UNDERSTANDING FACTORS THAT IMPACT RESPONSIVITY WITHIN CASE MANAGEMENT PLANS OF COMMUNITY-BASED OFFENDERS WITH AND WITHOUT MENTAL HEALTH NEEDS

by

Ainslie M. McDougall

Master of Science, University of Surrey, 2008

Bachelor of Arts, Saint Mary's University, 2005

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Supervisor: Mary Ann Campbell, PhD, Psychology

Examining Board: Caroline Brunelle, PhD, Psychology
Greg Marquis, PhD, History and Politics
Linda Neilson, PhD, Sociology

External Examiner: Kevin Douglas, PhD, LL.B.
Department of Psychology, Simon Fraser University

This dissertation is accepted by the
Dean of Graduate Studies

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Abstract

Many factors influence an offender's ability to respond to community intervention, such as the severity of mental health issues, motivation to change, quality of the case manager-offender alliance, and level of compliance/adherence to case management plans. Consistent with the Risk-Need-Responsivity (RNR) model (Andrews, Bonta, & Hoge, 1990), case plans should address factors that maximize treatment responsivity and positive outcomes. However, very little is known about the responsivity factors that influence community-based case plan compliance among offenders with and without mental health problems. Examining these mental health factors is essential given the overrepresentation of mental health disorders in the Canadian Criminal Justice System (Mental Health Commission of Canada, 2012). This dissertation assessed the case management plans of adult community-supervised offenders (N = 111) to identify responsivity factors (i.e., offender-case management relationship, motivation and/or therapeutic engagement, severity of mental health symptoms, and presence of psychopathic traits) that best predict dimensions of case plan compliance (i.e., lack of adherence to structure aspects of supervision as well as lack of engagement within the intervention process). Results showed that these responsivity factors partially mediated the hypothesized relationship between criminological predictors and case plan compliance, and therefore would be important targets for pre-intervention programming. Unfortunately, few conclusions can be drawn regarding whether case plan compliance fluctuates with varying levels of adherence to the principles of the RNR model because of insufficient information available to code adherence in case records. Collectively, this research provides insight into the development of more effective strategies for

enhancing responsivity among offenders supervised in the community, especially for those suffering from mental health difficulties.

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Curriculum Vitae

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CHAPTER ONE: INTRODUCTION

> "When overtaxed mental health systems do not meet [mentally ill] people's needs, this not only exacts a toll on the lives of the people with mental illness, their families, and the community in general, it also threatens to overwhelm the criminal justice system'" (Council of State Governments, 2002, p. 6).

Over the previous decades, significant changes in the treatment of individuals with mental health problems have resulted from the movement toward deinstitutionalization. Partially due to the advances in psychotropic medications, mental health treatment has shifted from inpatient care to community-based services as a means of offering greater autonomy to those suffering from mental health problems and of improving their quality of life (Cosden, Ellens, Schnell & Yamini-Diouf, 2005). Despite these positive changes, there have been problems with lack of access to, and poor utilization of, community-based services by those with mental health problems. The mental health system has been described by some as "underfunded, overburdened, impersonal, and programmatically limited" (Skeem, Encandela, & Eno Louden, 2003, p. 439). Generally, these problems have resulted in a large portion of individuals who could benefit from mental health treatment being diverted to the criminal justice system at dramatically increasing rates over the past few decades (Mental Health Commission of Canada, 2012; Ogloff, Davis, Rivers, & Ross, 2007). The problem is further exacerbated by the reluctance of the mental health system to provide services for individuals with legal problems (Skeem et al., 2003; Teplin, 1990). This trend is problematic given that individuals with mental health problems who come in contact

with police because of criminal behaviour are more likely to get arrested, often stay longer in incarceration settings, are more likely to be subsequently charged with breaches of conditions, and frequently have much longer offence histories than persons without mental health problems charged with similar crimes (Bureau of Justice Assistance, 2008). Because police and other front-line workers act as gatekeepers to the criminal justice system, it is essential that these individuals have the education and training to know how best to address individuals with mental health problems, appropriately diffuse crisis situations, and direct these individuals to appropriate services (Mental Health Commission of Canada, 2012).

The recently published mental health strategy from the Mental Health Commission of Canada (2012) highlights these factors as part of Priority 2.4, which attempts to address the over-representation of people with mental health problems within the criminal justice system and ensure that those involved in that system receive access to appropriate services. One of the highlighted ways to address these concerns involves diversion programs. Many diversion programs have been developed to help rectify the difficulties in providing adequate treatment to offenders with mental health problems in the community (e.g., Mental Health courts, pre- or post-arrest diversion programs; Mental Health Commission of Canada, 2012). The goal of some of these programs is to use the criminal justice system to mandate individuals with mental health difficulties to seek community-based treatment and to act as a linkage or access point to those much needed services. Although the goal of mandated case management is clear for offenders with and without mental health problems, difficulties arise when an offender does not comply with the regulations or expectations of the treatment. Many individuals with

mental health problems who commit crimes are very resistant to psychological treatment (Draine, Solomon, & Meyerson, 1994; Laberge & Morin, 1995). Refusing, or being unable to adhere to, necessary treatment can substantially impact on the success of said intervention (Lamb & Weinberger, 1998).

Although some research has been conducted within institutional settings on personality characteristics potentially associated with compliance (Gudjonsson & Main, 2008; Main & Gudjonsson, 2006), little is known about which criminological or personality characteristics of offenders with and without mental health problems make them more likely to comply with interventions in community-based settings. In addition, research on program effectiveness with offenders has found that program integrity is problematic, with limited consistency in therapeutic focus and a failure to target factors related to criminal behaviour or the risk of recidivism (i.e., criminogenic needs; Cullen, Smith, Lowenkamp, & Latessa, 2009). This picture is further complicated with the presence of a mental health disorder. Some of the correctional programs have been found to have no effect, or even increase the likelihood of future criminal behaviour (Andrews & Bonta, 2010). Fortunately, programs that adhere to the principles of the Risk-Need-Responsivity (RNR) model (Andrews & Bonta, 2010) have been found to decrease the likelihood of recidivism in general offenders (Andrews & Bonta, 2010; Dowden & Andrews, 2000). The degree to which this model applies to offenders with mental health problems is not yet clear. In particular, there is a gap in the offender research literature as to who is likely to comply, respond, or adhere to interventions, and whether compliance increases when a case plan shows a high level of adherence to the RNR model, especially as it applies to an offender population with

mental health problems. Thus, the first purpose of this dissertation is to identify the typical case management plans of community-based offenders with and without mental health problems in two intervention settings: a Mental Health Court and community-based correctional service. Second, case plans will be analyzed to determine which of a range of potential responsivity factors best predict offender outcomes (i.e., compliance; Serin & Kennedy, 1997). Finally, this research will assess whether an offender's case plan compliance increases as a function of the plan's adherence to the principles of RNR model.

CHAPTER TWO: Literature Review

The Traditional Adversarial Process in the Canadian Criminal Justice System

In the past few decades, the Canadian institutionalized population has increased among federally sentenced offenders (i.e., those serving 2 years of custody or greater), while it has been decreasing for those serving more minor sentences since 1995 (Boe, Motiuk & Nafekh, 2004). The "get tough" on crime approach for offences has resulted in tougher sentences for minor crimes, overcrowding of institutions, and the depletion of resources available for offender rehabilitation and will likely continue with the implementation of *Safe Streets and Communities Act* in Canada (which emphasizes stricter sentences and lengthier incarceration periods). During the 1950s and 1960s, there was only limited evidence for the effectiveness of rehabilitation programs for offenders as exemplified in a famous review by Martinson in the 1970s that concluded "*nothing works*" (Martinson, 1974). Given that the prevailing view at the time was that interventions were "ineffective", the only appropriate option for deterring antisocial behaviour in the eyes of policy makers was punishment and incarceration (Andrews & Bonta, 2010). Although the overreliance on punishment still exists today, it is contrary to the bulk of accumulated evidence over the previous four decades. This evidence has shown that punishment and incarceration-based strategies do not reduce recidivism and, in some cases, actually increase it (Andrews & Bonta, 2006; Bales & Piquero, 2012). Since the 1980s, the field of offender rehabilitation has undergone major transformations, moving from "*nothing works*", to "*what works*" and now to "*making what works work*" as a means of reducing recidivism (Skeem, Manchak, & Peterson, 2011). The offender rehabilitation research has become more rigorous in

methodological standards, and effective offender interventions have been identified (Andrews, 2006; Gendreau, Little & Goggin, 1996; Skeem et al., 2011).

The Risk-Need-Responsivity Model

Perhaps one of the most significant advances in rehabilitating offenders was the development of the Risk-Need-Responsivity model (RNR; Andrews et al., 1990; Andrews & Bonta, 2010). This comprehensive model was developed as a reaction to the shortcomings of the "get tough" on crime movement (i.e., harsher punishments and increased incarceration lengths). The RNR model has been contextualized within a general personality and cognitive social learning theory of criminal conduct and stresses the importance of including empirically-tested theories to account for individual differences in criminal behaviour (Andrews & Bonta, 2010). The basic principles underlying this theory postulate that an offender should be matched to appropriate services based on the psychological or social needs that likely impact their criminal behaviour.

The RNR model is comprised of three main principles: Risk, Need, and Responsivity. The Risk principle acknowledges that a person's risk of recidivism can be reliably predicted using empirically-supported risk assessment tools (Andrews et al., 1990; Andrews & Bonta, 2010) and that the level of service/intervention an individual receives should match the identified risk level (i.e., a low-risk offender should receive low-intensity services, whereas a high-risk offender should receive intensive services). Andrews and Dowden (2006) suggested that the assessment of risk and needs should be completed as part of routine practice when attempting to predict recidivism risk.

A meta-analysis of 64 studies (Bonta, Law, & Hanson, 1998) examined recidivism rates in a mixed sample of offenders with and without mental health problems and found that 45.8% had generally recidivated and 24.5% had violently recidivated. However, these studies had extremely variable rates in recidivism, which likely depended on the methodology used (e.g., the sample, how it was defined, where the crimes had taken place). Bonta et al. found that, although offenders with mental health problems were more likely to recidivate than the general population, their risk for re-offence was lower than non-disordered offenders. Canales, Campbell, Wei, and Totten (2014) examined the recidivism rates of offenders with mental health problems specifically to determine the general applicability of the risk principle, finding similar rates to those reported by Bonta et al. (general recidivism: 47.8%; violent recidivism: 20.3%). Thus, despite public opinion (Canadian Mental Health Association, 2011; Corrigan, Watson, Warpinski, & Gracia, 2004), much of the research indicates that offenders with mental health problems are at no greater risk for recidivism than their counterparts without mental health symptoms. Moreover, once the confounding factors of substance abuse or personality disorder (i.e., Antisocial Personality Disorder) are controlled, individuals with mental illness are at no greater risk for violence than the general public (Monahan & Steadman, 1994; Mullen, 1997; Soyka, 2000). Thus, the risk principle appears to similarly apply to offenders with and without mental health problems.

The Need principle highlights the importance of assessing and targeting criminogenic needs during the design and delivery of a case plan. Criminogenic needs represent primarily responsivity risk factors that are empirically and directly linked to

criminal behaviour. These factors are theoretically changeable and, therefore, well suited to be the focus of intervention. Based on meta-analytic reviews and analyses of the correctional research literature, Andrews and Bonta (2006) identified the "Central 8 risk/need factors" that should be of primary focus when designing case plans. The first of these criminogenic factors is primarily static (i.e., fixed) and captures a history of antisocial behaviour, which is characterized by early and/or continued involvement in antisocial acts. Particularly problematic patterns include committing a diverse array of criminal acts in a variety of settings. The remaining seven risk/need factors tend to be conceptualized as being dynamic (either stable or acute) as they tend to change over time or as a result of intervention. The second criminogenic factor is an antisocial personality pattern, and reflects various personality and behavioural traits associated with impulsivity, weak self-control, thrill seeking, callousness, aggression, restlessness and/or disagreeableness. The third criminogenic need is the presence of antisocial cognitions reflected in a person's attitudes, values, and beliefs that are procriminal in nature (e.g., negative attitudes towards police, minimizing and rationalizing criminal behaviour). This factor also may be represented through cognitive emotional states of anger, defiance, or resentment. The fourth criminogenic factor involves the presence of antisocial associates/peers/isolation from prosocial support systems. This factor provides a context for reinforcement of a procriminal lifestyle. Together, these first four factors constitute the "Big 4" risk/need factors because they have the strongest associations to the risk of recidivism. In a meta-analysis of 374 effect sizes assessing the risk principle and its relationship to recidivism outcomes, Andrews and Dowden (2006) found that the "Big 4" factors ranged in mean *r* effect sizes from .10 - .12 for

offenders deemed at low risk for re-offence, and .23 - .24 for offenders at high risk for re-offence. Interventions that reflect and target these factors have been found to significantly reduce recidivism risk (Andrews & Bonta, 2010; Andrews & Dowden, 2006).

The remaining four central criminogenic needs also are associated with a reduction in recidivism rates; however, their effect sizes are smaller. The first of these "moderate" four criminogenic factors is characterized by problems in family and/or marital relationships through weak caregiver nurturance/caring and poor parental monitoring or supervision in childhood for youth. For adults, this factor relates to partner conflict and dysfunction within the family. The next two factors involves poor achievement or decreased satisfaction in school and/or work settings (which may in turn lead to lower socioeconomic attainment) and low level of involvement or satisfaction in leisure or recreation activities that are anti-criminal in nature. Finally, the last of the eight criminogenic needs is the presence of substance abuse. All of the Central 8 factors have been primarily identified in general offenders, but research indicates that they are equally relevant to offenders with mental health problems (Bonta et al., 1998).

The final major principle of the RNR model is the Responsivity principle, which represents the means by which intervention should be delivered to maximize its positive impact. This principle represents factors associated with the client that can influence his/her potential for achieving positive intervention gains (Serin & Kennedy, 1997). It is subcategorized into general and specific responsivity and also as internal versus external responsivity. General responsivity operates under the principle that only empirically-supported treatments should be used as it is these interventions that lead to actual

reductions in criminal behaviour. Cognitive social learning interventions have been found to be some of the most effective means of teaching individuals new behaviours, regardless of the behaviour of interest, and operate through the relationship principle (i.e., establishing a warm and supportive relationship) and the structuring principle (i.e., influencing change in a prosocial direction; Andrews & Bonta, 2006; Dowden & Andrews, 2004). These interventions attempt to maximize the relationship between the client and the intervener. Furthermore, specific responsivity emphasizes maximizing the offender's ability to respond by tailoring interventions to a person's strengths, capacities, and socio-biological-personality attributes that could either improve or hinder treatment response. Internal responsivity refers to client factors such as motivation, mental health, personality characteristics, cognitive intellectual deficits, and other demographic variables such as race, gender, age, and ethnicity. External responsivity denotes intervener and setting characteristics (e.g., language barriers, poverty) that often interact with the internal responsivity factors to influence outcomes (Serin & Kennedy, 1997). For some cases, these responsivity factors may need to be addressed before targeting criminogenic needs, such as stabilizing an individual's mental illness so that he/she can attend and participate fully in criminogenic-focused forms of intervention. Addressing low motivation and other barriers to treatment are also essential before offender rehabilitation can truly begin. Despite the critical importance of these responsivity factors, they are often overlooked in treatment planning (Birgden, 2004; Serin & Kennedy, 1997). In summary of the RNR model, the Risk principle highlights *who* to treat, the Need principle highlights *what* to treat, and the Responsivity principle highlights *how* to treat.

Since the development of the initial RNR model, a host of other principles have been added to expand the depth and breadth of the theory (Andrews & Bonta, 2010). One of these principles includes the use of professional discretion when confronted with specialized circumstances that make it necessary for the professional to deviate from the principles of the RNR model. Others stress the importance of adopting a human services approach to client care and interaction that includes building on client strengths, delivering treatment in a community-based setting whenever feasible, linking the individual to satisfactory community resources, and ensuring that staff administering RNR-consistent treatment are adequately trained, supervised, and monitored to maximize treatment integrity.

The RNR principles of risk and need have been extensively empirically tested, with research showing that matching intervention intensity to the appropriate level of risk leads to positive outcomes. Inappropriate matches have been found to have negative outcomes (i.e. placing low-risk offenders in intensive services can actually increase their risk for recidivism; Lowenkamp, Latessa, & Hostlinger, 2006). Adherence to the RNR principles creates large effect sizes for risk reduction (Andrews & Bonta, 2006), with the results of one meta-analysis indicating an average treatment effect size of $r = .29$ for rehabilitation programs that adhere to all these major RNR principles (Andrews & Dowden, 2007). Specifically, Andrews and Bonta (2010) compared recidivism rates in offenders undergoing treatment in the community versus offenders in custodial treatment to determine the effect of adhering to no principles of the RNR model, 1 principle, 2 principles, or all 3 principles. Greater adherence to these principles was associated with greater decreases in the rates of subsequent recidivism (1

principle, $r = .02$; 2 principles, $r = .18$; 3 principles, $r = .26$). These lower recidivism rates were most prominent in community-based settings. Interestingly, treatment protocols that did not adhere to any of these key RNR principles showed a small increase in the risk of recidivism, especially when the treatment was delivered in custodial settings.

The effectiveness of RNR-consistent treatments is maximized when delivered in a community-based setting. This is fortunate given that community corrections is the most prevalent form of correctional services in Canada, with as many as 95,000 offenders being supervised under probation or parole services (Bonta, Bourgon, Rugge, Scott, Yessine, Gutierrez & Li, 2010; Public Safety Canada, 2009). In addition, a meta-analysis by Bonta and colleagues (2010) found that community supervision reduced the risk for general recidivism more so than any specific offender rehabilitation programming, although it had no preferential impact for violent recidivism. These results were found despite the focus of most of the reviewed offender programs in their analyses not exhibiting many of the important evidence-based ingredients of the RNR model (Bonta et al., 2010).

Offender Rehabilitation in the Community

As stated previously, the majority of offenders in Canada are currently serving sentences in community-based settings either on parole, probation, pre-trial releases, conditional sentences, or conditional discharges (Bonta, Rugge, Sedo, & Coles, 2004). In addition to the work these individuals do with the community corrections officer, offenders can be referred to various types of rehabilitative programs depending on availability and suitability. These programs attempt to promote prosocial behaviours

through mental health, education, life skills training, and specialized treatment programs (e.g., substance abuse interventions). However, the actual treatment received in the community varies considerably between offenders, even amongst those with the same level of risk. As it currently stands, significant resources are being expended on small groups of offenders with little effort to determine whether these offenders are appropriate for these services. There also is a tendency for these services to over-emphasize non-criminogenic needs during interventions (e.g., mental illness or self-esteem) (Bonta et al., 2010, Gendreau et al., 1996; Listwan, Cullen, & Latessa, 2006; Lowenkamp, Latessa, & Smith, 2006).

In a report published by Public Safety Canada, Bonta and colleagues (2010) examined the effectiveness of RNR training with probation officers in community-based settings. Offenders (*n* = 52) were randomly assigned to a group of probation officers who received RNR training (known as the Strategic Training Initiative in Community Supervision or STICS) or a group who did not have this training. Relative to untrained officers, trained probation officers exhibited more RNR-based skills (i.e., structuring skills, relationship building, behavioural techniques, cognitive techniques, and effective correctional skills) and emphasized criminogenic needs more frequently in audio-taped segments of sessions. Further to these findings, Bonta et al. used an additional sample of offenders (who were medium- to high-risk cases, *n* = 143) under the supervision of trained probation officers were found to have lower rates of recidivism relative to these officers' pre-training caseload recidivism rates, and relative to non-RNR-trained probation officers. Specifically, 25.3% of offenders who were supervised by a RNR-trained probation officer had recidivated compared to 40.5% of control cases supervised

by a non-RNR-trained officer during a 2-year-follow-up period. Thus, adoption of RNR principles and practices enhances offender rehabilitation and reduction of recidivism. However, despite promising findings with the RNR model as a case management strategy in general offender populations, more research is needed to test how well this model applies in populations of offenders with mental health problems, especially in community-based settings. The presence of mental health issues can complicate case management in a system not traditionally equipped to manage such issues alongside criminogenic issues (Correctional Service Canada, 2010; Sapers, 2011, Skeem et al., 2011).

Of the few studies that have extended the RNR model to more specialized populations, including offenders with mental health problems (Bonta et al., 1998; Skeem et al., 2011), the emphasis has been placed on validating the risk and need principles rather than the responsivity principle (Andrews, Bonta & Wormith, 2011). Fortunately, this research does indicate that many of the established risk assessment instruments used with general offenders are also useful for offenders with mental health problems (Canales, 2011; Girard & Wormith, 2004) and highlights that the primary criminogenic needs of these cases are often identical to general offenders (Bonta et al., 1998). Given that the principles of risk and need are similar for offenders with and without mental health problems (Bonta et al., 1998), responsivity may be the only principle that would theoretically differ for offenders with mental health problems. Within the RNR framework, a mental health problem is conceptualized as a responsivity factor as it may influence the degree to which an offender responds, participates, and engages in the intervention process.

Multifactor Offender Readiness Model and the RNR Model

Although the RNR model generally has received a lot of research attention, the specific responsivity principle has had comparatively less investigation. Ward, Day, Howells, and Birgdon (2004) highlighted one of the shortcomings of the concept of responsivity as being overly focused on the adaptation of a program to meet offender needs and not on individual factors that create success and engagement within case management (see also Howells & Day, 2003). These authors attempted to rectify these conceptual problems through the concept of treatment readiness, which is conceptually similar. The Multifactor Offender Readiness Model (MORM; Ward et al., 2004) outlines the necessary factors and skills that are required to complete or engage effectively in a task rather than solely focusing on what is preventing engagement. It encompasses aspects of the person, context, therapy, or therapeutic environment. The authors of the MORM model postulated that although treatment responsivity and motivation are essential factors to consider for successful intervention with offenders, the concept of treatment readiness is broader and more inclusive. Significant overlap does exist among these two important factors. The model hypothesizes that when treatment readiness is taken into account, higher rates of participation, attendance, and improved engagement with the therapy will ensue. In turn, decreases in risk and criminogenic needs will result.

In summary, the MORM fits within the RNR concept of responsivity and may allow for this principle to be more empirically defined and testable. For the purposes of the current dissertation, the specific concepts of responsivity will be conceptualized under the umbrella of treatment readiness as defined by the MORM (Howells & Day,

2003, 2007; Ward et al., 2004). All of the concepts discussed above are relevant for promoting the efficacy of rehabilitation efforts for offenders in the community; however, oftentimes, a major impediment to efficacy is how much an offender complies with the intervention.

Promoting Compliance

All of the concepts discussed above are relevant for promoting the efficacy of rehabilitation efforts for offenders in the community; however, a major impediment to efficacy often relates to how much an offender complies with the intervention. Associated with the concept of responsivity/readiness, “non-compliance with intervention” has been conceptualized as an umbrella term that includes lack of attendance for treatment sessions (initial or ongoing appointments), drop-out from the treatment process (i.e., treatment attrition), refusing to engage within and between sessions, and showing low motivation for treatment. Poor compliance and dropouts from programs not only places clinical, financial, and professional strains on mental health professionals, but it also poses risks to public safety because the offenders at highest risk to recidivate are the ones who are most likely to be lost due to attrition (Olver, Stockdale, & Wormith, 2011; Wierzbicki & Pekarik, 1993). Individuals who are involved in MHCs and specialty programs usually have extensive histories of poor treatment adherence which has been associated with erratic behaviour, breaches of community supervision, and new offences (Boothroyd, Poythress, McGaha, & Petrila, 2003; De Leon, 2000; Steadman, Davidson, & Brown, 2001). To promote compliance, some jurisdictions have mandated treatment participation through court orders as part of the case plan. Assumptions underlying the use of mandated treatment are that it will

increase treatment adherence, and that this improved adherence will subsequently lead to better clinical and social/criminal justice outcomes, such as fewer arrests, less violence, increased public safety, and decreased need for future mental health services (Redlich, Steadman, Robbins, & Swanson, 2006). In summary, rehabilitation readiness is essential in forensic and correctional settings because it impacts on the design and delivery of services that increase motivation to change, engagement in change process, as well as increase completion rates, enhance the ability to respond to the necessary rehabilitative content, and ultimately reduce the risk of recidivism (Wormith & Olver, 2002).

Research on treatment adherence is a common topic within the community-based mental health treatment literature, but this research has focused mainly on adherence/non-adherence with medication regimens. There is general consensus that poor adherence to the case plan and failure to comply with prescribed treatment leads to poorer outcomes, especially when considering severe mental illness (Anderson, Ford, Robson, Cassis, Rodrigues & Gray, 2010; Vuckovich, 2010). Studies also have examined predictors of missing the first appointment and risk of drop-out (i.e., attrition). In the general clinical literature, inconclusive results have been found in studies attempting to predict which clients are most likely to miss their first appointment. Daniels and Jung (2009) reviewed 1630 clinical charts and found that 71.7% had attended their first scheduled appointment. Younger age, those who were voluntarily committed as opposed to those whose attendance at the appointment could affect sentencing, and the presence of substance use were more characteristic of the group of individuals who did not show up for their initial appointments. In addition, those who

had missed the first appointment were most likely to miss the second. All other measured variables (e.g., clinic characteristics, living outside the city limits, morning appointments, or the season in which the appointment was scheduled) did not differ significantly between those who showed up for the initial appointment, those who no-showed for subsequent appointments, and those who never attended any scheduled appointment.

A meta-analysis by Wierzbicki and Pekarik (1993) examined variables associated with drop-out from community-based psychiatric treatment across 125 studies. These authors found that the mean drop-out rate was 46.8%. Although many of the studies in their analyses defined “drop-out” differently, factors that were most predictive of attrition from psychotherapy included three client demographic variables: minority racial status, lower levels of education, and low income. In general, poor compliance and non-attendance at treatment can lead to a variety of health-related costs, such as illness exacerbation and potential relapse, risk of re-hospitalization, and increased risk of engaging in harmful behaviours toward self or others (Knapp, King, Pugner & Lapuerta, 2004).

Theoretical Predictors of Compliance

In addition to the many other areas already discussed, the following variables may be especially important for capturing compliance in community-based offenders. For the purposes of this dissertation, these variables will be subcategorized into criminological predictors and responsivity predictors of compliance. These categorizations were made based on the definitions of criminogenic needs and responsivtiy factors as outlined by the RNR model. They correspond to the distinctions

made between the criminogenic needs sections and the additional case management sections on the Level of Service/Case Management Inventory. The criminological factors which are slightly more static or historical in nature include: demographic variables, risk for recidivism, history of compliance behaviour, history of mental health difficulties, and the length of the current period of supervision. The responsivity predictors (which would be the focus of any pre-supervision interventions to enhance readiness) include such things as intervention motivation/engagement, the presence of mental health difficulties, presence of psychopathic traits, and the quality of the professional relationship experienced by the offender and the case manager. While these distinctions have been made for the purposes of the theoretical model, there may be some conceptual overlap between these distinctions in which some variables could be captured in either the criminological or responsivity sections (e.g., psychopathic traits). Overall, Steadman et al. (2011) highlighted that it is essential to consider both criminal justice and clinical historical/responsivity factors when determining who is likely to succeed in community-based programs.

When considering the static/historical predictors, demographic information may be key initial indicators of a person's likelihood for compliance difficulties. Aspects such as younger age, being single (i.e., never married), education level, and client racial minority status (e.g., aboriginal) have all been implicated as predictors of intervention attrition or compliance difficulties. Wormith and Olver (2002) examined various factors, including demographics, that contribute to attrition from correctional treatment in a secure facility (n = 93). They found that treatment non-completers were more likely to have less formal education, a poorer history of employment in the community, to be

aboriginal, and have a maximum security designation relative to treatment completers. Sung, Belenko, and Feng (2001) also found that younger age, poor education and employment background, and early involvement with the criminal justice system were linked to treatment noncompliance. When considering gender, it appears that, although many of the major risk factors in the criminological literature are gender neutral (i.e., they are equally important in both genders), these risk factors appear more often in males, and more greatly affect their overall level of re-offending risk as a result. However, there are a few factors related to risk that appear to be gender-specific to females, such as family factors, socioeconomic status, criminality of partners, and mental health issues (e.g., post-traumatic stress disorder, major depressive disorder, borderline personality traits, and substance abuse disorders). In summary, the demographics and personal characteristics of the client appear to be important indicators of their likelihood of compliance difficulties in the community.

Interestingly, many predictors of drop-out and non-compliance with intervention in offender populations appear to be the same or similar to those that influence his/her risk for recidivism (Barber-Rioja, Dewey, Kopelovich, & Kucharski, 2012; Browne, Foreman, & Middleton, 1998; Wormith & Olver, 2002). Individuals who are deemed to be high risk, and those who are most susceptible to committing violent acts, are often most likely to drop out of interventions (Hough & O’Brien, 2005; Olver et al., 2011). Therefore, much of the information collected regarding an individual’s risk for recidivism also may be helpful in determining the likelihood that that individual will comply with a case management plan. These factors can impact the person’s ability to

engage in intervention and increase the likelihood of intervention failure (Sung et al., 2001).

As with the positive relationship between criminal history and recidivism, individuals who have extensive histories of poor compliance and poor intervention adherence also are likely to continue to have difficulties with compliance. These individuals tend to have extensive histories of breaches of community-based supervision in the context of MHCs and traditional community corrections (Bootroyd et al., 2003; DeLeon, 2000; Steadman et al., 2001).

Finally, the length of time an individual has spent on supervision or participating in an intervention can be an important indicator of compliance (Wormith & Olver, 2002), as longer supervision periods may lead to greater compliance over time. Olver et al. (2011) indicated that there were greater problems with non-compliance and attrition when individuals were serving shorter supervision sentences. It is unclear at this point why compliance appears to increase over time and may be due to interactions with other more dynamic variables.

Responsivity (i.e., changeable) variables are important to consider when predicting compliance as these may be the variables that can be targeted in pre-intervention work to help enhance a person's readiness for their case management plans. Wormith and Olver (2002) examined various factors to determine the differences between correctional intervention completers and non-completers. The non-completers scored very poorly on treatment progress variables, including length of participation in treatment, denial, motivation/effort, level of improvement, attendance, homework

completion, aggressive behaviour on the unit, and attitude toward treatment. All of these factors appear to be more changeable in nature.

Responsivity variables such as lack of insight, negative attitudes towards intervention, anger, denial, and impulsivity have been deemed especially relevant for the prediction of noncompliance (Barber-Rioja et al., 2012; Olver et al., 2011). James and Milne (1997) argued that the most influential predictors of non-compliance and non-attendance at psychiatric treatment appointments was a lack of knowledge of, and harboring negative attitudes and expectations toward, the treatment process. Thus, it is important for professionals working with offenders to address all of these factors in the therapeutic context in order to maximize an offender's responsivity to intervention. Doing so is a central component of the RNR responsivity principle of effective case management.

Motivation for change is a fundamental responsivity factor to consider when evaluating an offender's likelihood of responding effectively to interventions. The absence of motivation is one of the most commonly cited reasons for patient drop-out, treatment failure, and lack of compliance (Ryan, Plant, & O-Malley, 1995). Much of the literature on motivation and the use of motivational interviewing to enhance a person's readiness to change has focused on treatment of substance abuse disorders. The Transtheoretical Model of Change (Prochaska & DiClemente, 1982, 1983) has been highly influential in conceptualizing the role of motivation in change behaviour. The model includes six stages of change and recommends that clinicians consider the client's stage before treatment so that intervention can be tailored to his/her stage of change at that point in time. These stages include pre-contemplation, contemplation, preparation,

action, maintenance, and termination. Similarly, Barrett, Wilson, and Long (2003) conceptualized motivation as a dynamic process that represents the degree of desire, or willingness to engage in, the therapeutic process and is a factor that can be positively influenced. Motivation can be inferred through behaviour (e.g., attendance at appointments, completion of homework) and by more global evaluations of internal features (i.e., readiness and psychological stance), which are necessary for creating initial and sustainable change. It is possible for motivation to have intrinsic (e.g., wanting to understand oneself better) and/or extrinsic sources (e.g., avoiding further court sanctions). Motivation is one of the most significant challenges for mental health and correctional professionals when trying to get offenders to willingly engage in mandated treatment (Willshire & Brodsky, 2001).

Some have argued that there should be a distinction made between “motivation to enter treatment” and “motivation to engage in therapy”. Motivation in therapeutic settings often has been contextualized as the internal intention a person has for entering into therapy, whereas treatment engagement is more often defined in terms of a behavioural contribution to therapy by the patient (e.g., attendance, adherence to program rules, and active participation in process) or willingness to make behavioural sacrifices (Drieschner, 2005; Sung et al., 2001). Drieschner refers to motivation as the patient’s desire to engage in the treatment and is accounted for by six internal determinants: problem recognition, level of suffering, perceived external pressure, perceived costs of treatment, perceived suitability of treatment and outcome expectancy. These factors of motivation then predict the patient’s treatment engagement, or in other words, the behavioural engagement required by that treatment approach. Drieschner

(2005) argued that these concepts are related conceptually. However, he also argued that while a person may be motivated to engage in his/her treatment, many cognitive and neuropsychological limitations can exist that impair the person's ability to behaviourally engage in the treatment. Collectively, Drieschner (2005) hypothesized that these factors all impact on treatment outcome.

Engagement in therapy is viewed as an essential component for maximizing the success of the therapeutic process and represents a level of commitment to that process (McMurran, Theodosi, & Sellen, 2006). Engagement is a reciprocal process between the therapist and client in which both individuals have responsibility for working together toward common therapeutic outcomes and is impacted by a variety of attitudinal, social, and interpersonal factors (Oetzel & Scherer, 2003). It is through this process of mutual engagement that the therapeutic alliance is developed. Although conceptually similar, engagement in therapy can be considered as a separate construct from motivation (McMurran et al., 2006). Engagement appears to be measured best through behavioural indicators encompassing several important areas: 1) attending and cooperation during therapy sessions, 2) the level of openness and self-disclosure concerning the individual's problems, 3) making use of the contributions provided by the therapist, 4) adequate between-session behaviour, including a willingness to try new behaviours, and 5) inhibiting behaviours associated with resistance and rejection of therapeutic change (Drieschener & Boomsma, 2008a). A higher level of engagement in therapy can lead to increased attendance at appointments, insight into one's difficulties, motivation to address problems, more successful therapeutic alliances, and results in better treatment outcomes relative to those who are not engaged within psychological

treatment (Melnick, De Leon, Thomas, Kressel, & Wexler, 2001; Rosen, Hiller, Webster, Staton, & Leukefeld, 2004). Engagement can be represented by the level of commitment an individual has to therapy and the degree of confidence that he/she has to meet his/her therapeutic goals, both of which interact with that person's desire to receive help (Rosen et al., 2004). Engagement is often conceptualized as a product of a collaborative and personalized process; however, it raises the question as to whether an individual who is mandated to treatment can perceive that treatment as truly collaborative. As it currently stands, little is known in the offender literature about engagement in therapy in the context of mandated community-based intervention, especially with offenders with mental health problems. However, collectively, high motivation and engagement are likely to predict decreased levels of non-compliance and intervention attrition (Olver et al., 2011).

Related to motivation to change and engagement is the perception of the therapeutic alliance within mental health intervention. Bachelor and Horvath (1999) indicated that, aside from the factors that bring a client to therapy, the therapeutic relationship is responsible for the most gains in therapeutic outcome. Skeem, Eno Louden, Polascheck, and Camp (2007) developed a questionnaire to measure the unique relationship of care and control that exists between the therapist and an involuntary client in community-based settings. The resulting Dual-Role Relationships Inventory-Revised (DRI-R) was then validated in a population of probationers who were mandated to seek psychological treatment in the community. The authors concluded that the DRI-R is internally consistent, relates to theoretically relevant questionnaires, and assesses important domains of therapeutic alliance (i.e., caring, fairness, trust, and toughness) in

probationers mandated to treatment. Three subscales of the DRI-R exist: the Caring-Fairness dimension (i.e., mutual respect and consideration of needs within the therapeutic relationship), the Trust domain (i.e., measuring the extent that an individual feels comfortable and open within the relationship) and the Toughness domain (i.e., a punitive orientation with expectations of compliance and independence). This measure was found to have predictive validity for future compliance with rules as indexed by probation violations and revocation of community supervision. Specifically, probationers' rated Toughness subscale and officers' rated Trust subscale were both predictive of the number of recent rule violations. A relationship characterized by caring, trust, and authoritative style (i.e., lower Toughness and higher Caring-Fairness and Trust subscales for probationers', officers', and observers' ratings) were predictive of a longer period of time until one or more conditions were violated. Finally, when considering time to probation revocation as a result of noncompliance, lower DRI-R Toughness and higher DRI-R Caring-Fairness were predictive for higher probationers' and higher officers' ratings of the relationship, meaning perceptions of a better quality relationship. As well, higher levels of Trust and Caring-Fairness subscales were positively predictive of observers' ratings of the relationship. Therefore, a strong positive relationship between the offender and case manager appears to be related to an increased ability by the offender to respond and comply with interventions in community settings.

Skeem et al. (2010) examined the role of the offender-case manager relationship in determining the likelihood of revocations of community release. Factors that were deemed important in the professional relationship were the use of assertiveness in the

context of remaining respectful and caring; problem solving attitudes to identify, manage, and remove obstacles to compliance rather than relying on threats and punitive styles; listening, reflecting, showing empathy and concern for the client's welfare; and finally, encouragement and praise for compliant behaviours. When probation officers followed this style of interaction with offenders with mental health problems, there was a greater avoidance of parole revocation as opposed to the more authoritarian, punitive approach characteristic of more traditional probation officers. Thus, developing a collaborative, fair, and respectful relationship between the case manager and the client is essential to achieving compliance in this population (James & Milne, 1997; Skeem et al., 2003, 2010). This approach is consistent with the human service approach of the RNR model.

Another factor theoretically linked to compliance, as well as recidivism risk, is the presence of psychopathic traits. Individuals high on psychopathic traits are likely to have difficulty with community-based treatment, show low motivation, and are more likely to end treatment prematurely (Barber-Rioja et al., 2012; Rice, Harris, & Cormier, 1992). These individuals are also more likely to engage in new offences that may lead to noncompliance violations with the conditions of their existing case management plans. Barber-Rioja and colleagues (2012) examined the role that the Psychopathy Checklist Screening Version (PCL-SV; Hart, Cox, & Hare, 1995) had in predicting noncompliance (i.e, treatment non-adherence, noncompliance with case management conditions, drug/alcohol relapse, and violent behaviour) with diversion programs and re-incarceration risk in a sample of mentally ill offenders. Their results indicated that the PCL-SV was a significant predictor of diversion noncompliance and re-incarceration.

Interestingly, the study also included the Historical-Clinical-Risk Management – 20 (HCR-20; Webster, Douglas, Eaves, & Hart, 1997), a risk instrument that its total and historical, clinical, and risk subscales were each found to be stronger predictors than the PCL-SV. Adding the PCL-SV to the HCR-20 did not add any incremental validity to the prediction of compliance, which highlights the importance of considering aspects relating to clinical responsivity in addition to the risk variables. Specifically, variables such as lack of insight, negative attitudes, active symptoms of major mental illness, impulsivity, and history of unresponsiveness to treatment were important variables for diversion compliance. However, a potential shortcoming of this study was that compliance was dichotomized into presence/absence, which does not capture the variability in the nuances of compliant behaviour and oversimplifies the definition of compliance to only whether or not a person is compliant with rules. Main and Gudjonsson (2006) indicated that a person's eagerness to please, low self-esteem, high trait anxiety, and desire to avoid conflict were all associated with compliance for rules in an institutional setting. These traits can be considered the opposite to many of the traits of psychopathy, such as selfishness, callousness, and manipulativeness. Thus, it is likely that the affective and interpersonal traits of psychopathy are particularly related to noncompliance with interventions.

Related to many of the personality traits previously discussed, Olver et al. (2011) found that severe psychopathology (e.g., psychosis, borderline personality disorder) predicted treatment attrition in offenders. When an individual is experiencing mental health symptoms, it may be a significant barrier to effective engagement in case management as mental health problems can destabilize the presence of any protective

factors that may be present. As well, individuals with a history of various mental health difficulties are often resistant to intervention. This is especially problematic if the individual has a history of unresponsiveness to interventions (Barber-Rioja et al., 2012; Draine et al., 1994; Laberge & Morin, 1995). The presence of disordered personality traits compounds these difficulties with responsivity. Gudjonsson and Main (2008) examined the relationship between personality disorders and compliance in 58 mentally disordered offenders in a medium-secure unit. Over 90% of the sample met criteria for a personality disordered trait or diagnosis, and 72% showed the presence of at least one other clinical syndrome. The authors found that higher levels of compliance were positively correlated with dependent, avoidant, passive-aggressive, and masochistic personality, as well as anxiety, dysthymia, and delusional disorders. These authors concluded that the primary link between personality and compliant behaviours is through the presence of trait anxiety combined with low self-esteem. This link appears to motivate individuals to avoid conflict and confrontation from others and, thereby, comply with requests bestowed upon them. Ironically, antisocial personality traits or disorder were not related to self-reported compliance, perhaps because these traits were also self-reported. This may be an important consideration when examining compliance in offender samples with mental health problems.

Mental health problems are considered a key responsivity factor in the RNR model, and these needs should be addressed before an individual can meaningfully participate in the criminogenic intervention (Andrews & Bonta, 2010; Serin & Kennedy, 1997). Following medication regimens is also very important when considering individuals with severe mental health problems. Individuals with severe mental illness

also are more likely to be violent when pressured or under stress if they have not been compliant with their treatment regimen (i.e., adhering to medication plan; Elbogen, Mustillo, Van Dorn, Swanson, & Swartz, 2007). Notably, those individuals with severe mental illness who are at the highest risk for violence are those who are least likely to keep appointments and less likely to adhere to medication (Hough & O'Brien, 2005), most likely to abuse substances, and tend to live in impoverished conditions with little access to social support (Swanson, Swartz, Borum, Hiday, Wagner, & Burns, 2000). Moreover, Swanson et al. found that those who were the least likely to be violent were those who engaged in, and adhered to, long-term community-based treatment and did not engage in substance abuse. Therefore, ensuring compliance to rehabilitation plans in offenders with mental health problems is imperative for their own safety and the safety of others.

Relevance of Responsivity and Compliance within Offenders with Mental Health Problems

In order to appropriately contextualize the RNR model and understand its potential application to various offender groups, as well as capture the nuances of compliance, it is necessary to first conceptually define what is meant by offenders with mental health problems. Mental illness is defined as a disruption that causes clinically significant problems in cognition, emotion regulation, or behaviour. The illness appears to reflect an underlying psychological, biological, or developmental dysfunction, has consequences that cause clinically significant distress or impairment in various areas of functioning, and is not better explained by stressors, medical conditions, etc. (American Psychiatric Association, 2013; Stein, Phillips, Bolton, Sadler, & Kendler, 2010). The

term “mentally ill offenders” is an umbrella term that covers a variety of different groups of offenders, including, but not limited to, those found not criminally responsible or unfit to stand trial, and those who have been diagnosed with a myriad of different mental disorders but who are criminally responsible and competent to stand trial (including those with formal diagnoses or with subthreshold symptoms of disorders). The term traditionally refers to those individuals who present with a disorder that is severe enough to warrant intervention beyond what an offender would normally receive as part of the criminal justice system (Blackburn, 2004). These individuals present complex challenges to the legal, mental health, and the public safety systems as they are a heterogeneous population with varying needs (Elsayed, Al-Zahrani & Rashad, 2010).

Theoretically speaking, those who are high on mental health needs will likely pose greater challenges for compliance to interventions as would be similarly expected for individuals who present with severe and comorbid forms of formal diagnoses (Blackburn, 2004). Discussing the current difficulties associated with the validity and reliability of diagnoses of mental illnesses is beyond the scope of the current dissertation (e.g., Kendall & Jablensky, 2003; Regier, Narrow, Kuhl, & Kupfer, 2009). However, given that not all mental health difficulties are formally diagnosed, and that sub-threshold symptoms can still negatively impact a person’s behaviour and functioning, mental illness will be defined in the current research in terms of those with mental health problems/symptoms/impairments as opposed to restricting the focus to formal DSM-IV-TR/DSM-5 diagnoses given that shortcomings with the current definitions of many of the mental health disorders have been noted (e.g., Carson, 1991; Goldberg, Krueger, Andrews, & Hobbs, 2009; Kendall & Jablensky, 2003; Regier et al., 2009). This

dimensional approach to defining mental health problems or symptoms may be more beneficial and practical for those non-mental health professionals working in populations of offenders with mental health needs (American Psychiatric Association, 2013; Kraemer, 2008; Okasha, 2009; Wright, Krueger, Hobbs, Markon, Eaton, & Slade, 2013).

The criminal justice system is becoming the largest provider of mental health services in Canada, with estimates of mental health problems as high as three times that of the general population (Brink, Doherty, & Boer, 2001; Mental Health Commission of Canada, 2012). Interestingly, these estimates may underestimate the true rates of mental health problems in offender populations because they often do not include offenders with intellectual disabilities or other clinical problems (e.g. subclinical symptom presentations). Rather, these rates tend to be limited to severe mental illnesses (i.e., those with the presence of psychotic features). Recent projections have shown that the presence of *any* mental illness (including personality disorders and substance use disorders) ranges from 55% to 80% of offenders, with even higher rates occurring when considering lifetime prevalence (Brink, 2005). The prevalence of serious mental illness in offender populations is 5-15%, whereas it is 2-3% in the general population (Brinded, Simpson, Laidlaw, Fairley, & Malcolm, 2001; Brugha et al., 2005; Butler, Allnutt, Cain, Owens, & Muller, 2005; Dvoskin & Steadman, 1989; Fazel & Danesh, 2002). Thus, it is not surprising that Correctional Services of Canada (CSC) is the largest employer of psychologists in Canada, with over 300 on staff across the country (CSC, 2010). Despite such staff, mental health problems often go undetected and untreated in correctional institutions (Brinded et al., 2001; Ogloff et al., 2007). Criminal justice

institutions are far from the appropriate place to house and treat individuals with mental health problems.

The Overrepresentation of Mental Illness in the Criminal Justice System

The cause of the overrepresentation of persons with mental health needs in offender settings has been the source of some debate. Currently, the most notable theory involves the "the criminalization of the mentally ill". This refers to the inappropriate arrest and detainment of mentally ill individuals for behaviour that may be more appropriately managed within the mental health system, which arguably resulted from the inadequacy of the mental health system, deinstitutionalization, stricter laws for involuntary psychiatric hospitalization, and mandatory sentencing procedures (Fisher, Silver, & Wolff, 2006; Lamb & Weinberger, 1998; Mental Health Commission of Canada, 2012; Serin, Forth, Brown, Nunes, Bunnell, & Pozzulo, 2010; Skeem et al., 2011). The culmination of these factors has been the predominant explanation for the large numbers of persons with mental health problems coming into contact with the criminal justice system. This theory postulates that individuals with mental health problems engage in criminal behaviour as a direct result of their mental illness. Therefore, to reduce criminal offending, the untreated mental health symptoms must be addressed and alleviated. However, there is limited empirical support for these assumptions as an explanation for the overrepresentation of cases in correctional contexts. Interventions for mentally ill offenders that improve access to appropriate psychiatric treatment has been found to have little to no effect on criminal justice outcomes, such as reducing the risk of recidivism (Skeem et al., 2011).

According to an empirical review by Hiday and Burns (2010), offenders with mental health problems typically fall into five profiles of criminal behaviour, each posing unique challenges relative to offenders without mental health problems. The first profile involves those who commit misdemeanor/summary offences or nuisance crimes (e.g., petty crimes). The second profile includes those who commit offences involving survival behaviours (e.g., theft of necessities). The third profile includes alcohol/drug abusers. Substance use can lead to higher rates of criminal offences for substance use/possession and other crimes committed in an attempt to support the habit. The fourth profile includes offenders with a personality disorder (e.g., antisocial personality disorder) and who have high rates of offending, including violence against others. Finally, the fifth profile captures severely mentally ill persons who commit violent crimes as a result of psychotic processes, such as paranoid/persecutory delusions and auditory hallucinations. These symptoms can be associated with an individual's risk for violence, especially when they contain command hallucinations to harm others or threat/control-override delusions (Silver, Felson, & Vaneseltine, 2008; Steadman et al., 1998; Swanson, Holzer, Ganju, & Jono, 1990; Taylor & Gunn, 1984). It is also clear that mental health problems themselves are only directly responsible for criminal behaviour in a minority of cases (Bonta et al., 1998; Junginger, Claypoole, Laygo, & Cristiani, 2006; Skeem et al., 2011), likely reflected in Hiday and Burns' fifth profile. For most cases, criminogenic factors play a stronger role (Andrews & Bonta, 2010).

Elsayed and colleagues (2010) examined 100 psychiatric court reports to uncover common characteristics of individuals with mental illness who come into contact with the law. Individuals included in their study were referred for legal accountability

assessments (i.e., assessments of criminal responsibility) over a 13-month period. Results indicated that the majority of cases were male (93%), younger than age 40 (73%), single (64%), classified as having a lower education level (51%), unemployed (34%), had previous contact with psychiatric services prior to the current offence (58%), and had substance abuse problems (56%). The most common psychiatric diagnoses were schizophrenia (13%) and antisocial personality disorder (10%). Thus, individuals referred for criminal responsibility assessments have significant psychosocial difficulties and criminogenic needs in addition to their mental health issues that may influence criminal risk and rehabilitation planning. They represent diverse groups, each with their own unique patterns of criminality.

Research by Fisher et al. (2006, 2011) showed that among those individuals in the general population who have been diagnosed with a mental health disorder, 28% had a history of at least one arrest. These rates were much higher in the 18- to 25-age group, with as many as half of mentally ill individuals having at least one arrest in their history; however, this number does appear to decline with age differentially across offence groups. Their study indicated that the most typical offences included public order offences (16.1% including disorderly conduct, drinking in public, etc.) and property crimes (10.5% such as shoplifting and damage to property). Only a small minority (13.6%) engaged in a serious violent crime such as murder, sexual assault, robbery, or assault. Assault on a police officer was the most likely offence in this category. Similar to the general population, a small minority of the mentally ill persons in this sample accounted for a large number of arrests (17%) in the sample.

It comes as no surprise that the arrest and incarceration rates are higher in populations of people with mental health problems than in the general population. In a birth cohort of 14,401 individuals from Sweden who were followed prospectively from gestation to 30 years of age, it was found that men with a mental disorder were 2.5 times more likely to have committed a criminal offence than those without a mental disorder/handicap (Hodgins, 1992). In women, the risk increased to five times higher in the mentally disordered group than the non-mentally disordered group. However, the onset of criminal behaviour often preceded the onset of mental disorder in these cases. Individuals with an intellectual disability were also 3-4 times more likely to have committed at least one offence than those without a disability. As well, those with a history of psychiatric hospitalization were more likely to have a history of criminal offences (Hodgins, Mednick, Brennan, Schulsinger, & Engberg, 1996). Thus, although individuals with mental illness may be overrepresented in the criminal justice system, it is important to remember that their criminal justice involvement often *precedes* the onset of the mental health problem.

Hodgins and Cote (1993) examined criminal offending patterns among individuals with a history of mental disorder (n = 107) relative to other inmates (n = 349), both with and without antisocial personality disorder (APD). Those with a history of both a mental disorder and a diagnosis of APD were more likely to have juvenile records compared to those with mental disorder in the absence of APD (87.3% vs. 27.8%). However, no differences were found between those with APD, with or without the presence of a mental disorder, on mean number of convictions, nonviolent convictions, and violent convictions. Interestingly, in most of these cases, the onset of

the antisocial personality traits *preceded* that of the major mental disorder and exemplified the importance of targeting antisocial traits for early intervention as a means of reducing an individual's risk for recidivism. Swartz and Lurigio (2007) also have discovered that the presence of APD and/or psychopathy were valid predictors of criminality, the risk for violence, and the presence of substance use disorders in those who have mental illness. Therefore, focus on antisocial elements should be incorporated into the assessment of risk and treatment planning for offenders with mental health problems as much as they should be for offenders without such problems.

Constantine and colleagues (2010) followed a sample of seriously mentally disordered offenders over a 4-year period and identified three trajectories of arrest patterns. A sporadic arrest group was identified, comprising 9% of the population. These individuals typically showed a median of 2 arrests per year and were predominantly female offenders. A low rate, but chronic arrest group made up the majority of the sample (82%). This group was only a third female and had a median of 4 arrests per year. Finally, a high rate, chronic arrest group was identified, comprising just 5% of the sample. These latter individuals accounted for 17% of all arrests in the sample and had a median of 14 arrests per year. Consistent with prior research, these groups did not differ according to disorder type, but did differ based on many criminological factors present in non-mentally ill offender samples (e.g., early onset of antisocial behaviour, homelessness, and substance abuse). Thus, the criminogenic factors appear to be better predictors of antisocial behaviour than the mental health factors, which may be a weak predictor of future general criminality. Therefore, mental

illness may be best conceptualized as a potential destabilizing factor that can elevate the influence of other criminal risk factors and reduce that of protective factors.

In light of contemporary research, Skeem and colleagues (2011) have proposed a new conceptual framework that provides a means for contextualizing appropriate interventions for mentally ill offenders. Skeem et al. (2011) suggested that there is a moderated mediation between mental health problems and criminality. This means that the link between mental illness and offending is often mediated by other factors (e.g., poverty, antisocial cognition, antisocial personality traits, or substance abuse). This conceptualization challenges the underlying assumptions of many diversion programs that are founded on the belief that psychiatric treatment alone will lead to reductions in the risk for recidivism. Skeem and her colleagues have extended their arguments to address why mentally ill offenders are disproportionately more likely to fail while under community-based correctional supervision. They argued that system bias and stigma toward offenders with mental health problems plays a role in creating an increased likelihood of incurring a community supervision failure (Messina, Burdon, Hagopian, & Prendergast, 2004; Skeem, Nicholson, & Kregg, 2008). Providing more effective treatment in the community is essential given that up to 70% of offenders are managed outside of criminal justice institutions through parole or probation services (Glaze & Bonczar, 2007). The framework is useful for conceptualizing this bias, and is consistent with the use of evidence-based rehabilitative methods that focus on treatment provided within community-based settings.

Given the tendency to prioritize mental health issues as targets for treatment under the mislead assumption that it will reduce criminal behaviour, little intervention is

typically provided that actually targets the factors directly related to criminal behaviour in this population (Skeem et al., 2011). Without the provision of adequate mental health services, attention to criminogenic needs, support within criminal justice institutions, and proper linkage to community-based services upon release from institutions, individuals with mental health problems are more likely to continue cycling through the criminal justice system, the mental health system, and/or substance abuse treatment programs (McNiel & Binder, 2005; McNiel, Binder, & Robinson, 2005; Morris, Steadman & Veysey, 1997; Olley, Nicholls, & Brink, 2009; Walsh & Holt, 1999).

Specialized Services to Address the Needs of Offenders with Mental Health Problems

Efforts have been made to combat the overrepresentation of individuals with mental health problems in the correctional system, as well as their increased risk of community supervision failures. Alternative approaches to imprisonment have been created that attempt to divert these individuals from the criminal justice system. Examples of alternative programs that involve criminal justice models include: law enforcement-based specialized response programs, pre- and post-booking jail diversion initiatives, diversion from the criminal justice system to specialized hospitals programs, improved jail and prison transition planning protocols, specialized courts designed to adjudicate offenders with mental health problems through the criminal justice system, and assistance within the criminal justice system through specialized mental health probation and parole caseloads (Bureau of Justice Assistance, 2008; Skeem et al., 2011; Steadman & Naples, 2005). In addition, community mental health treatment services

have started to focus on forensic issues as part of case plans for persons with chronic and persistent mental health disorders and criminal justice issues, such as Forensic Assertive Community Treatment (F-ACT; Lamberti, Weisman, & Faden, 2004) and Forensic Intensive Case Management (FICM; Morrissey, Meyer, & Cuddeback, 2007).

An underlying assumption of these diversion programs and specialized services is that access to and engagement in, adequate treatment for psychiatric and/or substance abuse symptoms will naturally lead to better criminal justice outcomes (e.g., decreased recidivism; Hiday & Wales, 2003; Redlich et al., 2006). These programs are also designed to reduce court caseloads and overcrowding in jails, while also theoretically addressing public safety concerns through the treatment of mental health problems (Goldkamp & Irons-Guyn, 2000; Petrila, Poythress, McGaha, & Boothroyd, 2001). Research indicates that clients who engage in diversion programs tend to have positive improvements in independent living skills, decreased substance abuse (Cosden, Ellen, Schnell, Yamini-Diouf & Wolfe, 2003), reduced homelessness and psychiatric re-hospitalization (Lamb, Weinberger, & Reston-Parham, 1996), decreased criminal justice contact (i.e., lower arrests, violence), and decreased time spent in jail (Steadman, Cocozza & Veysey, 1999). Clients diverted to hospital tend to have similar outcomes, with improved mental health functioning and better discharge planning, more positive health outcomes, and maintenance of ongoing contact with various community-based services (Rowlands, Inch, Rodger, & Soliman, 1996).

Despite the general success of diversion initiatives, the specific programs and their components that lead to the most favorable outcomes are unclear (Steadman & Naples, 2005). This lack of clarity stems from the fact that the full array of these

services is rarely described in the literature (Sly, Sharples, Lewin, & Bench, 2009) and there may be qualitative differences between those who are diverted to these programs and those who are not (Steadman & Naples, 2005). A systematic review by Sirotich (2009) of what little evidence exists about these alternative programs indicated that they can reduce the amount of time spent in jail, but do not have much effect on reducing the rates of recidivism in offenders with mental health problems. Even less is known about the impact of multiple diversions on a case (Sly et al., 2009). Skeem et al. (2011) provided a brief summary of the current evidence of many of the above listed diversion programs, all of which have inconsistent effects on recidivism and reduced mental health recovery. These inconsistent results may be due to a sole focus on mental health treatment and failure to incorporate an emphasis on criminogenic factors.

Management of Offenders with Mental Health Problems in Traditional Community Correctional Services.

When an offender with mental health issues has not been diverted from the criminal justice system, some jurisdictions have developed specialized probation services to manage the needs of these persons within the regular correctional system. Whether in the context of MHC or regular correctional systems, probation officers are an important professional group who has frequent contact with offenders with mental health problems. They are in charge of monitoring and enforcing compliance with case management plans involving rehabilitation that includes supervision of court-ordered conditions. For offenders with mental health problems, one of these conditions is often to attend mental health services. However, little is known about how this implementation takes place and which supervision methods work best to achieve

compliance with these case plans (Skeem et al., 2003). Additionally, it is clear from the literature that the main challenge faced by probation officers when working with offenders with mental health problems is concern about their ability to achieve and maintain the client's treatment compliance (Skeem, Emke-Francis, & Eno Louden, 2006). In response to these challenges, recent developments have occurred in some jurisdictions that involve training specialty probation officers to work with offenders who have mental health problems. Within such specialty services, there is a greater emphasis on the importance of rehabilitation rather than sanctions/compliance. Specialty probation officers often receive training on mental health and the management of mentally ill offenders, and have smaller and specialized caseloads involving only those diagnosed with severe mental illnesses (Skeem et al., 2003). Probation officers with specialized training may be more qualified to identify the symptoms of mental health problems, are better able to coordinate and manage the services an offender receives within the community, and may be especially aware of the issues relating to noncompliance with conditions of probation orders and how to strategically respond to these issues in a proactive and perhaps different manner than that used with offenders without mental health problems (Slate, Roskes, Feldman, & Baerga, 2003).

Skeem et al. (2006) described five components of a prototypical specialty agency that includes specially trained probation officers. These components should include: 1) probation officers who only have mental health caseloads rather than "mixed" caseloads; 2) smaller caseloads to permit the provision of more intensive supervision and services; 3) specialized training opportunities for issues related to mental health; 4) delivery of case management through the active integration of internal and external resources to

meet the specific needs of the individual with the mental health problem; and 5) using problem-solving strategies to address noncompliance (i.e., equal time spent on the causes of the noncompliance, generation of alternatives to address the problem, and mutually agreeing on a plan), and using incarceration as the absolute final resort. The fifth component is contrary to the fact that treatment compliance in forensic populations is often enforced by implementing the threat of sanctions, including jail time for those who do not adhere to their case management protocols (Cosden et al., 2005). These components were designed to address the issues that probation officers usually encounter when dealing with offenders with mental health problems especially, when there are limited opportunities for consultation and collaboration with psychiatric services (Roberts, Hudson, & Cullen, 1995).

In a similar vein to specialty probation services articulated by Skeem et al. (2006), Roskes and Feldman (1999) described a collaborative community-based treatment program for offenders with mental illness that involved deliberate collaboration between the mental health system and the probation service. This program was designed to ensure that well-coordinated care existed for mentally ill offenders, with ongoing communication and feedback between mental health workers and probation officers. The overarching goal of this program, as well as all other diversion programs, is to continue to manage and maintain the mentally ill offender within the community. These authors highlighted that the assumption of this type of collaborative specialized probation service is that it will facilitate linkage to necessary services in the community, improve the individual's functioning, and decrease their already heightened risk of probation failures and re-arrests. Individuals who participated in the program (n = 16)

were described qualitatively. Only three participants were found to have violated the terms of their probation due to noncompliance with mental health treatment during the 24 months follow-up period. Probation officers were routinely informed about offenders who had compliance concerns, such as missed appointments, and acted as an outreach for the clinical program to increase an individual's engagement in the treatment, although it was unclear from the description how these aspects were measured. However, little empirical conclusions can be drawn from Roskes and Feldman's study because it was solely descriptive.

Skeem and colleagues (2003) attempted to decipher how specialty probation officers perform compared to more traditionally trained probation officer's whose primary role is to enforce community safety. Focus groups of probation officers (n = 32) and their probationers (n = 20; diagnosed with a severe Axis I mental illness) from several sites were formed to identify the methods that were used in both traditional and specialty settings. Skeem et al. specifically focused on methods used to monitor and enforce compliance and the role of the practitioner-officer relationship in promoting adherence to mandated treatment and supervision. Skeem et al. found differences in the nature, range, and timing of strategies used by these two groups of probation officers. Specialty officers were more likely to foster the development of a complete "compliance toolkit" with probationers by implementing more positive pressures for addressing compliance (i.e., persuasion and inducement), and engaging more closely with mental health providers. They also intervened much earlier, more often, and more consistently than did traditional probation officers. Traditional probation officers were more likely to address noncompliance through negative pressures, such as orders, deception, and

threats of incarceration. The quality of the relationship between the probation officer and the probationer influenced the chosen strategies and was considered central to treatment adherence and outcome. Finally, contextual differences were found in the emphasized outcome in that specialty probation officers focused specifically on rehabilitation, whereas traditional workers focused on community safety and control in conjunction with the general state of disarray of the mental health system.

Although there has been limited research into the effectiveness of specialized probation programs, preliminary results indicate that these programs are promising. Harper and Hardy (2000) found that probationers who were supervised by specialty probation officers in the United States showed a greater change in their criminogenic attitudes relative to those supervised by more traditionally trained probation officers. Moreover, Skeem et al. (2006) found that probationers viewed specialty programs as being more useful and more effective in reducing their risk of re-arrest and supervision failures than regular supervision. Thus, how an intervention responds to and relates to an offender is a major factor influencing that offender's responsivity to a case plan and his/her ultimate recidivism risk reduction.

Treatment Readiness Factors in the Rehabilitation of Offenders with Mental Health Problems

Whether in the context of MHC, traditional community supervision, or specialty probation services, the above section highlights the imperative of gaining a better understanding of the responsivity factors that influence the effective ingredients of community-based rehabilitation programs and case management plans. These factors must be better understood to achieve successful outcomes for offenders with mental

health problems. Serin and Kennedy (1997) suggested that, in order to maximize the effectiveness of treatment programs for offenders, treatment readiness and responsivity must be assessed and addressed during the treatment planning process. Addressing offender responsivity in rehabilitation programs is critical (Andrews & Bonta, 2010), especially when considering that many offenders are not seeking treatment on their own accord. It is also important to remember that getting the offender to treatment is one thing, whereas keeping him or her there is quite another. Therefore, considering responsivity factors, such as mental health issues, access to effective and appropriate services, motivation to change, quality of therapeutic alliance, engagement, and compliance/adherence to case management are essential aspects that influence the effectiveness of community-based programs for offenders with mental health problems. Serin and Kennedy conceptualized many of these components as “treatment responsivity”, which includes treatability (i.e., motivation and compliance) and treatment effectiveness (i.e., treatment gain and generalization of effects). Heilbrun, Bennett, Evans, Offult, Reiff and White (1992) identified four key aspects relevant to assessing offender treatability: appropriateness of the goals of the treatment to the client, history of the client’s response to treatment, client motivation, and the presence of contraindications (i.e., when a certain treatment is not appropriate). Although there is evidence to suggest that many interventions, including behavioural, cognitive-behavioural and multi-modal, are effective in correctional settings, Heilbrun et al. argued that these techniques are insufficient if responsivity is not considered. These factors are consistent with those noted as relevant under the responsivity principle of the RNR model. In addition, the MORM model also extends the concept of responsivity to

include treatment readiness which describes not just adapting a program to fit a person's responsivity concerns, but also enhancing individual factors that allow for the client to engage effectively.

It is currently unclear what role specific mental health diagnoses play in terms of readiness, especially when these diagnoses are clouded with co-occurring substance use disorders. Health Canada has published specific Best Practice guidelines for treatments to address concurrent disorders (e.g., Health Canada, 2002), but the question remains as to what is the most appropriate approach and sequence of intervention for offenders with mental health problems in light of the complexity of their issues (Chandler, Peters, Field, & Juliano-Bult, 2004). This is a question of responsivity/readiness because, if an individual is currently experiencing acute distress due to a mental illness and substance use problem, then this would likely impair his/her ability to respond to treatment addressing criminogenic and non-criminogenic needs. At a minimum, Chandler et al. (2004) highlighted the need for flexibility in providing integrated services in a way that provides intervention for an offender's most urgent needs.

Access to appropriate mental health treatment is an essential consideration when examining readiness factors. There is little debate about the lack of access to appropriate mental health services in Canada (Mental Health Commission of Canada, 2012). Many individuals with mental health problems go untreated because of barriers to accessing appropriate and evidence-based services, limited numbers of qualified professionals to deliver these services, lack of coordination and collaboration between care providers and disciplines, and extensive wait-lists for publicly funded services (Kirby & Keon, 2006). Several reports have been published to highlight the current

state of affairs in Canada regarding mental health services such as the Kirby and Keon (2006) report and the Mental Health Strategy (Mental Health Commission of Canada (2012). Despite the many successes to date of the Mental Health Commission of Canada, the complexity of managing antisocial behaviour in individuals with mental illness portrays an even more dismal picture given limited access to adequate care. There are few individuals practicing within our communities who are trained to adequately care for mentally ill offenders in a way that addresses both the mental health and the criminogenic needs of the individual (Mental Health Commission of Canada, 2012; Skeem et al., 2011).

Encouraging Compliance

Notably, many of the previously discussed theoretical predictors of compliance are likely not be unique to offenders with mental health problems; however, as it currently stands in the literature, this is unclear. Based on a review of the literature and information collected from focus groups, Skeem and colleagues (2003) identified methods that can be used to increase and encourage compliance in probationers with severe mental illnesses, which also appear to have merit with those who are not exhibiting such symptomatology. First, these methods included developing a collaborative, fair, and respectful relationship between the professional and the mentally ill individual in which there is a shared goal of improving the client’s functioning. Second, problem-solving strategies should be used to remove any obstacles at the onset of treatment and frequently throughout the intervention process. Third, using positive pressures (e.g., persuasion and inducement) to encourage compliance is thought to be much more effective than negative pressures (e.g., orders and threats of incarceration).

Fourth, discussing noncompliant behaviour with the individual to identify the potential causes of this behaviour is important and can inform the implementation of prevention strategies that discourage the repetition of such behaviours. Finally, frequent collaboration should occur between probation officers, other criminal justice personnel, treatment providers, and the mentally ill individual to discuss progress and address potential obstacles to change and engagement. Under these circumstances, incarceration should be the very last option to address noncompliance and only used if there is a threat to public safety or deliberate noncompliance. In addition to these strategies recommended by Skeem et al., James and Milne (1997) argued that the most influential predictors of non-compliance and non-attendance at psychiatric treatment appointments was a lack of knowledge of, and harboring negative attitudes, expectations toward, the treatment process. Thus, it is important for professionals working with offenders with mental health problems to address all of these factors in the therapeutic context in order to maximize an offender's responsivity to intervention. Doing so is a central component of the RNR responsivity principle of effective case management.

Compliance is also important in circumstances in which courts mandate an individual to participate in mental health treatment, which is especially problematic in outpatient settings (Daniels & Jung, 2009; Redlich et al., 2006). As mentioned previously, the criminal justice system often used criminal justice leverages to mandate an individual to participate in interventions within the community. The concept of 'outpatient commitment' means that the court has mandated a person to follow a treatment plan delivered in the community and expects the person to comply to avoid sanctions. Mandated community treatment has been found to promote treatment

compliance in 80% of patients, reduces the need for psychiatric re-hospitalization by about 50-80%, and reduces the predicted probability of future violent behaviour (Fernandez & Nygard, 1990; Munetz, Grande, Kleist, & Peterson, 1996; Zanni & deVeau, 1986).

Issues of compliance also have an impact on MHC participation. The supervision of MHC clients receive is often more intensive than that of those in traditional probationary services. Therefore, issues with compliance may be noticed more readily and earlier in MHC clients relative to traditional forensic and correctional settings (Moore & Hiday, 2006). Specific to MHCs, non-attendance may lead to potential delays in the court process, need for increased or extended community supervision, and the risk of further criminal charges or incarceration (Daniels & Jung, 2009).

In summary, rehabilitation of offenders with mental health problems needs to be placed into a context that highlights the importance of placing offenders in programming that effectively targets their risk and criminogenic factors, as well as their mental health needs, via evidence-based methods of case management and intervention. When considering the appropriate intervention for offenders with and without mental health problems, identifying factors that positively and negatively influence their responsivity and compliance are crucial to the goal of maximizing the individual's capacity to change and respond to the treatment, and the interventionist's ability to match the appropriate nature and level of intervention required for that offender to their risk-need level. These approaches will thereby, increase compliance with community-based offender rehabilitation.

The Current Study

The deinstitutionalization movement over the previous century has led to an increase in the number of people seeking and requiring community-based mental health and social services (Cosden et al., 2005). Unfortunately, the existence of under-funded and under-resourced community services has culminated in many individuals with mental health problems not receiving adequate care, and, subsequently leading to their inappropriate involvement in the criminal justice system (Ogloff et al., 2007). Individuals with mental health problems cycle in and out of the doors of criminal justice institutions, which have proven to be inappropriate and often harmful places to receive limited, if any, mental health care (McNiel & Binder, 2005; Morris et al., 1997; Olley et al., 2009; Sapers, 2006; Torrey & Zdanowicz, 2001; Walsh & Holt, 1999; Wolff, 1998).

In response to the deinstitutionalization and the anti-criminalization of the mentally ill movements, diversion and modified criminal justice programs have been instituted to reduce the number of individuals with mental health concerns within the criminal justice system and to better respond to those within it (Hiday & Wales, 2003; Petrila et al., 2001; Redlich et al., 2006). Examples of these programs include pre- and post-arrest diversion programs, specialty probation services, and Mental Health Courts (Bureau of Justice Assistance, 2008; Steadman & Naples, 2005). Much of the research to date has indicated that these programs have merit in addressing mental health concerns (Cosden et al., 2003) and have some success with reducing the rates of recidivism and criminal justice outcomes for offenders with mental health difficulties (Lamb et al., 1996; Steadman et al., 1999). Nonetheless, the results are inconsistent. Moreover, a glaring gap in the literature is that little is known about empirically-based

responsivity factors that influence the compliance, engagement, motivation, and effectiveness of treatment for offenders with and without mental health problems managed within the community. The value of uncovering this information is vast. Understanding who may be most likely to respond successfully to a traditional correctional rehabilitation/case management style program, or conversely, who may need more individualized treatment to enhance motivation and engagement, correct negative attitudes about intervention and change, and knowledge about treatment may allow for more efficient use of what limited resources exist within community-based treatment settings (James & Milne, 1997; Prandoni & Wall, 1990). Such information should not necessarily be used to develop an “attrition” or “non-compliant” offender profile to exclude certain offenders from necessary rehabilitation. Rather than view these issues as problems inherent within the offender, these responsivity indicators should be seen as markers for areas of improvement that need to be addressed as part of the case plan to maximize a person’s response to the available intervention (Beyko & Wong, 2005).

In drawing on the offender rehabilitation literature, the Risk-Need-Responsivity (RNR) model is supported as an effective approach for addressing the criminogenic needs of offenders and reducing recidivism rates (Andrews & Bonta, 2006), including programs delivered in community-based settings (Bonta et al., 2010). Notwithstanding the evidence in support of the RNR model, research on the applicability of this model to offenders with mental health problems is still preliminary (Bonta et al., 1998; Nagi & Davies, 2010). Therefore, understanding the usefulness of the Responsivity component of the model as applied to offenders with mental health difficulties is paramount for

advancing the effectiveness of community-based diversion and rehabilitation programs for this unique population. In addition, understanding whether rates of case plan compliance varies as a function of the plan's adherence to the RNR model will shed light on the best practice strategies for managing offenders in the community. Finding ways to incorporate methods that increase compliance in treatment programs is imperative to reduce recidivism in offenders with and without mental health difficulties (Gudjonsson & Main, 2008).

Given that community supervision is the most prevalent form of correctional control in Canada (Bonta et al., 2010), this dissertation focused specifically on identifying the factors that are predictive of compliance with case management plans among offenders with and without mental health problems under court-ordered community supervision. Participants were drawn from a community-based MHC program and traditional probation services. Mental health and correction case file information and self-report questionnaires were used to address the primary research objectives within the current dissertation, which includes: 1) to identify the predictors of non-compliance in offenders with and without mental health problems and to determine whether current responsivity factors can mediate the influence of the criminological factors on compliance outcomes; 2) to examine the degree to which case plan adherence to the RNR model influences indicators of supervision and intervention compliance. Collectively, this research will help to identify the characteristics of offenders with higher levels of compliance with rehabilitation programming under community supervision and discriminate them from those who are at risk of non-compliance and in need of additional services to enhance motivation and engagement in order to be

successful with these programs. Should mediation occur, then this will provide more support for the importance of incorporating responsivity considerations into case management planning and guide case managers in decision-making regarding how to effectively address these concerns prior to conducting criminogenic interventions.

Hypotheses

Hypothesis 1: Testing the predictors of compliance:

A. Criminological variables assessing index recidivism risk level, previous responsivity, gender, and age will be most strongly associated with measures of compliance (Anderson et al., 2010; Browne et al., 1998; Daniels & Jung, 2009; Kirby & Keon, 2006; Serin & Kennedy, 1997; Skeem et al., 2007; Willshire & Brodsky, 2001; Wormith & Olver, 2002).

B. The risk for recidivism will account for the largest portion of variance in recent compliance indicators (Browne et al., 1998; Olver et al., 2011; Wormith & Olver, 2002).

C. The influence of prior compliance history during earlier periods of community supervision (correctional or mental health) on recent compliance indices will be mediated by current mental health functioning, perceived case manager-offender relationship as measured by the offender and the case manager, psychopathic traits, case management engagement, and motivation (Anderson et al., 2010; Barber-Rioja et al., 2012; Browne et al., 1998; Daniels & Jung, 2009; Kirby & Keon, 2006; Serin & Kennedy, 1997; Skeem et al., 2007; Willshire & Brodsky, 2001; Wormith & Olver, 2002).

Hypothesis 2: Participants managed with case management plans that strongly adhere to the three RNR principles will show the greatest level of compliance during their current period of supervision (Andrews & Dowden, 2007; Bonta et al., 2010; Hanson, Bourgon, Helmus, & Hodgson, 2009; Skeem et al., 2011). This adherence is expected to be higher in the traditional correction system given its more regular use of the RNR philosophy in New Brunswick's Public Safety Department.

Hypothesis 3: Responsivity adherence, in particular, will maximize compliance with community supervision in both Public Safety and Mental Health settings. However, this effect is expected to be most strongly achieved in the mental health setting given its tendency to focus on mental health issues as the primary case management targets (Bonta et al., 2010; Skeem et al., 2011).

CHAPTER THREE: Methodology

Participants

The sample of participants consisted of consenting individuals from two settings; the New Brunswick Department of Public Safety and the Horizon Health Region's Addiction and Mental Health Services and each site's respective primary case managers. Cases were recruited via two procedures. Offenders identified at the time of the study by the New Brunswick Department of Public Safety in its Saint John and Fredericton offices as being supervised in the community because of involvement with the criminal justice system made up the Public Safety group. All referred cases were included regardless of whether the individual had a formal mental health disorder given the high rate of mental health issues in correctional populations (Canadian Institute of Health Information, 2008). For the purposes of the current research, a mental health problem was broadly defined to include diagnosed mental disorders, and/or the presence of sub-threshold mental health symptoms that cause difficulties in adjustment as measured by a self-report measure of psychological distress/adjustment (i.e., Symptom Checklist-90-Revised).

Public Safety participants (n = 102) were drawn from various forms of community supervision, such as Alternative Measures, Community Service Orders, Extra Judicial Sanctions Program, and Probation. While under supervision, the offender often needs to comply with court-ordered conditions to report to a probation officer, abstain from alcohol/drugs, perform community service, abstain from contact with persons known to have criminal justice involvement, respect a specified curfew, participate in designated programs (e.g., anger management), and obtain psychiatric

treatment or counseling, among others. More specific conditions could be imposed depending on the type of crime committed and/or specific factors relevant to the offender with the purpose of encouraging a more pro-social lifestyle. The offender often works closely with a probation officer, especially if on a probation or conditional sentence. The underlying assumption of community supervision is that the offender can be encouraged to be a more law-abiding citizen within the community without necessitating a period of incarceration (Public Safety of New Brunswick, 2011). The role of the probation officer includes preparing a pre-sentence report (if requested by the court), providing community-based supervision, guidance, and enforcement, reporting any violations of court orders to the police, developing case plans, and referring the offender to the appropriate services (i.e., mental health, education, addictions, etc.). For Public Safety cases, policy dictates that offenders should meet with probation officers according to the frequency dictated by their risk level. They also are monitored by probation officers via contact with family, employers, and other community members. All information about their compliance with case management is documented in the Public Safety file or on the Client Information System (CIS), a database of community-based or custodial offenders in the province of New Brunswick. For Public Safety cases involved in mental health, they also were asked for consent to a review of these records held by mental health services. Offenders were recruited from Public Safety New Brunswick offices located in Fredericton and Saint John, as well as some of their satellite offices in Woodstock and St. Stephen, New Brunswick.

The second group of offenders ($n = 9$) were recruited from Addiction and Mental Health Services (Horizon Health Network, Zone 2). Eligible participants were those

partaking in treatment services provided by the Forensic Mental Health Team or the Long-term Mental Health Team of the Horizon Health Network in Saint John, New Brunswick, who had a documented recent criminal history. These teams provide access to mental health treatment to offenders through referrals from the Probation Service (in Saint John and Fredericton) and the Saint John Mental Health Court (SJMHC). The SJMHC was developed in 2000 as an initiative by the Provincial Court of New Brunswick to provide mentally ill offenders with increased access to mental health and social services while balancing public safety concerns (Mental Health Court Saint John, 2003). The MHC team includes: a designated judge, defense counsels, a crown prosecutor, a probation officer, a psychiatrist, a social worker, a mental health nurse, and a representative from the Salvation Army Residential Centre. The court only accepts cases who do not pose a major concern to public safety because the treatment will be conducted using community-based services. Cases accepted into MHC are typically in the program for 10-12 months and, as with the Public Safety cases, they receive services from mental health, addictions, and social services to assist with psychosocial needs. The court often imposes court orders to keep the peace, attend counseling, avoid places/people associated with criminal behaviour, abide by a curfew, and abstain from substance use. Cases in MHC also could be on probation or other court orders, but they are supervised within the MHC context more so than Public Safety. Participants drawn from MHC and other mental health services undergo various forms of treatment throughout their time in the program, and are expected to attend regular meetings with their case manager, as well as follow-up appearances in the court before the presiding

judge. These meetings are documented within the mental health case file information and the CIS database.

In order for a participant from Addiction and Mental Health Services and Public Safety settings to participate in the current study, they had to have been under some form of court-ordered community supervision (e.g., probation or Form 12 New Brunswick) at the start of the study and needed to have been under this supervision for at least six months in Saint John or Fredericton, New Brunswick, and surrounding areas (e.g., St. Stephen, Woodstock). Individuals needed to be at least 19 years of age, male or female, and capable of speaking and understanding English. Those with reading difficulties were still eligible for participation. In such cases, the principal investigator would gather all the information orally. As stated previously, individuals with and without mental health problems were eligible for participation in this study.

Support for the study was obtained prior to the beginning of the study from New Brunswick Public Safety Management, the SJMHC, and Horizon Health Network staff and management staff to ensure that they were willing to refer clients and participate in the case manager portion of the study. Each participant identified through the Mental Health Court and Public Safety New Brunswick staff was first approached by his or her case manager to inform the participant generally about the study. Each participant was asked if he or she would agree to speak to a researcher to learn more about the study and about potentially participating in it. If the client agreed, then the principal investigator met with each participant on one occasion at the Saint John Mental Health Clinic, Public Safety office, or a mutually agreed public location (e.g., Tim Horton's) to describe the study and obtain consent for participation (see Appendix N and O for consent forms).

Consent also was obtained from each case manager (see Appendix P for consent form).

As shown in Table 1, the sample was predominately composed of Caucasian (84%), single (55%), and unemployed (54%) individuals with a mean age of 33.16 years (*SD* = 11.97, range: 19-63). Consistent with the population of offenders in Canada (Dauvergne, 2012), the majority of participants were male (84%). These individuals had been supervised for a mean of 11.31 months (*SD* = 7.43). Offenders generally fell within the moderate Risk range on the Level of Service/Case Management Inventory (*M* = 17.11, *SD* = 9.02). The types of index offences varied, with the majority convicted of assaults (35.6%), breaches of court orders (24.3%), and drug-related offences (20.4%). The sample had a chronic degree of criminality with 23% having one arrest, 34% having 2-5 previous arrests, 17% having 6-10 arrests, and 27% having more than 10 previous arrests (Table 2). Approximately 30% of the sample had a history of violent offences, 7.3% had a history of sexual offences, and 35.4% had a history of technical charges (e.g., breach of court order). Although not the focus of the current study, recidivism data was collected when available from file data if it occurred during the data collection period. Approximately 32% of the sample had re-offended between the beginning of their current supervision period and the date that the participant consented to the study. The average number of months before the first re-offence was 8.45 (*SD* = 6.66). The most common re-offences were breach of conditions (23.5%), drug-related offences (7.1%), and other (predominantly DUI; 7.1%). In terms of mental health functioning, the sample was in the moderate to high clinically elevated range for global functioning (SCL-90-R Total score; *M* = 66.25, *SD* = 13.37) with the highest mean subscales being

Obsessive Compulsive symptoms (*M* = 64.99, *SD* = 12.82), anxious symptoms (*M* = 64.01, *SD* = 14.05), and somatic complaints (*M* = 63.38, *SD* = 14.19).

For the case managers, the sample consisted of 22 case managers from the two settings who referred participants to the study. Each case manager referred a range of one to fourteen participants (*M* = 5.56, *SD* = 4.09). Of those who referred participants, nine case managers completed the demographic questionnaires. Sixty-seven percent of case managers were male, with a mean age of 42.33 years (*SD* = 12.83). Most case managers were probation officers with a minimum of a Bachelor's education. These case managers had an average of 18.06 years (*SD* = 10.86, Range = 3-30) experience with mental health and/or criminal justice populations.

Materials.

Participant Demographic Questionnaire (Appendix A). Demographic information was collected using a multi-source method. First, the Participant Demographic Questionnaire for offenders was a self-report questionnaire developed for the current study that consisted of 17 questions inquiring about such variables as the participant's age, gender, ethnicity, education level, marital status, previous number of arrests, index offence, age at first arrest, and total number of times hospitalized for mental health reasons. Second, further information, such as the duration of current community supervision and history of prior community supervision failures, was gathered from extensive file review of the records of the SJMHC, Mental Health, and Public Safety (i.e., Client Information Systems) using a Coding Guide (see Appendix L). This information also was used to confirm self-report information. Official records were relied upon when discrepancies existed between the file and self-report information.

Case Manager Demographic Questionnaire (Appendix B). The demographic information of the case manager was collected using a self-report measure developed for the current dissertation. It consisted of seven questions measuring variables such as age, gender, ethnicity, education level, employment type and status, and degree of experience working with offender and/or mental health populations.

Adapted Version of the Treatment Motivation Scale for Forensic Outpatient (TMS-F; Drieschner & Boomsma, 2008a, 2008c; Appendix C). The TMS-F was originally an 85-item Dutch self-report instrument designed to measure the motivation to engage in intervention, as well as six cognitive and affective determinants of motivation for forensic outpatients receiving services in the community. For the purposes of the current dissertation, these ratings were made in reference to the previous 6-month period of the current supervision. The original measure was made up of seven content scales and one social desirability scale. The content scales included: motivation to engage in treatment, problem recognition, distress, perceived legal pressure, perceived costs of the treatment, perceived suitability of the treatment, and outcome expectancy. The seven content scales have been found to have adequate internal reliabilities with alphas ranging from .70 to .91. The measure was found to significantly correlate with therapist ratings of the offender's motivation to engage in treatment. The measure has been cross-validated across independent samples of forensic outpatients as well (Drieschner & Boomsma, 2008a, 2008c). The content of this questionnaire was translated to English by the principal investigator using Google Translate and each item was reviewed and modified for clarity and wording. Items that appeared redundant were eliminated (e.g., "If I had not gone into treatment, I would have received some awful legal consequences"

and "If I were to stop my programs, then I would receive consequences from the justice system"). Twenty five items were eliminated resulting in a pool of 60 items that were rated based on a 5-point Likert scale from 0 (Totally Disagree) to 4 (Totally Agree). Higher scores are indicative of higher levels of motivation. The adapted version of this measure was found to have adequate psychometric properties with an internal consistency of .80 in the current sample. It also correlated significantly and positively with measures of the offender/case manager relationship ($rs = .30 - .54$, $ps < .01$) and with lower levels of perceived toughness from the case managers' view ($r = -.29$, $p = .02$). Because items were translated and the measure was updated, the original subscales were not used. An exploratory factor analysis was completed to determine whether a similar factor structure could be derived with the shortened English version. However, due to the insufficient sample size (Tabachnick & Fidell, 2007), the factor analysis failed to converge and was not usable. Because of the adequate internal consistency of the overall measure only, the Adapted TMS-F total score was used for all subsequent analyses. During the initital planning stages of this dissertation, other inventories were considered for the measurement of motivation (e.g., University of Rhode Island Change Assessment Scale, Treatment Motivation Questionnaire). However, due to questionable validity and reliability of these scales for offender populations (e.g., McMurran et al., 2006), the adapted version of the Treatment Motivation Scale – Forensic was deemed to be the most appropriate measure.

Intervention Engagement (Appendix D). Each offender's engagement with their case plan was rated by the principle investigator on a three-point-rating scale based on file review. A score of 0 was given if the rater deemed the client to have no engagement

(e.g., often missing appointments, showing poor motivation for change, no engagement with the probation officer or other service providers, and having frequent non-compliant behaviour). Approximately 11% of the sample fell within this category. A score of 1 was given if the rater thought the client had moderate or partial engagement (e.g., inconsistent attendance at appointments, showing partial motivation to change, some engagement with the probation officer/service providers, and showing inconsistent patterns of compliant behaviour). Just over one third of the sample fell within this category (37%). Finally, a score of 2 was given if the rater deemed the client to have good engagement (e.g., attendance at most appointments, appearing to have adequate motivation for change, actively working and engaging with the probation officer/service providers, and exhibiting consistent compliant behaviours). This category captured half of all individuals in the sample (52%). Inter-rater analyses for 20% (n = 24) of these ratings was completed by the principal investigator and a trained graduate student and was found to be adequate (ICC = .82). Raters agreed on ratings in 67% of the cases. In the remaining inter-rater reliability cases, the ratings were never discrepant by more than 1 point. This rating scale was used as a replacement for the TER[1]; however, due to

[1] *Treatment Engagement Rating Scale* (TER; Drieschner & Boomsma, 2008b; Appendix E). The TER measures aspects of behavioural engagement in community-based offenders receiving correctional treatment over the previous 8 weeks. For this dissertation, this time period was adapted to the previous 6 months. Engagement is rated by the clinician/case manager over 21 items in 9 different areas: session attendance, making sacrifices (e.g., social, financial, or psychological), openness, effort to change problem behaviour (within and outside therapy sessions), goal directedness, efforts towards improving socio-economic situation (e.g., work, housing, social relationships), constructive use of the therapy sessions, dealing with the content of therapy sessions between sessions, and a global assessment of treatment engagement. Ratings are made on a 5-point scale, with lower scores representing lower levels of engagement, and higher scores representing high levels of engagement. The clinician also has the option of deeming the item “not applicable”. The measure generates nine component scores

multicollinearity and redundancy concerns with the Process Compliance ($r = .48$, $p < .001$) measure described below, it was also omitted from inferential analyses, but served as a concurrent validity index for the compliance measure used as the major dependent variable in the current dissertation. The Structure Compliance measure also was highly correlated with the engagement measure ($r = .50$, $p < .001$).

Dual Role Relationship Inventory (DRI-R; Probationer and Case Manager Forms; Skeem et al., 2007; Appendix F/G*)*. The DRI-R was designed for use with individuals who have been mandated to seek mental health treatment in the community. It assesses the quality of the relationship between the case manager/probation officer and the client. For the purposes of the current dissertation, these ratings were made in reference to the previous 6 months of supervision. It was developed using focus groups of mentally ill offenders as described in Skeem et al. (2003). There are three forms: a Probationer (i.e., the client), an Officer (i.e., the case manager), and an Observer form, but only the first two were used in the current dissertation. The case manager form consists of 35 questions and the probationer form consists of 30 questions. The DRI-R measures two domains: Alliance and Relational Fairness, each of which is measured on a 7-point Likert scale (1 = *never shows this behaviour*, 7 = *always shows this*

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and a total score (a mean of all the component scores). The TER has high internal consistency ($a = .93$), satisfactory inter-rater reliability for the total score (ICC = .76) and for the component scores (ICC's between .56 and .69). It also has adequate concurrent validity with other measures of motivation and engagement for forensic outpatient samples (Drieschner & Boomsma, 2008b). It was developed and validated on a Dutch sample of outpatient offenders; however, it has been translated to English by its developers. Minor aspects of the item phrasing were altered on the measure to best reflect the target population of the current dissertation (e.g., 'therapist' was changed to 'case manager'). Unfortunately, the case managers in the current study did not complete the TER given its length and limited time to complete the tool around their busy workload, especially when they had multiple clients for whom they needed to complete the tool. Thus, the TER was omitted from the current study.

behaviour). Skeem et al. (2007) showed that the scale co-varied strongly with various measures of therapeutic alliance (i.e., ratings of within-session behaviour, relationship satisfaction, symptoms of psychological distress, and treatment motivation) and appears to appropriately capture the nuances of mandated intervention as opposed to other measures of therapeutic alliance. The scale has high levels of internal consistency (ranging from .87 to .96 for the subscales and the total score). The quality of dual-role relationships as measured by the DRI-R was also shown to have predictive utility for future compliance with rules and probation conditions (Skeem et al., 2007). Some of the item phrasing was altered to better reflect the target population of the dissertation (e.g., ‘therapist’ was changed to ‘case manager’). In the current sample, both the offender and case manager forms of the DRI-R had excellent internal consistency ($\alpha = .96$ and .92, respectively), and the two response forms were moderately, positively related ($r = .39$, $p = .002$).

Symptom Checklist-90 Revised (SCL-90-R; Derogatis, 1996; Appendix H). The SCL-90-R is a 90-item self-report questionnaire designed to measure the severity of a broad range of mental health problems and symptomatology at the current time of assessment. The scale yields scores for nine primary symptom dimensions and three indices of global functioning. Responses are rated on a 5-point rating scale of distress ranging from 0 (none) to 4 (extreme), with higher scores indicating more psychological dysfunction. Specifically, the subscales assess symptoms related to psychoticism, somatic complaints, obsessive-compulsiveness, depression, anxiety, interpersonal problems, phobic anxiety, hostility, and paranoid ideation. The global scales include the Global Severity Index, the Positive Symptom of Distress Index, and the Positive

Symptom Total. The Global Severity Index can be used as a summary score for the test (Derogatis, 1996). The items are written at a sixth grade reading level. Norms are available for adult non-patients, adult psychiatric outpatients, adult psychiatric inpatients, and adolescent non-patients. The adult non-patient norms were used in the analyses. There appears to be adequate evidence for test-retest reliability with correlations ranging from 0.68 to 0.80 over a 10-week interval (Derogatis, 2000). The test also has adequate construct, concurrent, and discriminant validity; and is an internally consistent measure (Derogatis, 1996; Derogatis, Rickels, & Roch, 1976). The SCL-90-R is a valid and reliable measure of psychological distress (Holi, 2003), has been used in studies assessing mental health difficulties in offenders (Davison & Taylor, 2001), and can be used to distinguish psychotic from non-psychotic male offenders remanded to a prison for psychiatric assessment (Wilson, Taylor, & Robertson, 1985). The measure places emphasis on a continuous measure of psychological distress; therefore, it will be useful given that many individuals in the criminal justice system may not meet criteria for a mental health disorder but still have symptoms that cause some impairment. Using the data for the current study, the SCL-90-R was found to have excellent internal consistency (α = .96). During the planning stages of this dissertation, other inventories were considered for the measurement of mental health needs (e.g., Personality Assessment Inventory, Brief Symptom Inventory, and the Structured Clinical Interview for DSM Disorders). However, due to concerns regarding length of administration of these longer measures, and concerns with some of these measures' validity and reliability in offender populations (e.g., Stewart, Harris, Wilton,

Archambault, Cousineau, Varrettem et al., 2010; Holden, Starzyk, McLeod, & Edwards, 2000), the SCL-90-R was deemed to be the most appropriate measure.

Level of Service Inventory-Case Management Inventory (LS/CMI; Andrews, Bonta, Wormith, 2004; Appendix I). The LS/CMI is a third-generation risk instrument that is designed to measure risk for general recidivism based on an actuarial score and to inform the case management needs of offenders by means of a review of eleven content sections corresponding to the RNR model of criminal behaviour. The LS/CMI is designed to assess risk and need factors of late adolescents and adult offenders and yields a total risk score and subscale scores for each criminogenic need. The LS/CMI is part of a group of instruments that incorporate the evaluation of criminogenic factors and was developed in conjunction with the RNR model (e.g., Level of Service Inventory-Revised [LSI-R; Andrews & Bonta, 1995]; Level of Service/Risk, Need, Responsivity [LS/RNR; Andrews, Bonta, & Wormith, 2008]). The first section contains 43 items that assess eight criminogenic categories, including criminal history, antisocial attitudes, personality, and peers/criminal associates, employment history, family, leisure activities, and substance abuse problems. Items are scored as Yes or No with the Yes items receiving one point toward the total risk-need score. The total score can be divided into five risk categories: very low (0-4), low (5-10), moderate (11-19), high (20-29), and very high (30-43). This first section is the only officially scored section as other sections of the LS/CMI are used descriptively to contextualize the risk estimate.

A Specific Risk/Need section is also used to address personal problems that may have criminogenic potential that are important considerations for interventions as well as a section capturing history of perpetration. An additional section known as Other Client

Issues captures items that may also be relevant to case management planning like psychological and physical health, history of victimization, and socioeconomic status indicators. Finally, a section titled Special Responsivity Concerns also measures important responsivity variables that have been identified in clinical and correctional research. Although these scales are intended to be used descriptively in clinical practices, other studies have summed the items endorsed on these scales to generate a total score and have produced acceptable internal reliabilities (Canales, 2011; Girard & Wormith, 2004). For the purposes of the current dissertation, the endorsement of any specific responsivity items was summed (with a Yes receiving one point) and this total score was used in the analyses. Other relevant sections include Other Client Issues, which involves supplementary non-criminogenic information that may impact on decisions made for classification and case management (e.g., diagnosis of a serious mental disorder, physical health problems, or financial difficulties) and the Special Responsivity Considerations section that includes important responsivity information that can impact on choices and modes of service delivery. Each of these important sections are summarized in the Case Management Plan section of the LS/CMI, which highlights the main criminogenic and non-criminogenic needs, as well as special responsivity considerations, that are to be targeted during the period of supervision.

The LS/CMI was designed as an extension to the LSI-R (Andrews & Bonta, 1995) to inform case management planning for offenders in justice, forensic, correctional, and other related agencies. Each of these measures can be administered by many different professional groups working in criminal justice capacities (i.e., probation, parole, psychologists, police and correctional officers) and are useful in

making decisions regarding supervision, security level placements, and treatment progress. The LSI-R has produced an average effect size (*r*), of .39 for predicting general recidivism, and .28 for predicting violent recidivism (Gendreau, Goggin & Smith, 2002). Additionally, Girard and Wormith (2004) examined the utility of the General (43 items that measure the individual's antisocial history and personal characteristics) and Specific Risk/Need sections (measures Personal Problems with Criminogenic Potential subscale involving 14 items and the History of Perpetration subscale involving 8 items) of the Level of Service Inventory-Ontario Revision (LSI-OR) across various offender populations, including those with mental health problems, for predicting general and violent recidivism. The results of their study indicated that the LSI-OR General Risk/Need section (measured similarly to the LS/CMI and LS/RNR) has predictive utility for general recidivism in offenders with mental health problems, but was not as useful for violent offending. Conversely, the Specific Risk/Need section (which is similarly measured in LS/CMI and LS/RNR and examines personal problems that may be relevant criminogenic needs and items indicative of a history of antisocial perpetration) was predictive of violent recidivism and highlighted its contribution to violent risk assessment in this population. These results suggest that the LSI tools are potentially valid tools with offenders with mental health problems for the estimation of general and violence risk. Canales, Campbell, and Wei (2011) examined the predictive validity of the LS/RNR instrument for general and violent recidivism in a sample of individuals (n = 127) discharged from an Atlantic Canadian mental health court program. Canales and his colleagues found that general recidivism was strongly predicted by the General Risk/Need total score (mainly due to the criminal history and

antisocial pattern variables) and by the Specific Risk/Need. As with the Girard and Wormith (2004) study, violent recidivism was most strongly predicted by Specific Risk/Need section (across all diagnostic groups), and outperformed the General Risk/Need section. These authors speculated that many of the items captured with this specific section may tap into acute risk factors that are associated with unstable and chronic conditions. Notably, the Special Responsivity considerations section was highlighted as a moderate to strong predictor of violent recidivism. Canales and his colleagues concluded that the LS/RNR instrument has predictive utility for general and violent recidivism and recommended its use for case management of mentally ill offenders in community contexts. Specifically, the LS/CMI has demonstrated moderate to high predictive validity for general recidivism outcomes with male and female offenders, in incarcerated and community based-settings, in Canada, the United States, England, Australia and Germany (Heilbrun et al., 2008; Holtfreter & Cupp, 2007; Kelly & Welsh, 2008; Raynor, 2007; Rettinger & Andrews, 2010; Vose, Lowenkamp, Smith, & Cullen, 2009). The instrument also has been found to be moderately predictive of violent recidivism (Campbell et al., 2009). For the purposes of this dissertation, all of the LS/CMI information was extracted from file records as they are routinely completed by case managers involved with the study; therefore, no scores were completed by the researchers. Case manager LS/CMI ratings were found to have an adequate internal consistency score of .71 and were moderately correlated with other indices of criminal behaviour, such as number of previous incarceration periods ($r = .44$, $p < .001$), number of previous court-ordered supervision periods ($r = .48$, $p < .001$), total number of known

criminal convictions prior to the index offence ($r = .35$, $p = .001$), and a trend towards recidivism during the current supervision period ($r = .19$, $p = .06$).

Levenson Self Report Psychopathy Scale – Primary Dimension (LSRP-P; Levenson, Kiehl, & Fitzpatrick, 1995; Appendix J). The LSRP is a 26-item self-report scale that measures the presence of psychopathic traits using primary and secondary trait dimensions that are conceptually similar to the original two factors of the Psychopathy Checklist-Revised (PCL-R; Hare, 2003; Levenson et al., 1995). The scale is designed for use in non-institutionalized samples (e.g., community-based offenders). The primary scale was designed to measure affective components of psychopathy using 16 items that reflect a selfish personality, an uncaring nature, and a manipulative posture toward others. These items are worded in an antisocial-desirability manner. Each item is measured on a 4-point scale ranging from strongly disagree (1) to strongly agree (4), with higher scores indicating higher levels of psychopathic traits. The scale appears to have good construct, convergent, and discriminant validity (Brinkley, Schmidtt, Smith, & Newman, 2001; Miller, Gaughan, & Pryor, 2008; Seibert, Miller, Few, Zeichner, & Lynam, 2011; Sellbom, 2011). It also moderately correlates with the PCL-R total score ($r = .34$, $p < .001$), the PCL-R Factor 1 ($r = .30$, $p < .001$), and the PCL-R Factor 2 ($r = .31$, $p < .001$; Brinkley, Schmidtt, Smith, & Newman, 2001). Although the reading level of the measure is not established, it has been used in many offender and non-offender samples and obtained adequate psychometric properties. Therefore, it is assumed that the items are worded in a manner that most offender populations are able to comprehend. The Primary subscale of the LSRP scale has been shown to have high correlations with Factor 1 and Factor 2 of the PCL-R and overlaps most strongly with

the PCL-R Callousness/Manipulation dimension (Seibert et al., 2011). Although the LSRP has been criticized in the literature for some inconsistent results, especially in comparison to the Psychopathic Personality Inventory-Revised (PPI-R; Lilienfeld & Widows, 2005), the fewer number of items on the LSRP made it a more appealing measure for the current dissertation. Only the primary subscale was used to measure the affective traits of psychopathy as these may be more theoretically relevant to the responsivity and treatment readiness. These factors are more likely to discriminate offenders from the general antisocial traits captured by the Secondary Dimension that overlap with the LS/CMI. The LSRP scale was found to have adequate internal consistency ($\alpha = .79$), concurrent validity with the Hostility subscale of the SCL-90-R ($r = .30$, $p = .003$), and appropriate discriminant validity with the anxiety subscales of the SCL-90-R (i.e., Anxiety, Phobic Anxiety, and Obsessive Compulsive were all unrelated: rs = .07 - .15, ps > .05). During the planning stages of this dissertation, other inventories were considered for the measurement of psychopathic traits (e.g., Psychopathy Checklist Revised Screening Version, Youth Psychopathic Traits Inventory, Psychopathic Personality Inventory Revised). The Psychopathy Checklist-Revised Screening Version is a measure that is scored after extensive file review. It was not deemed appropriate for this dissertation due to the concerns regarding insufficient information in the case files to adequately score the affective and interpersonal traits of psychopathy. As well, the other measures have significantly more items and include measurements of behavioural components of psychopathy. Given that the hypotheses related to psychopathic traits were more focused on the affective and interpersonal components, the LSRP-P was considered an appropriate and time efficient measure.

The Structural and Process Compliance Measures (SPCM; Appendix K). These scales were developed for the purposes of the current dissertation and were designed to measure various structural and process indicators of case management compliance. As it stands currently, courts can mandate an individual to attend intervention but cannot mandate a person to actually participate in these interventions. Therefore, the SPCM taps into two different forms of compliance. The first subscale measures structural factors (i.e., those behaviours that can be mandated by the courts), such as the number of missed or rescheduled appointments over the previous 6 months and includes 4 items rated on Yes or No format. The structural subscale ranges from 0 (no structural compliance) to 4 (complete structural compliance). The second subscale measures the process aspects of compliance (i.e., aspects that cannot be controlled by the courts), such as level of knowledge of the intervention process, degree of involvement in developing case management goals, history of noncompliance, and degree of satisfaction with the case plan, etc. The process subscale is composed of 16 items rated by the primary case manager using a 5-point Likert scale: 0 (significant problem, the client does not comply with this component of the case plan) to 4 (not a problem, the client adheres to this component of the case plan). Therefore, higher total scores indicate greater levels of process compliance. In cases for which the case manager was unable to complete the scoring of the SPCM, the principal investigator (Ainslie McDougall) scored the measure based on an extensive file review. In the current sample, the Structure section of the SPCM scale was found to have adequate internal consistency. As well, the Process section of the SPCM scale was found to have strong internal consistency ($\alpha = .93$), and adequate concurrent validity with similar measures of offender/case manager alliance

(DRI-R case manager: $r = .49$, $p < .001$; DRI-R offender: $r = .33$, $p = .006$), motivation (adapted TMS-F: $r = .28$, $p = .02$), and engagement ($r = .48$, $p < .001$). An exploratory factor analysis was completed using the decision guidelines of Fabringar, Wegener, MacCallum, and Strahan (1999) to examine the underlying latent structure of the items included in the measure. With the goal of balancing parisimony and plausibility, the EFA identified that items seem to be loading on a single factor representing overall process compliance. Given the methodological flaws associated with a single decision-making method, decisions were made by balancing the results from the Kaiser criterion of eigenvalues, Scree plot, as well as using a minimal factor loading of .3 to examine loadings (Tabachnick & Fidell, 2007). Given that only one factor was determined from the model, no rotations were necessary to facilitate the interpretation (Fabringar et al., 1999). Given the low number of items in the Structure measure, a measure of internal consistency was not calculated.

File Review Coding Guide (Appendix L). Offenders working in the community often have extensive mental health, addictions, and corrections case files. A comprehensive coding guide was developed for this dissertation to capture important demographic, mental health and/or addictions, criminal history, case plan information, and compliance indicators (e.g., intervention engagement ratings) for each participant. The coding guide was used to gather information relevant for analyses. Inter-rater reliability was found to be adequate for two coders using the same coding guide (average Kappa = .62, range = -.22 – 1.0). Because of fair to poor Kappa values (Kappa of less than .40 is described as moderate; Altman, 1991), 21% of the variables (48 out of 231 variables) from the coding guide needed to be eliminated and not used in the

analyses of the current dissertation. Once these variables were eliminated, the average Kappa for the remaining variables increased to .84.

Adherence to the RNR model Coding Guide (Appendix M). The method used to code case management plans in terms of their degree of adherence to the RNR model was similar to what has been used in previous research (Hanson et al., 2009). Specifically, case plans were coded as adhering to the Risk principle when they matched (coded as 1 point) the level of intensity of intervention to the level of risk of the individual as assessed by the LS/CMI (e.g., longer hours per session/greater number of sessions to those who are higher risk and lower/no intervention to low risk individuals). Adherence to the Need principle was coded as present (coded as 1 point) if the primary treatment goals were evidence-based criminogenic factors associated with recidivism as identified by the LS/CMI (e.g., poor cognitive problem solving, negative peer associations, drug/alcohol use, antisocial behaviour, impulsive tendencies, unstructured leisure time, and unstable employment; Hanson et al., 2009). Finally, adherence to the Responsivity principle was coded as present when there was evidence to indicate that the intervention was tailored to match the offender’s strengths and limitations (e.g., such as the use of concrete psycho-educational material and learning models for offender’s with cognitive difficulties) as identified by the LS/CMI and when evidence-based interventions were used (e.g., cognitive-behavioural approaches, social learning approaches; Andrews & Dowden, 2007). To ensure that rater judgments were accurate regarding the nature of interventions used in these case plans, program manuals/brochures, research articles, accreditation credentials, site visits, and interviews with case workers were used to understand their nature and content when this was not

articulated sufficiently in the case file however, it is unclear what exactly occurred in real time without direct observation of the case manager and offender sessions. For each principle not met, a score of 0 was given. Thus, the overall score for case plan RNR adherence ranged from 0 (*no compliance*) to 3 (*fully compliant*), in which a score of 3 means that all three RNR principles were adhered to in the case plan. These ratings were included in the File Coding Guide therefore the inter-rater reliability of these statistics was included in the results report for that guide. Previous research (Campbell, Dyck, & Wershler, 2014) has shown that this coding guide has strong psychometric properties and multiple raters have attained high levels of agreement when coding the same cases (e.g., Kappa = .91).

Procedure

Ethical review for the proposed research was obtained from the University of New Brunswick-Saint John Research Ethics Board, Horizon Health Network Research Ethics Board, and the Minister of the New Brunswick Department of Public Safety. It also was conducted with the support of the Saint John Mental Health Court.

Once participants were identified and consent was obtained, they met individually with the principal investigator to complete the Participant Demographic Questionnaire, DRI-R (offender version), SCL-90-R, LSRP-P, and TMS-F in a counterbalanced order. They were instructed to complete these ratings while considering the previous 6 months of their supervision period, with the exception of the SCL-90-R which represented their mental health functioning over the previous week. Individuals showing difficulties with reading or concentration were met over a couple of sessions. The forms also were left with the case managers (especially in the satellite

offices) to be completed at scheduled appointments if the principal investigator was not present but available through telephone to conduct the consent procedure. In such cases, clear instructions were given for the participant to seal their completed forms in an envelope so that the case manager could not view their responses. For incentive to participate, participants were informed that they had an opportunity to win one of ten (odds of 1 out of 20) $10 gift certificates to local restaurants (e.g., Tim Horton's, Wendy's, McDonald's). Participants also consented to allow the investigators to review their New Brunswick mental health and public safety files to obtain other relevant information about their case management compliance and mental health information. The principal investigator reviewed each participant's file information in CIS to code specific variables in the Coding Guide (Appendix L). They also were told that their case manager/probation officer would be asked to complete several forms regarding their views of how the participant has done on supervision with his/her case plan, how they perceived the case manager-offender relationship, and how engaged the participant appeared to be in the process. Each participant was assigned a 3-digit identification number that was unknown to anyone aside from the principal investigator. Participants were informed that their participation in the study would not affect their community supervision, legal situation, or involvement with mental health.

Once relevant participants were identified and met with the principal investigator, the researcher met with their assigned case manager to obtain that professional's consent to participate in the study as well. The case managers completed the Case Manager Demographic Form, DRI-R (Case Manager Version), TER, and the SPCM in counterbalanced order in reference to the previous 6 month period of

supervision with the offender in question. As an incentive, case managers were offered a chance to win one of four 25 dollars gift certificates to local restaurants (e.g., Tim Horton's, Swiss Chalet, or Boston Pizza). Each case manager was assigned a two digit identification number to use each time they completed the measures for a participant to increase their anonymity and confidentiality. The case managers were informed as to which participant(s) they were to complete the forms on. The principal investigator replaced the names with the corresponding participant IDs upon return of these forms to maintain their anonymity.

The LS/CMI is scored for individuals as part of the screening process for admission to the SJMHC and also is completed by protocol for all community-supervised offenders involved with Public Safety at the start of their community supervision. The scored forms were extracted and recorded and the final coded forms and other relevant study information were stored separately from consent forms in a locked cabinet in the Centre for Criminal Justice Studies at the University of New Brunswick Saint John campus.

For all information gathered in the File Coding Guide as well as the RNR Adherence Coding Guide, inter-rater reliability was calculated from a random selection of 20% of the completed files (n = 24). The additional ratings were completed by a trained graduate student familiar with the information systems and files. The records were assessed onsite through the electronic database and paper records. All information in the coding guides was compared using SPSS. An average Kappa statistic was calculated and found to be adequate (range = -.22 – 1.0, Kappa = .62; Altman, 1991). As previously stated, 21% of the variables in the coding guide were deleted because of

Kappa values being less than the acceptable value (Kappa = .40) which lead to a more acceptable value (Kappa = .84).

CHAPTER FOUR: Results

Data Cleaning

Before any analyses were completed, the dataset was examined to identify potential data entry errors. A variety of methods were used to treat missing data including listwise or pairwise deletion when conducting analyses in SPSS. Descriptive statistics were then conducted and graphical representations of all variables were created to identify errors in data entry and any univariate and multivariate outliers (i.e., examining the Mahalonobis and Cook's distances). Finally, the assumptions of each of the statistical tests used in the current dissertation were examined (e.g., univariate and multivariate outliers, homogeneity of variance-covariance, normality, linearity). In instances where there was concern for Type I error during multiple group comparisons, a conservative alpha was used to reduce the risk while balancing the possibility of Type II error (i.e., $p = .01$; Tabachnick & Fidell, 2007). After these preliminary checks of the dataset, data were assessed to uncover the descriptive statistics including frequencies, means, standard deviations, and ranges of each variable in the dataset. Table 1 shows the descriptive statistics for the variables used in the inferential analyses.

Results for Testing Hypothesis 1

Criminological variables assessing index recidivism risk level, intake responsivity concerns, gender, and age will be most strongly associated with measures of compliance.

The Pearson product-moment correlation coefficient, r, is a measure of the degree of linear association between two variables that is independent of sample size and method of measurement (Tabachnick & Fidell, 2007). It is a measure of the covariance

of two variables relative to the variance in each of the separate variables. Pearson product-moment correlations were calculated to determine the relationships between variables of interest and to identify potential sources of multicollinearity between these variables. The matrices revealed that many variables were significantly correlated with the compliance outcome measures. Table 3 shows the pattern of relationships with the Structure and Process Compliance Measures. When examining the correlations between the predictor variables and these outcomes, the results indicated that few of the demographic variables related significantly to compliance. The highest level of education achieved was positively related to higher levels of Structure Compliance ($r = .32$, $p = .004$) and to Process Compliance to a lesser degree ($r = .26$, $p = .02$). Similar to education, being employed was related to greater compliance (rs = .37-.41, ps < .01). Surprisingly, none of the other demographic variables were significantly correlated with compliance measures including gender (rs = -.13-.03, ps > .05), and race (rs = -.04-.08, ps >.05). There was a significant relationship between higher age in years and greater process compliance ($r = .25$, $p = .03$).

A variety of criminal history variables were evaluated in relation to their association with the Structure and Process Compliance measures. Total number of previous charges (rs = -.01 to .05, ps > .05) and number of months incarcerated (rs = .01 to .08, ps > .05) were not related to either type of compliance. However, older age at first arrest ($M = 21.99$, $SD = 10.74$) was significantly related to higher levels of Structure Compliance ($r = .30$, $p = .01$) but not to Process Compliance ($r = .16$, $p = .18$). Thus, individuals who began offending at younger ages often have more difficulty with attending appointments, completing intervention homework, and getting breached

during supervision. When examining other criminological variables, there was a significant negative correlation between the LS/CMI variables and the Structure Compliance measure (*r*s = -.34 to -.46, *ps* $< .01$) and for the process indicators of compliance (*r*s = -.31 to -.46, *ps* $< .01$). Thus, higher risk cases tended to have less Structure and Process Compliance. As well, length of current supervision period was not significantly related for either compliance outcome ($r = -.19$, $p = .14$ for Structure Compliance, and $r = .13$, $p = .33$, for Process Compliance). Conversely, the LS/CMI additional sections total scores were significantly associated to both types of compliance ($r = -.32$ to -.44, *p*s $< .05$) and reflected that these participants with broader criminogenic and non-criminogenic issues, which could include responsivity factors, tended to have greater difficulties with compliance in the past 6 months of their supervision.

To determine whether responsivity predictors (i.e., motivation, psychopathic traits, mental health functioning, and the case/manager offender relationship) were related to the compliance outcomes, several aspects were examined. In general, the responsivity predictors also had significant relationships with compliance. Engagement as rated from file review on a three point scale was highly significantly related to Structure ($r = .50$, $p < .001$) and Process Compliance ($r = .48$, $p < .001$). This indicated that higher levels of engagement were related to better attendance at appointments and more compliance with the process factors of the case plan. Motivation as measured by the adapted TMS-F scale ($M = 154.44$, $SD = 22.64$, range = 102-202) was only significantly positively correlated with the process measure of compliance ($r = .28$, $p = .02$) and not with structure compliance ($r = .21$, $p = .086$).

Self-report scores of psychopathic traits as measured by the LSRP primary scale (M = 27.74, SD = 7.65) were unrelated to Structure (r = -.09, p = .44) or Process compliance (r = -.06, p = .63).

Although mental health appears to be an important responsivity factor as described in the RNR model, very few of the measures addressing this domain were significantly related to either compliance measures. A history of accessing mental health services was not related to Structure compliance (r = -.03, p = .78) or Process compliance (r = -.17, p = .16). Few of the subscales from the SCL-90-R had a significant relationship with the compliance measures, aside from greater hostility being associated with poorer structure compliance (r = -.27, p = .02), and greater depression and phobic anxiety being tied to reduced process compliance (rs = -.26 and -.27, $p < .05$, respectively). Despite being not statistically significant, it is worth noting that all of the subscales of the SCL-90-R had negative correlations with compliance indicating that greater mental health symptomatology was indicative of greater difficulties with compliance. Likewise, there was a non-significant trend for the overall index of distress on the SCL-90-R to be negatively correlated with Structure (r = -.20, p = .076) and Process Compliance measures (r = -.21, p = .071). The subscales of the SCL-90-R appeared to have sufficient variability to determine correlations and were not impacted by a restriction of range. Therefore, it appears as though mental health issues do not increase/decrease compliance but rather it is related to interpersonal dynamics (i.e., hostility), motivation (i.e., depression), and avoidance (i.e., anxiety).

To understand the role of the relationship between the offender and case manager on compliance, correlations between the DRI-R forms and the SPCM were examined.

The total DRI-R case manager response form score was not significantly related to Structure Compliance (r = .17, p = .16); however, two of its subscales were related and this included increased Trust (r = .31, p = .008) and lower Toughness (r = -.23, p = .05). The pattern of association was different for the DRI-R offender response form. The offender DRI-R total (r = .33, p = .008) and its subscales of higher caring/fairness (r = .37, p = .003) and trust (r = .37, p = .001) were related to greater Structure Compliance, whereas the perception of case manager Toughness did not have a significant relationship from the offender perspective (r = .04, p = .76). For process compliance, the DRI-R case manager total and its subscales for these respondents were all significantly related to higher levels of this form of compliance (Total: r = .49, p < .001 and the subscales: rs = -.44 to .24, ps < .05). The same pattern existed for the offender DRI-R respondents with the total score (r = .35, p = .006), and its subscales significantly, and positively, correlating with Process Compliance (rs = .29 to .31, ps < .05). Despite being highly, positively correlated (r = .39, p = .002), offender ratings on the DRI-R were significantly higher than those provided by the case managers, $t(70)$ = 76.96, p < .001. Difference scores between DRI-R respondent forms were calculated by standardizing the average score per item to examine how this discrepancy related to compliance. These discrepancy scores were not associated with process compliance (r = -.04, p = .76), but there was a marginally significant trend toward lower structure compliance with greater discrepancy in perceptions of the case manager-offender relationship quality (r = -.26, p = .053).

Thus, in relation to hypothesis 1, criminological variables were most strongly correlated with compliance. The offender/case manager responsivity variables also

played a role, whereas mental health factors were more weakly associated with compliance in comparison.

The risk for recidivism will account for the largest portion of variance in recent compliance. The influence of the criminological variables on recent compliance indices will be mediated by current mental health functioning, perceived case manager-offender relationship as measured by the offender and the case manager, psychopathic traits, case management engagement, and motivation.

To examine the second and third portion of hypothesis 1, various regressions were used to test the predictive role of recidivism risk. These regressions also test whether the mental health, case manager/offender relationship, psychopathic traits, and motivation mediate the relationship between the criminological variables and compliance outcomes. A mediator is defined as a third variable that has a causal, or highly overlapping, relation between the antecedent and outcome variable. Mediation analyses postulate that chain relationships exist between an antecedent variable(s), a third variable(s), and the outcome and that that third variable helps to explain the mechanism behind how one variable relates to another (MacKinnon, Fairchild, & Fritz, 2007). In order for mediation to occur, four aspects need to be established based on the Sobel test described by Preacher and Hayes (2004): 1) the independent variable(s) must significantly predict the dependent variable, 2) the independent variable(s) must significantly predict the mediating variable(s), 3) the mediating variable(s) must significantly predict the dependent variable while controlling for the effects of the independent variable, and 4) the independent variable must no longer have an effect on the dependent variable when the mediating variable is controlled. Should the fourth

condition not be met, but the relationship is attenuated, then partial mediation is occurring (Preacher & Hayes, 2004). Specifically, these analyses examined whether the above mentioned relationships between the antecedent (criminological) and outcome variables (structure and process compliance) were mediated by the direct relationship between the variables measuring case manager-offender relationship, current mental health functioning, psychopathic traits, case plan engagement, and motivation to change.

For a mediation analysis, SEM is appropriate as it provides the researcher with the ability to control for measurement error and various options for exploring mediation effects (Baron & Kenny, 1986; Preacher & Hayes, 2004); however, due to an insufficient sample and poor power (i.e., a suggested n of 145 was obtained through a power analysis; Cohen, Cohen, West, & Aiken, 2002; MacCallum, Browne, & Sugawara, 1996; Rigdon, 1994; Tabachnick & Fidell, 2007), a series of hierarchical regressions were completed instead to test the mediation models. As well, the only variables included in the subsequent analyses were those that had a significant bivariate relationship with either structure or process compliance.

The first step of the mediation analysis required the establishment of a relationship between the criminological variables and each of the compliance outcomes. This was achieved through two hierarchical regressions: one for structure compliance and another for process compliance. As shown in Table 4, Step 1 included key demographic variables. The demographic variables of gender and ethnicity were excluded because neither had a significant bivariate relationship with these outcomes. Thus, only offender age was included in the model at this step to control for its influence. Education and employment were excluded because of redundancy issues

between each other, as well as with the LS/CMI Total (they are captured within items of this measure). The second step included the LS/CMI total risk score and the three LS/CMI sections of Special Risk, Non-Criminogenic Needs, and Responsivity Considerations.

When Structure Compliance was the dependent measure, the overall model was significant and explained approximately 21% of the variance in this form of compliance, $F(5, 59) = 4.15$, $p = .003$. Age did not appear to uniquely add to the overall prediction ($\beta = .06$, $p = .64$), as hypothesized. The LS/CMI Total Risk score accounted for a significant portion of the variance in structure compliance ($\beta = -.30$, $p = .03$), indicating that the higher the risk of future recidivism measured by the LS/CMI, the poorer the structure compliance. Despite their strong bivariate relationships with structure compliance, none of the additional LS/CMI sections had significant beta weights (βs = -.04 to -.17, *ps* > .05).

The pattern of relationships found with Structure Compliance was similar when the dependent measure of process compliance was used in the model. The overall model was significant and explained approximately 17% of the variance in process compliance, $F(5, 57) = 3.41$, $p = .01$. Age appears to be more relevant for the prediction of process compliance as there was a non-significant trend towards higher age leading to more process compliance ($\beta = .23$, $p = .08$). In contrast to the results for structure compliance, LS/CMI Total risk was not a significant predictor for process compliance. However, in combination with the block of variables containing all other LS/CMI sections, this second step of the regression significantly explained an additional 19.6% of the variance in process compliance. The LS/CMI subsections were moderately to highly inter-

correlated (*r*s = .30 - .79, $p < .01$), but were more strongly correlated with the structure compliance outcome as opposed to process, which could explain these differences in patterns between compliance dimensions. Collectively, these results satisfy step 1 of the mediation requirements as outlined by the Sobel test for both Structure and Process Compliance (Preacher & Hayes, 2004).

To assess step 2 of the Sobel test, bivariate relationships were examined between the criminological variables and the responsivity predictors of mental health functioning, motivation, and the perceptions of the offender/case manager relationship. Due to the multiple dependent variables involved in this step, multiple regressions were not used given that regressions have one dependent outcome. To determine the relationships between the multiple criminological and responsivity variables, the step 2 of the Sobel test was amended and correlations were used. As previously stated, the measure of psychopathic traits was not bivariately related to either compliance outcome and was removed from the analyses. As well, due to the degree of overlap with compliance outcomes, no analyses were completed using the engagement index. Considering each of the responsivity predictors separately, not surprisingly, mental health functioning was significantly and positively related to ancillary sections of the LS/CMI (*r*s = .25 to .34, *ps* < .05), but was not related to LS/CMI risk ($r = .09$, $p = .41$). Case manager perception of the offender/case manager relationship was significantly, negatively correlated with the LS/CMI Special Risk ($r = -.31$, $p = .02$) and Responsivity Considerations ($r = -.34$, $p = .01$) sections but unrelated to other areas of the LS/CMI. However, motivation (*r*s = -.07 to -.16, *p*s > .05) and offender perceptions (*r*s = .01 to -.09, *p*s > .05) of the offender/case manager relationship were unrelated to all of the

criminological variables. Collectively, there appears to be significant relationships between the criminological and some of the responsivity predictors. Additionally, Table 5 shows that many of the responsivity predictors are explaining a significant portion of variance in compliance, but predominantly just for process compliance.

Step 3 of the Sobel test determined whether the addition of the above noted responsivity variables affected the predictive utility of the criminological variables for the two dimensions of compliance. To assess Step 3, two hierarchical regressions were completed with each compliance outcome. Due to a large amount of missing data in the compliance outcomes, the number of subjects in each group (n = 33-59 depending on outcome and step in the analyses) was reduced significantly which calls into question the power of the statistical tests. An additional power analysis was completed using G power, which indicated that in order to have a medium effect size (.30) at an alpha of .05, the sample size should be composed of 55 individuals. Therefore, the following results must be interpreted as preliminary given the poor power. As shown in Table 6, Step 1 included offender age. Step 2 was comprised of the total scores for the SCL-90-R, the adapted TMS-F, as well as the offender and case manager forms of the DRI-R. Once the responsivity predictors were entered, Step 3 included the criminological variables. For structure compliance, the overall model explained only 13.5% of its variance and was not statistically significant, $F(9, 34) = 1.36$, $p = .26$. None of the variables entered had significant beta weights, meaning that none significantly contributed to the prediction of structure compliance. This is in contrast to the regression results of Step 1 of the Sobel test, in which the LS/CMI total score had a beta weight of -.30. Therefore, this indicates that some of the variance that was captured by

the LS/CMI total score in the first Sobel test was better accounted for by the responsivity variables, although not sufficient to be deemed significant predictors by themselves. Therefore, the addition of these responsivity variables reduced the predictive utility of the risk score for structure compliance.

The pattern of results also changed upon examination of the Step 3 regression for process compliance. Again, caution is warranted given the small n in these analyses because of missing data in the outcome variables. Although none of the variables had significant beta weights, there were non-significant trends for the adapted TMS-F total score, and the case manager version of the DRI-R. Although previously none of the individual criminological variables were significant in Sobel Step 1, the magnitude of the weights decreased in Step 3 of the mediation test in the regression. Overall, the combination of responsivity variables contributed to the prediction of an additional 41.5% of the variance in process compliance, and the overall model was significant, $F(9, 33) = 2.57$, $p = .03$. To examine more closely the role of the responsivity predictors on process compliance, Table 7 shows additional regressions completed using the subscale scores of the particular responsivity variables that had a significant bivariate relationship with either structure or process compliance. For higher structure compliance, the particularly salient predictors were lower SCL-90-R Hostility ($\beta = -.60$, $p = .03$) and a non-significant trend for the lower scores on the offender DRI-R perception of case manager's Toughness ($\beta = -.41$, $p = .08$). For process compliance, the only significant predictor of better compliance was higher case manager DRI-R Trust ($\beta = .69$, $p = .003$). Including these case manager/offender relationship subscales in the regressions increased the predictive power of the responsivity variables and decreased even further

the predictive utility of the criminological variables relative to the total scores that were included afterwards in the model. These results satisfy the fourth condition of the Sobel test and indicate that there was a mediation effect of the responsivity predictors on the relationship between the criminological variables and both structure and process compliance[2].

In addition to the mediation analysis, a 3 (levels of mental health dysfunction) x 2 (gender) Multivariate Analysis of Variance (MANOVA) was conducted to determine whether any of the responsivity variables or compliance ratings differed between individuals with low and high levels of mental health symptomatology and by gender. The presence of mental health symptomatology was measured objectively using the SCL-90-R (Derogatis, 1996). An a priori power analysis was conducted for these multivariate analyses. In order to obtain a medium effect size ($r = .30$) at a conservative alpha level of .01, the *n* of the sample would need to be 77 participants. Due to a large amount of missing data in the compliance measures, the sample for this analysis was 45. Therefore, given the reduced power, the following results should be considered preliminary. Total SCL-90-R Global Severity Index scores and interpretive guidelines were used to divide offenders into three groups to attempt to avoid the consequences of solely dichotomizing continuous data (MacCullum, Zhang, Preacher, & Rucker, 2002). Consistent with the scores outlined in the SCL-90-R manual (Derogatis, 1994), the

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[2] Hayes and Preacher (2013) have proposed an updated version of the Sobel test as outlined in this dissertation. Using SPSS macros published in the appendix of this paper, the mediation analysis was assessed for Structure Compliance and Process Compliance, respectively. As part of the macros, a bootstrapping command was included that generated 1000 samples of data from this dissertation dataset. Mediation models were calculated for each of the compliance outcomes. Overall omnibus main effects were significant for both Structure, $R^2 = .21$, $F(2,42) = 5.41$, $p = .008$, and Process Compliance, $R^2 = .19$, $F(2,42) = 4.78$, $p = .01$. Follow-up analyses of the specific mediators were consistent with the results presented in this dissertation. Overall, these results were consistent with those previously reported in this dissertation despite concerns with power. These provide more confidence that the results reported are not attributable to Type I error.

group distinctions involved: a normal functioning group ($T < 59$, 30.3%, $n = 30$), an at-risk for dysfunction group ($T = 60$-69, 25.3%, $n = 25$), and a clinically elevated dysfunction group ($T > 70$, 44%, $n = 44$). This new variable was the independent variable used in the MANOVA to represent levels of mental health severity, and the dependent variables were case manager-offender relationship ratings, motivation to change, and degree of Structure and Process Compliance. Although it was expected that the dependent variables would differ significantly between these three groups, the results did not support this hypothesis (Pillai's trace = .32, $F(10, 72) = 1.39$, $p = .20$). There also was no omnibus multivariate effect of gender (Pillai's trace = .05, $F(5, 35) = .35$, $p = .88$) nor an interaction between gender and mental health severity category (Pillai's trace = .22, $F(10, 72) = .88$, $p = .56$). However, there was a univariate main effect of mental health severity on structure compliance, $F(2, 46) = 3.35$, $p = .04$, and a non-significant trend for a similar effect on process compliance, $F(2, 46) = 2.78$, $p = .07$. No significant interaction terms were noted for the mental health level and gender on any of the responsivity predictors or the compliance variables.

Results for Testing Hypothesis 2

Participants managed with case management plans that strongly adhere to the three RNR principles will show the greatest level of compliance during their current period of supervision. This adherence was expected to be higher in the traditional correction system given its more regular use of the RNR philosophy in New Brunswick's Public Safety Department.

The relationship between the degree of RNR adherence and compliance measures was examined using bivariate Pearson correlations. Neither structure nor

process compliance was significantly related to adherence ratings ($rs = .05$ to $.20$, $ps > .05$). However, to further examine the role of the RNR adherence ratings, a one-way Analysis of Variance (ANOVA) was used (Table 8). When comparing the mean scores for structure compliance across the different levels of adherence, a marginally significant effect was found in which Structure Compliance score was lowest for the no RNR adherence level, $F(3, 73) = 2.65$, $p = .055$. Post hoc analyses showed that the only statistical difference was between No Adherence and Slight Adherence (*M* difference = -1.06, $p = .01$) with higher levels of structure compliance with Slight Adherence.

However, the same pattern was not true for process compliance, $F(3, 72) = 1.91$, $p = .14$. Post hoc analyses showed that No adherence again differed from Slight Adherence (*M* difference = -8.23, $p = .03$) with higher compliance noted with Slight Adherence showing higher compliance scores. Additionally, there was a marginally significant difference between No Adherence and Complete Adherence (*M* difference = 9.05, $p = .06$) with higher compliance scores noted with Complete Adherence. All levels of RNR adherence produced equivalent levels of Process Compliance so the RNR model might not facilitate or impair engagement and motivation but could influence Structure Compliance to a degree.

A 2 (presence or absence of adherence to Risk principle) x 2 (presence or absence of adherence to Need principle) x 2 (presence or absence of adherence to Responsivity principle) factorial between-subjects ANOVA was used to examine each of the RNR principles and their individual degree of adherence. This analysis determined whether there were main effects and interactions between these individual principles' adherence on the degree of compliance to case management plans. Two-way

and three-way interaction terms were examined among the four levels of the RNR principle adherence variables. No main effects or interaction terms were significant for Structure Compliance in this regard, $F(1, 6) = 1.95$, $p = .09$, and these effects accounted for only 7.2% of the variance. The same was true of process compliance, $F(1, 6) = 1.63$, $p = .15$, with the overall model explaining only 5% of the variance in that outcome. Thus, specific RNR principle adherence did not individually influence or interact to enhance structure or process compliance. However, there was a global trend for RNR adherence to be tied to better structure compliance. It should be noted, however, that full RNR adherence was uncommon and may have limited the capacity of this data to fully demonstrate the effect of RNR management on compliance.

Results for Hypothesis 3

Responsivity adherence, in particular, will maximize compliance with community supervision in both Public Safety and Mental Health settings. However, this effect is expected to be most strongly achieved in the mental health setting given its tendency to focus on mental health issues as the primary case management targets.

Given the difficulties with coding the Responsivity principle adherence from case management records, it was not possible to test this hypothesis. As shown in Table 1, less than a fifth of the case management plans in the sample adhered to the Responsivity principle. Further research is needed before this hypothesis can be addressed.

Discussion

The purpose of the current dissertation was to determine which demographic, criminological, and responsivity variables are relevant for predicting community-supervised offenders' compliance with their case management plans. In addition to the hypothesized link between these variables, this research attempted to determine which responsivity predictors mediate the relationship between demographic and criminological variables when predicting compliance. Responsivity predictors shown to have mediation relevance could be targeted in pre-intervention sessions, or during criminogenic interventions, to increase an offender's readiness to engage and comply with the conditions of his or her case management plan. This research also attempted to determine whether the salience of these responsivity variables increased as a function of the case plan's overall adherence to the RNR model, as well as to each of its three main principles of risk, need, and responsivity. The implications for the conclusions are vast and can inform the development of more effective case management plans for community-based offenders.

For the current dissertation, compliance was conceptualized as being represented by two dimensions: structure compliance and process compliance. Structure compliance was defined as the presence/absence of administrative-type variables, such as appointment attendance, breaches of supervision conditions, homework completion, etc. This type of compliance is more characteristic of the already existing research literature in this area. Process compliance was conceptualized using a continuum of factors representing clinical and behavioural engagement within the intervention. The Structure and Process Compliance Measure (SPCM) was designed to measure each of these types

of compliance and was completed by the corresponding case manager for each offender who consented to participate in the study. However, there was significant missing data for the SPCM: 27% missing data for the Structure Compliance scale and 25% for the Process Compliance scale. These missing data occurred despite numerous attempts by the researcher to maximize their full completion by case managers, including means such as providing incentives for case managers to complete surveys and email/in person reminders to return completed surveys. Case managers also were given the option to only fill out the SPCM as opposed to the SPCM and the DRI-R when they felt pressed for time. Fortunately, much of the missing data from the Structure scale could be collected by the researcher through the CIS database when it was not completed by the case manager. Nevertheless, some data could not be captured. Participants with and without missing data on the SPCM were compared to determine whether they differed in meaningful ways (see Table 9). Individuals with missing data on the SPCM were found to have statistically higher means on many of the criminological variables, including higher LS/CMI Total Risk/Need Scores (and on many of the individual criminogenic needs measured), a more extensive history of violent offences and history of technical offences (e.g., breaches), more responsivity considerations as measured by the LS/CMI additional sections, and lower motivation (as measured by the adapted TMS-F). Participants with missing data on the Structure Compliance scale also had higher self-reported psychopathic traits. Given that the individuals with missing outcome data tended to have higher scores on many of the important predictor variables; it is likely that the exclusion of these missing data cases from the statistical analyses reduced the impact of these variables as predictors of compliance. With these caveats in mind, the

results examining the predictors of each of these compliance dimensions are discussed separately below.

Predictors of Structure Compliance

Despite having a hypothesized role to play in predicting poor compliance, many of the demographic variables examined in the current research had little to no relationship with structure compliance. The only exceptions were education and employment status; having a higher education and being employed were related to higher levels of structure compliance. It is likely that increased education facilitates the likelihood of finding employment. The literature clearly indicates that gaining meaningful employment can reduce recidivism risk among offenders (e.g., van der Geest, Bijleveld, & Blokland, 2011). Having increased job opportunities through enhanced education and securing of meaningful employment may be reflective of an individual's life stability, personal responsibility acceptance, and general psychosocial functioning that maximize his/her capacity to maintain employment. Such offenders also may be unwilling to risk losing what they perceive to be valuable life assets (e.g., family, home, status, security) by breaching the conditions of their community supervision through non-compliance or new criminal behaviour. Despite these important links, employment and education were not included in the inferential prediction analyses for compliance outcomes because they are captured by the LS/CMI (i.e., it is represented as one of the eight risk) and contribute to that instrument's total risk score, which was included in these analyses.

Gender was not predictive of structure compliance. When examining gender variations across variables of interest to this dissertation, the only variables that showed

statistically significant differences were the LS/CMI responsivity concerns score and the LS/CMI non-criminogenic section score, which arguably makes sense if gender is conceptualized as a responsivity factor (Hubbard, 2007). Given that these responsivity sections were scored based solely on a summed score, it is difficult at this time to determine what LS/CMI responsivity variables were truly involved in these gender differences. Race/ethnicity also was not predictive of structure compliance in contrast to what would be expected from the literature (Sung et al., 2001; Wierzbicki & Pekarik, 1993; Wormith & Olver, 2002). These results for gender and ethnicity may have been in contrast to the published literature because of the restricted range and limited variability in the sample, despite being consistent with the demographic population distribution in New Brunswick (Statistics Canada, 2012). The majority of offenders in the sample were male and Caucasian. Thus, given that there were few females and ethnic minorities in the sample, it is difficult to determine the potential influence that these variables may have on any of the criminological or responsivity variables and their respective influence on structure (and process) compliance. Perhaps an interesting area for future research would involve looking at the demographic match between the offender and the case manager as a predictor for structure (or process) compliance. Match between the client and the clinician has been found to have a potential relationship with treatment outcome in the general clinical literature as clinicians are hypothesized to have an increased understanding of the nuances of gender and cultural components for the client (e.g., Comas-Diaz, 2006; Sterling, Gottheil, Weinstein, & Serota, 1998). Due to the limited number of case managers included in the study as well as the restricted variability in demographic profile, this match was unable to be assessed in the current dissertation.

The variables that were most strongly tied to structure compliance were the criminological factors, especially the LS/CMI total recidivism risk score, which is consistent with the literature (e.g., Barber-Rioja et al., 2012; Olver et al., 2011; Wormith & Olver, 2002). The recidivism risk score at the start of community supervision was highly, negatively correlated with subsequent structure compliance and was uniquely predictive of this outcome. The higher the LS/CMI total score, the lower the degree of structure compliance noted by offenders' case managers. Thus, as expected, higher risk offenders are statistically more likely to have difficulties with structure compliance. Actual recidivistic behaviour during the data collection period was also highly, negatively correlated with structure compliance. Further analyses examining the categorical risk categories (Figure 1) showed that there was a significant decrease in structure compliance as the LS/CMI risk category increased, indicating that risk appears to be predictive of objective measures of compliance such as showing up for appointments, completion of homework, and whether a case would be breached for violations of supervision conditions. This same pattern was found when the Very Low risk category was combined with the Low risk category and the High risk category was combined with the Very High risk category to address the small number of participants falling on the extremes of the risk continuum. Thus, these results suggest that there is a strong link between risk for recidivism and the likelihood of compliance difficulties and are consistent with the literature that the highest risk offenders are more likely to have difficulty with the structure aspects of compliance (Barber-Rioja et al., 2012; Olver et al., 2011).

Recidivism risk is likely a potent predictor of structure compliance because of the variables that are represented in this risk estimation, such as having more significant antisocial orientations that challenge authority and rules, as well as an increased likelihood of having substance abuse issues that make a person vulnerable to rule violation and supervision failure. Like unemployed offenders, substance users tend to have decreased stability in their lives, which makes it more difficult for them to attend frequent appointments, and they are often less likely to show up if a large portion of time is spent abusing substances (Daly & Pelowski, 2000). Finally, if case managers are adhering to the RNR model when setting the frequency of contact with their case loads, then higher risk offenders would likely have a higher dosage of supervision and intervention, resulting in more frequent appointments with the case manager and other treatment providers and greater expectations for between session work. Therefore, the nature of the intervention may inherently increase the risk of noncompliance given that case managers have higher expectations for offender attendance and participation.

One of the primary areas of the current dissertation involved an examination of the role that mental health factors play in offenders' compliance with community-based case management plans. Notably, the sample of participants endorsed a large variability of mental health concerns consistent with what has been observed in the general offender literature (e.g., Brink et al., 2001; CSC, 2010). As shown in Table 1, the mean score for the SCL-90-R Global Severity Index was in the at-risk range for overall mental health symptomatology, and 43% of participants fell within the clinically significant range ($T \geq 70$). These results indicate that the sample was showing moderate to high levels of mental health symptoms relative to general population. More specifically, the

mean scores for the SCL-90-R subscales were all in the at-risk range with the exception of Hostility, which was on the high end of the normal range. In terms of these specific subscales, 41% fell within the clinically elevated range for Anxiety, 36% for Obsessive Compulsive concerns, 35% for Somatic Complaints, 31% for Depression and for Paranoia, 28% for Interpersonal Sensitivity, 28% for Psychoticism, 26% for Phobic Anxiety, and 20% for Hostility. Thus, a significant portion of the sample reported suffering from significant levels of mental health symptoms.

Despite the high level of mental health symptomatology in the current sample, the findings were generally consistent with previous research, finding little to no direct link between mental health issues and criminal behaviour (e.g., Gendreau et al., 1996). Specifically, there were no significant correlations between any of the SCL-90-R subscales and the intake total risk LS/CMI score, recidivism outcomes, or structure compliance. However, although not directly correlated with structure compliance, the group of mental health factors examined in the current study did appear to have some relevance when separately examining individuals with higher and lower levels of structure compliance. Some of the SCL-90-R subscales, such as somatic complaints, interpersonal sensitivity, and depression, appeared to be elevated among individuals with poorer structure compliance scores. However, when these statistical differences were examined between those with high and low structure compliance scores, the overall general pattern showed that despite being elevated, they were not in the clinically elevated range. Overall, the specific subscales of the SCL-90-R were not correlated or predictive. Nonetheless, individuals with poor structure compliance tended to have higher mean scores relative to individuals with high structure compliance These results

support the notion that these mental health factors remain relevant for consideration as responsivity factors for structure compliance given that differing patterns in mental health functioning exist between those who have high levels of structure compliance versus those with low levels (e.g., poorer appointment attendance) but these patterns may be less directly impactful on structure compliance per se.

Although most of the SCL-90-R subscales did not predict structure compliance, there was one exception. SCL-90-R Hostility was significantly related to structure compliance, which means that offenders with higher levels of hostility also tended to have more difficulty complying with appointments, completing homework, and abstaining from breaches. It is noteworthy that Hostility as a subscale arguably captures interpersonal dysfunction as opposed to mental health symptomatology. The hostility items on the SCL-90-R are reflective of item content associated with anger, resentment, irritability, and aggression, which have been strongly linked to criminal behaviour and recidivism in offenders (e.g., Firestone, Nunes, Moulden, Broom, & Bradford, 2005; Peterson, Skeem, Hart, Vidal, & Keith, 2010). Many offenders commonly have the perception that they have been unfairly treated, which can lead to the development of learned hostile and defensive approaches to social interactions (Gornik, 2001). In addition, previous research has found that hostility is associated with misattribution of hostile and anger-based intentions to others (e.g., Dodge, 1980; Hawkins & Cougle, 2013), which can adversely affect their behavioural and social functioning in many environments. Specifically, when the hostile attributions are present, the hostile person’s interactions are oftentimes adversarial, anti-authority, and promote the use of aggressive behaviours. These hostile cognitions and behaviours can be directed towards

criminal justice or mental health professionals, or even the system as a whole. Hostility is associated with mistrust, suspiciousness, irritability, and will likely decrease the quality of the relationship between the offender and his/her case manager, and these factors could be linked to noncompliant behaviour, especially within the context of a punitive environment (Skeem et al., 2007). It is also likely that the particular features of Hostility on the SCL-90-R may in fact be tapping into features closely related to antisocial personality patterns, making it more criminological in nature as opposed to a responsivity variable per se (Haertzen, Hickey, Rose, & Jaffe, 1990; Lobbestael, Cima, & Arntz, 2013).

The importance of the case manager/offender relationship in maximizing structure compliance also was highlighted in the results of the current dissertation. This research lends support to the notion that case managers working with community-based offenders should emphasize and spend adequate time building a fair, respectful, and collaborative relationship with their supervisees (Skeem et al., 2003; Skeem et al., 2007) to achieve the important goals of the case plan for risk reduction. Overall, there was an important link between aspects of the offender/case manager relationship and achieving compliance with the structure of supervision. Much of this link is unique to conducting interventions with mandated clients because of the dual role that they play in emphasizing public safety, as well as care/concern for the client (Skeem et al., 2007). Specifically, case managers and offenders had generally consistent views of their relationship, with the exception of the role of toughness. Offenders who viewed their case manager as being more ‘tough’ were more likely to be structurally compliant with case plans. This finding is inconsistent with Skeem and colleagues (2007), who found

that offenders who perceived their probation officers as more tough had greater difficulties with supervision conditions and committed a higher number of supervision violations. The valuing of toughness by offenders in the current sample may in part be due to offenders' having traditional beliefs about the primary role of a case manager (i.e., a probation officer) within the context of the criminal justice system; they may see these staff as being tasked with enforcing the rules and maintaining public safety and would therefore expect toughness. In contrast, case managers viewed low levels of toughness as a value for enhancing structure compliance. The staff view may be explained by case managers receiving RNR and Motivational Interviewing training that emphasizes the usefulness of developing a firm, fair, non-confrontational, collaborative relationship for achieving positive correctional outcomes (Kennealy, Skeem, Manchak, & Louden, 2012; Skeem, et al. 2007). Thus, the offender/case manager relationship appears to be an important component for achieving compliance; however, it does not appear to be as strong or consistent a predictor as the criminological variables based on the regression analyses. The current results lend support to the notion that the relationship may be best conceptualized as a responsivity factor rather than one that strongly predicts changes in behaviour for structure compliance or even recidivism more broadly.

A surprising result in the current research was the lack of relationship between psychopathic traits as measured by the Primary scale of the LSRP with structure compliance (as well as process compliance), which is inconsistent with the literature (e.g., Barber-Rioja et al., 2012; Main & Gudjonsson, 2006, 2008; Rice et al., 1992). Much of the literature on compliance supports the notion that the presence of

psychopathic traits often leads to more difficulty complying with the conditions of a case plan and that it is predictive of noncompliant behaviour (although not after introducing the HCR-20 score in Barber-Rioja et al., 2012). Research using the LSRP has indicated that a cut-off score of 58 denotes those who are high on psychopathic traits as identified on the PCL-R, whereas those below 48 are considered non-psychopathic (Brinkley et al., 2001). Estimates vary, but somewhere between 15% and 25% of an offender population have a high degree of psychopathic traits (Hare, 2003), whereas the estimates of psychopathic traits in the general population and community offender samples are much more difficult to estimate (Hugues & Yuille, 2007; Ishikawa, Raine, Lencz, Birle, & Lacasse, 2001). Generally the rates of psychopathic traits were quite low in the current sample, with about half of the offenders falling below a LSRP total score of 26 and nearly 80% were below a score of 32 out of a total possible score of 64. The mean score was lower than observed in other community-based research, including non-offender samples (e.g., Falkenbach, Poythress, Falki, & Manchak, 2007; Kimonis, Branch, Hagman, Graham, & Miller, 2013) and incarcerated offender samples (Brinkley et al., 2001). Thus, the lack of an apparent relationship is likely due to the low base rate of psychopathic traits within the current sample, rather than the irrelevance of these traits to compliance indicators.

Although many of the above noted factors appear to have individual influences on compliance, the mediation analyses pulled the pieces of the puzzle together. Taken together, it appears that there is a mediation effect created by the specific responsivity variables on the link between the criminological variables and structure compliance. This means that, although risk for recidivism remains an important predictive factor for

structure compliance, this prediction is mediated by the presence of some of these more changeable responsivity factors. As noted previously, structure compliance was most strongly related to criminological variables, mainly risk for recidivism as measured by the LS/CMI Risk/Need score. Although this relationship remained, the presence of mental health symptoms (mainly high levels of hostility), and to a lesser extent, the offenders' perception of toughness as a quality of the case manager-offender relationship, mediated the influence of criminological variables on the prediction of structure compliance. Hostility is typically associated with the misattribution of hostile intent to others, and this may generalize to anger-based attitudes towards criminal justice or mental health professionals. This hostility may be alleviated through intervention that cultivates an effective working relationship with their case manager, and by challenging hostile attitudes that limit compliance (Barber-Rioja et al., 2012; James & Milne, 1997). There also was a non-significant trend for the degree of perceived toughness from the point of view of the offender to mediate structure compliance, showing that the perception of more punitive approaches to supervision lead to better appointment attendance and homework completion. Thus, offenders seem to respect a more firm demeanor from their case managers. Overall, these results should be tempered by the presence of poor power in the mediation analyses. These results should be considered preliminary in nature given that the regressions involved very low sample sizes.

Predictors of Process Compliance

When considering the results of the current dissertation for process compliance, many of the demographic variables examined in the current research also had little to no relationship with this aspect of compliance. The only exceptions again were education

and employment status; having a higher education and being employed were related to greater process compliance. Similar to structure compliance, gender and ethnicity also were not predictive in contrast to the literature (Sung et al., 2001; Wierzbicki & Pekarik, 1993; Wormith & Olver, 2002). However, there was a trend for older age to be an important predictor of an offender's ability engage and meaningfully participate in his or her sessions.

As with structure compliance, the criminological variables were strongly tied to process compliance. This was especially true for the recidivism risk score as measured by the LS/CMI, which is consistent with the literature (e.g., Barber-Rioja et al., 2012; Olver et al., 2011; Wormith & Olver, 2002). Recidivism risk was highly, negatively correlated with process compliance. The higher offender LS/CMI total risk scores, the lower the degree of process compliance noted by case managers. Thus, higher risk offenders were statistically more likely to have difficulties with process compliance. Actual recidivistic behaviour during the data collection period was also highly, negatively correlated with process compliance, but to a lesser magnitude than structure compliance. When examining the degree of process compliance at the full range of LS/CMI risk level categories, the same pattern was not initially true of process compliance as found with structure compliance. There was no significant difference in these process compliance scores across risk categories (Figure 2). Although a general pattern of decline was observed across risk levels, small sample sizes in each risk category may have limited these comparisons. Therefore, the Very Low and Low categories also were combined as well as the High and Very High categories, which then produced the expected significant decrease in the degree of process compliance as risk

category increased. Therefore, recidivism risk continues to be an important aspect to consider for process compliance prediction. However, once an individual begins attending his or her appointments, his or her risk level may no longer be as salient a predictor for his or her ability to engage in the process of complying with an intervention. It is possible that the responsivity predictors become much more salient as predictors of engagement and supervision process than they are for predicting the administrative indicators of structure compliance. This pattern was evidenced by the stronger correlations of motivation, specific aspects of mental health symptomatology, and all features of the offender and case manager perceptions of the professional relationship with process compliance relative to structure compliance.

When considering the responsivity variable of mental health symptomatology, the subscale of depression was significantly related to process compliance. Specifically, lower levels of depression were associated with increased process compliance. The literature indicates that these factors may be more relevant for women in the prediction of recidivism (Benda, 2005), but symptoms of personal distress do not generally have a strong link to the prediction of future criminal behaviour (Gendreau et al., 1996). Conversely, these responsivity factors of mental health are conceptually relevant to an individual’s ability to meaningfully engage in the process of their interventions. The Depression subscale of the SCL-90-R reflects many of the symptoms consistent with the DSM-IV-TR conceptualization (and similarly the DSM-5) of Major Depressive Disorder, such as negative mood, withdrawal, lack of motivation, and hopelessness, etc. Many of these factors, most especially lack of motivation and hopelessness about the

future, could be substantial impediments for being able to adequately participate in, and comply with, criminogenic interventions.

Despite the relevance this mental health variable, global mental health distress is usually not found to be a predictor of future general or violent recidivism and these variables as a group were not predictive of compliance. This finding lends support to the notion that mental health variables are better conceptualized as responsivity factors as opposed to targets of criminogenic interventions. When considering each of the subscales on the SCL-90-R, higher scores were noted on various subscales when there were poorer levels of process compliance. Thus, although these scores may not necessarily be predictive of compliance difficulties, they remain relevant as factors that should be considered when developing and implementing case management plans. A useful approach for intervention planning intended to reduce recidivism with community-based offenders with mental health problems is a two-pronged approach that balances criminogenic and mental health case management (Figure 3; Campbell & Canales, 2011; Skeem et al., 2011). In this model, individuals can be assessed along two dimensions: one of varying criminal risk/need and the other across varying mental health needs that requires case managers to flag individuals who would benefit from an assessment and/or intervention with a mental health professional. Individuals would be categorized across the two dimensions as being low, moderate, or high criminal risk/need and low, moderate, or high mental health need. This approach can be easily integrated into a formal case plan by means of the LS/CMI measures, as well as screening tests of mental health symptomatology. By doing so, case managers avoid the current shortcomings and difficulties associated with attempting to integrate mental

health treatment plans with criminogenic planning. It does not have to be an either/or case plan, but rather an integrated case plan that involves collaboration of relevant mental health and correctional professionals. This type of conceptualization can inform case management planning in a way that takes into account all aspects of the RNR model, including responsivity. The RNR model suggests that identified criminogenic needs should be targeted through empirically-supported methods to reduce the person's risk for recidivism and that these methods should be matched to their identified risk-need level. This intervention needs to be contextualized around the person's mental health needs by prioritizing attention to destabilizing factors and modifying the intervention to address other identified responsivity concerns. Once these prioritized needs have been addressed, other relevant life factors can be targeted to enhance the person's general functioning and quality of life.

Similar to structure compliance, the offender/case manager relationship was tied to achieving compliance with the process aspects of case management. These relationship variables have been implicated as key elements for predicting positive outcomes in effective correctional programming (Andrews & Kiessling, 1980; Dowden & Andrews, 2004; Ulrich, Ricciardelli, & Brown, 2012). Notably, the presence of trust, mutual caring, openness, and empathy were essential characteristics for achieving process compliance in the current study and largely the most influential features. Similarly, Beech and Fordham (1997) found that a non-confrontational style balanced with a challenging stance brought the greatest benefits for outcome as opposed to aggressive, confrontational styles. In contrast to the varying role of toughness on structure compliance, this quality had no significant impact on process compliance.

Therefore, offender's perceived firmness of the case manager may influence whether he/she shows up for scheduled appointments, but does not help or hinder engagement in the intervention process itself.

Interestingly, although both offenders and their case managers viewed their professional relationship in positive terms, offenders rated the relationship in more positive light than did case managers. The point of view of the offender has been shown to be a better predictor of outcome in the general psychotherapy literature (Castonguay, Constantino, & Holforth, 2006); therefore, more research is needed to understand the nuances of these different viewpoints and which specific aspects of these perceptions actually influence changes in offender behaviour. Understanding this responsivity factor is especially relevant when examining predictors of process compliance, given that all aspects of the offender and case manager DRI-R forms were strongly correlated with process compliance and have been found to be important predictors for intervention outcomes in the literature (Polaschek & Ross, 2010; Ulrich et al., 2012).

When considering the responsivity variable of motivation, caution is warranted in the current study with the TMS-F due to concerns regarding the quality of the English translation and the shortened adapted version of the TMS-F (Drieschner, 2005). The TMS-F was originally a Dutch measure designed to capture aspects of motivation in populations of offenders mandated to seek treatment. Despite the adjustments made to the TMS-F in the present dissertation, the measure had adequate psychometric properties in the current sample. The factor structure of the adapted TMS-F in the current study was different from that published by Drieschner and colleagues. Therefore, more research is needed to further examine the psychometric properties of the updated English

version in Canadian offender populations. With those caveats in mind, the results of the current study show that higher offender motivation as measured by the adapted TMS-F was significantly related to better process compliance. This finding is consistent with the literature, which indicates that motivation is essential for maximizing the retention of clients in interventions, the success of an intervention, and for promoting compliant behaviours (Ryan et al., 1995).

Based on Drieschner's conceptualization of engagement and motivation, motivation should be more strongly tied to structure compliance, whereas engagement should be likely more directly to process compliance (Melnick et al., 2001; Rosen et al., 2004). Engagement is an important variable to consider when trying to enhance both forms of compliance (Olver et al., 2011); this sentiment was supported in the current study given the significant bivariate correlation between the Intervention Engagement measure and both structure and process compliance, as well as its predictive utility for process compliance. Engagement theoretically represents the behavioural contributions to the process and, therefore, conceptually overlaps with the various indicators of process compliance (McMurran et al., 2006). However, due to the high correlations between the Intervention Engagement measure and the compliance measures, as well as the significant conceptual overlap with process compliance in particular, the Intervention Engagement measure was excluded from the regression and mediation analyses. Thus, specific conclusions regarding engagement measured by this tool were not tested in the current study due to the high multicollinearity with the process compliance measure. Nonetheless, given this high degree of relationship between engagement and process compliance, it is apparent that engagement would play a large role in ensuring that an

offender is compliant with the process components of criminogenic intervention much of which is consistent with the literature in this area.

Given the conceptualization of process compliance used in the current dissertation, it is not surprising that the responsivity variables played more of a role in predicting this dimension of compliance, especially with regard to the degree of mediation between the criminological variables and this outcome. Particularly important variables included a strong case manager/offender relationship, higher levels of motivation, and to a lesser extent, lower levels of mental health symptoms. Mental health symptoms as measured by the SCL-90-R had predictive utility on their own for process compliance, but were not relevant as mediating variables when the criminological variables were added to the regression model. This non-mediation effect may be, in part, due to the degree of overlap between mental health factors and the responsivity indices of the LS/CMI included in the criminological variable set however the results remained non-significant when the analyses were completed without these variables included.

In the prediction model for process compliance, it was unclear why the offender's perceptions of the offender-case manager relationship did not influence the prediction of either form of compliance despite having a large bivariate relationship with these outcomes. A possible explanation is that the compliance measures were completed by the case managers and not the offenders. Thus, the case manager's perception of this relationship may be most strongly tied to their own perception of process compliance more so than the offenders' views. Further research is needed to tease apart the nuances of the working relationship and what particular aspects are especially related to structure

versus process compliance. Each variable represents particularly salient responsivity factors that could be essential to maximizing the efficacy of any criminogenic intervention. Nevertheless, the regression model suggests that it is the combination of these responsivity factors that is particularly important, as opposed to their unique contributions as mediators on the influence of criminological variables on process compliance.

Summary of Predictors for Structure and Process Compliance

In summary, by conceptualizing compliance as representing two dimensions (structure and process), it allows for an examination of the variables that uniquely contribute to these dimensions. The degree of structure compliance is heavily influenced by criminological (i.e., antisocial) variables, especially the risk of future recidivism as measured by the LS/CMI. Given that higher risk offenders appear to be at an increased risk for structure compliance difficulties, it is possible that problems with structure compliance may decrease as risk is reduced through criminogenic interventions. In addition, those with high levels of interpersonal hostility appear to be at risk of structure compliance problems. Particular aspects of the case manager offender relationship are important as well to maintaining structure compliance, mainly the offender's perception of the level of toughness used by their case managers to enforce compliance. Although mental health issues are important considerations because of their mediation effect on structure compliance, such responsivity factors were comparatively less relevant for predicting this type of compliance (i.e., appointment attendance, homework completion, and avoidance of breaches). Conversely, the relationship between the criminological variables and process compliance (i.e.,

engagement) was largely attenuated by responsivity variables such as motivation and the case manager/offender relationship. These variables are much more clinical in nature and continue to highlight the importance of putting sufficient weight on the responsivity principle of the RNR model, as well as using specialized mental health training for case managers and probation officers (Skeem et al., 2003, 2007). Addressing these responsivity factors appropriately within criminogenic interventions may maximize the level of engagement demonstrated by an offender and may increase the efficacy of those interventions for reducing risk for recidivism.

To address responsivity concerns, many communities have implemented court mandated treatment orders. Court mandated treatment has been found to be especially effective with individuals who have psychotic disorders as it results in fewer hospital readmissions and days spent in institutions (Swartz, Swanson, Wagner, Burns, Hiday & Borum, 1999). In Canada, such community treatment orders (CTOs) can facilitate access to treatment for those with severe mental illness when they may not voluntarily seek treatment or may have problems with compliance (Hough & O'Brien, 2005). In a sample of 553 offenders with mental illness, Hough and O'Brien (2005) examined criminal records one year prior to the implementation of a CTO, one year during the CTO, and one year post-completion of the CTO. Individuals under a CTO showed a reduction in general and violent offending from the pre-CTO to during the CTO periods, and from the pre-CTO to post-CTO periods. These authors also concluded that enforced adherence to medication regimens is likely to reduce a severely mentally ill person's likelihood of recidivism. However, these CTOs do not exist in every province of Canada (e.g., New Brunswick or Nova Scotia). Therefore, the court can only order

attendance to mental health/counseling as part of other conditions, rather than mandate participation in a treatment plan.

Therapist ratings of treatment adherence tend to be lower when individuals are referred for intervention because of the combination of criminal offences *and* substance abuse (Schoenwald, Halliday-Boykins, & Henggler, 2003). Voluntary participation in treatment is an expectation of MHC and traditional probation services plans in New Brunswick. Failure to comply could result in a return to regular court or have legal ramifications. Thus, non-compliance can lead to punitive consequences. The sanction for non-compliance raises questions about the true “voluntariness” of court supported/advocated intervention. Redlich et al. (2006) interviewed 1000 outpatients with mental illness about their experiences with criminal justice leverages and how they related to clinical and treatment histories (Redlich et al., 2006). Redlich et al. found that at least one experience with the criminal justice system (i.e., arrest, conviction, or mandated treatment as part of parole/probation) was more common among younger males, African Americans, people with substance abuse problems, and those who had more frequent hospitalizations. However, a person’s involvement with the criminal justice system was not associated with treatment compliance, treatment satisfaction, or perceptions of coercion by the presence of mandated treatment. From these results, it is apparent that mandated treatment as part of parole or probation may not have an effect on the compliance to, or satisfaction with, the case management plan. The expansion of these CTO programs across the country could help address many of the compliance concerns highlighted within the results of the current dissertation.

Responsivity Needs and Compliance

Although specific responsivity variables, such as mental health symptoms, were generally not overly predictive of structure and process compliance, the three Responsivity sections of the LS/CMI (i.e., Special Risk Section, Non-Criminogenic Needs, and Responsivity Concerns) were relevant. This finding is consistent with the research of Barber-Rioja and colleagues (2012) and James and Milne (1997), who found that some of the most influential variables in the prediction of non-compliance are lack of knowledge about the treatment process, harboring negative attitudes toward the intervention process, lack of insight, active symptoms of mental illness, denial, and impulsivity. Each of these factors is captured in the LS/CMI additional sections. In the current study, the summed total from each of these three LS/CMI responsivity consideration-focused sections were highly and significantly related to each type of compliance, indicating that higher levels of responsivity concerns lead to less structure and process compliance. The strongest relationship with the two types of compliance was with the Special Risk Section, which taps into items that address personal problems with criminogenic potential (e.g., diagnosis of psychopathy, anger management deficits, and poor social skills). These variables do not contribute to the total LS/CMI risk/need score, but they may have personal relevance to an offender's risk for recidivism and should be conceptualized as contributing to their risk of non-compliance. The other two sections, while still highly related, tap into aspects more relevant to specific responsivity concerns, such as low intelligence and motivational barriers. Nonetheless, each of these responsivity concerns sections did not account for any additional explained variance in structure or process compliance over and above the demographic and LS/CMI total risk

score. Thus, it is the criminogenic factors that more strongly predict compliance, but these other factors are still important nevertheless from a responsivity point of view. Unfortunately, responsivity considerations are not exhaustive or highly detailed in terms of their nature on the LS/CMI, and are simply items on a checklist. Overall, these results validate the importance of the responsivity principle, not only for case planning, but also for its predictive validity with compliance and possibly recidivism. However, at this stage, there is limited guidance as to how these responsivity factors should even be adequately addressed in case plan development intended to reduce recidivism risk. More specific research is needed to examine the responsivity concerns that best explain the nuances of compliance for community-based case management plans.

RNR Adherence and Compliance

Unfortunately, few conclusions can be drawn regarding the effect of adherence to the RNR model on case plan compliance. Few of the case plans reviewed in the current study actually adhered to all three principles of the RNR model (only 16% of the sample). These results are comparable to a study completed by Campbell et al. (2014) which examined RNR adherence for a sample of 236 adult and youth offenders in New Brunswick which found that only 9% of the sample showed full RNR adherence. The results of this dissertation indicated that although 78% of case plans adhered to the Risk principle, only 46% adhered to the Need principle, and only 20% adhered to the Responsivity principle. In addition, it was very difficult to assign ratings for the three principles based only on case notes recorded in the records by case managers. Although these notes were sufficient to rank how often the appointments were occurring (i.e., to code the Risk principle), and often mentioned the content of what was discussed (i.e., to

code the Need principle), it was difficult to determine what, if any, adjusts were made to address key responsivity factors (i.e., Specific Responsivity) as well as which evidence-based methods were used (i.e., General Responsivity). The additional sections of the LS/CMI were often not completed, which made it difficult to know whether responsivity was taken into consideration for the case plan development. Consistent with the results of Campbell et al. (2014), adherence to the RNR model, especially the responsivity principle, could not be meaningfully evaluated in this dissertation. Specifically, these limitations in the records make it impossible to draw conclusions as to whether any of the demographic, criminological, or responsivity indicators would be more or less relevant to predicting offender compliance with case plans when that plan adhered to none or all of the RNR principles, especially the responsivity principle. This finding is consistent with the limited research that exists on RNR adherence, especially for the responsivity principle (Bonta et al., 2011; Bonta, Rugge, Scott, Bourgon, & Yessine, 2008). Much more research needs to be completed to examine how case managers are addressing this principle, if at all, and to understand the impact of adherence on compliance. Nonetheless, the results do appear promising in that the mean structure and process compliance scores generally did increase, though not significantly, as adherence to the RNR principles increased.

Practice Recommendations

Based on the results of the current dissertation, specific recommendations can be made to address supervision compliance difficulties among community-based offenders. Specifically, clear policy procedures are needed regarding greater transparency and accountability for case managers to develop case plans that adhere to the evidence-based

principles of the RNR model. Special attention needs to be placed on the responsivity principle as more research continues to be published highlighting its importance for successful intervention. In addition to further training in the use and application of all sections of the LS/CMI, case managers should be trained to use strategies that effectively assess the needs of offenders that should be targeted to address anticipated case plan compliance difficulties before a criminogenic-focused intervention begins. Training programs also should be developed for case managers using Skeem et al. (2003)'s methods to increase and encourage compliance, including developing a fair, collaborative relationship, using problem-solving strategies, using positive pressures, discussing barriers to compliance, and finally collaborating with other service providers as well as the client. In addition to these steps, training should be provided to identify and assess the responsivity components related to compliance and to learn how these factors can effectively be incorporated into case planning, addressed before an intervention begins, as well as ensure that these factors are monitored throughout the intervention. Finally, training is needed to help case managers integrate and balance case plans to meet criminogenic needs, as well as mental health needs when they are present. Addressing mental health needs will not decrease recidivism risk, but it will enhance criminogenic treatment responsivity when they are addressed.

Strengths, Limitations, and Considerations

Like all psychological research, the current dissertation has various strengths and limitations. The project represented a large multi-source database of information collected from offenders, case managers, and files that permitted the examination of the typical case management plans of community-based offenders with and without mental

health problems in New Brunswick, Canada. This dissertation highlighted just how diverse these case plans can be even among offenders with the same level of risk or similar criminogenic needs. The information gathered can be used to inform policy procedures with regard to strategies for addressing compliance. Case plans can be developed to address the identified barriers to compliance before difficulties arise, such a practice would be consistent with the Effective Case Plan Strategy of Public Safety New Brunswick, which integrates principles of Motivational Interviewing with the RNR principles. Over-burdened case managers can more effectively use the resources they have to address these barriers as opposed to using all their time completing paperwork associated with breaches of community supervision orders and court appearances. Enhanced compliance also would likely have a spill-over effect to the over-taxed and backlogged court system that spends a significant amount of time and taxpayers money processing offenders for breaches of court-ordered conditions. Taking a more proactive, rather than reactive approach, to address the risk of non-compliance is a better use of the limited services that are currently available with the mental health and criminal justice systems in Canada.

The present dissertation provided some support for the importance of using the RNR model in offender rehabilitation. Although many of the case plans assessed did not meet criteria for full adherence to the RNR model, when cases did adhere, there was a trend towards individuals being more compliant with their case plans. Further training needs to be made available so that case managers are aware of the benefits of using the RNR model to frame the development of their case plans collaboratively with offenders. The principles of risk and need are important considerations for all offenders; however,

it is the responsivity principle that appears to be especially important for compliance and engagement in intervention. Although this project draws some conclusions regarding the usefulness of the RNR model, it is clear that much more needs to be done in terms of increasing case managers' adherence to the model in their practice.

Finally, the present dissertation involved some prospective components that assessed offenders' current functioning in the areas of the dynamic responsivity factors. This provided a means of identifying how well the offender was doing after a minimum of six months of supervision and how these variables related to their progress during that time.

Several noteworthy limitations of the current research are important to consider when interpreting the results. First, recruitment of offenders in the community proved difficult, especially given the method of data collection. Mainly, individuals who had a past history of compliance difficulties and those at the highest risk for future compliance problems are those individuals who were the least likely to: a) attend appointments with their case managers and be available for recruitment, and b) agree to participate in a research study. This recruitment strategy may have led to the inclusion of a skewed sample of offenders who have been more compliant with their case managers, and this trend was reflected in the generally higher number of individuals rated as being compliant with the structure and process of supervision. Although there was appropriate variability in the sample to draw conclusions regarding compliance, it is possible that the most high-risk and non-compliant cases were not included in the study despite attempts to be flexible and available to maximize recruitment. The results do indicate that there is a pattern to the missingness of the variables as those individuals who consented to

participate in the study, those offenders with missing data on the outcome measures were higher risk and had more criminogenic needs. To rectify these concerns, it would be helpful to have the offenders complete ratings about their perceived view of compliance. As well, it would be helpful to have tried to increase the buy-in from case managers as to the value of the study to increase their cooperation with completing the measures.

Secondly, the research involved a combination of prospective/retrospective post-dictive designs in that the offenders' responsivity functioning was measured in the present and used to predict their compliance over the previous six months. This is problematic given that independent variables temporally occurred after the dependent variables. This limits conclusions regarding causation and only allows inferences about relationships. Future research should use prospective longitudinal designs where offenders are followed over time to determine more conclusions regarding the role of responsivity factors on compliance with case management plans.

A third limitation was the limited gender and racial/ethnic diversity in the current sample. Although the sample does mimic the typical demographic profile of New Brunswick, the lack of diversity limits the generalizability of the results to larger urban centers in Canada or the Unites States of America with greater diversity. Further research is needed to determine how much of a role cultural diversity plays in the prediction of compliance difficulties in community-based offenders.

Much of the information used in the present study relied on the self-report of offenders and ratings of case managers. Unfortunately, no measures impression management or lie/validity scales were included due to the already intensive testing

sessions required of each offender and case manager. This limitation can potentially affect the accuracy of the information obtained from the offender self-report questionnaires pertaining to mental health. However, given that these scales were completed for research purposes only, and would not be shared with public safety staff, there was less incentive for offenders to misrepresent their experiences and views. As well, the quality of the information available in the files and CIS was occasionally poor. Sometimes file information was unavailable or contradictory to other information available in these files. Therefore, because no interviews were conducted with the offender or the case manager, it is difficult to get a full picture of the case management plans or the veracity of the information collected from the questionnaires or case files. As well, many important variables consisted of ratings made solely from the opinions of the case managers, such as process compliance, the LS/CMI risk and responsivity considerations scores, and the case manager perceptions of case manager-offender the relationships. Many of these variables were highly related. Although these opinions were consistent across measures, it is not necessarily indicative of an accurate portrayal of an offender's overall functioning. Nevertheless, we can put some confidence in these results given that they were collected using a multi-informant and multi-measure format.

The final limitation involves the poor power in the regressions for the mediation analyses. Because of large amounts of missing data, the low sample sizes available to be included in the analyses lead to some concerns with power. Therefore, the results of these analyses should be considered preliminary. More research is needed in large samples to draw conclusions regarding the role of the variables measured in predicting structure and process compliance.

Future Directions

Potential areas of expansion for this responsivity research are vast and not limited to examinations of the effectiveness of community-based rehabilitation programs. These areas include the development and subsequent testing of programs designed to train case managers to target compliance-promoting areas in offenders, extending the methodology to study youth populations, examining the role of other variables such as degree of cognitive distortions, and assessing whether these factors vary as a function of whether the individual pleaded guilty versus was found guilty for the index offence, whether the client was deemed not criminally responsible (Craissati & Beech, 2004; Hunter & Figueredo, 1999; Langevin, 2006; Levenson & Macgowan, 2004), as well as taking a balanced approach to consider important risk and protective factors in community-based rehabilitation for offenders with and without mental health symptoms. The current results suggest that various clinical and criminal outcomes should be examined to determine the effect of incorporating these responsivity compliance factors into the case management plan. This research should test whether targeting these specific areas promotes more compliance and less recidivism over the course of community-based supervision. Future research should identify specific target responsivity variables that should be assessed regularly by case managers to address these factors and track their fluidity over time.

Finally, it is imperative to consider the protective factors important for offenders managed in the community and how these factors can positively impact on compliance with case plans just as they have an impact on recidivism (Efta-Breitbach & Freeman, 2004). Although this was not so much the focus of the current dissertation, it remains an

important area for case management planning nonetheless. These strengths are important, as they have the potential to reduce or manage risk for offenders in terms of recidivism, as well as compliance difficulties (Fougere & Daffern, 2011). Protective factors typically fall into three categories: individual, familial, and social/external. Individual protective factors can include things such as resilient temperament, prosocial values, and adequate social and problem-solving skills. Familial protective factors include positive and supportive relationships with and between family members, relationship stability, and prosocial influence from these individuals. Lastly, social/external protective factors can involve prosocial peers, involvement with the greater community, access to effective interventions and services, as well as a positive and prosocial neighborhood (Serin et al., 2011). Therefore, given that the traditional risk factors for recidivism have been found to be relevant for predicting compliance difficulties in the current dissertation, theoretically speaking, it would seem that relevant protective factors also might be important considerations for their impact on compliance with community-based offenders. Future research should examine the protective factors that are relevant from each of the above mentioned areas to determine whether they too can have a mediating effect on the risk factors of compliance difficulties, much like they do for recidivism risk.

Conclusions

The current dissertation aimed to uncover the characteristics that influence offenders' compliance with, and adherence to, intervention while under community supervision. Compliance is much more complex than just indicating whether an offender is attending appointments (i.e., structure compliance). It also reflects the

degree to which an offender has engaged in the intervention (i.e., process compliance). When examined separately, many variables were implicated as correlates of both structure and process compliance. These results also indicated that responsivity variables, such as motivation, mental health functioning, and the offender/case manager relationship, played a particularly salient role for predicting process compliance, whereas the criminological variables, such as recidivism risk, appear to be more relevant to structure compliance. This information can be used to develop more effective case plan strategies that adequately address the needs of offenders both with and without mental health problems in the community. As well, these results allow case managers to continue to evaluate the progress and outcomes of these case management plans by paying attention to these important responsivity factors. This research also can provide a means of identifying those individuals who may have more complex needs in terms of community-based supervision and require more intensive, wraparound services to enhance case plan compliance. Additionally, in identifying the key ingredients to successful case management plans for offenders in the community, we can promote coordination and cohesion between the goals of criminal justice and mental health systems in more effective ways to address the overrepresentation of persons with mental health difficulties involved in the criminal justice system and better respond to their needs (Kirby & Keon, 2006; McNeil & Binder, 2005; Sapers, 2008; Skeem et al., 2011).

Finally, the RNR model has received extensive research in the correctional literature (Andrews et al., 1990; Andrews & Bonta, 2010; Dowden & Andrews, 2000). Although the literature consistently indicates that the principles of Risk and Need appear to be similar for all offenders, the responsivity principle has received comparatively less

attention especially in particular subgrouping of offenders such as those with mental health problems (Serin & Kennedy, 1997). By highlighting particularly relevant predictors of compliance, professionals can more adequately address these issues through the development of successful case management plans. It was expected that compliance would increase as adherence to the principles of the RNR model also increases (Chandler et al., 2004), but conclusions regarding this could not be drawn from the current data due to insufficient file information regarding responsivity-based adjustments and considerations in case plans.

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Table 1

Descriptive statistics of the sample.

Variable	Mean (SD)	Range	Percent
Age (years)	33.15 (11.97)	19-63	
Gender			
Male			84.4
Female			15.6
Ethnicity			
Caucasian			84.1
African Canadian			8.4
Native Canadian			4.7
Highest Education Attained			
Junior high/Some High School			26.9
High School/GED			42.3
Post-Secondary Education (e.g., University)			30.8
Employed			46.2
Marital Status			
Single			54.8
Married/Common Law			29.8

Table 1 continued

Variable	Mean (SD)	Range	Percent
Other			15.4
Length of Current Supervision (months)	11.31 (7.43)	6-30	
Number of Previous Arrests			
1			22.8
2-5			33.7
6-10			16.8
10+			26.7
Age at First Arrest (years)	21.99 (10.74)	10-62	
SCL-90-R GSI Score	66.25 (13.37)	34-81	35.4
Adapted TMS-F Total	154.44 (22.64)	102-202	
DRI-R			
Case Manager Total	203.82 (22.32)	124-209	
Offender Total	185.85 (25.99)	77-210	
LSRP Total	27.74 (7.65)	16-53	

Table 1 continued

Variable	Mean (SD)	Range	Percent
SPCM Structure	2.39 (1.17)		
0			7.2
1			14.5
2			28.9
3			30.1
4			19.3
SPCM Process	45.96 (11.52)	14-65	
RNR Adherence Ratings			
No Adherence			19.4
Slight Adherence			35.7
Some Adherence			29.6
Total Adherence			15.3
RNR Principle Adherence			
Risk			77.6
Need			45.9
Responsivity			20.4

Note: GED = General Educational Development; SCL-90-R GSI = Symptom Checklist 90 Revised Global Severity Index; TMS-F = Treatment Motivation Scale – Forensic; DRI-R = Dual-Role Relationship Inventory Revised; LSRP = Levenson Self-Report Psychopathy Scale, SPCM = Structure and Process Compliance Measure; RNR = Risk Need Responsivity

Table 2

Criminal History Offences

Criminal History Offences	Percentage of Sample
Breach of Probation or Court Order (Fail to Comply)	33.7
Assault (Common, Aggravated, or Causing Bodily Harm)	28.4
Theft	25.3
Mischief, Vandalism, or Destruction of Property	16.8
Break and Enter (with or without intent)	9.5
Drug Possession	8.4
Fraud or Forgery	7.4
Threats	6.3
Sexual Offences	5.3
Drug Trafficking	4.2
Weapons Offence (Possession, dangerous use)	4.2
Public Disturbance	3.2
Prostitution/Soliciting	1.1
Robbery (with or without a weapon)	0
Murder/Manslaughter	0
Other (predominantly Driving Under the Influence)	27.4

Table 3

Correlations with Structure and Process Compliance Outcomes

Predictors	Structure Compliance	Process Compliance
Demographic Variables		
Age	.05	.25*
Gender	-.13	.03
Race	-.04	.08
Education	.32**	.26*
Employment	.41**	.37**
Marital Status	-.004	-.03
Criminological Variables		
Number of Prior Charges	.05	-.01
Age at First Arrest	.30**	.16
Number of months Incarcerated	.078	.01
Length of Supervision	-.19	.13
LS/CMI Risk Score	-.46**	-.35**
Recidivism during Current Supervision	-.40**	-.30*
Clinical Variables		
LSRP	-.09	-.06
LS/CMI Special Risk Section	-.44**	-.37**
LS/CMI Non-Criminogenic	-.34**	-.32*

Table 3 continued

Predictors	Structure Compliance	Process Compliance
LS/CMI Responsivity	-.43**	-.32*
Intervention Engagement Rating	.50**	.48**
Adapted TMS-F	.21	.28*
Mental Health Services Access	-.21 †	-.17
SCL-90-R		
Somatic Complaints	-.22	-.12
Obsessive Compulsive	-.09	-.19
Interpersonal Sensitivity	-.20	-.10
Depression	-.22	-.26*
Anxiety	-.13	-.18
Phobic Anxiety	-.13	-.12
Hostility	-.27*	-.27*
Paranoid Ideation	-.12	-.16
Psychoticism	-.15	-.16
Global Severity Index	-.20 †	-.21 †
DRI-R		
Case Manager Total Form	.17	.49**
Caring/Fairness	-.01	.24*

Table 3 continued

Predictors	Structure Compliance	Process Compliance
Trust	.31**	.65**
Toughness	-.23*	-.44**
Offender Form Total	.33**	.35**
Caring/Fairness	.37**	.31*
Trust	.37**	.29*
Toughness	.04	.30*
RNR Adherence Ratings	.05	.20 †

Note: LSRP = Levenson Self-Report Psychopathy Scale; LS/CMI = Level of Service/Case Management Inventory; TMS-F = Treatment Motivation Scale – Forensic; SCL-90-R = Symptom Checklist-90 Revised; DRI-R = Dual-Role Relationship Inventory Revised.
*$p < .05$, **$p < .01$, ***$p < .001$, † non-significant trend

Table 4

Path Analysis of Criminological Variables and Compliance Outcomes

	Structure Compliance		Process Compliance	
Variable	*β*	% R^2 change	*β*	% R^2 change
Step 1		.4%		5.1%
Age	.06		.23±	
Step 2		27.4%**		19.6%*
LS/CMI Risk	-.30*		-.21	
LS/CMI Special Risk	-.17		-.20	
LS/CMI Non-Criminogenic	-.13		-.20	
LS/CMI Responsivity Considerations	-.04		.08	
Total Adjusted R^2	21.1%**			17.4%**
n	59			57

**p* < .05, ***p* < .01, ****p* < .001, † non-significant trend

Note: LS/CMI = Level of Service/Case Management Inventory

Table 5

Mediation and Path Analysis of Responsivity Variables (Total Scores) and Compliance

	Structure Compliance		Process Compliance	
Variable	*β*	% R^2 change	*β*	% R^2 change
Step 1		7.5% †		7.9% †
Age	.28 †		.28 †	
Step 2		12.7%		43.6%***
SCL-90-R GSI	-.20		-.25*	
Adapted TMS-F Total	.18		.28 †	
Offender DRI-R Total	.17		.00	
Case Manager DRI-R Total	-.08		.40**	
Total Adjusted R^2	10.3%			45.4%***
n	45			45

*$p < .05$, **$p < .01$, ***$p < .001$, † non-significant trend

Note: SCL-90-R GSI = Symptom Checklist 90 Revised Global Severity Index; Adapted TMS-F Total = Adapted Treatment Motivation Scale-Forensic Total; Offender DRI-R Total = Offender form of the Dual-Role Relationship Inventory Revised Total; Case Manager DRI-R Total = Case Manager Form of the Dual-Role Relationship Inventory Revised Total.

Table 6

Responsivity Predictors as Mediators on Structure and Process Compliance

	Structure Compliance		Process Compliance	
Variable	*β*	% R^2 change	*β*	% R^2 change
Step 1		4.9%		5.0%
Age	.17		.23	
Step 2		14.5%		41.5%**
SCL-90-R GSI	-.28		-.24	
Adapted TMS-F Total	.26		.32 †	
Offender DRI-R Total	.06		.04	
Case Manager DRI-R Total	-.11		.30 †	
Step 3		13.5%		2.5%
LS/CMI Risk Total	-.25		-.03	
LS/CMI Special Risk	-.30		-.20	
LS/CMI Non-Criminogenic	-.01		-.10	
Total Adjusted R^2	13.5%			30%*
n	34			33

*p < .05, **p < .01, ***p < .001, † non-significant trend

Note: SCL-90-R GSI = Symptom Checklist 90 Revised Global Severity Index; Adapted TMS-F Total = Adapted Treatment Motivation Scale-Forensic Total; Offender DRI-R Total = Offender Form of the Dual-Role Relationship Inventory Revised Total; Case Manager DRI-R Total = Case Manager Form of the Dual-Role Relationship Inventory Revised Total.

Table 7

Responsivity Predictors as Mediators (Subscale Scores with Significant Bivariate Relationship) of Structure and Process Compliance

	Structure Compliance		Process Compliance	
Variable	*β*	% R^2 change	*β*	% R^2 change
Step 1		4.9%		5.0%
Age	.22		.23	
Step 2		49.5%		64.7%*
Adapted TMS-F Motivation to Engage	-.19		-.07	
Adapted TMS-F Perceived Costs of Treatment	.09		.22	
Adapted TMS-F Perceived Suitability of Treatment	.39		.14	
Adapted TMS-F Distress	-.19		.08	
SCL-90-R Hostility	-.60*		-.19	
SCL-90-R Depression	.34		.02	
SCL-90-R Phobic Anxiety	-.13		-.03	
Offender Caring/Fairness	.63		.18	
Offender Trust	-.51		-.07	
Offender Toughness	-.41 †		-.11	

Table 7 continued

	Structure Compliance		Process Compliance	
Variable	β	% R^2 change	β	% R^2 change
Case Manager DRI-R Caring/Fairness	-.28		-.31	
Case Manager DRI-R Trust	.40		.69**	
Case Manager DRI-R Toughness	.03		-.11	
Step 3		7.2%		1.7%†
LS/CMI Risk Total	-.18		-.03	
LS/CMI Special Risk Total	-.01		-.09	
LS/CMI Non-Criminogenic Needs	-.15		-.19	
LS/CMI Responsivity Considerations	-.14		.13	
Total Adjusted R^2	18.4%		37.2%	
n	34		33	

*$p < .05$, **$p < .01$, ***$p < .001$, † non-significant trend

Note: TMS-F = Treatment Motivation Scale-Forensic; SCL-90-R = Symptom Checklist 90 Revised; DRI-R = Dual-Role Relationship Inventory Revised; LS/CMI = Level of Service/Case Management Inventory.

Table 8

Mean Score Compliance as a Function of RNR Case plan Adherence

Degree of RNR Adherence	Structure Compliance	Process Compliance
No Adherence (*M, SD*)	1.83 (1.34)*a*	40.15 (10.38)*a*
	$n = 12$	$n = 13$
Slight Adherence (*M, SD*)	2.89 (1.05)*b*	48.38 (10.68)*bc*
	$n = 27$	$n = 26$
Some Adherence (*M, SD*)	2.33 (1.17)*a*	47.42 (11.38)*bc*
	$n = 24$	$n = 24$
Full Adherence (*M, SD*)	2.45 (.93)*a*	49.20 (12.45)*bc*
	$n = 11$	$n = 10$
F	$F(3, 73) = 2.65$, $p = .055$	$F(3, 72) = 1.91$, $p = .14$

Significant differences are noted within each column: use of the same letter superscript reflects a non-significant mean difference, whereas the use of different letter superscripts reflects a significant difference at the $p \leq .05$ level.

Note: RNR = Risk Need Responsivity.

Table 9

Statistical Differences between Variables of Participants with Missing Structure Compliance and Process Compliance Outcomes

Variable	Structure Compliance				Process Compliance			
	M	*SD*	*N*	*t*	*M*	*SD*	*n*	*t*
LS/CMI Total Score				$t(95) = -3.67$, $p < .001$				$t(95) = -2.75$, $p = .01$
Missing	22.63	9.93	24		21.24	10.35	25	
Not Missing	15.30	7.96	73		15.68	8.10	72	
History of Violent Offences				$t(94) = -2.85$, $p = .005$				$t(94) = -2.64$, $p = .01$
Missing	.52	.51	25		.50	.51	26	
Not Missing	.23	.42	71		.23	.42	70	
History of Technical Offences				$t(94) = -2.56$, $p = .012$				$t(94) = -1.83$, $p = .07$
Missing	.56	.51	25		.50	.51	26	
Not Missing	.29	.45	71		.30	.46	70	
LS/CMI Special Risk				$t(74) = -3.72$, $p < .001$				$t(74) = -3.50$, $p = .001$
Missing	4.88	4.26	16		4.61	4.16	18	
Not Missing	2.12	2.03	60		2.10	2.01	58	

Table 9 continued

	M	*SD*	*N*	*t*	*M*	*SD*	*n*	*t*
LS/CMI Non-Criminogenic				$t(74) = -3.72$, $p = .03$				$t(74) = -2.31$, $p = .02$
Missing	4.07	4.28	16		4.00	4.20	18	
Not Missing	2.32	2.23	60		2.28	2.16	58	
Adapted TMS-F Total				$t(87) = 2.33$, $p = .02$				$t(87) = 2.29$, $p = .03$
Missing	144.91	21.94	22		145.09	22.02	22	
Not Missing	157.57	22.13	67		157.51	22.14	67	
LSRP Total				$t(92) = -1.86$, $p = .066$				-
Missing	30.36	8.92	22		-	-	-	
Not Missing	26.94	7.09	72		-	-	-	

$^*p < .05$, $^{**}p < .01$, $^{***}p < .001$, † non-significant trend

Note: LS/CMI = Level of Service/Case Management Inventory; Adapted TMS-F Total = Adapted Treatment Motivation Scale-Forensic Total; LSRP = Levenson Self-Report Psychopathy Scale.

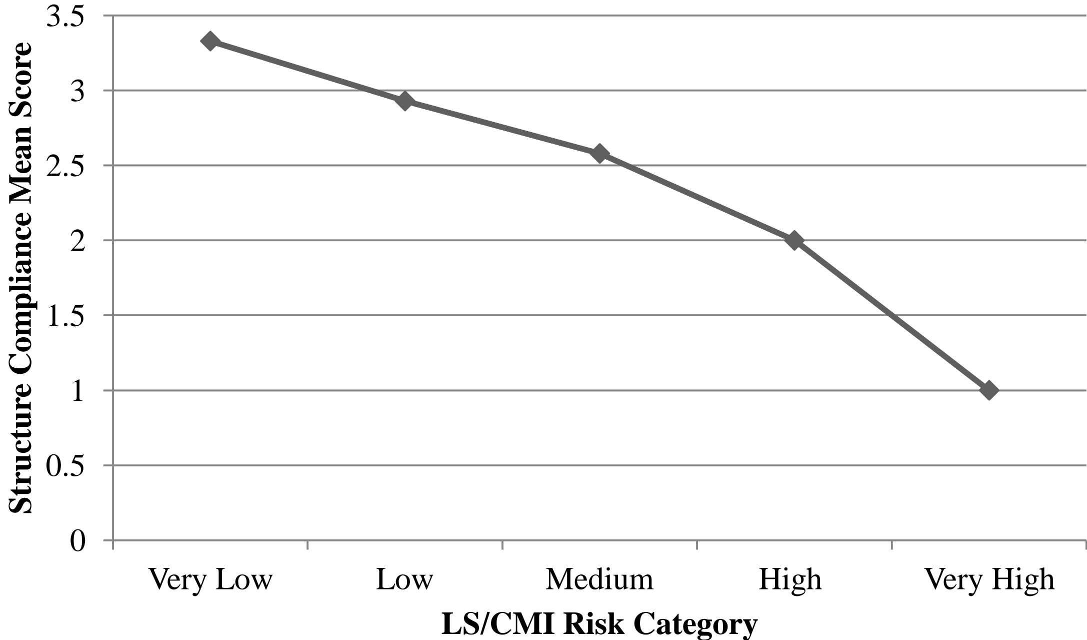

Figure 1. Structure compliance mean scores as a function of LS/CMI risk categories

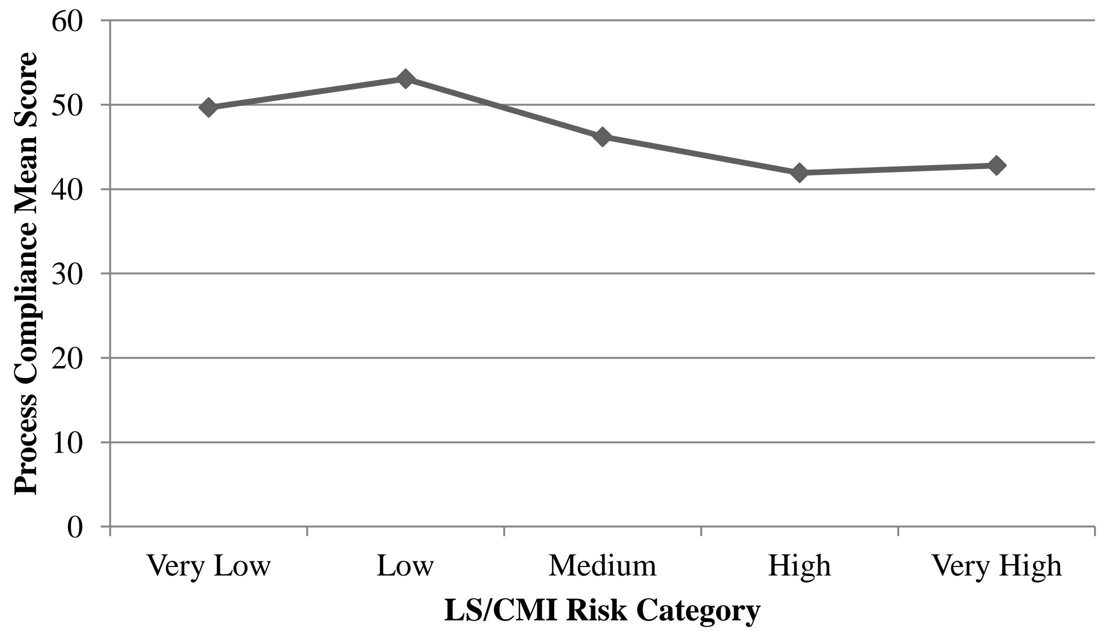

Figure 2. Process compliance mean scores as a function of LS/CMI Risk Categories

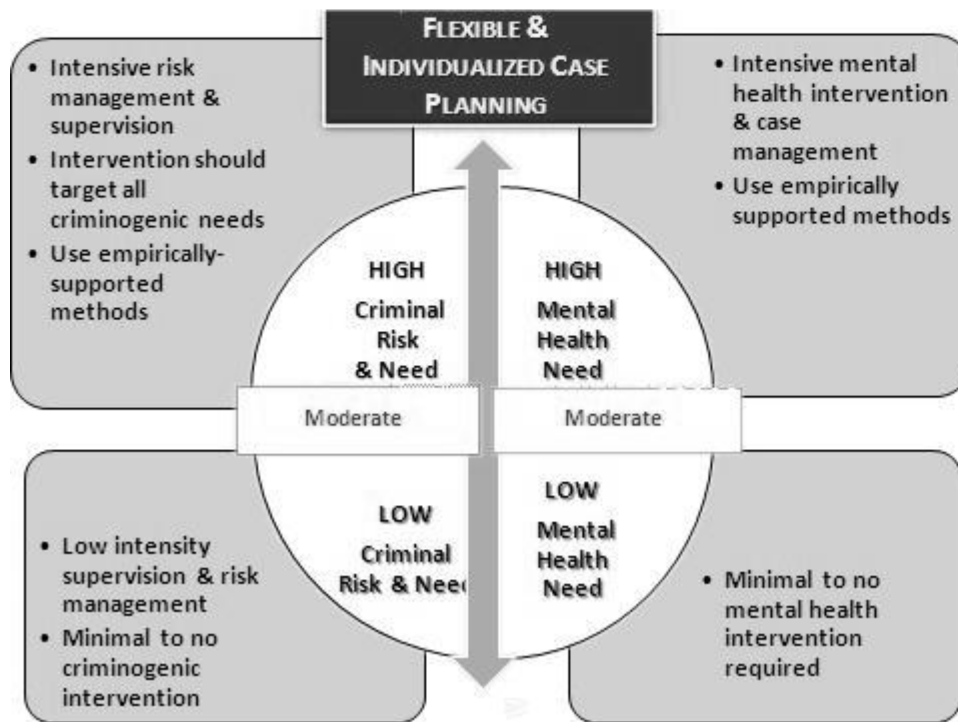

Figure 3. Flexible and Individualized Case Planning Model (Used with permission from Campbell and Canales, 2011).

APPENDIX A

Participant Demographic Form

Participant Demographic Form

ID: __________________________ Date: ___________________________

1. What is your gender:
   _____ Male
   _____ Female
   _____ Other

2. How old are you (years)? _______

3. What category best describes your ethnic background:
   _____Asian
   _____African Canadian/American
   _____First Nations/Métis
   _____Caucasian
   _____Latino/a
   _____Arabian
   _____Other (please specify): ____________________________

4. What is the highest level of education you have completed?
   _____Elementary
   _____Junior High School
   _____Some High School
   _____High School/GED
   _____Some College
   _____University/College Graduate
   _____Advanced/Professional/Graduate Degree

5. What is your current marital status:
   ____Never married and single
   ____Never married, but in a relationship now (we don't live together)
   ____Married/Common-law (I live with my relationship partner)
   ____Divorced / Separated, and currently single
   ____Divorced/Separated, but currently in a relationship (not living together)
   ____Widowed, and not currently in a relationship
   ____Widowed, but currently in a relationship (not living together)

6. Are you currently employed?
   ____Yes
   ____No

7. If yes, what is your current employment status?
   ____Full time
   ____Part time

____Seasonal employment
____unemployed

8. What is your typical monthly income: $_________________

9. Including your most recent arrest, how many arrests have you had?
____1
____2-5
____6-10
____10+

10. What offence (or crime) lead to your current community supervision with correctional services or the Saint John Mental Health Court:
_____Assault (Common, Aggravated, or Causing Bodily Harm)
_____Robbery (With or without a weapon)
_____Breach of Probation or Court Order (Fail to Comply)
_____Weapons Offence (Possession of a weapon, dangerous use of a weapon)
_____Break and Enter (with or without intent)
_____Drug Possession
_____Prostitution/Soliciting
_____Drug Trafficking (selling)
_____Sexual Offence (indecent exposure, sexual interference, sexual assault)
_____Theft (includes shoplifting)
_____Fraud or Forgery
_____Mischief, Vandalism or Destruction of Property
_____Other (please specify): ____________________________

11. How old were you the very first time you were arrested?_____ years

12. Please estimate the total time spent in detention center/jail/prison (if known):
____ 0
____ Less than 1 month
____ 1-2 months
____ 3-6 months
____ 7-12 months
____ 1-2 years
____ 3-5 years
____ More than 5 years

13. Please estimate the total time spent in hospital for a mental health reason.
____0 days
____1 day
____2-7 days
____Between 1-2 weeks

____3 weeks
____4 weeks
____Greater than 1 month

14. If yes to number 13, please estimate the total number of times you have been hospitalized for a mental health reason.
___ 1
___ 2
___ 3
___ 4
___ More than 4: Please Specify Number of Times: ____

15. In the past 6 months, have you wondered whether or not (or know) you have a mental health problem?
____Yes
____No

16. Have you ever had/suspected you had a mental health problem at some point in your life?
____Yes
____No

17. If you have had/suspected you had a mental health problem in the past, what was the problem?
____
____
____

Appendix B

Case Manager Demographic Form

Case Manager Demographic Form

ID: ___________________________ Date: ______________________________

1. What is your gender:
   _____ Male
   _____ Female
   _____ Other

2. How old are you (years)? _______

3. What category best describes your ethnic background:
   _____Asian
   _____African Canadian/American
   _____First Nations/Métis
   _____Caucasian
   _____Latino/a
   _____Arabian
   _____Other (please specify): ______________________________

4. What is the highest level of education you have completed?
   _____Elementary
   _____Junior High School
   _____Some High School
   _____High School/GED
   _____Some College or university
   _____University/College Graduate
   _____Advanced/Professional/Graduate Degree

5. What is your current employment status?
   ____Full time
   ____Part time

6. Which category best captures your current employment?
   ___Probation Officer
   ___Psychologist
   ___Social Worker
   ___Counsellor
   ___Addictions Counsellor
   ___ Other (please specify):___________________________________

7. How many years' experience do you have working with offender/mental health populations? _______years

Appendix C

Adapted Treatment Motivation Scale for Forensic Patients (TMS-F)

Adapted TMS-F

ID #:
Date of Completion:

Instructions

On the following pages are some statements accompanied by five possible answers about your case plan and intervention. Please indicate to what extent you agree with the statements by circling the answer choice.

Totally agree	***Somewhat agree***	***Neutral***	***Somewhat disagree***	***Totally disagree***
0	***1***	***2***	***3***	***4***

- If you completely agree with the statement, then choose "***Totally agree***".
- If the statement did not apply to you, then choose "***Totally disagree***".
- If that statement is true, but you cannot entirely accept it, then choose "***Somewhat agree***".
- If the statement is false but you cannot entirely reject it, then choose "***Somewhat disagree***"
- If you are unable to decide whether you agree or disagree, then choose "***Neutral***"

IMPORTANT!

- There is no right or wrong answer as they reflect your own opinion.
- Please respond to **ALL** questions.
- **Consider your answers as they apply to the past 6 months**

Questions

1. I always feel good during my therapy sessions/case manager meetings.	0 1 2 3 4
2. Even without outside help, I have my life in order.	0 1 2 3 4
3. I am very satisfied with the services or care I am receiving.	0 1 2 3 4

4. If my case manager thinks that I am not committed to my case plan, then I would receive some negative legal consequences.	0 1 2 3 4
5. My case plan is going to fail for me sooner or later.	0 1 2 3 4
6. When I am not meeting with my case manager, I avoid thinking about what I am doing during my sessions.	0 1 2 3 4
7. There have been times that I did not want to listen to others when they asked me to do something, even though I knew it was the right thing.	0 1 2 3 4
8. I worry about my problems often.	0 1 2 3 4
9. The topics that you have to talk about in my sessions are too difficult to discuss.	0 1 2 3 4
10. In order to prevent things from going wrong again, I really need to change the way I live my life.	0 1 2 3 4
11. I have doubts that my case plan will make much of a difference for the problems I have.	0 1 2 3 4
12. If I were to be kicked out of my programs, I would definitely receive consequences from the justice system.	0 1 2 3 4
13. My case plan takes too long to change any of my problems.	0 1 2 3 4
14. If I had the choice, I would change my case plan from what it is right now.	0 1 2 3 4
15. If I do not see any progress from my programs for several weeks, my commitment is going to go down.	0 1 2 3 4
16. I often feel bad because of the problems I have.	0 1 2 3 4
17. Even without my case plan, I think I would be able to get my life back on track.	0 1 2 3 4
18. Outside the sessions, I do not have to think about my behaviour and its consequences.	0 1 2 3 4
19. If there is a subject that I do not want to talk about in my sessions, my case manager needs to accept that.	0 1 2 3 4
20. Sessions are often very difficult for me.	0 1 2 3 4

21. The threat of having legal consequences doesn't change the way I behave.	0 1 2 3 4
22. I have not seen any changes because of my case plan sessions.	0 1 2 3 4
23. Attending my programs costs me some of the things that are important to me and I would rather stop going than give up those things.	0 1 2 3 4
24. If I make a mistake, I am always willing to admit it.	0 1 2 3 4
25. My life is terrible.	0 1 2 3 4
26. Sometimes it is better to hide what you are feeling inside than bring it up to your case manager.	0 1 2 3 4
27. My case manager really knows how to work well with me.	0 1 2 3 4
28. If I were to stop my programs, then I would receive consequences from the justice system.	0 1 2 3 4
29. In order for me to change my behaviour, there is still much more that I need to do.	0 1 2 3 4
30. If I go to my sessions, the bad things in my life will probably go away.	0 1 2 3 4
31. I sometimes doubt whether my case plan will make a difference.	0 1 2 3 4
32. I am often hopeless because of the chaos in my life.	0 1 2 3 4
33. The sessions of my programs are very difficult.	0 1 2 3 4
34. I feel a lot of pressure to avoid legal consequences.	0 1 2 3 4
35. Despite everything, I generally feel as good as others do.	0 1 2 3 4
36. I do not like that I have to attend case plan sessions and programs.	0 1 2 3 4
37. I am absolutely sure that the new behaviours I have developed from my programs will continue in the future.	0 1 2 3 4
38. If I did not see any changes in my life, I would stop attending my programs.	0 1 2 3 4

39. I definitely need case plan programs because of the problems I have.	0 1 2 3 4
40. I find it difficult to continue with something when I am not encouraged.	0 1 2 3 4
41. Receiving help for my problems means I have to sacrifice too much.	0 1 2 3 4
42. Another type of case plan would probably be better for me.	0 1 2 3 4
43. I have enough patience to be successful in case plan sessions.	0 1 2 3 4
44. The stress of my problems causes me a lot of suffering.	0 1 2 3 4
45. I don't think the legal consequences would be that bad if I stopped going to my programs.	0 1 2 3 4
46. I really need to change my behaviour.	0 1 2 3 4
47. I find it hard to make the time for the things I am supposed to be doing related to my programs (e.g., homework).	0 1 2 3 4
48. Sometimes I feel humiliated that I am in programs for my problems.	0 1 2 3 4
49. The goals of my case plan are very clear to me.	0 1 2 3 4
50. I often hate myself because of my behaviour.	0 1 2 3 4
51. I think my problem behaviour will never change.	0 1 2 3 4
52. I sometimes have doubts about the usefulness of what is discussed or completed during my meetings with my case manager.	0 1 2 3 4
53. I need learn how to handle certain situations better or things will go wrong again.	0 1 2 3 4
54. Despite everything, I have quite a nice life.	0 1 2 3 4

55. I would like to keep certain things secret in my personal life and my case manager needs to accept that.	0 1 2 3 4
56. I should be thinking about the topics we discuss in my programs in my free time.	0 1 2 3 4
57. I think I need more programs to change my behaviour.	0 1 2 3 4
58. The time and effort it takes for my programs is not worth it for me because I doubt that it can really change my life.	0 1 2 3 4
59. My motivation would decline if my programs get even more difficult.	0 1 2 3 4
60. Because of the potential legal consequences, I have no real choice so I have to finish the case plan.	0 1 2 3 4

Appendix D

Case Management Engagement Rating Guide

Estimate the offender's recent/current level of engagement in the case management plan:

0 – No engagement (often missed appointments, unmotivated to change, no engagement with probation officer or other service providers, frequent non-compliance)

1 – Moderate/partial engagement (inconsistent attendance at appointments, partially motivated to change, some engagement with probation officer/service providers, inconsistent compliance)

2 – Good engagement (attends most appointments, appears motivated to change, actively works with probation officer/service providers, consistent compliance)

Appendix E

Case Management Engagement Rating Scale (TER)

Case Management Engagement Rating Scale (TER)

Please complete the following ratings for the previous 6 month period of community supervision.

ID: ____________________

Client's ID: ____________________

Date of Completion: ____________________

Assessment Period: In the Previous 6 MONTHS

INSTRUCTIONS

In the TER, several aspects of a client's engagement in their case plan over the past 6 months are assessed. This is done on 5 point scales, where a higher score always represents greater engagement.

Example*: Making sacrifices for case plans/interventions*

1	Tries to avoid all sacrifices even if this puts the case plan at risk
2	Between 1 and 3
3	Makes limited sacrifices but tries to avoid painful sacrifices. Does not put case plan at risk.
4	Between 3 and 5
5	Makes even substantial and painful sacrifices.
N/A	No sacrifice required

Above the points on the scale, descriptions of the behaviour are presented for which the respective scores are appropriate. When none of the descriptions exactly represents the patient's behaviour, assign the most applicable score. In some cases, the option 'not applicable' is available.

STEPS IN THE ASSESSMENT:

1. Bring to mind the start of the assessment period (6 months).
2. Read the description and examples for the aspect to be assessed.
3. Read the description above scale point 3.
4. Determine whether in the past 6 months, the client deviated from the description in a positive direction (to the right) or in a negative direction (to the left). Depending on this, read the description at scale point 1 or 5.
5. When scoring, pay attention to the following:
   a. Assess only the required aspect – don't allow yourself to be led by a general impression of the client
   b. Use the complete scale; don't hesitate to give a score of 1 or 5 where required.

1. **PARTICIPATION (Assessment Period: Previous 6 months)**

1.1 Appointments in the last 6 months	
Originally Planned: ☐ 1-3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ More Frequently: ___	Cancelled by case manager/program setting: ☐ 0 ☐ 1 ☐ 2 ☐ More Frequently: ___
Net amount of sessions (A – B): _________	
1.2 Appointments missed in the past 6 months	
Number missed: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ More: ___	Appropriately cancelled: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ More: ___ Special circumstances (e.g., long-term illness): ____
1.3 Late for appointments in the past 6 months	
Number of times more than 5 minutes late: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ More: ___	

2. MAKING SACRIFICES FOR TREATMENT (Assessment Period: Previous 6 months)

NB: The idea of a sacrifice applies only if this could have been avoided by making a different choice. For example, "loss of income" is not a sacrifice if the alternative of the intervention is a prison sentence where one would also have lost income.

2.1 Financial sacrifices for case plan interventions/programming

- Costs associated with intervention (e.g., non-reimbursed travel expenses; own financial contribution towards programs).
- Loss of income
- Other (e.g., costs of moving house in the interest of former victims or to give up an antisocial peer group).

2.2.Social sacrifices for case plan interventions/programming

- Less time for partner, children, friends, etc.
- Having to give up antisocial or otherwise problematic social contacts
- Other (e.g., loss of status with peer group).

2.3 Psychological sacrifices for case plan interventions/programming

- Giving up pleasurable activities (e.g., risky activities, alcohol and drug use, etc.)
- Strain of the intervention itself (unfamiliarity, blow to pride, confrontation)
- Aversive activities or situations (e.g., doing intervention-related homework, getting up early or traveling a long distance to attend appointments)
- Other (e.g., significant others are scornful of programs)

Measurement Ratings:

1	Actively tries to avoid making sacrifices even under pressure or if this has a significant negative impact on the case plan
2	Between 1 and 3
3	Making minor sacrifices but tries to avoid making more substantial sacrifices
4	Between 3 and 5
5	Willingly makes substantial and painful sacrifices
N/A	No particular sacrifice required.

2.1 Financial	**1**	**2**	**3**	**4**	**5**	**N/A**
2.2 Social	**1**	**2**	**3**	**4**	**5**	**N/A**
2.3 Psychological	**1**	**2**	**3**	**4**	**5**	**N/A**

3. OPENNESS (Assessment period: Previous 6 months)

3.1 Openness about relevant facts

- Regarding own behaviour (past and present)
- Regarding events (past and present)

3.2.Openness about own inner world

- Regarding thoughts or fantasies
- Regarding feelings (of which one is aware)
- Regarding inclinations or plans

Measurement Ratings:

1	Generally plays his/her cards very close to chest. When specific questions are asked, withholds important information or even lies to avoid creating an unfavorable impression.
2	Between 1 and 3
3	Is reticent about delicate issues, however is more open and honest when specific questions are asked.
4	Between 3 and 5
5	Generally discloses even delicate information of his/her own accord.

3.1 Openness about Facts	**1**	**2**	**3**	**4**	**5**
3.2 Openness about own inner world	**1**	**2**	**3**	**4**	**5**

4. EFFORT TO CHANGE PROBLEM BEHAVIOUR (Assessment period: Previous 6 months)

NB: Inasmuch as this is about behaviour not observable by the assessor, the assessment must be inferred from indications such as the way the client talks, information from third parties, etc.

4.1 Effort towards behaviour change within case manager-client sessions:

For example:
- Efforts towards more adequate social behaviour
- Efforts to control impulsive behaviour
- Allowing oneself to be more vulnerable

4.2 Effort towards behaviour change outside case manager-client sessions:

For example:
- Avoiding risky situations
- Improving communication with partner
- Actively tackling problems

Measurement Ratings:

1 Makes hardly any effort to replace old behaviour with new behaviour.
2 Between 1 and 3
3 At times tries to change behaviour. However, lacks the commitment and perseverance to continue.
4 Between 3 and 5
5 Makes consistent efforts towards behaviour change, even when this requires a lot of effort.

4.1 Within sessions	**1**	**2**	**3**	**4**	**5**
4.2 Outside sessions	**1**	**2**	**3**	**4**	**5**

☐ **No assessment possible**

5. GOAL DIRECTEDNESS (Assessment Period: Previous 6 months)

NB: 'Agreed goals' include everything that is explicitly aimed for in the case plan. This includes not only the final goal of the case plan, e.g. 'prevention of delinquency', but also all intermediate goals.

5.1 Knowledge of an commitment to the agreed goals					
Measurement Ratings: 1 Is hardly aware of the agreed goals and doesn't seem to care. 2 Between 1 and 3 3 Has a general idea of the agreed goals. Subscribes to these goals but often loses sight of them. Often prioritizes other things. 4 Between 3 and 5 5 Experiences case plan goals as personal goals with high priority. Is strongly committed to engage in goal directed efforts.					
5.1 Knowledge	**1**	**2**	**3**	**4**	**5**
5.2 Effort towards the translation of goals into concrete stepped action plans					
Measurement Ratings: 1 Appears to have little interest in translating goals into concrete behavioural plans. 2 Between 1 and 3 3 Is generally interested in translating goals into concrete plans. However, the case manager often has to lead in this. 4 Between 3 and 5 5 Actively engages in translating general goals into concrete realistic plans. If necessary, takes the initiative to do this him/herself.					
5.2 Effort	**1**	**2**	**3**	**4**	**5**

6. EFFORTS TOWARDS IMPROVING SOCIO-ECONOMIC SITUATION
(Assessment period: Previous 6 months)

NB: Assess each aspect separately.

Measurement Ratings:

1	Makes hardly any recognizable effort to improve the current situation. Dismisses advice and does not follow through on agreements.
2	Between 1 and 3
3	Inconsistent efforts to improve the current situation. Takes relevant steps but generally shows insufficient commitment and perseverance.
4	Between 3 and 5
5	Puts a lot of effort into improving the current situation. Does not give up when obstacles or setbacks are encountered. Takes even difficult steps.
N/A	Not relevant to this case plan.

6.1 Work	**1**	**2**	**3**	**4**	**5**	**N/A**
6.2 Housing	**1**	**2**	**3**	**4**	**5**	**N/A**
6.3 Relationship with partner	**1**	**2**	**3**	**4**	**5**	**N/A**
6.4 Leisure/Social contacts	**1**	**2**	**3**	**4**	**5**	**N/A**
6.5 Financial Situation	**1**	**2**	**3**	**4**	**5**	**N/A**

7. CONSTRUCTIVE USE OF THE CASE MANAGER – CLIENT SESSIONS (Assessment Period: Previous 6 months)

7.1 Discussing relevant topics

Measurement Ratings:

1 Avoids discussion of relevant topics or is vague when the case manager insists on discussing the topic.
2 Between 1 and 3
3 Often doesn't raise important topics him/herself, but actively engages when the case manager does so.
4 Between 3 and 5
5 Generally raises relevant issues by him/herself, even delicate ones, and is sufficiently specific.

7.1 Discussing Relevant topics	**1**	**2**	**3**	**4**	**5**

7.2 Constructive use of advice and offered cognitive frameworks

Measurement Ratings:

1 Regularly rejects or ignores advice, feedback and offered cognitive frameworks.
2 Between 1 and 3
3 Open to advice, feedback, and offered cognitive frameworks. However, does little to follow through with these or apply them to personal problems.
4 Between 3 and 5
5 Often asks for feedback, advice or opinion. Actively tries to get as much out of this as possible.

7.2 Advice	**1**	**2**	**3**	**4**	**5**

7.3 Focus on concrete behavioural change or problem solving

Measurement Ratings:

1 During sessions, rarely appears to focus on concrete behavioural change or solving problems.
2 Between 1 and 3
3 Obviously strives for behaviour change and solving problems during sessions, but is often insufficiently persistent and concrete.
4 Between 3 and 5
5 During sessions focuses consistently on concrete behavioural change or problem solving.

7.3 Focus	**1**	**2**	**3**	**4**	**5**

8. DEALING WITH THE CONTENT OF CASE MANAGER-CLIENT MEETINGS BETWEEN SESSIONS (Assessment Period: Previous 6 months)

For example:

- Continues to think constructively about a topic that has been discussed in sessions
- Constructively discusses with others a topic that has been discussed in sessions
- Experiments with behaviour change in line with something discussed in sessions

Measurement Ratings:

1 Between sessions, probably rarely dealt in a constructive way with what was discussed during the meetings.
2 Between 1 and 3
3 Between sessions, regularly dealt in a constructive way with what was discussed in meetings. It appears that this has generally not been very intensive
4 Between 3 and 5
5 Between sessions, usually dealt in a constructive and often intensive way with what was discussed in the meetings.

8.1 Content	**1**	**2**	**3**	**4**	**5**

9. GLOBAL ASSESSMENT OF ENGAGEMENT (Assessment Period: Previous 6 months)

NB:

- ***Try to provide a global assessment as you would have done before you started completing the above ratings. In order to do this, you need to distance yourself from the previous assessments.***
- ***Remember, the rating relates only to the past 6 months.***

Measurement Ratings: 1 Little engagement. 2 Less than average engagement 3 Average engagement 4 More than average engagement 5 High level of engagement					
9.1 Engagement	**1**	**2**	**3**	**4**	**5**

Appendix F

Dual Role Relationship Inventory-Revised Offender Version

Dual Role Relationship Inventory: Revised

Form P

ID: ______________________________
Date of Completion: ______________________________
Case Manager's ID: ______________________________

Instructions

On the following pages there are sentences that describe some of the different ways a person might think or feel about his or her case manager. As you read the sentences, mentally insert the name of your case manager in the blank, or "_________".

Next to each sentence inside there is a seven point scale

1	**2**	**3**	**4**	**5**	**6**	**7**
Never	*Rarely*	*Occasionally*	*Sometimes*	*Often*	*Very Often*	*Always*

If the statement describes the way you ***always*** think or feel circle the number 7; if it ***never*** applies to you circle the number 1. Use the numbers in between to describe the variations between these extremes.

This questionnaire is CONFIDENTIAL; neither your case manager nor the agency will see your answers.

Please answer honestly.

Work fast, your first impressions are the ones we would like to see.
PLEASE DON'T FORGET TO RESPOND TO EVERY ITEM.
Thank you for your help!

REMEMBER:

1	**2**	**3**	**4**	**5**	**6**	**7**
Never	*Rarely*	*Occasionally*	*Sometimes*	*Often*	*Very Often*	*Always*

Item							
1. ___________ cares about me as a person.	1	2	3	4	5	6	7
2. I feel free to discuss the things that worry me with ____________.	1	2	3	4	5	6	7
3. ___________ explains what I am supposed to do and why it would be good to do it.	1	2	3	4	5	6	7
4. ___________ tries very hard to do the right thing by me.	1	2	3	4	5	6	7
5. When I have trouble doing what I am supposed to do, ___________ talks with me and listens to what I have to say.	1	2	3	4	5	6	7
6. If I break the rules, ___________ calmly explains what has to be done and why.	1	2	3	4	5	6	7
7. ___________ is enthusiastic and optimistic with me.	1	2	3	4	5	6	7
8. I feel safe enough to be open and honest with ___________.	1	2	3	4	5	6	7
9. ___________ talks down to me.	1	2	3	4	5	6	7
10. ___________ encourages me to work together with him/her.	1	2	3	4	5	6	7
11. ___________ trusts me to be honest with him/her.	1	2	3	4	5	6	7
12. ___________ really considers my situation when deciding what I'm supposed to do.	1	2	3	4	5	6	7
13. ___________ seems devoted to helping me overcome my problems.	1	2	3	4	5	6	7
14. ___________ puts me down when I've done something wrong.	1	2	3	4	5	6	7
15. ___________ is warm and friendly with me.	1	2	3	4	5	6	7

16. ___________ treats me fairly.	1	2	3	4	5	6	7
17. ___________ really cares about my concerns.	1	2	3	4	5	6	7
18. ___________ praises me for the good things I do.	1	2	3	4	5	6	7
19. If I'm going in a bad direction, ___________ will talk with me before doing anything drastic.	1	2	3	4	5	6	7
20. I know that ___________ truly wants to help me.	1	2	3	4	5	6	7
21. ___________ considers my views.	1	2	3	4	5	6	7
22. I feel that ___________ is looking to punish me.	1	2	3	4	5	6	7
23. ___________ does give me enough of a chance to say what I want to say.	1	2	3	4	5	6	7
24. ___________ makes unreasonable demands of me.	1	2	3	4	5	6	7
25. ___________ expects me to do all the work alone and doesn't provide enough help.	1	2	3	4	5	6	7
26. ___________ knows that he/she can trust me.	1	2	3	4	5	6	7
27. ___________ is someone that I trust.	1	2	3	4	5	6	7
28. ___________ takes enough time to understand me.	1	2	3	4	5	6	7
29. ___________ takes my needs into account.	1	2	3	4	5	6	7
30. ___________ shows me respect in absolutely all his/her dealings with me.	1	2	3	4	5	6	7

Appendix G

Dual Role Relationship Inventory-Revised Case Manager/Officer Version

Case Manager-Client Relationship Inventory: Revised

Form CM

ID: ______________________________
Date of Completion:______________________________
Client's ID: ______________________________

Instructions
On the following pages there are sentences that describe some of the different ways a person might think or feel about his or her client. As you read the sentences, mentally insert the name of your client in place of _________ in the text.

Next to each sentence inside there is a seven point scale

1	**2**	**3**	**4**	**5**	**6**	**7**
Never	*Rarely*	*Occasionally*	*Sometimes*	*Often*	*Very Often*	*Always*

If the statement describes the way you ***always*** think or feel circle the number 7; if it ***never*** applies to you circle the number 1. Use the numbers in between to describe the variations between these extremes.

This questionnaire is CONFIDENTIAL; neither your client nor the agency will see your answers.

Please answer honestly.

Work fast, your first impressions are the ones we would like to see.
PLEASE DON'T FORGET TO RESPOND TO EVERY ITEM.
Thank you for your help!

REMEMBER:

1	**2**	**3**	**4**	**5**	**6**	**7**
Never	*Rarely*	*Occasionally*	*Sometimes*	*Often*	*Very Often*	*Always*

Item							
1. I care about __________ as a person.	1	2	3	4	5	6	7
2. __________ feels free to discuss the things that worry him/her with me.	1	2	3	4	5	6	7
3. I explain what __________ is supposed to do and why it would be good to do it.	1	2	3	4	5	6	7
4. I try very hard to do the right thing by __________.	1	2	3	4	5	6	7
5. When __________ has trouble doing what is required, I talk with him/her and listen to what he/she has to say.	1	2	3	4	5	6	7
6. If __________ breaks the rules, I calmly explain what has to be done and why.	1	2	3	4	5	6	7
7. I am enthusiastic and optimistic with __________.	1	2	3	4	5	6	7
8. __________ seems to feel safe enough to be open and honest with me.	1	2	3	4	5	6	7
9. I talk down to __________.	1	2	3	4	5	6	7
10. I encourage __________ to work together with me.	1	2	3	4	5	6	7
11. I trust __________ to be honest with me.	1	2	3	4	5	6	7
12. I make allowances for __________'s situation when deciding what he/she needs to do.	1	2	3	4	5	6	7
13. I am really devoted to helping __________ overcome his/her problems.	1	2	3	4	5	6	7
14. If __________ does something wrong, I put him/her down to prevent the problem from happening again.	1	2	3	4	5	6	7
15. I'm interested in how __________ feels about	1	2	3	4	5	6	7

what he/she is required to do.							
16. I am very warm and friendly with__________.	1	2	3	4	5	6	7
17. I treat __________ fairly.	1	2	3	4	5	6	7
18. I am always clear with __________ and about what he/she is required to do.	1	2	3	4	5	6	7
19. If __________ breaks the rules, I disapprove in a way that is not at all angry.	1	2	3	4	5	6	7
20. I really care about __________'s personal concerns.	1	2	3	4	5	6	7
21. I praise __________ for good things he/she does.	1	2	3	4	5	6	7
22. When __________ is going in a bad direction, I talk with him/her before taking serious action.	1	2	3	4	5	6	7
23. I genuinely want to help __________.	1	2	3	4	5	6	7
24. I consider __________'s views.	1	2	3	4	5	6	7
25. __________ seems worried that I am looking to punish him/her.	1	2	3	4	5	6	7
26. __________ keeps some important things to him/herself and won't tell me about them.	1	2	3	4	5	6	7
27. I give __________ much room to voice complaints.	1	2	3	4	5	6	7
28. Given my job, I make tough demands of __________.	1	2	3	4	5	6	7
29. I expect __________ to do things independently, and don't help him/her too much.	1	2	3	4	5	6	7
30. I know that I can trust __________.	1	2	3	4	5	6	7
31. __________ seems to feel I am someone he/she can trust.	1	2	3	4	5	6	7

32. I take the time required to really understand ___________.	1	2	3	4	5	6	7
33. I take all of ___________'s needs into account.	1	2	3	4	5	6	7
34. I show ___________ respect in absolutely all of my dealings with him/her	1	2	3	4	5	6	7
35. I treat ___________ like everyone else on my caseload.	1	2	3	4	5	6	7

Appendix H

Symptom Checklist 90 – Revised (SCL-90-R) Subscales

Primary Symptoms Dimensions and Global Indices of the SCL-90

1. **Somatization**
   This subscale is made up of 12 items that reflect a measure of distress related to perceptions of bodily symptoms. The items are designed to reflect many of the physical symptoms associated with anxiety disorders such as complaints of cardiovascular, gastrointestinal, and respiratory difficulties. It is possible that these symptoms may reflect the presence of a physical illness as opposed to an anxiety disorder.

2. **Obsessive-Compulsive**
   This subscale is made up of 10 items that reflect symptoms consistent with Obsessive-Compulsive Disorder. It assesses impulses, thoughts, compulsions, and actions that reflect uncontrollable, ego-dystonic, and undesirable experiences to the individual.

3. **Interpersonal Sensitivity**
   This subscale is made up of 9 items that measure the individual's feelings of their own adequacy or inferiority as compared to others. It assesses the individual's interpersonal interactions and the degree of uneasiness/discomfort and adequacy of performance.

4. **Depression**
   This subscale is made up of 13 items measuring core aspects of depression such as sadness, loss of energy, hopelessness, withdrawal, and thoughts of suicide, etc. The items capture many of the cognitive and somatic correlates of depressive symptoms.

5. **Anxiety**
   This subscale is made up of 10 items that reflect core aspects of anxiety. These include feelings of worry, nervousness, tension, and panic, etc. While many of the somatic features of anxiety are addressed in the Somatic Complaints subscale, many other somatic correlates of anxiety are represented within this subscale as well.

6. **Hostility**
   This subscale is made up of 6 items that assess various aspects of the state of anger. Aggression, irritability, rage, and resentment are included within the subscale.

7. **Phobic anxiety**
   This subscale is made up of 7 items that address the avoidance or escape behaviour of persistent fears. It measures specific types of phobias as well as the irrationality and disproportionate fear of said phobias.

8. **Paranoid Ideation**
   This subscale is made up of 6 items that address aspects of paranoia such as hostility, suspiciousness, grandiosity, etc. Various aspects of delusions are also included within this subscale.

9. **Psychoticism**
   This subscale consists of 10 items that reflect various aspects of schizophrenia and other psychotic disorders. Assessed aspects include positive (hallucinations and delusions) and negative symptoms (withdrawal and isolation).

10. **Global Severity Index**
    The GSI represents an average rating score of all 90 items of the scale.

11. **Positive Symptoms of Distress Index**
    The PSDI reflects the average score of all items on the questionnaire that had a score above zero.

12. **Positive Symptoms Total**
    The PST reflects the number of items on the questionnaire that had a score above zero. This index may also provide information about the client's response style (i.e., the tendency to exaggerate or downplay the distress of current symptomatology; Derogatis, 2000).

13. **Additional Items**
    There are 7 additional items that contribute to the global scores of the SCL-90 that are not reflected in any of the primary dimensions. These items measure functional disturbances in sleep and appetite.

Appendix I

Sections of the Level of Service/Case Management Instrument (LS/CMI)

Section 1: General Risk/Need

Criminal History

1. Any prior youth or dispositions or adult convictions?
2. Two or more prior youth/adult dispositions/convictions?
3. Three or more prior youth/adult dispositions/convictions?
4. Three or more present offences?
5. Arrested or charged under age 16?
6. Ever incarcerated upon conviction?
7. Ever punished for institutional misconduct or a behaviour report?
8. Charge laid, probation breached, or parole suspended during prior community supervision?

Education/Employment

9. Currently unemployed?
10. Frequently unemployed?
11. Never employed for a full year?
12. Less than regular grade 10 or equivalent?
13. Less than regular grade 12 or equivalent?
14. Suspended or expelled at least once?
15. Participation/Performance.
16. Peer interactions.
17. Authority interaction.

Family/Marital

18. Dissatisfaction with marital or equivalent situation.
19. Nonrewarding, parental.
20. Nonrewarding, other relatives.
21. Criminal – family/spouse.

Leisure/Recreation

22. Absence of recent participation in an organized activity.
23. Could make better use of time.

Companions

24. Some criminal acquaintances.
25. Some criminal friends.
26. Few anticriminal acquaintances.
27. Few anticriminal friends.

Alcohol/Drug Problem

28. Alcohol problem, ever.
29. Drug problem, ever.
30. Alcohol problem, currently.
31. Drug problem, currently.
32. Law violations related to drug/alcohol use.

Marital/Family.

School/Work.

Medical or other clinical indicators

Procriminal Attitude/Orientation
36. Supportive of crime.
37. Unfavorable toward convention.
38. Poor, toward sentence/offence.
39. Poor, toward supervision/treatment.

Antisocial Pattern
40. Specialized assessment for antisocial pattern.
41. Early and diverse antisocial behaviour
42. Criminal attitude
43. Pattern of generalized trouble

Section 2: Specific Risk/Need
Personal Problems with Criminogenic Potential
1. Clear problems of compliance (specific conditions).
2. Diagnosis of "psychopathy."
3. Diagnosis of other personality disorder.
4. Threat from third party.
5. Problem-solving/self-management skill deficits.
6. Anger management deficits.
7. Intimidating/controlling.
8. Inappropriate sexual activity.
9. Poor social skills.
10. Peers outside of age range.
11. Racist/sexist behaviour.
12. Underachievement.
13. Outstanding charges.
14. Other. Specify

History of Perpetration
Sexual Assault
1. Sexual assault, extrafamilial, child/adolescent-male victim.
2. Sexual assault, extrafamilial, child/adolescent-female victim.
3. Sexual assault, extrafamilial, adult- male victim.
4. Sexual assault, extrafamilial, adult- female victim.
5. Sexual assault, intrafamilial, child/adolescent-male victim.
6. Sexual assault, intrafamilial, child/adolescent-female victim.
7. Sexual assault intrafamilial, adult-spouse/partner victim.

Nonsexual Physical Assault and Other Forms of Violence
8. Physical assault, extra familial-adult victim.
9. Physical assault, intrafamilial-child/adolescent victim.
10. Physical assault, intrafamilial- adult partner victim.
11. Assault on an authority figure.
12. Stalking/harassment.
13. Weapon use.
14. Fire setting.

Other Forms of Antisocial Behaviour
15. Impaired driving.
16. Shoplifting.
17. While collar crime.
18. Gang participation.
19. Organized crime.
20. Hate crime.
21. Terrorist activity.

Section 4: Other Client Issues
Social, Health, and Mental Health
1. Financial problems.
2. Homeless or transient.
3. Accommodation problems.
4. Immigration issues.
5. Parenting concerns.
6. Health problems (HIV, AIDS, etc.).
7. Physical disability.
8. Learning disability.
9. Fetal Alcohol Spectrum Disorder (FASD)
10. Depressed.
11. Suicide attempts/threat.
12. Low self-esteem.
13. Shy/withdrawn.
14. Diagnosis of serious mental disorder.
15. Other evidence of emotional distress. Specify
16. Victim of family violence.
17. Victim of physical assault.
18. Victim of sexual assault.
19. Victim of emotional abuse.
20. Victim of neglect.
21. Other. Specify

Section 5: Special Responsivity Considerations
1. Motivation as a barrier.
2. Engages in denial/minimization.

3. Interpersonally anxious.
4. Woman, gender-specific issues.
5. Cultural issues.
6. Ethnicity issues.
7. Low intelligence.
8. Communication barriers.
9. Mental disorder.
10. Antisocial personality/psychopathy.
11. Other. Specify

Note: Items listed are not intended to be used for research or clinical purposes. Please consult the LS/RNR scoring guide (Andrews, Bonta, & Wormith, 2008) for scoring instructions.

Appendix J

Levenson Self-Report Psychopathy Scale – Primary Dimension (LSRP-P)

LSRP-P

Levenson Self-Report Psychopathy Scale – Primary Dimension (LSRP-P)

ID: ______________________________
Date: ______________________________

Disagree Strongly	***Disagree Somewhat***	***Agree Somewhat***	***Agree Strongly***
0	**1**	**2**	**3**

Item	Rating			
1. Success is based on survival of the fittest; I am not concerned about the losers.	0	1	2	3
2. For me, what's right is whatever I can get away with.	0	1	2	3
3. In today's world, I feel justified in doing anything I can get away with to succeed.	0	1	2	3
4. My main purpose in life is getting as many goodies as I can.	0	1	2	3
5. Making a lot of money is my most important goal.	0	1	2	3
6. I let others worry about higher values; my main concern is with the bottom line.	0	1	2	3
7. People who are stupid enough to get ripped off usually deserve it.	0	1	2	3
8. Looking out for myself is my top priority.	0	1	2	3
9. I tell other people what they want to hear so that they will do what I want them to do.	0	1	2	3
10. I would be upset if my success came at someone else's expense.	0	1	2	3
11. I often admire a really clever scam.	0	1	2	3
12. I make a point of trying not to hurt others in pursuit of my goals.	0	1	2	3
13. I enjoy manipulating other people's feelings.	0	1	2	3
14. I feel bad if my words or actions cause someone else to feel emotional pain.	0	1	2	3
15. Even if I were trying very hard to sell something, I wouldn't lie about it.	0	1	2	3
16. Cheating is not justified because it is unfair to others.	0	1	2	3

Appendix K

The Structural and Process Compliance Measure

The Structural and Process Compliance Measure

STRUCTURAL AND PROCESS COMPLIANCE MEASURE
ID: ____________________________________
Date of Completion: ____________________________________
Client's ID: ____________________________________

Structural Indicators of Compliance

1. Missed appointments: Y/N

2. Number of missed appointments: ___

3. Rescheduled appointments: Y/N

4. Number of rescheduled appointments: ___

5. Number of appointments attended late: ____

6. Number of appointments where client left early: ____

7. Number of attended appointments: ___

8. Between-session homework completed: Y/N

9. Number of breaches of conditions on probation/undertaking: ___
   i. Minor breaches: ___
   ii. Serious breaches: ___

10. If present, degree of medication compliance

0	1	2	3	4	N/A
Very poor compliance					*High Compliance*

11. Client/supervisee's degree of dishonesty to case management staff about completion of homework

0	1	2	3	4
Frequent Deception				*Absence of Deception*

12. Client/supervisee lying or misrepresenting to case management staff about behaviours outside of program setting

0	1	2	3	4
Frequent Deception				*Absence of Deception*

13. Client/supervisee's level of respect to staff (case manager, and other individuals working on team)

0	1	2	3	4
Very low respect				*High Respect*

Process Indicators of Compliance

14. Client/supervisee's level of knowledge regarding case management process

0	1	2	3	4
Low knowledge				*High knowledge*

15. Client/supervisee's level of engagement with in case plan session (i.e., working hard):

0	1	2	3	4
No engagement				*High engagement*

16. Client/supervisee's degree of agreement with developing case plan goals

0	1	2	3	4
No agreement				*High agreement*

17. Client/supervisee's commitment to case plan goals

0	1	2	3	4
No commitment				*High commitment*

18. Client/supervisee's positive views/attitudes toward intervention

0	1	2	3	4
Very negative				*Very positive*

19. Client/supervisee's level of expectation of success in intervention

0	1	2	3	4
Very low expectation				*Very high expectation*

20. Client/supervisee's degree of concentration during sessions

0	1	2	3	4
No/low concentration				*High concentration*

21. Client/supervisee's degree of contribution during sessions

0	1	2	3	4
No contribution				*Significant contribution*

22. Client/supervisee's satisfaction with case plan and intervention (method and rationale)

0	1	2	3	4
Not satisfied				*Very satisfied*

23. Client/supervisee's degree of perceived costs to the individual (e.g., time, effort)

0	1	2	3	4
Significant costs				*No costs*

24. Client/supervisee's degree of perceived external pressure (e.g. family, legal system)

0	1	2	3	4
Significant pressure				*No significant pressure*

25. Client/supervisee's degree of adherence to rules

0	1	2	3	4
No adherence				*Total adherence*

Appendix L

File Coding Guide

FILE CODING GUIDE

SUMMARY OF VARIABLES TO CODE FOR EACH PARTICIPANT

ID #: ________________________ Coder: ________________________

1). *Demographic Variables*

A. ***Age***: ____

B. ***Age at the beginning of supervisory period:*________** (yy/mm)

C. ***Gender:*** Male / Female/Other

D. ***Ethnicity:***
- ☐ Caucasian
- ☐ African Canadian/American
- ☐ First Nations
- ☐ Latino/a
- ☐ Asian
- ☐ Arabian
- ☐ unknown
- ☐ Other (please indicate): ____________________

E. **Client Type**:
- ☐ Mental Health Court
- ☐ Public Safety Community-Supervised
- ☐ In Mental Health Court, but also on Public Safety Community Supervision, such as probation

F. ***Highest level of education achieved at the start of the index period of supervision***
- ☐ Elementary
- ☐ Junior High/Middle School
- ☐ High School/GED
- ☐ Partial completion of community college/trade program/university degree
- ☐ Completion of community college/trade program/university degree

G. ***Marital Status at the start of index period of supervision***
- ☐ Single
- ☐ Dating (non-cohabitating)
- ☐ Married / Common-Law
- ☐ Separated / Divorced
- ☐ Widowed (not in a new relationship)

H. ***Family Status/Number of Dependents***

a. Children ☐ Yes ☐ No

b. Number _________

- ☐ Biological

- ☐ Adopted
- ☐ Step children

c. Other dependents (e.g., younger siblings) ☐ Yes ☐ No

I. ***Socioeconomic status***

a. Estimated Income: ________

b. Collecting income assistance ☐ Yes ☐ No

2). *Mental Health Functioning:*

A. *DSM-IV-TR Diagnoses*

- ☐ Axis I: ____
- ☐ Axis II: ____
- ☐ Axis III: ____
- ☐ Axis IV: ____
- ☐ Axis V (GAF score): _________________________________

B. *Mental health diagnoses (as determined by the most recent psychiatric/psychological assessment) – tick all that apply:*

- ☐ Schizophrenia/schizoaffective disorder/psychosis NOS
- ☐ Bipolar Disorder I or II /Manic Episode
- ☐ Major Depressive Disorder or Episode/Dysthymia
- ☐ Anxiety Disorder (e.g., agoraphobia, generalized anxiety, panic disorder, phobia, PTSD)
- ☐ ADHD/Impulse control disorder
- ☐ Mental retardation/cognitive dysfunction/brain damage
- ☐ Histrionic/Borderline Personality Disorder/traits
- ☐ Narcissistic Personality Disorder/traits
- ☐ Antisocial Personality Disorder/traits
- ☐ Avoidant/Dependent Personality Disorder Traits
- ☐ Substance Abuse/Dependence
- ☐ Substance-induced mental disorder
- ☐ Other (specify): ____

C. *Comorbid Disorder* ☐ Yes ☐ No

D. *Dual Diagnosis:* ☐ Yes ☐ No

Specify: ____

E. *Substance Abuse History:* ☐ Yes ☐ No

F. *Types of Drugs used:*

____

____

____

G. *Estimated Frequency*: ____times/week or ____times/month

H. ***Estimated Severity***: ____________________

I. ***Estimated Impairment***

- ☐ Lost employment/school failure
- ☐ Difficulties in social relationships
- ☐ Impairment in daily functioning
- ☐ Financial difficulties

J. ***Substance Abuse Treatment History***: ☐ Yes ☐ No

K. ***Presence of Specific Symptomatology (evidence-based predictors of violence)***

L. ***Evidence of threat-control override delusions***

- Method of measurement: ____________________________________

M. ***Evidence of command hallucinations***

- Method of measurement: ____________________________________

N. ***Poor emotional coping skills***:

- Method of measurement: ____________________________________

O. ***Evidence of behavioural dyscontrol (i.e., impulsivity)***:

- Method of measurement: ____________________________________

P. ***Evidence of medication non-compliance***:

- Method of measurement: ____________________________________

Q. ***History of mental health services received***:

R. ***Estimated degree of difficulty with accessing services based on file information***:

0	1	2	3	4
No difficulty difficulty				Extreme

S. ***Number of months spent in psychiatric hospitalization***: ______ months

T. ***Number of previous mental health hospitalizations***: ________

U. ***Number of crisis calls to Mobile Mental Health***: ________

V. ***Number of Emergency Room visits due to Mental Health difficulties***: _____________

W. ***Profession of Primary Case Manager***

- ☐ Psychologist
- ☐ Social Worker
- ☐ Probation Officer
- ☐ Mental Health Nurse
- ☐ Other: ______________________________

X. ***Composition of Case Management Team/Professionals working with Client (check all that apply)***

- ☐ Psychologist

☐ Social Worker

☐ Probation Officer

☐ Mental health nurse

☐ Other: ____

Y. ***Family history of Mental Illness***: Y / N

Family member/mental illness :

____

____

Z. ***Medications***

☐ Any prescribed psychotropic medication Y / N

☐ Type: ___________________

☐ Dosage: _________________

Estimated degree of compliance taking medication as prescribed:

1 2 3 4

(low compliance) (Full compliance)

Medication for any other condition ☐ Yes ☐ No

3). ***<u>Index Offence Information and Criminal History</u>***

B. ***Age at index offence:*** ___________ (years/months)

C. ***Date of the index offence***: __________ (dd/mm/yy) (or date of arrest, or court appearance if actual date of offence is unknown; if multiple offences dealt with in this sentence, record the first offence date in the sequence)

D. ***Total number of criminal charges at time of index offence***: __________

E. ***Type of index criminal charges associated with index offence – tick all that apply***

☐ Assault (Common, Aggravated, or Causing bodily harm)
☐ Robbery (with or without weapon)
☐ Breach of Probation or court order (Fail to Comply)
☐ Weapons offence (possession of a weapon, dangerous use of a weapon)
☐ Break and Enter (with and without intent)
☐ Murder/Manslaughter
☐ Drug Possession
☐ Prostitution/Soliciting
☐ Drug Trafficking (selling)
☐ Sexual offence (indecent exposure, sexual interference, sexual assault)
☐ Theft (includes shoplifting)
☐ Fraud or Forgery
☐ Mischief, Vandalism or
☐ Destruction of Property
☐ Other (please specify): ________________________

F. ***Was this the client's first contact with correctional services?***

☐ Yes

☐ No

G. ***Total number of known criminal convictions at time of index offence (count charges if no known information about whether charge lead to conviction)***

H. ***Date of first meeting with case management professional (i.e. probation officier for Community-Supervised offenders and Mental Health Case Management for MHC clients) during the index probationary period:*** _____________ (dd/mm/yy)

I. ***Starting date of index probationary period***: ___________ (dd/mm/yy)

J. ***Termination date of index probationary period***: ___________ (dd/mm/yy)

K. ***Length of supervisory period***: ____________ (days) (do *not* count days incarcerated or in police lock-up; only time free in the community)

L. ***Date of first meeting with probation officer during the index probationary period***: ________ (dd/mm/yy)

M. ***Type of community supervision order placed on offender***:

- ☐ Probation
- ☐ House arrest
- ☐ Form 12
- ☐ Conditional sentence
- ☐ other: ___________________________

N. ***Nature of community supervision order conditions (tick all that applied)***

- ☐ curfew
- ☐ restrictions on geographic areas or places at which could be
- ☐ restrictions on with whom the client can associate
- ☐ substance use restrictions
- ☐ attendance of mental health counseling/services
- ☐ keep the peace/be of good behaviour
- ☐ no access to weapons
- ☐ residency conditions
- ☐ other(s): ____

O. ***History of violent offence(s)***

- ☐ Yes
- ☐ No

P. ***History of sexual offence(s):***

- ☐ Yes
- ☐ No

Q. ***History of technical charge(s):***

- ☐ Yes
- ☐ No

R. ***Nature of Criminal history. Record number of each type of charge next to each category:***

- ☐ Assault (Common, Aggravated, or Causing bodily harm) # ____
- ☐ Breach of Probation or court order (Fail to Comply) # ____
- ☐ Break and Enter (with and without intent) # ____
- ☐ Drug Possession # ____
- ☐ Drug Trafficking (selling) # ____
- ☐ Theft (includes shoplifting) # ____

- ☐ Fraud or Forgery # ____
- ☐ Mischief, Vandalism or Destruction of Property # ____
- ☐ Robbery (with or without weapon) # ____
- ☐ Weapons offence (possession of weapon, dangerous use of a weapon) # ____
- ☐ Murder/Manslaughter # ____
- ☐ Prostitution/Soliciting # ____
- ☐ Sexual (indecent exposure, sexual interference, sexual assault) # ____
- ☐ Threats (Threats of bodily harm, homicide) # _____
- ☐ Public Disturbance # ____
- ☐ Other (please specify): ________________

S. ***Number of Breaches of Probation or undertaking***: ____________________

T. ***Number of past court-ordered supervision periods/probations:*** _______________

U. ***Number of previous incarceration periods***: _____

V. ***Number of months spent in incarceration***: ______ months

W. ***Time to recidivism (if known):*** ______ months

4). LS/CMI information

1. **Transfer LS/CMI criminogenic needs score/level and overall risk score/level information measured at INTAKE from case files (if none exits, complete one based on information known up to and including the period of intake/screening**
   - Date of assessment: ________________ (dd/mm/yy)

- Who completed the assessment: ☐ probation officer ☐ mental health professional ☐ research assistant

Level of Supervision-Case Management Inventory (LS/CMI) General Risk/Need Total Score at Intake: ________

Date of assessment: ________________ (dd/mm/yy)

- Criminal History (_____) Very Low Low Medium High Very High
- Education/Employment (_____) Very Low Low Medium High Very High
- Family/Marital (_____) Very Low Low Medium High Very High
- Leisure/Recreation (_____) Very Low Low Medium High Very High
- Companions (_____) Very Low Low Medium High Very High
- Alcohol/Drug Problem (_____) Very Low Low Medium High Very High
- Procriminal Attitude (_____) Very Low Low Medium High Very High
- Antisocial Pattern (_____) Very Low Low Medium High Very High

Total LS/CMI score: _______

Overall Intake risk/need level: *Very Low* *Low* *Medium* *High* *Very High*

Clinical Override used for risk level? Yes No

If yes what was the override decision? ________ (use labels noted above)

Justification for override as noted by the assessor? (write down general reason without identifying info; e.g., sex offender, not-compliant with medication, etc.)

____
____
____
____

LS/CMI - Special Risk Section total score (count all "yes" responses) _______

LS/CMI - Non-Criminogenic Needs total score (count all "yes" responses) _______

LS/CMI - Responsivity Considerations (count all "yes" responses) _______

OVERALL CURRENT RNR CASE PLAN ADHERENCE SCORE (see separate coding instructions guide for this variable):

FOR RISK PRINCIPLE: ______
FOR NEED PRINCIPLE: ______
FOR RESPONSIVITY PRINCIPLE: General (___) + Specific (__) = ______

Total RNR Adherence Score = ______

PARTICIPANT BEHAVIOUR DURING CURRENT COMMUNITY-SUPERVISION/MHC INVOLVEMENT

Assessment period:

☐ 6 months into community supervision

☐ 12 months into community supervision

☐ Other – specify time frame _______________

Participant Status:

☐ supervision completed

☐ supervision ongoing consistent with initial time period of community supervision

☐ supervision prematurely terminated due to incarceration (not counting being in lock-up or remand)

☐ supervision ongoing, but extended due to new offences without incarceration disruption

2. Has the participant received any **new charges** for behaviour engaged in during the index supervision period: **Yes / No**

   - *If yes,* what is the **date of the *first* re-offence**? __________ (dd/mm/yy) – *base date of charge if known, otherwise use date of first conviction for offences committed*

- *If yes,* what **type of new charges** did the client accrue during the probation period - tic all that apply, and record the number of offences within each category of offences:

☐ Assault (Common, Aggravated, or Causing bodily harm) #_____
☐ Robbery (with or without weapon) # _____
☐ Breach of Probation or court order (Fail to Comply) # ____
☐ Weapons offence (possession of a weapon, dangerous use of a weapon) #_____
☐ Break and Enter (with and without intent) # _____
☐ Murder/Manslaughter # _____
☐ Drug Possession # ______
☐ Prostitution/Soliciting # ______
☐ Drug Trafficking (selling) # ______
☐ Sexual offence (indecent exposure, sexual interference, sexual assault) # _____
☐ Theft (includes shoplifting) # ____
☐ Fraud or Forgery # _____
☐ Mischief, Vandalism or Destruction of Property # _____
☐ Other (please specify): ______________________________

3. Total number of **days** between the start of the current supervision period and the *first* offending event: _______
4. Total number of **charges earned** while on current supervision prior to its termination date or return to custody if given custody time for the new charge prior to this date (excluding breaches of court orders and community supervision orders): ___________
5. Total number of **charges accrued for breaches** of court orders and community supervision orders (e.g., Form 12, probation, parole) received **<u>for non-criminal violations</u>** (e.g., violation of curfew, places to avoid, abstain from substances, residency clauses, etc) during current supervision prior to its termination date or return to custody if given custody time for the new charge prior to this date._________
6. Total number of charges accrued for breaches of court orders and community supervision orders (e.g., Form 12, probation, parole) received **<u>for criminal violations</u>** (i.e., breached because committed a new criminal offence while under court-ordered supervision) during current supervision and prior to discharge: ___________
7. Total number of **days spent in jail/incarcerated** during current supervision period on remand or due to sentencing prior to the scheduled termination of the index probationary period: ________
8. Pattern of changes in supervision order restrictions/conditions during the current supervision period:

    ____ generally no changes
    ____ inconsistent pattern of increased & decreased restrictions over time
    ____ primarily moved towards a decrease in restrictions
    ____ primarily moved towards an increase in restrictions

9. Type of interventions offender participated in (regardless of the successfulness of the intervention) **during current supervision period** (check all that apply; but <u>do not count</u> recommended programs that the client never attended at all)

    ☐ General anger management (individually or in group; excludes domestic violence programs)
    ☐ Domestic violence/intimate partner violence programs (individually or in group)
    ☐ Offender relapse prevention programs (individually or in group)
    ☐ Substance abuse treatment/detox (individually or in group)
    ☐ Sex offender treatment (individually or in group)
    ☐ Family therapy/counseling/support

- ☐ Individual generic mental health counseling
- ☐ Group-based mental health counseling (e.g., crisis skills, assertiveness training, interpersonal group – exclude PILS and DBT)
- ☐ Dialectical Behaviour Therapy (either individually or in group)
- ☐ PILS Program
- ☐ Psychiatric medication (medication prescribed to manage behavioural and psychiatric issues)
- ☐ Educational upgrading
- ☐ Employment services or re-training
- ☐ Supervised housing (e.g., special care home)
- ☐ Assisted housing (e.g., access shelter, temporary housing)
- ☐ Other: ____

10. Estimate the offender's recent/current level of engagement in the case management plan:
    - 0 – No engagement (often missed appointments, unmotivated to change, no engagement with probation officer or other service providers, frequent non-compliance)
    - 1 – Moderate/partial engagement (inconsistent attendance at appointments, partially motivated to change, some engagement with probation officer/service providers, inconsistent compliance)
    - 2 – Good engagement (attends most appointments, appears motivated to change, actively works with probation officer/service providers, consistent compliance)

11. **Transfer updated LS/CMI criminogenic need level information for the above noted point of the progress evaluation time-frame**

Date of re-assessment: _________________ (dd/mm/yy)

CHANGE?

- Criminal History (_____) Very Low Low Medium High Very High ↑/↓
- Education/Employment (_____) Very Low Low Medium High Very High ↑/↓
- Family/Marital (_____) Very Low Low Medium High Very High ↑/↓
- Leisure/Recreation (_____) Very Low Low Medium High Very High ↑/↓
- Companions (_____) Very Low Low Medium High Very High ↑/↓
- Alcohol/Drug Problem (_____) Very Low Low Medium High Very High ↑/↓
- Procriminal Attitude (_____) Very Low Low Medium High Very High ↑/↓
- Antisocial Pattern (_____) Very Low Low Medium High Very High ↑/↓

Re-assessed Total LS/CMI score: (_____)

Overall risk/need level at 6 MONTHS: *Very Low Low Medium High Very High*

Overall risk/need level at 12 MONTHS *Very Low Low Medium High Very High*

(OR AT TERMINATION POINT IF LESS THAN 12 MONTHS AND GREATER THAN 6 MONTHS)

Very Low Low Medium High Very High

FINAL CASE PLAN ADHERENCE SCORE AT TIME OF TERMINATION OF COMMUNITY-SUPERVISION:

FOR RISK PRINCIPLE: ______
FOR NEED PRINCIPLE: ______
FOR RESPONSIVITY PRINCIPLE: General (___) + Specific (__) = ______

Total RNR Adherence Score = ______

5). MHC Specific Information for MHC Group

A. ***Date of first MHC referral or date of first appearance if referral date unknown***: ________ (dd/mm/yyyy)

B. Admitted to MHC?

☐ Yes

☐ No

C. ***Number of times admitted to the MHC program?*** ______

D. ***Number of appearances before the Judge during follow-up process***: ____

6). Interventions Received During Involvement with Case Management:

A. ***Number of mental health interventions received***:_____

B. ***Number of community interventions received***:_____

C. ***Date of discharge (if any)***: _________(dd/mm/yy)

D. ***Type of interventions client participated in (regardless of the successfulness of the intervention) during probationary period (check all that apply; but do not count recommended programs that the client never attended at all)***

☐ General anger management (individually or in group; excludes domestic violence programs)
☐ Domestic violence/intimate partner violence programs (individually or in group)
☐ Offender relapse prevention programs (individually or in group)
☐ Substance abuse treatment/detox (individually or in group)
☐ Sex offender treatment (individually or in group)
☐ Family therapy/counseling/support
☐ Mental health interventions for assessment, therapy, or psychiatric medication follow-up
☐ Educational upgrading
☐ Employment services or re-training
☐ Other:
____
_
____
____
____

Appendix M

Risk-Need-Responsivity Case File Coding Guide

Risk-Need-Responsivity Case File Coding Guide
(adapted from Hanson, Bourgon, Helmus, & Hodgson, 2009)

SCALE FOR CODING RISK PRINCIPLE ADHERENCE IN THE CASE PLAN:

0 = There was a mismatch between the type of intervention/ intensity of supervision and the formal LS/CMI recidivism risk level (low, medium, high) identified at intake.

For example:

- Offender had an intake risk-need level that was rated as “high-risk”, but was NOT referred to a “high intensity” program or service (e.g., longer hours per session; more sessions).
- Offender had an intake risk-need level that was rated as “low-risk”, but was NO referred to a “low intensity” program or service (e.g., fewer hours per session; little to no intervention).

1 = There was a match between the type of intervention/ intensity of supervision and the formal LS/CMI recidivism risk level (low, medium, high) identified at intake.

For example:

- Offender had an intake risk-need level that was rated as “high-risk” and was referred to “high intensity” programs (e.g., longer hours per session; more sessions) and supervision (e.g., weekly monitoring).
- Offender had an intake risk-need level that was rated as “low-risk”, and no to minimal intervention or supervision was included in the case plan (e.g., no or very few referrals to other agencies; infrequent monitoring – once a month or less).

SCALE FOR CODING NEED PRINCIPLE ADHERENCE IN THE CASE PLAN:

Please note that treatment (e.g., interventions, programs, or services) could have occurred at Mental Health Services or at a community-based resource through referrals from Mental Health Services or Public Safety.

Coding 0: Criminogenic need is identified as problematic (medium, high, or very high), but records indicate that it was NOT addressed. For example:

- Education/employment need was rated as “medium-risk”, but no service was provided to address this concern.
- Attitudes need is rated as “high-risk”, but no service is offered to address criminal cognitions

OR

Criminogenic need is identified as not problematic (very low, low) but file indicates case plan included this as a target for treatment. For example:

- Drug/alcohol is rated as “low-risk” because client’s use of marijuana is controlled and not problematic. However, drug treatment was part of the case plan.

- Companions is rated as “very low-risk”, because client has no criminal influences and some prosocial acquaintances, but several treatment sessions focus on establishing peer relationships.

Coding 1: Criminogenic need was identified as problematic (medium, high, or very high), and file indicated that the area WAS addressed in case plan. For example:

- Leisure/recreation is rated as “very high-risk”, and client is encouraged to engage in recreational activities and some may even be explicitly stated as accessed.
- Attitudes is rated as “medium-risk”, and case plan addresses issues regarding the client’s lack of motivation, noncompliance, or rationalizations towards offense.

*****OR*****

Criminogenic need is identified as not problematic (very low, low) and file indicates that the area was NOT targeted for treatment. For example:

- Family/marital is rated as “low-risk” because client has good relationships with family or intimate partner. This area is not targeted for treatment and is not part of the case plan.
- Antisocial personality is rated as “very low-risk” because client does not exhibit an antisocial personality pattern. There is no evidence of services addressing aggressiveness, problem-solving or impulsivity deficits.

Coding A, B, or C: Rating A, B or C means that insufficient information was available to rate the need as a 0 or 1. Instead of coding it as “missing”, we want to know why.

A. Evidence that client received treatment services of some kind, but there is no information as to the content of the sessions. Exact issue addressed is unknown.

B. Client was referred to an external service (Ridgewood, education upgrading, job training but there is no information that indicates whether client actually went and participated in these services. Generally reflects poor inter-service communication.

C. Notes are very generic, vague, or irrelevant, or there is simply no information.

Coding Notes:

A rating **A, B or C** means that insufficient information was available to rate the principle as either 0 or 1. In this case, coding the principle adherence rating as “missing”, and note the reason by specifying which of the following reasons apply:

D. Evidence that client received treatment services of some kind, but there is no information as to the content of the sessions. Exact issue addressed is unknown.

E. Client was referred to an external service (Ridgewood, education upgrading, job training but there is no information that indicates whether client actually went and participated in these services. Generally reflects poor inter-service communication.

F. Notes are very generic, vague, or irrelevant, or there is simply no information.

INTERVENTIONS AND SERVICES

Some of the common services you'll see in the computerized database will include:

Individual therapy

- Client met with case manager, psychologist, or social worker but ***NOT*** psychiatrist
- Usually one-on-one counselling for mental health issues (e.g., depression/anxiety)

- Can consist of cognitive-behaviour therapy, dialectical behaviour therapy, counselling.

Emergency/crisis

- Client could have met with anyone but primary issue was crisis intervention
- Client contacted MHS center regarding a personal emergency/crisis

Rehabilitation/Skill teaching

- Mostly likely met with a support worker but there was no counselling
- Usually involves support services (e.g., shopping, drug store, bank, etc)

Consultation/Assessment

- Usually the first face-to-face session with MHS to figure out problem, possible referral.
- Could be either consulting with client or with other staff regarding the client.

Psychiatrist consultation

- Meeting with psychiatrist. Could range from a 5min follow-up to a 1hour session.
- Could involve some therapy and prescription refill.

Medication or injection

- Just taking medication. No therapy.

DBT (dialectical behaviour therapy)

- Intensive intervention that combines group and individual therapy into a single program

Recreational

- Social activities (movies, bowling, etc)

Home support

- Counseling at their residence

Other services mentioned in the notes. Careful, sometimes the program is referred to by some clinical lingo (i.e., AA) or by the name of the program (e.g., Girl's Circle).

- Anger management programs

- Substance abuse treatment (Ridgewood, AA, or NA)
- Behaviour modification (aka, B-MOD, it's an intensive program)
- Domestic violence/intimate partner violence programs
- Sex offender treatment
- Family therapy
- Group therapy (too generic, make sure you read notes for content)
- Self-esteem therapy
- Educational upgrading (e.g., GED)
- Employment services or re-training

Criminogenic Need	Risk Indicators	Intervention goals
Education-Employment	▪Low satisfaction in school-work, poor performance ▪Unemployed, no high school (suspended, expelled) ▪Poor peer-authority interaction	▪ Enhance work/study skills and interpersonal relationships within the context of work and school ▪ Educational upgrading (i.e., GED), job training, helping clients look for, apply for, and retain a job. ▪ Shop 211, Key Industries, Garden Buds, Simply Good Catering
Family-Marital	▪Inappropriate parental disciplining, abuse. ▪Poor family relationships, ▪Chaotic intimate relationships	▪ Teaching parenting skills, enhance warmth and caring, build positive relationships ▪ Reduce conflict in relationships ▪ Family/couples therapy, individual therapy focused on interpersonal/family issues, DBT
Leisure-Recreation	▪Lack of involvement in prosocial recreational/leisure activities ▪Could make better use of time	▪ Encourage prosocial recreational activities, teach prosocial hobbies and sports ▪ Volunteer activities, attending church, community involvement, productive use of free time ▪ Recreational activities (bowling, movies, etc) ▪ Open Door Club, Recovery Services
Companions	▪Criminal friends, or people who get into "trouble" ▪Isolation from prosocial others ▪Few prosocial friends, just acquaintances	▪ Replace procriminal friends and associates with prosocial friends and prosocial support network ▪ Discouraging isolation, boredom ▪ Social activities, reconnecting with old friends ▪ DBT, individual, CBT focused on social skills and positive peer relations.

Alcohol-Drug	▪Current alcohol/drug use ▪History of alcohol/drug use ▪Leads to legal, family, marital, school, work, medical problems	▪ Reduce substance abuse, reduce supports for substance-oriented behaviour, enhance alternatives to substance use, avoiding high relapse risk situations ▪ Detox, Ridgewood (methadone treatment), AA/NA ▪ Individual therapy
Attitudes	▪Attitudes, rationalizations, and beliefs supportive of crime ▪Negative attitudes towards the law, offense or treatment ▪Finds criminal behaviour useful	▪ Build a prosocial identity, counter rationalizations, minimizations, justifications (related to crime in general or specific offenses) with prosocial attitudes ▪ Individual therapy, CBT, DBT
Antisocial Personality	▪Impulsive, adventurous pleasure seeking, anger problems, aggressive and irritable ▪Antisocial Personality Disorder or traits ▪History of assault/violence	▪ Build problem-solving skills, self-management skills, teach anger management and coping skills ▪ Fostering noncriminal thinking, victim awareness and empathy, and development of prosocial values. ▪ Individual therapy, CBT, DBT

Scale for Coding Responsivity Principle Adherence in the Case Plan

A score of 1 for general responsivity and 1 for specific responsivity is required to code the case plan adherence to this principle as a 1 (Match). Otherwise it would be coded as a 0 (no match)

General Responsivity

0 = Non-adherence – interventions and strategies used in the case plan were INCONSISTENT with evidence-based methods of effective intervention for reduction of criminal behaviour.

For example,

- Used psychoresponsivity methods of intervention

1 = Adherence - interventions and strategies used in the case plan were CONSISTENT with evidence-based methods of effective intervention for reduction of criminal behaviour

For example:

- The use of cognitive-behavioural intervention techniques are understood to adhere to the Responsivity Principle.
- For interventions that are not cognitive-behavioural in orientation, a program that is moderated by a prosocial therapist, who is trained in developing respectful relationships (i.e., “firm but fair” relationships) would be considered to adhere to the Responsivity Principle

Note: Program manuals or brochures, research articles, accreditation credentials, and, if necessary, site visits, may be used by the rater to understand the nature and content of the referral programs or services if this information is not articulated sufficiently in the case file.

Specific Responsivity

0 = Non-adherence - Case files indicate that the referred intervention WAS NOT tailored to the offender's specific strengths and/or limitations when evidence-based interventions were used. For example:

- An offender is identified as having cognitive difficulties and there is no description of program alterations made to ensure the offender understood the presented material in the case plan (e.g., use concrete psycho-educational material or learning models to explain complex concepts).

1 = Adherence - Case files indicate that the service or treatment provided WAS tailored to the offender's identified strengths and/or limitations.

For example:

- Adjusted intervention to be responsive to identified strengths and weakness in the LS/RNR profile, such as providing interventions in the client's preferred language, responding to motivational barriers to change, adjusting for learning disabilities or cognitive limitations, addressing mental health issues that interfere with response to criminogenic intervention and supervision, building on prosocial aspects of offender's characteristics.

Total Responsivity Score : 0 = no match (score of 0-1) 1 = match (score of 2)

OVERALL RNR ADHERENCE SCORE:

No Adherence	Slight Adherence	Some Adherence	Full Adherence
0	**1**	**2**	**3**

Appendix N

Consent Form – Participants from the Saint John Mental Health Court

CONSENT FORM – PARTICIPANTS FROM THE SAINT JOHN MENTAL HEALTH COURT

You are invited to participate in a project conducted by the researchers at the Centre for Criminal Justice Studies at the University of New Brunswick in Saint John. The researchers would like to conduct an evaluation of the services that you are receiving through the Saint John Mental Health Court or through the Horizon Health Network Addiction and Mental Health Services. The purpose of this evaluation is to understand what factors contribute to you doing well with your community supervision. To conduct this evaluation, we would like to gather information about how you have been doing while under supervision for at least six months with the Public Safety Service of New Brunswick, including what types of treatment you are receiving, whether you are attending appointments, and how engaged you are in community supervision and case management plan as recommended by your case manager. We specifically want to better understand the factors about you (e.g., mental health functioning, age, gender, type of living arrangements) and your case management (e.g., types of intervention programs and mental health treatment received) that have an impact on 1) Your ability to engage in the case plan developed with your case manager and any intervention you participated in as part of this case plan, and 2) determining which factors are more like to ensure that you will be successful with the case plan by contributing to changes/improvements in mental health functioning and reduced involvement with the criminal justice system. To gather all of this information, we would like to review any records that you may have from Addiction and Mental Health Services (Horizon Health Network) and from the New Brunswick Departments of Justice and Public Safety. You also will be asked to fill out some self-report questionnaires with a researcher on one occasion that will take approximately 50 minutes. To compensate you for your time, you will be offered the chance to win one of ten $10 gift certificates to local restaurants (e.g., Tim Hortons, Wendy's, McDonald's). Your chances of winning are 1 in 20. Please note that this meeting will be confidential, therefore, information shared will not be relayed to anyone, including your case manager, or any other staff with Public Safety, Justice, or Addictions and Mental Health Services. However, confidentiality must be breached by law if you report that you are likely to hurt yourself or someone else, or that a child under the age of 16 if currently being harmed.

The review of these records would only be done by the principal investigator, Ainslie McDougall, her doctoral dissertation supervisor, Dr. Mary Ann Campbell, and other relevant members of the research team directly under Dr. Campbell's supervision. The information collected would only be used for the purposes of this research project. You do not need to answer any questions you are uncomfortable with on the self-report questionnaires. Because these questionnaires will ask questions about your mental health, personal experiences and feelings, you might find some of the questions upsetting. If that happens, please know that you are free to skip the question or stop filling out the questionnaire at any time with no penalty. No one person's information will be singled

out when we publish these findings so that we can protect each person's confidentiality, and we will only use the information to describe groups of people. We also won't share any personal information (e.g., address, place of work, mental health information, criminal history) with third parties who do not already have access to it. Once the study is completed, we will have no further access to these records and any records we have containing personal identifying information (e.g., your name, etc.) will be destroyed and only de-identified information will be retained for analysis. In this way, it will not be possible to identify who the information we retain for analysis belongs to and your information will be protected and remain private.

Please note that, no matter what you decide, your answer will in no way influence your current or future involvement with the Saint John Mental Health Court in current or future legal matters, or access to Addictions/Mental Health services or any of the agencies involved in this research evaluation. You are free to decline to participate if you so choose or stop participating at any point in the process, without any penalty whatsoever and your information will not be included in the study. There are no foreseeable risks to you participating in this study. Once signed, this form will be stored in Dr. Campbell's office in a locked filing cabinet for a 5 year period after which it will be destroyed. Any concerns about the study can directed toward Ainslie McDougall (principal investigator), Dr. Mary Ann Campbell (Associate Professor at the University of New Brunswick, Director of the Centre for Criminal Justice Studies), or Dr. List Best (Chair of the University of New Brunswick – Saint John Research Ethics Board).

Ainslie McDougall	Ainslie.mcdougall@unb.ca
Dr. Mary Ann Campbell	mcampbel@unb.ca
Dr. Lisa Best	reb@unb.ca

I have read the information provided above and have had all of my questions about this research project answered to my satisfaction. I understand that by consenting to participate in the study described above, I am giving permission for Ainslie McDougall, Dr. Mary Ann Campbell, and her supervised research team to review my Addiction and Mental Health Services records and my New Brunswick Department of Justice and Public Safety records, as well as agree to fill out several self-report questionnaires about myself for the purposes of the research project. I understand that all of this information will be kept confidential and will only be used for the stated purposes of this research project.

Please indicate whether you consent or do not consent to participating in the study as described by circling one of the responses below:

I CONSENT **OR** **I DO NOT CONSENT**
(Please circle your choice)

Name (please print): ________________________________

Signature: __________________________ **Date**: _____________________

☐ **Please check here if you'd like to receive a summary of the results after the study has been completed (this information will be stored separately from any information we collect about you to protect your privacy).**

Please provide the best means for us to send you this summary if you would like one:
Mailing Address (this should be one that will be active for at least the next 12 months so we can reach you when the study is complete):

____

____

____

Email address (will not be distributed to any other party and will only be used for the sharing the general findings from the study): ____________________________

Please Note: Should you become distressed at any point as a result of this research (before, during, or after it has been completed), please use the following contact information to speak to a professional:

1. Chimo (Provincial Crisis Phone Line)
    a. All of New Brunswick: 1-800-667-5005
    b. Fredericton, New Brunswick: (506) 450-4357
2. Mobile Mental Health Crisis Service
    a. Saint John, New Brunswick: 1-888-811-3664
    b. Fredericton, New Brunswick: (506) 453-2132

Appendix O

Consent Form – Participants Form

Public Safety New Brunswick

CONSENT FORM – PARTICIPANTS FROM PUBLIC SAFETY NEW BRUNSWICK

You are invited to participate in a project conducted by the researchers at the Centre for Criminal Justice Studies at the University of New Brunswick in Saint John. The researchers would like to conduct an evaluation of the services that you are receiving through the New Brunswick Department of Public Safety. The purpose of this evaluation is to understand what factors contribute to you doing well with your community supervision. To conduct this evaluation, we would like to gather information about how you have been doing while under supervision for at least six months with the Public Safety Service of New Brunswick, including what types of treatment you are receiving, whether you are attending appointments, and how engaged you are in community supervision and case management plan as recommended by your case manager. We specifically want to better understand the factors about you (e.g., mental health functioning, age, gender, type of living arrangements) and your case management (e.g., types of intervention programs and mental health treatment received) that have an impact on: 1) Your ability to engage in the case plan developed with your case manager and any intervention you participated in as part of this case plan, and 2) determining which factors are more like to ensure that you will be successful with the case plan by contributing to changes/improvements in mental health functioning and reduced involvement with the criminal justice system. To gather all of this information, we would like to review any records that you may have from Addiction and Mental Health Services (Horizon Health Network) and from the New Brunswick Departments of Justice and Public Safety. You also will be asked to fill out some self-report questionnaires with a researcher on one occasion that will take approximately 50 minutes. To compensate you for your time, you will be offered the chance to win one of ten $10 gift certificates to local restaurants (e.g., Tim Hortons, Wendy's, McDonald's). Your chances of winning are 1 in 20. Please note that this meeting will be confidential, therefore, information shared will not be relayed to anyone, including your case manager, or any other staff with Public Safety, Justice, or Addictions and Mental Health Services. However, confidentiality must be breached by law if you report that you are likely to hurt yourself or someone else, or that a child under the age of 16 if currently being harmed.

The review of these records would only be done by the principal investigator, Ainslie McDougall, her doctoral dissertation supervisor, Dr. Mary Ann Campbell, and other relevant members of the research team directly under Dr. Campbell's supervision. The information collected would only be used for the purposes of this research project. You do not need to answer any questions you are uncomfortable with on the self-report questionnaires. Because these questionnaires will ask questions about your mental health, personal experiences and feelings, you might find some of the questions upsetting. If that happens, please know that you are free to skip the question or stop filling out the questionnaire at any time with no penalty. No one person's information will be singled out when we publish these findings so that we can protect each person's confidentiality,

and we will only use the information to describe groups of people. We also won't share any personal information (e.g., address, place of work, mental health information, criminal history) with third parties who do not already have access to it. Once the study is completed, we will have no further access to these records and any records we have containing personal identifying information (e.g., your name, etc.) will be destroyed and only de-identified information will be retained for analysis. In this way, it will not be possible to identify who the information we retain for analysis belongs to and your information will be protected and remain private.

Please note that, no matter what you decide, your answer will in no way influence your current or future involvement any of the agencies involved in this research evaluation. You are free to decline to participate if you so choose or stop participating at any point in the process, without any penalty whatsoever and your information will not be included in the study. There are no foreseeable risks to you participating in this study. Once signed, this form will be stored in Dr. Campbell's office in a locked filing cabinet for a 5 year period after which it will be destroyed. Any concerns about the study can directed toward Ainslie McDougall (principal investigator), Dr. Mary Ann Campbell (Associate Professor at the University of New Brunswick, Director of the Centre for Criminal Justice Studies), or Dr. List Best (Chair of the University of New Brunswick – Saint John Research Ethics Board).

Ainslie McDougall	Ainslie.mcdougall@unb.ca
Dr. Mary Ann Campbell	mcampbel@unb.ca
Dr. Lisa Best	reb@unb.ca

I have read the information provided above and have had all of my questions about this research project answered to my satisfaction. I understand that by consenting to participate in the study described above, I am giving permission for Ainslie McDougall, Dr. Mary Ann Campbell, and her supervised research team to review my Addiction and Mental Health Services records and my New Brunswick Department of Justice and Public Safety records, as well as agree to fill out several self-report questionnaires about myself for the purposes of the research project. I understand that all of this information will be kept confidential and will only be used for the stated purposes of this research project.

Please indicate whether you consent or do not consent to participating in the study as described by circling one of the responses below:

I CONSENT OR I DO NOT CONSENT

(Please circle your choice)

Name (please print): ________________________________

Signature: __________________________ **Date**: _____________________

☐ **Please check here if you'd like to receive a summary of the results after the study has been completed (this information will be stored separately from any information we collect about you to protect your privacy).**

Please provide the best means for us to send you this summary if you would like one:

Mailing Address (this should be one that will be active for at least the next 12 months so we can reach you when the study is complete):

____
____
____

Email address (will not be distributed to any other party and will only be used for the sharing the general findings from the study): ___________________________

Please Note: Should you become distressed at any point as a result of this research (before, during, or after it has been completed), please use the following contact information to speak to a professional:

3. Chimo (Provincial Crisis Phone Line)
    a. All of New Brunswick: 1-800-667-5005
    b. Fredericton, New Brunswick: (506) 450-4357
4. Mobile Mental Health Crisis Service
    a. Saint John, New Brunswick: 1-888-811-3664
    b. Fredericton, New Brunswick: (506) 453-2132

APPENDIX P

Consent Form - Case Manager from Saint John Mental Health Court or Public Safety New Brunswick

CONSENT FORM – CASE MANAGERS FORM

Researchers at the Centre for Criminal Justice Studies at the University of New Brunswick in Saint John would like to conduct an evaluation of the services offered through the Public Safety Service of New Brunswick for individuals with and without mental health problems. This study is being conducted with the support of Public Safety and Addiction and Mental Health Services (Horizon Health Network). The purpose of this research is to understand what factors contribute to an individual doing well with his or her community supervision/intervention. To conduct this research, we would like to gather information from you about how a client who has been under your supervision for at least six months is doing while involved with the Public Safety Service of New Brunswick or Addiction and Mental Health Services, including what types of programming he or she is receiving, whether he/she is attending appointments, and how engaged he/she is in community supervision and case management plan as recommended by you as his/her case manager. We specifically want to better understand the individual factors (e.g., mental health functioning, age, gender, type of living arrangements) and case management factors (e.g., types of intervention programs and mental health treatment received) that impact on: 1). The client's ability to engage in programming and the case plan in general, 2) determining which factors are more like to maximize a client's response to their case plan to create changes/improvements in mental health functioning and reduce recidivism risk. To gather all of this information, we would like to review any records from Mental Health Services and records from the New Brunswick Departments of Justice and Public Safety for each client. The client also will be asked to fill out self-report questionnaires with a researcher on one occasion. You will be asked to fill out questionnaires on one occasion as well regarding the client's engagement with their case plan, your perceptions of the offender-case manager relationship with the client, and the degree of compliance that the client exhibits with the case plan. This will take approximately 40 minutes per client/supervisee or less and can be completed through an online forum with the confidential service of PsychData©. This process will be repeated for each client on your caseload that participates in this study. To compensate you for your time, you will be offered the chance to win one of four $25 gift certificates to local restaurants (e.g., Boston Pizza, Swiss Chalet).

The information collected will only be used for the purposes of this research project. No one person's information will be singled out when we publish these findings so that we can protect each person's confidentiality, and we will only use the information to describe groups of people. Once the study is completed, we will have no further access to these records. Personal identifying information (e.g., client name, your name, etc.) will be removed from collected information and only de-identified information will be retained for analysis. In this way, it will not be possible to identify to whom the information we gathered belongs and the confidentiality of the information will be protected.

Please note that you are free to decline to participate if you so choose, without any penalty whatsoever from Public Safety. Your information will not be included in the analyses. Once signed, this form will be stored in Dr. Campbell's office in a locked filing cabinet in the Centre for Criminal Justice Studies for a 5 year period, after which it will be destroyed. Any concerns about the study can directed toward Ainslie McDougall (principal investigator), Dr. Mary Ann Campbell (Supervisor, Associate Professor at the University of New Brunswick and Director of the Centre for Criminal Justice Studies), or Dr. List Best (Chair of the University of New Brunswick – Saint John Research Ethics Board).

Ainslie McDougall	Ainslie.mcdougall@unb.ca
Dr. Mary Ann Campbell	mcampbel@unb.ca
Dr. Lisa Best	reb@unb.ca

I have read the information provided above and have had all of my questions about this research project answered to my satisfaction.

Please indicate whether you consent or do not consent to participating in the study as described by circling one of the responses below:

I CONSENT OR I DO NOT CONSENT
(Please circle your choice)

Name (please print): ________________________________

Signature: _________________________ **Date**: _____________________

If you have consented to participate, then we will send you a link to the online system that contains the questionnaires we will ask you to complete about your supervisees and yourself. In order to do this, we require your professional contact information.

Contact Information
Phone Number: ______________
Which NB Department of Public Safety Office do you primarily work in:
_______________ ____________________________________
Email Address: ____

☐ **Please check here if you'd like to receive a summary of the results after the study has been completed.**

Please provide the best means for us to send you this summary if you would like one:
Mailing Address (this should be one that will be active for at least the next 12 months so we can reach you when the study is complete):

____
____
____

Email address (will not be distributed to any other party and will only be used for the sharing the general findings from the study):

____

CURRICULUM VITAE

Ainslie M. McDougall

UNIVERSITIES ATTENDED

2008-2014 Doctor of Philosophy, Clinical Psychology
University of New Brunswick (Fredericton, New Brunswick)
Supervisor: Mary Ann Campbell, Ph.D.
Doctoral Dissertation: *Understanding factors that impact treatment readiness and responsivity within case management plans of community-based offenders*

2008 Master of Science, Forensic Psychology: Distinction of Merit
University of Surrey (Guildford, United Kingdom)
Supervisor: Professor Jennifer Brown, Ph.D.
Master's Thesis: *The use of expert testimony to counter rape myth subscription*

2005 Bachelor of Arts (Honours. Psychology)
Saint Mary's University (Halifax, Nova Scotia)
Supervisor: Andrew Starzomski, Ph.D.
Undergraduate Thesis: *An investigation of mental health services: Forensic inpatients' and clinicians' perceptions of care*

PUBLICATIONS

McDougall, A., Dyck, H., Macaulay, A., Wershler, J., Canales, D.D., & Campbell, M.A. (2014). The responsivity principle of offender case management and the case of the long forgotten "R": Responsivity research at the Centre for Criminal Justice Studies. *Psynopsis, 36*(1), 18-19.

McDougall, A., Campbell, M.A., Smith, T., Burbridge, A., Doucette, N., & Canales, D. (2013). An analysis of general public and professionals' attitudes about mental health courts: Predictors of a positive perspective. *International Journal of Forensic Mental Health, 11*(3), 203-217. doi: 10.1080/14999013.2012.723666

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Porter, S., Bellhouse, S., **McDougall, A.**, ten Brinke, L., & Wilson, K. (2010). A prospective investigation of the vulnerability of memory for positive and negative emotional scenes to the misinformation effect. *Canadian Journal of Behavioural Science, 42*(1), 55-61. 10.1037/a0016652

Kutcher, S., & **McDougall, A.** (2009). Problems with access to adolescent mental health care can lead to dealings with the criminal justice system. *Paediatrics & Child Health, 14*(1), 15-18.

Kutcher, S., **McDougall, A.** & Murphy, A (2009). Preventing, detecting, and managing side effects of medication. In J. Rey & B. Birmaher (Eds.), *Treating adolescent depression*. Baltimore, MD: Lippincott Williams & Wilkins.

CONFERENCE PRESENTATIONS

Macaulay, W.A.C, **McDougall, A**., & Campbell, M.A. (2014, June). *Correlates of employment problems in community supervised offenders: The role of psychopathic traits and mental health symptoms.*Paper presented at the 75th annual convention of the Canadian Psychological Association. Vancouver, Canada.

McDougall, A., Campbell, M.A., & Macaulay, A. (2014, March). *The role of responsivity factors in predicting recidivism risk for offenders*. Paper presented at the conference of the American Psychology and Law Society, New Orleans, LA.

Canales, D., **McDougall, A.**, Wei, R., & Goggin, C. (2013, July). *A meta-analytic examination of criminogenic and clinical risk predictors for community-based violence among persons with mental illness*. Paper presented at the International Academy of Law and Mental Health Conference, Amsterdam, Netherlands.

McDougall, A., Campbell, M.A, & MacAulay, A. (2013, July). *The importance of the case manager/offender relationship in predicting compliance with mandated community-based interventions*. Paper presented at the International Academy of Law and Mental Health Conference, Amsterdam, Netherlands.

McDougall, A., Campbell, M.A., Doucette, N., & Earle, J. (2012, June). *The ins and outs of the Youth Psychopathic Traits Inventory for adolescents and adults*. Paper presented at the Annual Convention of the Canadian Psychological Association, Halifax, NS.

McDougall, A., Campbell, M.A., & Smith, T. (2011, June). *An analysis of general public and professionals' attitudes about mental health courts: Predictors of a positive perspective.* Paper presented at the North American Crime and Criminal Justice Psychology Conference, Toronto, ON.

McDougall, A., Campbell, M.A., & Santor, D. (2009, March). *Demographic, criminal history and mental health predictors of institutional offences in adolescent offenders*. Paper presented at the American Psychology and Law Society Conference, San Antonio, TX.

McDougall, A., & Brown, J. (2009, June). *The use of expert testimony to counter rape myth subscription*. Poster presented at the Annual Convention of the Canadian Psychological Association, Montreal, QC.

McDougall, A., Szumilas, M. & Kutcher, S (2008, June). *Effectiveness of school-based suicide prevention programs: A meta-analysis*. Poster presented at the Canadian Public Health Association Conference: Public Health in Canada: Reducing Health Inequalities through Evidence & Action, Halifax, NS.

McDougall, A., Starzomski, A., & Woodworth, M. (2006, June). *An investigation of mental health services: Patients' perceptions of care*. Poster presented at the Annual Convention of the Canadian Psychological Association, Calgary, AB.

Bellhouse, S., Porter, S., & **McDougall, A**. (2006, June). *Relative consistency of memories for negative, positive, and neutral scenes over time: A test of the paradoxical negative emotion hypothesis.* Paper presented at the Annual Convention of the Canadian Psychological Association, Calgary, AB.