session behaviors or homework and self-disclosure are active-based i.e. they represent offenders' efforts within and between sessions towards treatment and change. Attendance facilitates participation and out of session behaviors or homework, which are mutually important as participation infers engagement in the process of treatment, whereas out of session behaviors may infer engagement in the process of treatment *and* change. Offenders' self-disclosures within treatment of the efforts they have made between sessions forms part of their participation within treatment, creating an important link between these two engagement process variables. These engagement process variables lead to

engagement outcome variables: completion or dropout; treatment satisfaction; and behavioral change. Future research directions for this model are proposed in section 5.1 (below).

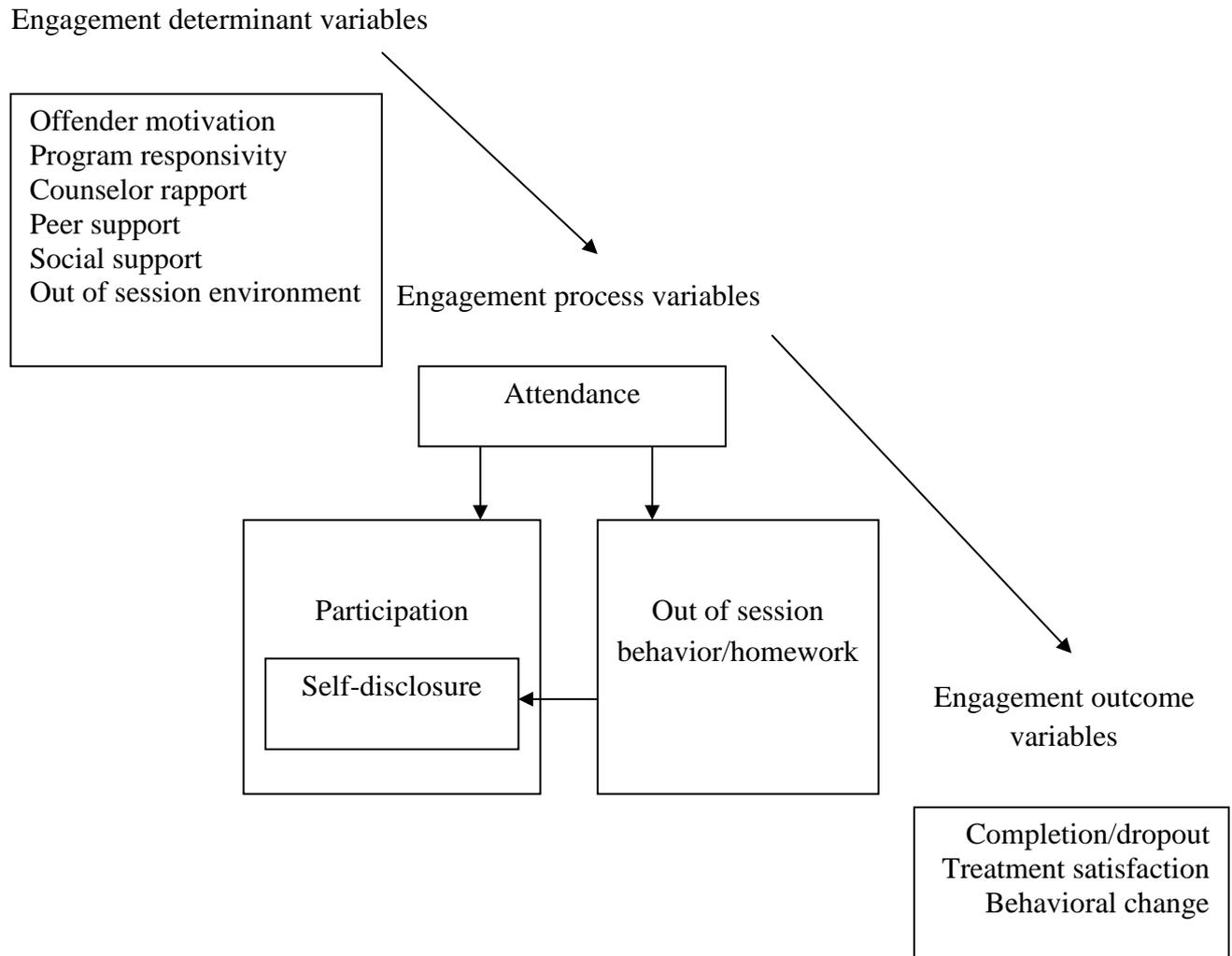


Figure 1. Model for offender engagement based on the findings and conclusions from the literature reviewed.

Attendance to treatment may represent the minimum amount of effort offenders make towards treatment, and therefore represent an engagement process variable. However, attendance merely provides the opportunity for offenders' active efforts towards treatment to occur; no quantification of treatment attendance can account for these efforts, and therefore cannot reliably infer engagement. Completion may represent an outcome of engagement and hence be assessed to infer engagement, but only if this is a qualitatively assessed in relation to program objectives. Completion criteria that are explicitly linked to the achievement of program objectives allow for the examination of offender characteristics and treatment factors associated with treatment progress, which may in turn reveal the quality of engagement. However completion can still only infer engagement retrospectively; i.e. it is not possible to assess engagement as completion during treatment. This is problematic for practitioners wishing to establish the extent to which participants are engaged during the treatment process, and identify any targets for enhancing engagement. If practitioners need to know what to look for during treatment as an early indication of whether or not group members are engaged, active participation within and between treatment sessions may be of greater use.

In nearly half the engagement-defined studies, participation was referred to or assessed but generally without clear operational definitions for what is arguably a multifarious but treatment-specific construct. The broad range of treatment programs for offenders (Ministry of Justice, 2012) leads to a diverse set of criteria for program participation, but they are likely to generically involve cognitive, discursive, and active participation within treatment-specified tasks. Participation as a proxy for engagement requires operational definitions and taxonomy for assessment that are clearly linked to the objectives of the program. There might be differing emphases placed on different types of participation (e.g. behavior in the study by Harkins et al., 2010) but it might be misleading for practitioners to assume that a lack of more observable types of participation such as undertaking role-play activities, indicates a lack of cognitive participation such as ruminating over issues (e.g. Frost & Connolly, 2004). The group setting and treatment environment may stimulate some group members to participate in some treatment activities but constrain others from doing so. Furthermore, participation can only reflect the efforts offenders make within treatment i.e. it can only represent engagement in the treatment process, not necessarily the process of change. This is a limitation of relying on within session participation to assess engagement that out of session behavior might help to address.

Only five studies focused on homework or out of session behaviors, yet these arguably represent the most important proxies for engagement in the process of change. Even though research among non-offender populations (Kazantzis, Whittington, & Dattilio, 2010) as well as offender populations (Morgan & Flora, 2002) have established the importance of homework to treatment outcomes, there has been relatively little research focusing on treatment factors associated with homework and out of session behaviors. Being given a set task in between sessions may generate resistance, compliance or engagement, depending on a variety of factors including: how the task is introduced (Scheel, Hanson, & Razzhavaikina, 2004); offenders' perceptions of the task's relevance to treatment objectives; offenders' environments; and whether the task reflects treatment responsivity (Polaschek, 2012; Taxman & Thanner, 2006). There may be a fine line between compliance and engagement, but not all 'engagement' or change behaviors may fit within the realm of treatment compliance. *Any* behaviors or strategies employed between sessions that involve moving away from behavioral pathways that previously led to offending, representing a concerted, practical effort towards positive change should be considered as evidence of engagement in treatment and change. These behaviors may to varying degrees be related to treatment objectives, but the objectives should have personal relevance to offenders' need for change, or even be dictated by offenders in the form of a personal goal (Lee et al., 2007). Furthermore, the offenders' environments are likely to have a considerable influence on out of session behaviors, potentially harnessing sources of support as well as obstacles (including dynamic risk factors for reoffending) to engagement in the process of change. It is important, therefore, that practitioners actively seek out, explore, and praise *any* instances of positive change, assisting offenders to progress towards treatment objectives that have been defined by them as relevant. This is likely to not only help establish the extent of their engagement in treatment and change, but it may also enhance it, as well as that of other members of the group. Any out of session treatment-related behaviors and within treatment participation should be assessed in conjunction to make more reliable inferences about engagement in treatment and change.

In eleven of the studies reviewed engagement was measured via the CEST or the GEM. Where the CEST and the GEM differ is on the variables of attendance, contracting, working on issues (GEM), counselor rapport (CEST) and treatment satisfaction (CEST), but both measures include assessments of offenders' active efforts; i.e. participation (CEST) or contributing (GEM) and working on issues (GEM). These are arguably of the most relevance to the *process* of engagement, with other subscales measuring determining or outcome

factors. The inconsistent use of subscales to assess engagement without adherence to the original model parameters contributes to a merging of what have been described elsewhere as determinant variables such as motivation and treatment readiness (Drieschner et al., 2004; Ward et al., 2004) with engagement process variables. The outcome is that engagement has become a conglomerate of disparate variables that are probably related to engagement, but which do not characterize the treatment and change processes offenders enter into.

Only three studies employed a purely qualitative methodology (Frost, 2004; Frost & Connolly, 2004; Roy et al., 2013) revealing a bias for pre-defining engagement as opposed to exploring it, but each offered a unique contribution to an understanding of engagement. The findings of Roy et al. (2013) supported associations between engagement conceptualized along the seven dimensions of the GEM and factors such as group cohesion and peer/social support. The study by Frost (2004) presented the only process-based conceptualization of engagement, yet the concept that engagement is on-going and evolving seems intuitive when engagement is directly associated with the process of change. Frost and Connolly (2004) viewed engagement through self-disclosure management styles. Arguably self-disclosure (and other such treatment requirements) may only provide an insight into compliance rather than engagement, but asking offenders to volunteer the most relevant treatment content and link these treatment details to offence details (or potentially change details for a more strengths-based approach) helps practitioners to determine which program components are most relevant to offenders' engagement, and potentially, behavioral change. The type of engagement that leads to, or represents, positive change may depend on developing strong connections within treatment between treatment concepts, the issues that bring offenders to treatment, and the positive cognitive and behavioral changes offenders are making.

4.2 Associated Offender characteristics and Treatment Factors

Offender demographics may frequently be relied upon to evaluate programs and differentiate those likely to engage in treatment, but nearly every offender demographic assessed produced equivocal findings in terms of how they were associated with the engagement variables. In turn, and further complicating matters, particular demographics seemed to interact (e.g. married male offenders were more likely to complete treatment than unmarried offenders, but only if they were court-referred and not self-referred: Rosenbaum et al., 2002). Further still, each variable was examined by few studies, investigating different interventions, resulting in few replicated findings. Therefore, the findings offer little clear and direct guidance for practitioners and may be of little use in predicting engagement. However,

there were consistent findings of an association between higher levels of education and completion and participation that has important implications. In a review by the Prison Reform Trust it was reported that 20% to 30% of offenders have learning difficulties or learning disabilities and are unlikely to benefit from conventional programs (Loucks, 2006). Furthermore, because they are time consuming and costly, adequate screening tests for learning disabilities are unlikely to be routinely used (McKenzie, Michie, Murray, & Hales, 2012). Thus a learning disability or difficulty (particularly if it is undetected) may represent an important obstacle to engagement.

The findings in relation to historic factors were also equivocal but there was a clear picture that they tended to distinguish between completers and non-completers of programs in the community rather than offenders within prison or treatment facilities, possibly due to the mediating influence of environmental factors which for community offenders may still harness dynamic risk factors for offending behavior. For example, young offenders with a greater history of violence who are still exposed to the same environment and social networks may be more likely to drop out of treatment, whereas in prison these factors may have less of an influence. It may be for this reason that a longer time served in prison was positively associated with participation (Jackson & Innes, 2000), whilst the number of previous convictions was not (McCarthy & Duggan, 2010). Environmental factors may potentially be of greater relevance to practitioners and the treatment process than historic factors, as they may be susceptible to change (e.g. moving away from negative peer influence) and addressed within treatment as a means of enhancing completion rates. Similarly to historic factors, offence-related factors, such as risk of reoffending, may not reliably predict completion, but might reflect the important environment factors they are embedded within, and varying levels of psychosocial factors more capable of discriminating completers and non-completers.

Unlike the demographic and historical factors, there was greater consistency among the psychosocial factors and attitudes to treatment relating to the engagement variables. There were equivocal findings in relation to: depression; confidence; anxiety; and risk-taking, but anger; use of substances; addiction severity; attitudes towards women and violence; and intelligence appear to be of little relevance to the engagement variables. Of greater relevance were lower scores in hostility, impulsivity, risk-taking, psychopathy, antisocial behavior, impulsive social problem solving, denial and criminal thinking, but higher scores in rational or passive problem solving, decision making, and a positive outlook were all associated with engagement. It must be noted that most of these psychosocial factors were investigated by only one, two, or three studies (with the exception of antisocial behavior which was

investigated by five studies), making it difficult to draw conclusions as to why certain psychosocial factors were relevant to engagement variables while others were not. However, a tentative conclusion is that it is the relevance of psychosocial factors to offenders' abilities to work in group settings that contributes to the differences.

Irrespective of how well a program is facilitated, factors such as hostility, impulsivity, anti-social tendencies and psychopathy may be more stable and produce behaviors difficult to control or subdue in a group setting, even in personality disorder treatment, and may therefore warrant the incorporation of drug treatments such as serotonin reuptake inhibitors (Butler et al., 2010) within a broader treatment program. Furthermore, these factors are likely to influence offenders' abilities to work on treatment-related tasks or apply learned skills or strategies in between sessions. Equally the tendency towards rational thinking and to perceive positive outcomes from treatment may remain stable and facilitate the engagement process, regardless, to some extent, of the influence of treatment factors. However, anger, anxiety or attitudes towards violence may be less stable and therefore more susceptible to fluctuation as a function of treatment factors, and therefore represent important treatment targets. A further possible explanation is that in some settings, the presence of traits such as hostility or impulsivity may lead practitioners to make negative estimations of the treatment outcomes for these offenders, further confounding a general lack of engagement. As there is currently scant research investigating facilitators' perceptions of engagement in group programs and what influences it, research would need to establish whether and to what extent this might be the case.

Focusing on offenders' approaches to treatment and treatment factors associated with engagement variables puts greater control in the hands of practitioners, yet out of all the studies reviewed, only six studies included a focus on approaches to treatment and only 14 included a focus on treatment factors. A nuanced picture emerged as to how treatment attitudes related to engagement variables. A positive outlook was associated with participating and cooperating with treatment requirements, while treatment readiness was not (Sowards et al., 2006). In turn, the findings in relation to treatment motivation were highly equivocal; hence offenders' baseline scores for motivation and treatment readiness may be unreliable predictors of treatment participation or completion. These factors should be considered as treatment targets susceptible to change and therefore assessed both before and during the course of treatment as a measure of engagement and treatment effectiveness. Personality-related attitudes towards treatment such as defensiveness were associated positively with participation (Kalichman et al., 1990), while ambiguity or evasiveness was

associated with disengagement (Frost, 2004). Ruminating on issues affected offenders' treatment engagement in either direction by preventing the recall of issues (e.g. earlier abuse), or enhancing treatment engagement through affective engagement (Frost, 2004). The findings suggest that the influence of offenders' approaches to treatment on engagement is dependent on treatment factors, particularly the therapeutic relationship which was argued by Frost and Connelly (2004) to promote the successfulness of each stage of engagement. However, the issues offenders ruminate about may also prevent the development of a therapeutic alliance (Lysaker, Davis, Outcalt, Gelkopf, & Roe, 2011).

The majority of findings in relation to the treatment factors investigated were consistent. Treatment community programs versus outpatient programs within prison do not appear to differentiate engagement, at least among female offenders. However, acquiring knowledge and learning new skills, learning how to control anger and aggression (particularly when the delivery of content is matched to offenders' stage of change), the use of role-play and being able to identify with other group members at a more advanced stage of change were all associated with completion, participation or homework. However, each factor was examined by only one or two studies. Some of the research findings may be unreplicated because their aims were specifically evaluative, focusing on particular factors expected to be associated with the program under investigation (e.g. Deschenes et al., 2009; Harkins et al., 2011) or exploratory, focusing on idiosyncratic factor associated with engagement (e.g. McMurran & McCulloch, 2007; Sowards et al., 2006). In both cases, research findings may not always be replicable.

4.3 General limitations

There are two main limitations to this review. Firstly, the review has only captured research where the variables employed in 21 engagement-defined studies were investigated. Therefore, other variables investigated in this area of literature such as the therapeutic or working alliance (Horvath & Greenberg, 1994) that arguably relate to engagement but not defined as such, were not included. The second limitation to this review was that the engagement definitions and associated offender characteristics and treatment factors were not always exclusively related to group work. For instance in much of the substance abuse there are treatment programs that encompass a range of treatment modules including group work (e.g. Ghodse et al., 2002). It is not possible in these studies to separate out what is only relevant to group-work, meaning a conflation of individual and group engagement proxies and the associated factors is inevitable. However, a broader view that takes advantage of the

considerable research on offender interventions, particularly in the area of substance abuse, is appropriate to synthesizing existing knowledge of engagement and establishing a useful direction for future research.

5. Conclusion

5.1 Future Research Directions

It appears that offender engagement in programs is a multifaceted construct determined by a number of inter-related offender and treatment variables, but inconsistent definitions and assessments generate confusion as to exactly what the scope and nature of the engagement process is and reflect the lack of theory. Researchers are likely to assess particular proxies that are theoretically linked to components of an intervention they are evaluating, but referring to them as ‘engagement’ contributes towards the confusion of what determines engagement, and what constitutes the process of engagement. There appears to be a similar issue in the motivation literature, observed by Drieschner et al. (2004) whereby many variables considered as relevant may not necessarily represent components of the construct itself. A problem with assessing engagement determinants (e.g. motivation, counselor rapport) is that this measures only a likelihood of offenders engaging, not whether they actually do. Even if engagement determinants are assessed in relation to treatment outcomes (e.g. reoffending rates) the important link of what happens during treatment (i.e. engagement in treatment and change) remains unexplained. The model for offender engagement proposed (Figure 1, section 4.1) seeks to clarify the role of engagement-related variables. Future research might explore further how this conceptualization of offender engagement in treatment and change links offender readiness to change, with desistance from offending behavior.

The influence of environmental factors on the engagement process may be of greater relevance to practitioners than the demographic or historic factors, yet this appears to have been largely overlooked. A focus on the extent to which psychosocial factors influence not only how offenders work in group settings, but also the extent to which they influence how practitioners facilitate sessions may enable a greater understanding as to the influence of psychosocial factors on engagement. Moreover, a focus on treatment factors relating to engagement is generally lacking, which would generate more practically relevant information for developing programs and training facilitators in order to enhance engagement.

5.2 Implications for Practice

Demographic factors are of little relevance to engagement, but learning disabilities or difficulties (particularly those undetected) are likely to present obstacles to engagement. In conjunction with the potential for homework (depending on how it is introduced) to generate treatment resistance, it may be more practicable and effective for programs to move away from an over-reliance on conventional approaches that depend on the learning abilities of the group. In terms of psychosocial factors, as denial and participation appear to be negatively related and that greater treatment gains can be established through non-confrontational approaches (Lee et al., 2007; Ware & Bright, 2008; Ware & Marshall, 2008), program facilitators might concentrate therapeutic efforts on tackling denial indirectly by enhancing engagement, which will incidentally reduce denial. Active participation is likely to be reciprocally related to self-efficacy and motivation, and therefore encouraged as a means of enhancing these factors. Offenders evidencing hostility or anti-social tendencies may be treatment resistant and either benefit from pre-treatment work (Pankow & Knight, 2012), or one-to-one interventions as an alternative to group work.

Regardless of whether offenders are mandated to programs, strategies at the referral stage or pre-treatment sessions such as motivational interviewing (Burke, Arkowitz, & Menchola, 2003; Miller, Moyers, Ernst, & Amrhein, 2003; Neighbors, Walker, Roffman, Mbilinyi, & Edleson, 2008) and encouraging offenders to perceive volition (Ward et al., 2004), autonomy and choice in treatment (Lee et al., 2007; McMurrin, 2002) as part of the referral process, may lead to greater participation. Pre-treatment preparation may also represent an opportunity to introduce offenders to the benefits of some of the program tasks that sometimes trigger resistance in treatment. Role-play or the use of drama may initially be met with reservations by some offenders but may stimulate active participation and is not dependent on the learning abilities of the group, providing a useful alternative to didactic approaches. Developing means of minimizing the anxieties associated with role-play are likely to be crucial to maximizing its therapeutic benefits, such as a less 'staged' approach involving group members in a discussion of how role-play should be performed. The influence of group dynamics on participation also indicates that practitioners should actively develop the role of group members who are motivated to change, or have experience of change, to inspire other less motivated group members to initiate positive change behaviors.

In between sessions, environmental factors including peers who have negative or positive influences are important considerations for practitioners in relation to out of session behaviors (Frost & Connolly, 2004) that apply to both prison and community settings. In both cases practitioners need to explore and praise within treatment, *any* out of session

behaviors that indicate change is taking place that are relevant to offenders' personal treatment objectives, and deal with any emotive issues that may arise (Frost & Connolly, 2004). This relies on the therapeutic relationship that not only enhances engagement within treatment, but also encourages offenders to make efforts to apply treatment concepts and make behavioral changes between sessions. Practitioners should therefore consider the therapeutic relationship as an important basis for engagement in both treatment and change, and that important engagement events occur between, not just within, treatment sessions. In conclusion, the maximization of offenders' engagement in treatment and change largely depends on the therapeutic skills of facilitators, requiring the appropriate training and support from treatment providers.

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