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Understanding gendered criminal involvement with a community-based criminal sample: Assessing substance abuse and mental health needs

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UNDERSTANDING GENDERED CRIMINAL INVOLVEMENT WITH A COMMUNITY-BASED CRIMINAL SAMPLE: ASSESSING SUBSTANCE ABUSE AND MENTAL HEALTH NEEDS

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Abstract

This study explored the gendered effect of substance abuse and mental health issues on the pathways to criminal convictions with a criminal population in the community setting. The data was retrieved through a file review of a sample of 48 female and 42 male offenders who received crisis care during a one-year period, at a community corrections agency in a medium-sized urban community in Ontario. The data collected was based upon factors derived from the LSI-R (Andrews & Bonta, 1995) and the Women's Supplemental Risk/Needs Assessment (Van Voorhis, Wright, Salisbury & Bauman, 2010). Results of the present study revealed gender differences with respect to exit disposition, nature of the offense, psychotropic medications, diagnoses, mental health symptoms, substance use and risk factors. It is hoped that information gathered in this study can be utilized to highlight the complex issues offenders face during their reintegration into society; specifically, the multitude of mental health and substance dependence issues that exist in the lives of offenders.

KEYWORDS: Female offenders, male offenders, substance abuse, mental health, community corrections

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Introduction

The majority of research that has examined correctional treatment interventions has been conducted with male offenders, with less emphasis on effective treatment interventions for female offenders. Recent literature suggests that females and males have unique pathways to the criminal justice system (i.e., CJS) (Belknap, 2007; Bloom et al., 2003; Chesney-Lind & Sheldon, 2004; Covington, 2000; Daly 1992; Owen, 1998; Reisig et al., 2006; Richie 1996; Steffensmeier & Allan, 1996). However, treatment interventions in the CJS have not focused on the unique needs of women which can include their histories of victimization and abuse, relationship problems, mental illness, drug abuse, self-concept, poverty and parental issues (Van Voorhis, Wright, Salisbury & Bauman, 2010). Of direct importance to the proposed research, women are entering the criminal justice system with higher prevalence rates for mental health disorders relative to men (Leschied, 2011). The literature suggests that women's mental health is differentially affected related to greater risk for gender based violence, socioeconomic disadvantage, low income, income inequality and low social status. It is essential to contribute to the knowledge related to the gender-sensitive needs of female offenders in order for correctional programs, such as those in community corrections, to be effective for women.

Literature Review

Community Corrections in Canada

Community Corrections, also known as halfway houses, in Canada provides housing to offenders once they are on conditional release from a penal institution (Christian, 2006). Corrections attempts to provide residential custody for offenders near their home communities. Generally, probation officers refer offenders for community corrections and court liaison

conducts the formal intake of offenders (Calverley & Beattie, 2004). Community corrections are typically in a group home or multi-unit facility (Christina, 2006). These environments do not have noticeable perimeters or internal barriers; however, they do usually have locked windows, doors, basic alarm systems and monitored access. The offenders are provided with food and accommodation; their daily activities are also monitored throughout the day. Most offenders are permitted to leave the premises during the day on temporary absences; so that they can attend to responsibilities such as jobs and/or training program, then the offenders are expected to return to the center in the evening.

There are two types of halfway houses in Canada, there are Community Correctional Centers (i.e., CCCs) under Correctional Service of Canada, and then there are other Community Residential organizations which are operated by different non-governmental organizations (Gibbs, 2006). Each residence typically consists of 3-6 counselors under the supervision of a Director. One to two counselors are at the residence at a time, with one security staff person working at night. Programming for the offenders is usually conducted at night time; examples of programs include substance abuse, living skills, employment counselling and crisis counseling (Correctional Service Canada, 2013; Gibbs, 2006) Offenders are also required to attend one or two house meetings a week. It is also essential that offenders abide by the house rules in order to remain at the residence.

Some communities fear having community corrections established in their neighborhoods (John Howard Society of Alberta, 2001). Neighborhoods with a community corrections facility fear their area will experience higher rates of crime, fear about escapes and a decrease in property value. However, research has shown that community corrections do not contribute to higher levels of crime or a decrease in property values (John Howard Society of Alberta, 2001). Also, the recidivism rates among offenders are lower when they have the opportunity to be

gradually reintegrated into the community. Therefore, despite a neighborhoods reaction to community corrections, it is a valuable and effective method of reintegrated offenders into the community.

Community corrections are an alternative to incarceration in order to ease an offender's transition between institution and community (Correctional Service Canada, 2013). It is a place where offenders can develop personal responsibility and positive attitudes in order to re-enter the community on a full time basis (Christian, 2006). Offenders who are placed in community corrections are not seen as a threat to the public or themselves, they demonstrate responsible behavior, motivation and that they would potentially benefit from programs such as educational, or vocational training in the community. Offenders typically serve in community correction for short sentences or near the end of a longer sentence. During their stay, offenders are connected to other community agencies for counselling and other support services. It is essential that offenders' needs and risk factors are addressed in community corrections in order to successfully transition and reintegrate an individual into the community (Gibbs, 2006).

Offender classification

In Canada, each offender's level of risk and needs are assessed upon intake at an institution. Risk is defined by Austin and McGinnis (2004) as, "an inmate's potential for serious misconduct within the prison setting, escape attempts, recidivism and the level of threats the inmate possesses to public safety" (p.7). An offender's level of risk is based upon one's age, previous incarcerations, and dynamic factors which can be changed (e.g., mental health, substance abuse, attitude and orientation, family functioning, employment) (Andrews & Bonta, 2003).

The intake risk assessment begins once an offender is first admitted to an institution. The institution examines an offender's police reports, sentencing judge's comments, victim impact

statements, information on offender's criminal history and social and family background, mental health history, education, and substance abuse history (Blanchette, 1996). The risk assessment affects the institution's decisions about the individual offender; such as the offender's security placements, supervision requirements, discretionary release and program placements (Gobeil & Blanchette, 2007). The risk assessment also determines the offender's level of dangerousness to others and self during their imprisonment and it predicts the likelihood of an offender reoffending (Champion, 1994).

Correctional interventions with offenders are based upon three principles known as risk, need and responsivity (Andrews & Bonta, 2010). Risk identifies offenders as high risk, who receive greater supervision of a longer duration (Lowenkamp et al., 2006); or lower risk who receive minimal or no interventions (Dowden & Andrews, 2000). The need principle addresses static factors (i.e., noncriminogenic factors) or dynamic factors (i.e., criminogenic factors) pertaining to offenders. Static factors include one's self-esteem, neighborhood living conditions, personal/emotional problems which are not linked to recidivism. Dynamic factors include one's impulsive behaviour, substance abuse, self-control, antisocial cognitions and moral values (Andrews, Bonta & Hoge, 1990). The responsivity principle includes matching a treatment program to the learning style of an offender. Andrews et al. (1990) concluded that rehabilitation programs should include services capable of influencing specific target needs set with offenders while ensuring the appropriate program is matched to the offender's learning style. The literature on risk, needs and responsivity inform treatment programs at criminal institutions in Canada. An offender's level of risk determines the treatment services which they will receive in the institution (Blanchette & Taylor, 2007). High risk offenders are placed in long term incarceration at maximum security institutions (Correctional Service of Canada, 2012a). High risk offenders are at risk of attempting to escape, they present a greater threat to public safety, and they require

a high degree of supervision. High risk offenders receive programs, employment and educational activities, motives to change one's behaviour in order to live as contributing, responsible members to society once they are released from incarceration. The Canadian criminal justice system's policy for offenders serving a life sentence for first or second degree murder are required to spend at least the first two years in a maximum security institution .

Risk Assessment

The criminal justice system utilizes the Level of Service Inventory-Revised (i.e., LSI-R; Andrews & Bonta, 1995) as a tool to assess offender risk and plan for appropriate levels of supervision and treatment. The LSI-R is an empirically validated measurement tool that examines factors characterized as gender-neutral, meaning that the assessment does not take into account any gender-specific factors.

Whether or not a gender-neutral risk assessment is appropriate for women has been the subject of a good deal of research over the last decade. Van Voorhis (2010) argues that the assessment does not reflect the unique needs of women because it does not include scales pertaining to relationships, depression, parental issues, self-esteem, self-efficacy, trauma, and victimization, and cautions that the criminal justice system needs more than a gender-neutral assessment tool to use as a guide to making risk assessment decisions for women offenders, which affects their access to treatment programs.

Several studies have found the LSI-R as a valid risk assessment for women (Andrews, Dowden, & Rettinger, 2001; Holsinger, Lowenkamp & Latessa, 2003; Smith, Cullen & Latessa, 2009); while other studies have produced contrary evidence (Salisbury, Van Voorhis & Spiropoulis, 2009; Olson, Alderden & Lurigio, 2003). Van Voorhis and colleagues have developed an alternative gender-responsive assessment tool for female offenders. This new measurement may provide a more accurate classification of female offender risk and targets their

gender specific mental health needs, and research is needed to determine if the criminal justice system needs to adopt a new gender-responsive measure for female offenders. Risk/needs assessments are critical for community corrections because they match the levels of supervision required to the offender's risk, it also allows for probation officers and offenders to become aware of the needs and/or interventions needed for successful reintegration into the community (Calverley & Beattie, 2004).

Reisig, Holtfreter and Morash (2006) conducted a study on assessing recidivism risk across female pathways to crime. The purpose of the study was to determine how well the LSI-R predicted recidivism rates for women who follow different pathways into criminality. Reisig and colleagues found varying results in the LSI-R measure's ability to predict women offender recidivism rates. The researchers found that the LSI-R predicted the recidivism rates for women whose offenses were economically motivated; that is, women who were engaging in criminal activity to acquire cash and material goods. The researchers also found evidence of the misclassification of drug-connected and harmed women in relation to their level of risk. Further, the relationship between risk-need and recidivism in this sample was deemed not statistically significant. This result questions the generalizability of the LSI-R to successfully classify women offenders.

This study had several limitations on how well the research was conducted. First, there was the issue of the threat of history. The observation period varied over an eighteen month period; therefore, there are specific events between the first interview and the follow up interview that could have impacted the women's lives. Second, instrumentation existed because financial constraints prevented the completion of all three interviews for every participant. This lack of interview consistency could have produced changes in the results. Third, the researchers had a selection bias because they chose individuals as participants based on a monetary award.

The researchers could have randomly selected their participants. Finally, experimental mortality was evident because the attrition rate between the initial and follow up interviews was only forty two percent. The loss of subjects affects the outcome of the results. The results of this study indicate that more research needs to be completed on predicting the recidivism rates of women offenders.

Blanchette and Taylor (2007) conducted a study on the development and field test of a gender informed security reclassification scale for female offenders. The results of the study suggest that the Security Reclassification Scale for Women (i.e., SRSW) is a reliable and valid tool for the security classification of federally sentenced women in Canada. Blanchette and Taylor (2007) included factors that are more pertinent to female offenders', as later indicated by Van Voorhis and colleagues. These factors included parenting, child custody issues, family factors, and self-injury and psychiatric problems. The SRSW also included risk and dynamic factors of the female offenders' program progress, motivation, drug-alcohol use, institutional behavior, social support and marital adjustment etc. The SRSW placed fewer cases of female offenders at the maximum security level and more cases of female offenders at the minimum security level. Also, at the three month follow up period, the SRSW was significantly more predictive of minor institutional misconducts of female offenders in comparison to the LSI-R. The SRSW also strongly predicted the misconducts for Aboriginal cases when the results for Aboriginal and non-Aboriginal cases were separated. The researchers concluded that the findings suggest that the SRSW was a useful tool for the prediction of institutional misconducts of female offenders.

This study had limitations in its research methodology although the SRSW indicates promising results. The second phase of the study had the issue of experimental mortality. Many women at the high risk level were reviewed more than once during the study period; as a result,

the sample of five hundred and eighty women went down to three hundred and twenty three cases. The study could have increased their statistical power had they had the original number of five hundred and eighty participants. The researchers also had the issue of selection because there was an overrepresentation by security reviews for cases at the maximum security level. The participants could have been randomly assigned in order to decrease the number of maximum security level participants. The researchers also suppressed evidence in their results. They removed one item on the scale that showed a weak association with the remainder of the scale variables; this resulted in a slight increase in the overall internal consistency of the study. The scale could also be an unreliable measure because the methodology used did not allow for an examination of interrater reliability of the scale. Further research on the SRSW would need to be established in order to validate and refine the tool.

Wright, Salisbury and Van Voorhis (2007) conducted a study on predicting the prison misconducts of women offenders and the importance of gender responsive needs. The researchers utilized the Missouri Women's Risk Assessment tool pertaining to gender specific questions of woman's criminal history, family lives, relationships, parenting issues, substance use or abuse, economic issues, mental health issues etc., along with the gender neutral items used in the LSI-R and Northpointe COMPAS scales. The researchers found that the inclusion of gender responsive needs along with traditional classification items is predictive of women offenders' misconducts. Further, items such as childhood abuse, unsupportive relationships, experiencing anxiety or depression and psychosis were highly related to the likelihood that a woman might incur misconducts within a six to twelve month period. A woman who also had a poor support network outside of prison had difficulty adapting to the prison environment. This study highlights the importance of a gender responsive measure for women's prisons.

Although the study demonstrates promise for a gender responsive measure, the study still has limitations. There is the issue of overgeneralization. The Missouri Women's Risk Assessment at intake was created by the Missouri Women's Issues Committee; therefore, the scales have yet to be confirmed in other samples around the world. History could also exist across this sample because the measures were conducted at a six and twelve month period. Specific events in the women's lives could have affected their scores between the first and second measurement. The researchers also chose not to focus on potential child custody stressors in their measure of parental stress, which results in the premature closure of inquiry. Potential child custody stressors could be a strong predictor of institutional misconducts for women offenders. Overall, the factors of needs, gender-neutral and gender-responsive were predictive of a woman's adjustment to prison.

Coulson, Ilacqua, Nutbrown, Glulekas and Cudjoe (1995) examined the predictive utility of the LSI-R for incarcerated female offenders. These researchers found the LSI-R as an effective method to estimate a woman's risk of recidivism. The two year recidivism data was consistent in comparison to the first year recidivism data; in that, there was a higher probability of recidivism in the high risk group than in the low risk group. Overall, as a woman's LSI-R's level increased, she had a greater probability of failing on parole.

There were several limitations that were evident in this study. The researchers changed the instrumentation of this study; they assumed that the LSI-R scores resulting from the computer assisted administration would be similar to those obtained by the original LSI-R guidelines of paper and pencil. The researchers also engaged in the suppression of evidence because they omitted the question related to an individual's suitability for community supervision. Finally, questionable cause seems relevant to this study. I believe it is possible that a third variable could be mediating the effect between the LSI-R scores and the recidivism rates.

Other research demonstrates that a woman's level of risk could be better predicted if gender responsive needs are taken into consideration.

Brennan, Dieterich and Ehret (2009) examined the validity of a risk/need assessment system known as the Correctional Offender Management Profiling for Alternative Sanctions (i.e., COMPAS), among an offender population. The researchers examined the validity of the assessment tool by constructing multiple record survival data sets utilizing assessment and event dates in the criminal history data. The sample of offenders consisted of 19% women. The results of the study indicate that the COMPAS significantly predicted the recidivism rates in both men and women offenders.

Limitations did exist in the study conducted by Brennan and colleagues. For example, the study did not address variations in the recidivism rates by offender subgroups by age, ethnicity, race, and level of addiction and the length of follow-up. Further, the set of base scales included criminal involvement, history of noncompliance, history of violence, current violence, criminal associates, substance abuse, financial problems, vocational or education problems, family criminality, social environment, leisure, residential instability, social isolation, criminal attitudes, and criminal personality; as a result, the COMPAS does not include gender responsive factors of women such as self-esteem, self-efficacy, victimization, child abuse, parental stress, relationship dysfunction and mental health history. It is essential that gender responsive factors for women offenders are considered in their risk assessments.

Van Voorhis, Wright, Salisbury and Bauman (2010) conducted a study on women's risk factors and their contributions to an existing risk/needs assessment. Van Voorhis and colleagues examined the validity of an assessment tool that was recommended to supplement widely used gender-neutral tools such as the LSI-R and COMPAS. The gender neutral variables significantly predicted a woman's offense-related outcome. However, the researchers concluded that the

addition of the gender responsive factors appeared to have created a more statistically significant prediction of offense related outcomes for women. The results of this study have strong implications towards custody, supervision or treatment programs for female offenders.

The results of this study are promising for the future of corrections; however, no study is perfect; as such, there are limitations to be found within the study. There is the issue of overgeneralization; researchers still need to confirm whether the results of this study can be generalized to a larger population. Research on larger samples is also needed in order to validate the ideal scale weights and cutoff scores. There is also the possibility of the reactive effect of experimental arrangements. It remains unclear where agencies can plan and implement changes accordingly if these scales are to be used to increase custody levels or community supervision levels. This gender-responsive measure could provide Canada's female offenders with improved mental health programming, promote more positive adjustment while incarcerated, increase their success in correctional treatment and reduce the potential for recidivism (Leschied, 2011).

Mental health prevalence rates in Canada's Criminal Justice System

Canada's criminal justice system is housing a significant population of offenders who have mental health issues. The Correctional Service of Canada (2009) reported that approximately 13% of male offenders and 29% of female offenders self-identified at intake with mental health problems. Also, most often offenders present with more than one psychological disorder; typically offenders present with substance abuse issues along with a broad range of service needs (Lurigio, Rollins & Fallon, 2004). Due to the high rates of mental health issues at Canadian institutions, mental health awareness training for institutional staff began in 2007 (Laishes, 2002).

Currently, female offenders outnumber male offenders in all major psychiatric disorders, except for anti-social personality disorder (Laishes, 2002). James and Glaze (2006) found that

female offenders present with higher rates of mental health issues than male offenders. According to the literature, women are at a much higher risk of being the victim of physical or sexual abuse, both within their families as well as through contact with strangers (Leschied, 2011). Women also experience marginalization, in that, they are still at a lower socio economic status and they have the responsibility of child-rearing regardless of whether they live in supportive contexts (Leschied, 2011). All of the aforementioned factors contribute to women experiencing higher rates of mental health disorders compared to men. Federally incarcerated women are three times more likely to suffer from depression when compared to their male counterparts. Male offenders are also more likely to engage in physically and sexually threatening and assaultive behaviour; while women offenders engage in more self-abusive and self-mutilating behaviours (Laishes, 2002). Further, female offenders are more likely to be imprisoned for drug and property offenses while male offenders are more likely to be imprisoned for more violent offenses (Sabol et al., 2007). In Canada, the criminal justice system's policy on mental health is to focus on strengthening intervention from an offender's admission to the end of their sentence, while ensuring public safety and successful transition into the community (Laishes, 2002).

Male offender mental health profile

The prevalence rate of mental health issues among male offenders remains problematic in Canada's criminal justice system. In 2010-11, a total of 20, 233 male offenders moved in and out of the federal correctional system (total number of admissions and releases), and out of those offenders, mental health treatment was accessed by over 45% of the total male offender population (Sapers, Correctional Investigator of Canada, 2012). Further, most offenders diagnosed with a mental health disorder had more than one co-occurring disorder. The most common mental health issue identified was substance abuse, and it is estimated that substance

abuse affects approximately 4 out of 5 offenders in federal custody. In addition to substance use, self-harm has been identified as becoming more prevalent among male offenders in correctional institutions in Canada; of importance here, at least 40% of the male offenders who engaged in self-harming behaviours did so for the first time at a criminal institution, specifically in maximum security institutions (Sapers, 2012). Male offenders who engaged in self-harming behaviours were also more likely to have a history of childhood sexual, emotional and physical abuse (Sapers, 2012). Of direct relevance here, offenders who identified as engaging in self-harming behaviours were more likely to exhibit depression, substance abuse, posttraumatic stress disorder, antisocial personality disorder and borderline personality disorder (CSC, 2011).

Women offender mental health profile

It is essential to evaluate the profile of female offenders at Canadian institutions because they entered the criminal justice system with high prevalence rates of mental health disorders. According to the Correctional Service Canada (2010) approximately 41.1% of female offenders are in minimum security, 50.3% of women are placed at medium security and 8.6% of women are placed at maximum security; it must be noted that Aboriginal women represented 31% of the total number of women incarcerated in Canada, a significant over-representation where Aboriginal people comprise only about 4% of the total population in Canada. Allenby et al., (2010) found that 59.4% of female offenders identified as having a current or previous addiction to drugs and 35.7% of women identified an addiction to alcohol. These researchers also found that 51.6% of female offenders commit their offenses while under the influence of substances which resulted in incarceration. Of the female offenders in these statistics, 69.9% have had access to substance abuse programs, 28.4% had access to dialectical behaviour therapy and 23.3% of women had access to survivors of abuse and trauma therapy. Further, Allenby and colleagues found that 55.4% of these female offenders saw a psychologist at an institutional

facility and 32.2% of women used psychiatric services; while 27.5% of these women did not seek psychological services because they reported difficulty getting an appointment. The evidence for female offender mental health services at Canadian institutions is insurmountable; as a result, Laishes (2002) stated that women offenders must have gender appropriate mental health services in relation to their experiences and related mental health needs.

The connection between risk classification and mental health is important here: The type of mental health program female offenders are offered is based upon their adjustment while incarcerated, the benefits from programs, their probability for success and an offender's potential for recidivism (Leschied, 2011). All of these factors are currently evaluated into an offender's level of risk. As a result, female offenders are receiving mental health programming based on their classification according to the LSI-R, a gender-neutral assessment tool. . The wrongful classification of women offenders is occurring because women are classified according to risk instead of solely on their needs (Wright, Salisbury & Van Voorhis, 2007). Further, some female offenders are not being considered as high risk when indeed the LSI-R is not capturing the true extent of their needs (Leschied, 2011). As a result, the LSI-R may not be sufficient to assess the mental health needs of female offenders.

Men's Pathways into substance abuse and criminal behaviour

Substance use is common among male offenders (Plourde, Brochu, Gendron & Brunelle, 2012). Brochu et al., (2001) revealed that 95.1% of male offenders had consumed alcohol and 80.5% had experimented with at least one drug; the three most common substances, which were used on a daily or weekly basis, were alcohol, cannabis and cocaine. Plourde et al., (2012) found that 86.3% of their male offender participants consumed alcohol at least 3 months prior to incarceration. Further, the male participants engaged in drug use, the majority of men used cannabis, in the 3 months prior to incarceration (Plourde et al., 2012). The other types of

substances reported were cocaine, benzodiazepines, hallucinogens and heroin (Plourde et al., 2012). Researchers also suggest that male offenders use illicit substances at a higher rate than the general population (Brochu & Plourde, 2012; Kairouz et al., 2008). For example, Patton and Adlaf (2005) found that 45.1% of the general population in a Canadian Addiction Survey used illicit substances at least once in their lifetime; while, Brochu et al., (2001) found that 80.5% of federal offenders in Canada used at least one drug on a daily or weekly basis. According to Weekes, Moser, Terns and Kunic (2009) substance abuse is linked to criminal risk and involvement; as a result, the proportion of male offenders in Canadian criminal institutions will remain high until a wider range of treatment options that address the male offenders' substance abuse needs are met (Plourde, 2012; Weekes et al., 2009)).

Women's Pathways into substance abuse and criminal behaviour

Women offenders are entering the criminal justice system with high rates of substance dependence disorders (Allenby et al., 2010). Fortin (2004) concluded that the impact of physical and sexual abuse, family disruption, mental health, and relationship difficulties greatly affect the well-being of female offenders ; they have also experienced trauma in their lives, typically at the hands of their partners or unhealthy relationships while a woman's relationship to a man was also at the center of their drug onset (Smith, 2011), and research has shown that female offenders are turning to substance abuse as a means to cope with the aftermath of trauma (Fortin, 2004).

Smith (2011) found that the dominant pathway for women entering the criminal justice system was a pathway that included drug use as occurring prior to first arrest, without the presence of childhood abuse. The second most traveled pathway for women entering the criminal justice system resulted from childhood abuse; the women's victimization triggered their drug use which then led to women entering the criminal justice system (Smith, 2011). Other researchers have also found that childhood victimization, along with a woman's involvement in foster care,

prior prescription of mental health medication, race, high school graduation, and age all predicted the likelihood of the number of lifetime convictions for female offenders (Bloom et al., 2003; Bloom et al., 2004).

Specific to female offender substance abuse, there are higher proportions of women using stimulants rather than opiates (Wright, 2002). Crack was identified as the most common type of drug used by female offenders followed by heroin then methamphetamine. Marijuana was identified as the first drug tried among female offenders according to research by Smith (2011), who reported that approximately 40% of women in that study also experienced family members' regular drug use during childhood. Smith also found that 48.2% had been neglected, sexually and/or physically abused during their childhood, and 21.7% of the women were first introduced to drugs by family members, with 19% of the women identifying specifically that their boyfriend, male lover or husband had introduced them to drugs. Looking retrospectively at women's histories with respect to criminal behaviour, drug use and mental health can be challenging; files may contain information about mental health symptoms, but a formal diagnosis may not be recorded. In an attempt to identify women who struggle with mental illness, researchers often will report information that is in women's files, and notations of drugs prescribed are often recorded, even in the absence of formal diagnoses.

Treatment Interventions

Correctional institutions deem a treatment program as successful if the program is able to reduce recidivism rates (Ross & Guarnieri, 1996). Recidivism rates are based upon whether an individual participates in further offending that result in a conviction or imprisonment. The aim of treatment programs in the correctional justice system is to alter the behaviour of offenders in order for offending rates to decline (Ross & Guarnieri, 1996). However, there are numerous factors, other than the alteration of offending behaviour, which can impact recidivism rates. For

example, some studies on treatment programs have varying lengths of follow-up periods which can alter the number of offenders who recidivate. There are also a wide range of variables that can influence an individual to continue to participate in criminal activities: socio-demographic factors (e.g., education level, race, age, employment status); personal characteristics (e.g., intelligence, personality type); prior criminal history (e.g., age at first offence, number of prior arrests/convictions, type of prior offences); past correctional and sentencing history (e.g., prior imprisonments breaches of orders) (Ross & Guarnieri, 1996; Sapouna, Bisset & Conlong, 2011). As a result, there are multiple factors that contribute to an individual reoffending; thus, treatment programs that address a multitude of issues are more likely to reduce reoffending rates (Ministry of Justice, 2010; Sapouna, Bisset & Conlong, 2011).

Treatment Interventions for Male Offenders

Babcock, Green and Robie (2004) conducted a meta-analytic study examining the efficacy of treatment for domestically violent males. These researchers concluded that domestic violence treatment had minimal impact at reducing the recidivism rates of male offenders. The treatment modalities utilized in the studies included feminist psychoeducational men's groups, cognitive-behavioural men's groups, anger management and couples' therapy. The researchers recognized limitations in their study; in that, the studies were confounded by treatment quality, high attrition rates, inconsistencies in reporting recidivism for dropouts and low reporting rates at follow-up (Babcock et al., 2004; Gondolf, 2001). Babcock et al., (2004) concluded that their meta-analysis contributes to further improving treatment efficacy of domestic violence treatment.

Henning and Frueh (1996) evaluated the recidivism rates of male offenders released from a medium-security prison who voluntarily participated in a cognitive-behavioural treatment program while incarcerated. The participants were referred to the Cognitive Self-Change program which was a group designed for incarcerated male offenders with a history of

interpersonal aggression. The researchers discovered a significant difference in recidivism rates between the treatment and comparison groups. The recidivism rate for the treatment group was 50%; whereas, the recidivism rate for the comparison group was 70.8%. Several limitations did exist in the study; however, the results indicated that the treatment versus no treatment facilitates lower recidivism rates.

Corabian, Dennett and Harstall (2011) conducted a structured overview of studies since January 1998 to evaluate the effectiveness of psychotherapy and pharmacotherapy aimed at reducing recidivism rates among adult male sex offenders. Seven out of the eight systematic reviews suggested that cognitive behavioural therapy that includes the risk/need/responsivity model is the most promising approach to reduce recidivism.

Treatment Interventions for Female Offenders

Zlotnick, Najavits, Rohsenow and Johnson (2003) evaluated the initial efficacy of a cognitive behavioural treatment, *Seeking Safety*, as an adjunct to treatment-as-usual with incarcerated women with a current substance abuse disorder (i.e., SUD) and comorbid post-traumatic stress disorder (i.e., PTSD). Forty-six percent of the participants no longer fit the criteria for PTSD at the three month follow up period. The recidivism rate was also thirty-three percent at the three month follow up period. This study illustrates the positive impact that a treatment intervention can have in the lives of women offenders.

Nee and Farman (2005) evaluated the delivery of a dialectical behavioural treatment (i.e., DBT) in a prison setting for women offenders. The results indicated a positive change on measures of impulsivity, locus of control and emotion regulation. There were also statistically significant changes on self-esteem, impulsivity and dissociation over the short intervention period. This DBT program provides promise for women offenders suffering from borderline personality disorder. This study exhibited limitations although the results appear promising.

Najavits, Rosier, Nolan and Freeman (2007) evaluated a women's manual-based substance abuse recovery model in a pilot study. The study indicated a significant improvement in the participants drug use, impulsive addictive behaviour and their knowledge of the treatment concepts. Najavits and colleagues conducted a study which demonstrates the potential utility of a substance abuse treatment program for women offenders. But, at this point it is difficult to generalize the results of the study to other populations because the sample size was small. The participants did indicate that they wanted more of a focus on parenting skills and a longer treatment plan. Najavits and colleagues would need to conduct further research on larger samples in order to determine the effectiveness of this recovery model.

Messina, Grella, Cartier and Torres (2010) compared post release outcomes for women in a prison based substance abuse treatment program. The researchers concluded that the gender responsive treatment participants had a greater reduction in drug use, they were more likely to remain in residential treatment longer and they were less likely to have been re-incarcerated within twelve months after parole. The findings of this study provide promising results towards the needs of treatment programs for women offenders.

Matheson, Doherty and Grant (2008) compared return to custody rates among women who participated in an intensive women's substance abuse program versus women from a previous treatment program. The lowest rates of return to custody were among the intensive women's substance abuse program. The results indicated that the participants who did not receive aftercare had a greater risk of recidivism; but, those participants also had higher rates of comorbid mental health issues which also affect an individual's transition into a community. This study demonstrates the potential need for an intensive substance abuse program for women offenders.

Shearer (2003) conducted a study in order to construct and empirically test a needs assessment instrument, the Female Offender Critical Intervention (i.e., FOCI) Inventory. The FOCI was administered to four groups of female offenders in the United States. The FOCI is based upon the research of Sanders, McNeil, Rienzi and DeLouth (1997) that identified the program needs of substance abusing women offenders. Program needs, identified by Sanders and colleagues, included self-esteem, fetal alcohol syndrome, triggers of addiction, domestic violence, childhood sexual and recovery skills, values, emotional abuse of self and others, physical abuse of others, posttraumatic stress syndrome, codependency relationship issues, and parenting skills class. The results indicate that the FOCI appeared to be a reliable and valid instrument that can be utilized to assess the critical needs of women offenders. The study concluded that women offender needs can be classified into three areas; these areas include substance abuse/lifestyle risk, personal abuse and personal attributes. The results of the study also indicated that substance abuse treatment programs, with gender specific needs, can reduce relapse and recidivism rates among women offenders.

Research Questions

Based on the literature reviewed and the critical issues identified, the current study proposed to compare the gendered effect of substance abuse and mental health issues on the pathways to criminal convictions with a criminal population in the community setting. The present study utilized factors derived from the formal LSI-R (Andrews & Bonta, 1995) and the gender responsive supplement (Van Voorhis, 2010).

The purpose of the present paper was to examine: (a) how is female offenders' involvement in the criminal justice system different than male offenders? (b) How does offenders' substance abuse and mental health needs contribute to their offending behaviours? (c)

Is there an association between offenders with substance abuse and mental health needs and the type of offence?

Methods

Participants

This study was an exploratory field study consisting of 90 case files of adult offenders (F=47; M=43) enrolled in the crisis care program in St. Leonard's Community Services in London, Ontario. St. Leonard's provides residential and non-residential programs for chronic substance abusers, long term offenders and developmentally challenged offenders (Christian, 2006). Each participant had to be eighteen years of age and/or involved in the criminal justice system in the past two years, between the years of 2011 and 2012.

Analysis

Case files utilized for this study were maintained by St. Leonard's Community Service for this data collection. The data was be collected by two mater's students under the supervision of two principal investigators. The data collected was based upon factors derived from the LSI-R and the Women's Supplemental Risk/Needs Assessment. The researchers developed a list of variables based upon the nature of offense, baseline/current legal status, source of referral, presenting issues addressed, diagnoses, education levels, living arrangements, employment status, psychiatric symptoms, past/current treatment, past/current use of substances, risk factors, client presentation on admission and goals (Appendix A). The researchers created psychiatric symptom clusters based on the DSM-IV manual (American Psychiatric Association, 2000), see Appendix B. We also created treatment clusters based on how the medication is utilized to treat a particular condition, see Appendix C. Every tenth case file was reviewed together to ensure internal consistency. The identifiable information of the subjects was secured at St. Leonard's

community services. Each case file name was assigned a numerical number in order to protect the identity of the participants outside of the agency. We conducted chi-square analyses in order to explore the relationship between two categorical variables.

Derived Measures

The Level of Service Inventory-Revised. The LSI-R is a quantitative, gender-neutral, 54-item risk/needs assessment tool utilized to make decisions about an offender's level of supervision and treatment. These factors include one's criminal history (10); education/employment (10); financial (2); family/marital (4); accommodation (3); leisure/recreation (9); companions (5); alcohol/drug problems (9); emotional/personal (5) and attitudes/orientation (4).

The Women's Supplemental Risk/Needs Assessment. Van Voorhis and colleagues have developed an alternative gender-responsive assessment tool specific to the needs of women offenders. This new measurement tool has been made to supplement the LSI-R; it includes two supplemental categories. Supplement (1) includes factors such as self-esteem, self-efficacy, victimization, child abuse, parental stress and relationship dysfunction. Supplement (2) includes factors such as current symptoms of depression and psychosis, mental health history, family of origin of support, family of origin conflict, relationship support, housing safety, anger/hostility and educational strengths. This new measurement provides a more accurate classification of women offender risk and targets their gender specific mental health needs.

Results

Description of the participants

Ages of the female offenders ranged from a minimum of 19 years to a maximum of 51 years old (*SD* = 9.7). The average age of female residents was 30 years old. The number of days female offenders remained in community corrections varied; the minimum number of days in

care was 1 and the maximum number of days in care was 98 (*SD* = 19.127). The average number of days in care was 17.98. Table 1 provides the descriptive data collected with regard to age and days in care for the female offenders.

The ages of the male offenders also varied from a minimum of 18 years to a maximum of 66 years old, with a mean age of 31 years old (*SD* = 11.8). The most common age of male residents was 19 years old. Male offenders remained in care across a minimum of 0 days to a maximum of 40 days (*SD* = 11.825). The average amount of days in care for male offenders was 21.29 days. Table 1 demonstrates the descriptive data collected with regard to age and days in care for the male offenders.

Source of referral

The offenders came to St. Leonard's from a variety of referral sources (Table 2). Most of the offenders were referred to St. Leonard's from a correctional facility; 16.7% of the male offenders and 20.8% of the female offenders were referred from a correctional facility. Approximately two-fifths of the male offenders were referred from a Canadian Mental Health Agency (i.e., CMHA); 19.0% were referred from CHMA case management and 16.7% were referred from another CMHA agency. Also, a large proportion of female offenders (18.8%) were referred to community corrections by themselves, family and/or friends.

Exit disposition

Table 2 illustrates the offenders' exit disposition. A successful exit disposition is where offenders complete the program. Half of the male offender residents (50%) successfully completed their stay at St. Leonard's. The number of female offenders who successful completed the program was less (33.3%). A withdrawal from St. Leonard's meant that the offender left the residence on an outing, and failed to return. There were more female offenders (37.5%) who withdrew from St. Leonard's than male offenders (14.3%). Approximately the same proportion

Table 1

Age and Days in Care

	Male		Female	
Characteristics	*M*	*SD*	*M*	*SD*
Age	31.2	10.2	30.26	9.7
Days in Care	21.3	11.8	17.98	19.1

Table 2

Demographic Description

	Male		Female	
Characteristic	*n*	%	*n*	%
Gender	42	47	48	53
Language				
English	42	100	46	95.8
Unknown	0	0	2	4.3
Aboriginal Status				
Aboriginal	14	33.3	8	16.7
Non-aboriginal	27	64.3	27	56.3
Unknown	1	2.4	5	10.4
Community Treatment Order				
Yes	0	0	1	2.1
No	40	95.2	46	95.8
Unknown	2	4.8	1	2.1
Exit Disposition				
Successful	21	50.0	16	33.3
Withdrawal	6	14.3	18	37.5
Early termination due to Rules	12	28.6	13	27.1
Early termination due to Charges	2	4.8	0	0
Relocation	0	0	1	2.1
Source of referral				
None selected	1	2.4	1	2.1
Referral general hospital	0	0	2	4.2
Referral psychiatric Hospital	0	0	0	0
Referral from other Institution	1	2.4	5	10.4
Referral from CMHA case Management	8	19	4	8.3
Referral from family Physician	0	0	0	0
Referral from psychiatrist	0	0	0	0
Referral from MHW	0	0	0	0
Referral from CJS police	0	0	0	0
Referral from CJS courts	3	7.1	3	6.3
Referral from CJS Correctional facilities	7	16.7	10	20.8

CJS probation	4	9.5	4	8.3
CJS parole	0	0	0	0
CJS crisis bed	2	4.8	0	0
CJS other	0	0	2	4.2
Self, family, friend	1	2.4	9	18.8
Other	0	0	1	2.1
CMHA other	7	16.7	6	12.5
SLCS	2	4.8	1	2.1
Lawyer	4	9.5	1	2.1
Highest level of education				
None selected	1	2.4	1	2.1
Some elementary/Jr. High	5	11.9	3	6.3
Some secondary/high School	30	71.4	28	58.3
Some college/university	6	14.3	11	22.9
Unknown/Declined	0	0	2	4.2
Secondary/ high school	0	0	3	6.3
Current educational status				
None selected	1	2.4	1	2.1
Unknown/decline	11	26.2	11	22.9
Not in school	29	69.0	31	64.6
Trade school	0	0	1	2.1
Vocational/ training centre	0	0	1	2.1
Adult education	1	2.4	1	2.1
Community college	0	0	1	2.1
Other	0	0	1	2.1
Baseline Living arrangement				
None selected	5	11.9	1	2.1
Self	15	35.7	20	41.7
Children	0	0	1	2.1
Parents	0	0	2	4.2
Non-relatives	15	35.7	22	45.8
Unknown or declined	2	4.8	2	4.2
Spouse/partner	3	7.1	0	0
Spouse/partner/other	1	2.4	0	0
Relatives	1	2.4	0	0
Current Living Arrangement				
None selected	5	11.9	0	0
Self	12	28.6	14	29.2
Spouse/partner	1	2.4	0	0

Spouse/partner/other	1	2.4	1	2.1
Children	0	0	1	2.1
Relatives	1	2.4	1	2.1
Non-relatives	7	16.7	5	10.4
Unknown or declined	13	31.0	26	54.2
Baseline Residence Type				
Correction/probation Facility	22	52.4	34	70.8
General hospital	0	0	1	2.1
Psychiatric hospital	0	0	1	2.1
No fixed address	2	4.8	3	6.3
Hostel/shelter	6	14.3	5	10.4
Private house/apt-owned/market rent	12	28.6	3	6.3
Unknown or decline	0	0	1	2.1
Current Residence Type				
None selected	3	7.1	0	0
Correction/probation Facility	7	16.7	2	4.2
No fixed address	0	0	2	4.2
Hostel/shelter	2	4.8	5	10.4
Private house/apt-owned/market rent	16	38.1	11	22.9
Private house/apt -subsidized	0	0	1	2.1
Supportive housing – Congregate	2	4.8	0	0
Supportive housing assisted - living	1	2.4	0	0
Unknown or declined	10	23.8	27	56.3
Baseline Employment Status				
Unknown or declined	1	2.4	1	2.1
Non-paid work experience	0	0	2	4.2
Independent/Competitive	1	2.4	0	0
No employment	24	57.1	21	43.8
Casual/sporadic	5	11.9	0	0
No employment of any Kind	11	26.2	16	33.3
No employment – other Activity	0	0	8	16.7
Current employment status				
None selected	1	2.4	0	0

Unknown or declined	10	23.8	18	37.5
Non-paid work experience	0	0	1	2.1
Independent/competitive	1	2.4	0	0
Casual/sporadic	2	4.8	0	0
No employment	21	50.0	11	22.9
No employment of any Kind	6	14.3	13	27.1
No employment – other Activity	1	2.4	5	10.4
Baseline Primary Income Source				
None selected	1	2.4	1	2.1
Employment Insurance	0	0	1	2.1
Employment	1	2.4	0	0
Pension	1	2.4	0	0
ODSP	15	35.7	17	35.4
Social assistance	14	33.3	19	39.6
No source of income	9	21.4	6	12.5
Other	0	0	3	6.3
Unknown or declined	1	2.4	1	2.1
Current Primary Income Source				
None selected	3	7.1	0	0
Employment insurance	0	0	1	2.1
Employment	1	2.4	0	0
Pension	1	2.4	0	0
ODSP	11	26.2	15	31.3
Social assistance	7	16.7	16	33.3
No source of income	4	9.5	0	0
Other	0	0	3	6.3
Unknown or declined	14	33.3	13	27.1

of male offenders (28.6%) and female offenders (27.1%) terminated their stay at the residence due to violation of house rules. Offenders who terminated early due to new charges were few; only 4.8% of male offenders, and none of the female offenders terminated early due to new charges. There were even fewer offenders who relocated to another community correction agency; only one female offender (2.1%) was relocated to another agency.

Education

Many of the offenders declined to provide information about their educational status, with 26.2% of the data on male offenders, and 22.9% of the data on female offenders being missing in this way. The offenders' highest level of education upon intake in represented in Table 2. The majority of the offenders had started, but not completed their secondary/high school education; more male offenders (71.4%) than female offenders (58.3%) fell into this category. A few male offenders (11.9%) and female offenders (6.3%) had started, but not completed their elementary/junior high school education. Not many offenders (14.3% of men and 22.9% of women) had any college and/or university education.

The offenders' education status did not change drastically while they resided at St. Leonard's. The majority of the offenders (69.0% of the male offenders and 64.6% of the female offenders) were not in school. The offenders' current educational status was reported in Table 2.

Living arrangements

The type of baseline living arrangement prior to coming to St. Leonard's, for both male and female offenders, did not differ significantly. Most of the offenders lived alone; 35.7% of male offenders and 41.7% of female offenders lived alone. Similar numbers of male offenders (35.7%) and female offenders (45.8%) lived with non-relatives. The type of baseline living arrangement for the offenders is shown in Table 2.

Most of the offenders prior to residing at St. Leonard's came from a correctional/probation facility. More female offenders (70.8%) than male offenders (52.4%) came from either a correctional or probation facility. On the other hand, more male offenders (28.6%) than female offenders (6.3%) came from a private house and/or apartment owned and/or market rent environment. The baseline residence type can be found in Table 2.

The offenders' living arrangement after they left St. Leonard's is found in Table 2. Unfortunately, the majority of the offenders' living arrangement was "missing" (i.e., it was unknown, or the offender declined to answer). More female offenders (54.2%) than male offenders (31.0%) had unknown or declined living arrangements. Approximately one third of both male offenders (28.6%) and female offenders (29.2%) were living alone once they left community corrections.

More female offenders (56.3%) than male offenders (23.8%) had unknown or declined current residence types. A larger number of male offenders (38.1%) than female offenders (22.9%) lived in a private house or apartment owned or market rent residence. However, more male offenders (16.7%) than female offenders (4.2%) returned to a correctional or probation facility once they completed their residence at St. Leonard's. The current residence type is listed in Table 2.

Employment and income status

It was evident from the offenders' baseline employment status (Table 2) that many of them had no employment. A large number of male (57.1%) and female (43.8%) offenders declined to indicate their employment upon intake. Further to that, 26.2% of male offenders and 33.3% of female offenders indicated no employment of any kind.

The majority of the offenders' income came from ODSP and social assistance. Practically the same number of male offenders (35.7%) and female offenders (35.4%) received their income

source from ODSP. Social assistance was also a common source of income for male offenders (33.3%) and female offenders (39.6%). It is important to note that some male offenders (21.4%) and female offenders (12.5%) had absolutely no source of income prior to entering St. Leonard's. The offenders' baseline primary income source is represented in Table 2.

The offenders' employment status once they left St. Leonard's did not change significantly (Table 2). Again, most of the offenders, 50.0% of male offenders and 22.9% of the female offenders, did not have any employment; similarly, 14.3% of male offenders and 27.1% of female offenders had no employment of any kind. According to the data, there remain a large number of offenders where their employment status remains unknown once they leave St. Leonard's.

The current primary income source that was indicated in the offenders' files does not provide the researchers with more detail compared to the income source at intake (Table 2). Again, several male offenders (26.2%) and female offenders (31.3%) relied on ODSP for their income source. More female offenders (33.3%) than male offenders (16.7%) relied on social assistance for income. However, there remained a large number of male offenders (33.3%) and female offenders (27.1%) where their current income source was unknown or declined.

Criminal history

Nature of offense

The nature of the offenders' offense is demonstrated in Table 3. More male offenders committed crimes against person(s) (40.5%) than female offenders (20.8%). On the other hand, more female offenders (31.3%) committed property crimes than male offenders (19.0%). Both male (19.0%) and female offenders (18.8%) committed crimes against both person(s) and property. There was evidence of a small percentage of offenders who solely committed drug offences; 4.8% of the men, and 12.5% of the women. Again, even fewer offenders had solely

breached their parole; 9.5% of the male offenders, and 8.3% of the female offenders. It was found that some offenders had committed more than one type of offence; therefore, they would have been categorized in one of the three categories of: crimes against person(s), crimes against property or both. Crimes against person(s) and crimes against property were considered more serious than other types of crime in this study.

Involvement in the criminal justice system

Table 3 demonstrates the offenders' previous involvement in the criminal justice system. The majority of offenders, both male (85.7%) and female (83.3%) had previous involvement in the criminal justice system.

Many of the offenders at intake were assessed to be at risk for legal problems in the future. Fifty-two percent of male offenders were at risk; while, 43.8% of female offenders were at risk for legal problems in the future. The number of male offenders (40.5%) and of female offenders (50.0%) who were on bail awaiting trial was also high. More female offenders (56.3%) than male offenders (42.9%) were on probation at time of intake. There were fewer offenders incarcerated at time of intake; 21.4% of male offenders and 14.6% of female offenders were incarcerated. Table 3 illustrates the offenders' baseline legal status.

Most of the offenders continued to be deemed at risk for legal problems while at St. Leonard's. The number of offenders who were at risk for legal problems dropped slightly, 42.9% of male offenders and 35.4% of female offenders. Further, the number of male offenders (23.8%) who were on bail awaiting trial dropped at a higher rate than female offenders (45.8%).

Table 3

Criminal history

	Male		Female	
Characteristics	*N*	%	*n*	%
Previous Involvement in the Criminal Justice System	36	85.7	40	83.3
Nature of offense				
Crimes against person	17	40.5	10	20.8
Property	8	19.0	15	31.3
Both crimes against person & Property	8	19.0	9	18.8
Drug offense	2	4.8	6	12.5
Breach	4	9.5	4	8.3
Baseline Legal Status				
None selected	0	0	0	0
At risk for legal problems	22	52.4	21	43.8
No legal problems	1	2.4	1	2.1
On bail awaiting trail	17	40.5	24	50
On probation	18	42.9	27	56.3
On parole	0	0	0	0
Unknown or declined	0	0	1	2.1
In community on own Recognizance	1	2.4	0	0
Incarcerated	9	21.4	7	14.6
Suspended sentence	0	0	1	2.1
Current Legal Status				
None selected	2	4.8	1	2.1
At risk for legal problems	18	42.9	17	35.4
No legal problems	0	0	3	6.3
On bail awaiting trial	10	23.8	22	45.8
Awaiting sentence	0	0	0	0
On probation	18	42.9	22	45.8
On parole	0	0	2	4.2
Unknown	1	2.4	8	16.7
In community on own Recognizance	3	7.1	0	0
Unfit to stand trail	0	0	0	0
Charges withdrawn	1	2.4	0	0
Current Incarcerated	6	14.3	1	2.1

However, approximately the same percentages of male offenders (42.9%) and female offenders (45.8%) were still on probation during their residency. The offenders' current legal status during their time at St. Leonard's, is shown in Table 3.

Presenting issues addressed

An overwhelming majority of the offenders presented with a variety of issues that needed to be addressed upon intake; the results are presented in Table 4. One of the most prominent issues was an offender's specific symptoms of mental illness; 64.3% of male offenders and 60.4% of female offenders needed this issue addressed. In the same vein, both male offenders (71.4%) and female offenders (68.8%) presented with substance abuse problems and/or addictions. Further, both male offenders (88.1%) and female offenders (77.1%) needed to have housing issues addressed. More female offenders (25.0%) than male offenders (14.3%) presented with physical and/or sexual abuse problems. It was also shown that more male offenders than female offenders had high needs in regard to financial and legal concerns.

Goals

The offenders presented several goals during their stay at St. Leonard's (Table 5). The most common goal was housing. Male offenders (76.2%) and female offenders (89.6%) had the goal of obtaining housing outside of St. Leonard's. There were also both male offenders (47.6%) and female offenders (45.8%) who had a common goal of being connected to other agencies outside of community corrections. Another common goal among the offenders was that of mental health programming; 52.4% of male offenders and 58.3% of female offenders had the goal of attending mental health programming. As a separate category, at least one-third of male offenders (31.0%) and half of the female offenders (54.2%) wanted to abstain from substances. Both male offenders and female offenders had the goal of obtaining basic necessities for living.

Table 4

Presenting Issues Addressed

	Male		Female	
Characteristics	*n*	%	*n*	%
None selected	3	7.1	2	4.2
Threat to others or attempted suicide	14	33.3	2	4.2
Specific symptoms of mental illness	27	64.3	29	60.4
Physical, sexual abuse	6	14.3	12	25
PIA Education	6	14.3	6	12.5
Occupational, employment, Vocational	12	28.6	12	25
PIA Housing	37	88.1	37	77.1
PIA Financial	29	69.0	13	27.1
PIA Legal	19	45.2	13	27.1
Problems with Relationships	15	35.7	12	25
Problems with substance abuse/addictions	30	71.4	33	68.8
Activities of daily living	17	40.5	5	10.4
PIA other	10	23.8	18	37.5

Table 5

Goals

	Male		Female	
Characteristics	*n*	%	*n*	%
Housing	32	76.2	43	89.6
Connection with other services	20	47.6	22	45.8
Abstain from substances	13	31.0	26	54.2
Attend to physical health concerns	5	11.9	6	12.5
Basic Necessities	2	4.8	2	4.2
Community service	0	0	4	8.3
Connect with child/children	2	4.8	9	18.8
Dentist	1	2.4	2	4.2
Education	9	21.4	12	25
Employment research and support	10	23.8	5	10.4
Finances	18	42.9	15	10
Follow bail and/or probation order	6	14.3	10	20.8
Leisure	2	4.8	4	8.3
Medication compliance and regime	3	7.1	4	8.3
Mental health programming	22	52.4	28	58.3
Obtain documentation	9	21.4	23	47.9
Obtain prescription medications	5	11.9	9	18.8
Parenting support	1	2.4	1	2.1
Physician	10	23.8	11	22.9
Psychiatrist	12	28.6	11	22.9
Reintegration program referral	2	4.8	0	0
Symptom management	7	16.7	7	14.6
Victim compensation	1	2.4	0	0

For example, 23.8% of male offenders and 22.9% of female offenders required a family physician. Further, male offenders (28.6%) and female offenders (22.9%) required care under a psychiatrist. More female offenders (47.9%) than male offenders (21.4%) also required to obtain documentation; such as, birth certificates, social insurance cards and health cards.

Mental health background

Treatments

Table 6 displays the offenders' previous treatment regime prior to arriving at St. Leonard's. The most common medications were antidepressants, stimulants and antipsychotics. Most female offenders (39.6%) than male offenders (38.1%) were on at least one type of antidepressant prior to residency. On the other hand, more male offenders (55.0%) than female offenders (43.8%) were on at least one type of antipsychotic prior to residency. More male offenders (19.0%) than female offenders (12.5%) were on one type of stimulant.

Once the offenders arrived at St. Leonard's, the types of treatments utilized among them did not change drastically (Table 6). The most common medications were antidepressants, antipsychotics and treatment for other illnesses. The same percentage of male offenders (33.3%) and female offenders (33.3%) were required to take at least one type of antidepressant. There were quite a few more male offenders (52.4%) than female offenders (37.5%) who were required to take at least one type of antipsychotic. It was also evident that the offenders' required several different types of medications for other medical illnesses. For example, one-tenth of the female and male offenders required medication for non-steroidal anti-inflammatories. There were also two individuals who required treatment for Parkinson's disease.

Table 6

Mental Health Background

	Male		Female	
Characteristic	*n*	%	*n*	%
Diagnoses				
Diagnoses – confirmed	2	4.8	2	4.2
Adjustment disorder	2	4.8	1	2.1
Anxiety disorder	16	38.1	22	45.8
Chronic illness	2	4.8	8	16.7
Concurrent disorder	17	40.5	35	72.9
Delirium, dementia, amnestic or Cognitive	11	26.2	3	6.3
Development handicap	7	16.7	0	0
Disorder of childhood or adolescence	20	47.6	9	18.8
Dissociative disorder	2	4.8	0	0
Dual diagnosis	3	7.1	1	2.1
Eating disorder	0	0	1	2.1
Hyper sexuality	0	0	1	2.1
Mood disorder	29	69	39	81.3
Personality disorder	8	19	3	6.3
PTSD	9	21.4	19	39.6
Schizophrenia or other psychotic Disorders	9	21.4	16	33.3
Sleep disorder	0	0	1	2.1
Substance related disorder	1	2.4	0	0
Reported Psychiatric Symptoms[a]				
Mood disorder symptoms	33	78.6	45	93.8
Anxiety symptoms	22	52.4	20	41.7
Schizophrenia psychosis symptoms	9	21.4	8	16.7
Substance dependence symptoms	5	11.9	11	22.9
Disorder of childhood symptoms	5	11.9	6	12.5
Dissociative symptoms	0	0	1	2.1
Sexual Identity symptoms	1	2.4	1	2.1
Personality disorder symptoms	4	9.5	2	4.2
Impulsive control disorder symptoms	12	28.6	11	22.9
Delirium cognitive disorder Symptoms	2	4.8	2	4.2
PTSD symptoms	6	14.3	11	22.9
Previous treatment[b]				
Antidepressants	16	38.1	19	39.6
Stimulants	8	19.0	6	12.5

Antipsychotics	23	55.0	21	43.8
Mood Stabilizers	3	7.1	1	2.1
Anxiolytics	4	9.5	6	12.5
Depressants	1	2.4	4	8.3
Analgesics	1	2.4	1	2.1
Antibiotics	1	2.4	0	0
Anti-addictive	2	4.8	3	6.3
Muscle relaxants	0	0	2	4.2
Non-steroidal anti-inflammatory	4	9.5	3	6.3
Treatment for stomach, GERD, Ulcers	2	4.8	1	2.1
Treatment for allergies	1	2.4	0	0
Treatment for Parkinson's disease	0	0	1	2.1
Treatment for other medical illness	3	7.1	4	8.3
Treatment for asthma	1	2.4	1	2.1
Treatment for seizures	3	7.1	2	4.2
Current treatment[b]				
Antidepressants	14	33.3	16	33.3
Stimulants	4	9.5	4	8.3
Antipsychotics	22	52.4	18	37.5
Mood Stabilizers	1	2.4	2	4.2
Anxiolytics	3	7.1	6	12.5
Depressants	1	2.4	4	8.3
Analgesics	3	7.1	4	8.3
Antibiotics	4	9.5	7	14.6
Anti-addictive	1	2.4	4	8.3
Muscle relaxants	0	0	2	4.2
Non-steroidal anti-inflammatory	4	9.5	6	12.5
Treatment for stomach, GERD, Ulcers	2	4.8	4	8.3
Treatment for allergies	2	4.8	1	2.1
Treatment for Parkinson's disease	1	2.4	1	2.1
Treatment for sexual symptoms	0	0	1	2.1
Treatment for other medical illness	7	16.7	6	12.5
Treatment for asthma	3	7.1	1	2.1
Treatment for seizures	6	14.3	2	4.2

[a] Frequency represents the population that reported having at least one symptom identified in each cluster. For a list of identified symptoms in each psychiatric symptom cluster, see Appendix B.

[b] Frequency represents the population that reported being on at least one medication identified in each cluster. For a list of identified medications in each treatment cluster, see Appendix C.

Diagnoses

There were very few offenders who had a confirmed diagnosis of mental illness (Table 6). More female offenders (72.9%) than male offenders (40.5%) had a concurrent disorder. The majority of both male offenders (69.0%) and female offenders (81.3%) had a mood disorder. Again, there were more female offenders than male offenders with a mental illness on several items. For example, more female offenders (45.8%) than male offenders (38.1%) had an anxiety disorder. More female offenders (39.6%) than male offenders (21.4%) had a PTSD disorder. Further, female offenders (33.3%) had a higher rate of a schizophrenia and/or psychotic disorder than male offenders (21.4%). On the other hand, more male offenders (47.6%) than female offenders (18.8%) had a disorder of childhood or adolescence.

Mental health symptoms

The majority of female offenders (93.8%) had symptoms of a mood disorder. Other common mental health symptoms among female offenders were anxiety (41.7%), schizophrenia and/or psychosis (16.7%), substance dependence (22.9%) and PTSD (22.9%). The mental health symptoms for female offenders are represented in Table 6.

The majority of male offenders (78.6%) also had symptoms of a mood disorder. Over half of the male offenders (52.4%) also had symptoms of anxiety. Other common mental symptoms among the male offenders were schizophrenia (21.4%), impulsive (28.6%) and PTSD (14.3%). The list of mental health symptoms for male offenders is found in Table 6.

Substance use history

Past substance use

A very large proportion of the offenders engaged in past substance use (Table 7). More female offenders (95.8%) than male offenders (88.1%) indicated that they had a past substance use history. The most popular substance among female offenders was cocaine; 47.9% of female

Table 7

Substance use history

Past substance use	Male		Female	
Characteristics	*n*	%	*n*	%
Used in the past – yes	37	88.1	46	95.8
Used in the past – no	4	9.5	2	4.2
Alcohol	25	59.5	17	35.4
Cocaine	13	31	23	47.9
Ecstasy	3	7.1	2	4.2
Hallucinogens	1	2.4	2	4.2
Hydromorph	3	7.1	5	10.4
Ketamine	0	0	1	2.1
Marijuana	17	40.5	16	33.3
Methamphetamine	5	11.9	9	18.8
Morphine	7	16.7	6	12.5
Opiates	8	19	14	29.2
Oxycontin	8	19	18	37.5
PCP	2	4.8	1	2.1
Prescription medications	7	16.7	13	27.1
Treatment in the past	4	9.5	9	18.8
Current substance use				
Alcohol	3	7.1	4	8.3
Cocaine	0	0	2	4.2
Hydromorph	0	0	1	2.1
Marijuana	9	21.4	7	14.6
Methamphetamine	1	2.4	0	0
Morphine	0	0	1	2.1
Opiates	0	0	1	2.1
Oxycontin	0	0	1	2.1
Prescription medications	3	7.1	3	6.3
Appeared under the influence	3	7.1	3	6.3
Drug paraphernalia found	1	2.4	11	22.9
Current treatment	2	4.8	7	14.6

offenders used cocaine in the past. Other popular substances that the female offenders used were alcohol (35.4%), marijuana (33.3%), and opiates (29.2%), Oxycontin (37.5%) and abuse of prescription medications (27.1%). The majority of male offenders used alcohol (59.5%); followed by: cocaine (31.0%), marijuana (40.5%), opiates (19.0%), Oxycontin (19.0%) and prescription medications (16.7%).

Current substance use

Offenders in the category of current substance use, as shown in Table 7, used the following substances during their stay at St. Leonard's. One of the house rules at a residence at St. Leonard's is to abstain from substances. Most offenders who engaged in substance while in community corrections used marijuana: 21.4% of male offenders and 14.6% of female offenders had used marijuana. A larger number of female offenders (22.9%) than male offenders (2.4%) had drug paraphernalia found on the premise of St. Leonard's. More female offenders (14.6%) than male offenders (4.8%) were also in current treatment, such as, methadone.

Risk Factors

The offenders in the present study presented with a wide array of risk factors that could impact their successful completion of the program and/or of their offending behaviour (Table 8). More male offenders (40.5%) than female offenders (33.3%) presented with a history of emotional abuse as a child. Further, male offenders (52.4%) presented with a higher rate of past physical abuse as a child than female offenders (27.1%). On the other hand, more female offenders (41.7%) than male offenders (11.9%) experienced intimate partner violence as an adult. Also, more female offenders (45.8%) than male offenders (33.3%) had a child or children removed from their care as an adult. The offenders also presented with a history of sexual abuse

Table 8

Risk factors

	Male		**Female**	
Characteristics	*n*	%	*n*	%
Child welfare as a child	3	7.1	1	2.1
Emotional abuse as a child	17	40.5	16	33.3
Maltreatment as a child	4	9.5	5	10.4
Neglect as a child	1	2.4	0	0
Physical abuse as a child	22	52.4	13	27.1
Sexual abuse as a child	8	19	11	22.9
Sexual violence as adult	2	4.8	7	14.6
Intimate partner violence adult	5	11.9	20	41.7
Children removed from care adult	14	33.3	22	45.8
Historical grief	0	0	1	2.1
Current grief	1	2.4	1	2.1
Historical trauma	1	2.4	1	2.1
Prenatal care	1	2.4	2	4.2

as a child; 22.9% of female offenders and 19.0% of male offenders experienced sexual abuse as a child.

Chi-square analysis

To identify whether there was a significant relationship between gender and exit disposition, a chi-square analysis was conducted. Exit disposition was coded into three categories: "successful", "not successful" (including both early termination due to new charges and early termination due to rule violations), and "withdrawal." As can be seen by the frequencies cross tabulated in Table 9, there is a significant relationship ($\phi = 0.26$) between gender and the offenders' exit disposition from St. Leonard's, χ^2 (2) = 5.944, $p < 0.05$. A chi-square was also conducted in order to determine if there was a relationship between gender and type of offense. The type of offense did not differ by gender, $\phi = 0.24$, χ^2 (2) = 3.990, $p = 0.136$. The type of offense is cross-tabulated with gender in Table 9.

The results of the chi-square analysis indicate that there is a significant relationship between gender and exit disposition; therefore, in order to predict gender differences, in terms of exit disposition, we conducted a multinomial logistic regression (Table 10). The results significantly predict that female offenders are almost six times more likely to withdraw from community corrections, Exp (B) = 5.744, $p = 0.02$. We also conducted a multinomial logistic regression in order to further examine the relationship between nature of offense and exit disposition. The results indicate a significant prediction that individuals who commit property offenses are almost 7 times more likely to have an early termination due to new charges and/or rule violations; Exp(B) = 6.678, $p = 0.03$.

Table 9

Chi-square Analysis

Exit disposition count	Successful	Withdrawal	Early termination	Total
Female	17	18	13	48
Male	21	6	14	41
Total	38	24	27	89

Chi-square Tests	Value	*df*	Asymp. Sig. (2-sided)
Pearson Chi-square	5.944[a]	2	0.051*
Likelihood ratio	6.187	2	0.045
Linear - by linear association	0.234	1	0.629
N of valid cases	89		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 11.06.
* p ≤.05

Nature of offense count	Property	Crimes vs. person	Both crime vs. person and property	Total
Female	15	10	9	34
Male	8	17	8	33
Total	23	27	17	67

Chi-square Tests	Value	Df	Asymp. Sig (2-sided)
Pearson Chi-square	3.990[a]	2	0.136*
Likelihood ratio	4.044	2	0.132
Linear - by linear association	0.872	1	0.35
N of valid cases	67		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 8.37.
* p ≤. 05

Table 10

Multinomial logistic regression

Effect	Model fitting criteria	Likelihood ratio tests		
		Chi-square	df	Sig.
Intercept	35.112	0	0	
Nature of the offense	42.996	7.883	4	0.096
Gender	41.016	5.904	2	0.052

Parameter estimates						
Exit disposition		B	Std.Error	Df	Sig.	Exp(B)
Withdrawal	Property	0.539	0.896	1	0.547	1.715
	Crimes vs. person	-0.841	0.833	1	0.313	0.431
	Both property and crimes vs. person	0		0		
	Female	1.748	0.77	1	0.23*	5.744
	Male	0		0		
Early termination	Property	1.899	0.85	1	0.26*	6.678
	Crimes vs. person	0.8	0.736	1	0.277	2.226
	Both property and crimes vs. person	0		0		
	Female	0.529	0.607	1	0.383	1.698
	Male	0		0		

* $p \leq .05$

Discussion

Overview

The primary purpose of this study was to describe the characteristics of a sample of offenders in a community corrections setting, and to compare the gender differences in substance abuse and mental health issues. The data were retrieved through a file review of a sample of 48 female and 42 male offenders who received crisis care during a one-year period, at a community corrections agency in a medium-sized urban community in Ontario. Results are presented by gender with the exception of one chi-square analyses where we examined the relationship between the nature of offense and exit disposition. The main research question that guided the present study was to compare the gendered effect of substance abuse and mental health issues on the pathways to criminal convictions with a criminal population in the community setting. Some planned analyses were not completed: we could not test for differences due to gender with respect to type of offense because of the small size of some of the cells (less than 5), and there was so little variability in terms of substance use, we could not generate a meaningful comparison of users versus non-users. Results of the present study revealed gender differences with respect to exit disposition, nature of the offense, psychotropic medications, diagnoses, mental health symptoms, substance use and risk factors. These results will be discussed within the context of the current research literature on offenders in the correctional systems. Following the discussion of the current study, strengths and limitations of the current study, implications and directions for future research will be discussed.

Research on correctional treatment interventions is beginning to focus on the unique needs of female offenders. Several researchers now emphasize that females and males have different pathways into the criminal justice system (Belknap, 2007; Bloom et al., 2003; Chesney-

Lind & Sheldon, 2004; Covington, 2000; Daly, 1992; Owen, 1998; Reisig et al., 2006; Richie, 1996; Steffenmeier & Allen, 1996; Van Voorhis et al., 2010). For example, male offenders are more likely to commit violent offenses, while female offenders are more likely to commit drug and/or property offenses (Sabol et al., 2007). Research indicates that factors such as histories of victimization and abuse, relationship problems, mental illness, drug abuse, self-concept, poverty and parental issues contribute to female offenders' histories which are different than male offenders (Van Voorhis et al., 2010). Further, female offenders continue to enter the criminal justice system with higher rates of mental health issues than male offenders (Leschied, 2011). The extent of female offenders' unique needs is not being taken into account in their risk assessments. The risk assessments of female offenders when they enter the criminal justice system are by means of a gender-neutral measurement tool, the LSI-R (Andrews & Bonta, 1995). This understanding that female offenders have unique needs in the context of gender-neutral risk assessments is what informed the present study's interest of the gender differences in community corrections.

Offender classification

Prior to offenders entering community corrections, they would have undergone a risk assessment upon intake at an institution. This risk assessment impacts the institution's decisions as to whether offenders could be placed on discretionary release and program placements, such as those found in community corrections (Gobeil & Blanchette, 2007). The risk assessment also determines what type of treatment programs the offenders will receive. The risk assessment used primarily in Canada's criminal justice system is known as the LSI-R (Andrews & Bonta, 1995). The LSI-R is a gender neutral assessment tool; therefore, it does not take into account gender-specific factors that may be more pertinent to the issues that female offenders face. Van Voorhis et al., (2010) emphasize that a risk assessment tool for female offenders needs to include scales

measuring gender-specific factors such relationships, depression, parental issues, self-esteem, self-efficacy, trauma and victimization. The study conducted by Van Voorhis et al., (2010), which presents the women's supplemental risk/needs assessment of gender-specific needs, was used to identify which additional factors the present study would examine within the community corrections population. Applying gender-specific risk assessment tools within the correctional system may positively impact female offenders in community corrections, as research has shown that when treatment is matched to specific needs and risks for offenders, outcomes are improved (Matheson et al., 2008; Messina et al., 2010; Nee & Farman, 2005; Van Voorhis et al., 2010; Zlotnick et al., 2003). Gender specific risk assessment tools and needs could also promote improved mental health programming, increase offender's success in treatment and reduce their potential for recidivism once released into the community (Leschied, 2011).

Community corrections

Community corrections play an integral role in an offender's transition into the community; for example, through the agency, offenders have the opportunity to be connected to outside resources and to attend programming at the residence. Community corrections have also had an impact at reducing recidivism rates among offenders (John Howard Society of Alberta, 2001). Because community corrections can play such an integral part in an offender's transition out of institutions and there is a relative lack of research relating to this transition, the current study was carried out to describe the characteristics of those involved in community corrections and, particularly, explore gender differences therein.

Mental health in Canada's Criminal Justice System

Canada's criminal justice system can no longer ignore the high rates of mental health issues among offenders. One of the most common mental health issues among offenders is that of substance abuse (Lurigio, Rollins & Fallon, 2004). Research has revealed that offenders are

abusing substances such as alcohol, cannabis, cocaine and benzodiazepines, at a higher rate than the general population (Brochu & Plourde, 2012; Kairouz et al., 2008). The high substance abuse rates among offenders may be interpreted as a way of coping with difficulties in their lives. Female offenders, for example, utilize crack cocaine in order to cope with the aftermath of trauma from childhood abuse (Fortin, 2004). Male offenders have high rates of alcohol consumption prior to their incarceration (Plourde et al., 2012). Substance abuse among offenders is a critical factor to consider in treatment programming, as high levels of substance abuse is linked to criminal risk and involvement (Weekes et al., 2009). As a result, it was a priority in the current study to examine substance abuse among offenders in order to clarify the needs of offenders that still exist, and may be a negative influence, during their successful transition back into society.

The other important component examined in the current study was the prevalence of mental health among offenders in community corrections. Research indicates that female offenders have more mental health needs in comparison to male offenders (James & Glaze, 2006). For example, female offenders are three times more likely to suffer from depression in comparison to male offenders (Leschied, 2011). It was hypothesized that female offenders would exhibit higher rates of mental health issues compared to males and, further, that this would be connected to experience of physical and/or sexual abuse, lower socio economic status and responsibilities of child-rearing in less supportive contexts (Leschied, 2011). According to the literature, female offenders exhibit different patterns of mental health and substance abuse issues; therefore, the present study sought to highlight the differentiated needs based on gender, that are present in community corrections.

Treatment interventions

Offenders still receive treatment interventions once they are placed in community corrections and the aim of treatment programs is, in general, to target and alter an offender's criminal behaviour in order to reduce the likelihood that they will reoffend (Ross & Guarnieri, 1996). As previously mentioned, high levels of substance use is linked to criminal behaviour and involvement (Weekes et al., 2009); therefore, treatment programs in community corrections need to address offenders' substance abuse issues. Importantly, substance use among offenders often co-occurs with other mental health issues (Lurigio et al., 2004). These findings were compelling in the design of the current study, which aimed to capture the need for substance abuse and mental health programming in community corrections.

The following discussion offers interpretation of the results from the numerical data alongside the existing research literature. The offenders presented with an array of complex and significant mental health and substance abuse issues; however, only 4 out of the 90 participants had a confirmed diagnosis. This in itself becomes an issue, as a confirmed diagnosis communicates to any professional working with someone with a mental health issue, the specific needs and treatment they require. The absence of confirmed diagnoses from psychologists or psychiatrists presents a significant barrier to effective treatment and rehabilitation. Other factors emerged as important and worthy of note: The offenders are also coming into community corrections at a very young age, and most of them had not completed their high school education. Not surprisingly then, the offenders needed to rely on social assistance as an income, as the majority of them were unemployed. In all, community corrections encompass individuals who have complex issues that ultimately inter-relate to one another. Failing to address just one those issues prior to reintegration into society ultimately impedes their success.

The story of the female offenders

All of the female participants in the present study resided in the crisis care program in the same community corrections agency residence between the years of 2011 and 2012. The average age of the female offenders was 30 years old; however, overall, the ages between the female offenders varied greatly. This wide range in ages may influence the social relationships within the residence, with tensions or challenges in managing a residence where some residents are 19 and others in their late fifties. Most residents were referred via correctional institutions or the Canadian Mental Health Association.

Most of the female residents had not completed their high school education. A report by Statistics Canada (2006) on education and employment highlights that for women, education is the biggest predictor of stable employment and income; the lack of income will undoubtedly have effects on the women's abilities to find and sustain suitable housing. The majority of the women relied on ODSP and social assistance and shifted from correctional institutions to locations unknown after treatment completion. It is highly unlikely that the women were able to obtain suitable housing after treatment completion; this leaves the researchers with questions as to what environments the women find themselves in after leaving the residential facility where the data was gathered. It would be very beneficial for researchers to be able to track the locations of female offenders after residence in order to identify any possible barriers to their successful transition to the community.

The female offenders came to community corrections with an overwhelming variety and intensity of issues that needed to be addressed during their stay. The most predominant presenting issues included symptoms of mental health and substance abuse and/or addictions, and the struggle to obtain safe and affordable housing. This combination of presenting issues highlights the unique vulnerability of female offenders as they try to transition back into society

from the criminal justice system, attempting to balance mental health with a safe and affordable place to live and work. Other common goals for the female offenders included obtaining critically important personal identification, such as a health card, social insurance number, and birth certificate. Women also needed help with access to a family physician and a psychiatrist. Fulfilling these needs is critical for female offenders in order to obtain the health care necessary for balanced health. The lack of health care specialists, for this population especially, could alter the offenders' probability of sustaining their mental health, which then alters the probability that they will be successful in abstaining from crime in the community. This finding highlights the fact that female offenders' high complex needs once they are in community corrections. Female offenders in this study also had higher rates of physical and/or sexual abuse issues than male offenders, a finding that is important in understanding the impact on their response to treatment. For instance, one of the bases for counselling is building trust between therapist and client; but, individuals with trauma histories have difficulty trusting others (Courtois, 2004).

On average, the female offenders are also leaving care very early on; findings from this study indicate that the majority of female offenders stays at the residence for only three days and more often than the men, withdraw early. The researchers of the present study hypothesize that the female offenders may withdraw earlier than male offenders because of gendered reasons, including ceding to the influence of those who seek to exploit them in the sex trade, or to be physically close to their children. There still remain a large number of women who terminate their residence due to violation of house rules. For example, more female offenders than male offenders are found to have drug paraphernalia in their rooms; which would result in termination of residence. This may be explained by the fact that female offenders abuse different drugs than male offenders. For example, research has shown that the drug of choice for female offenders is

crack cocaine; whereas, the drug of choice for male offenders is alcohol (Plourde et al., 2012; Wright, 2002).

A large number of female offenders had previous involvement in the criminal justice system. The majority of the women in the study committed property crimes. This finding confirms the results of research completed by Sabol et al., (2007) which indicated that female offenders are more likely to be imprisoned for drug and/or property offenses.

Our research findings confirmed what was uncovered in the literature review, namely that female offenders (as compared to their male counterparts) present with more complex mental health and substance abuse needs (Allenby et al., 2010; Leschied, 2011). Overall, female offenders presented with higher rates of mood disorders; followed by higher rates of anxiety, post-traumatic stress disorder, schizophrenia and/or psychotic disorders. This may be explained by the greater proportion of women, overall, who receive such diagnoses compared to men (Laishes, 2002). Further, female offenders in the sample were also found to be abusing substances at a higher rate than male offenders; specifically, they had higher rates of dependence with cocaine and/or crack cocaine. One possible explanation advanced here is that the high rates of substance dependence among female offenders reflect that women may be turning to substances as a means to cope with the aftermath of trauma (Fortin, 2004), and trauma was experienced by nearly the entire current female sample. The overwhelming presenting mental health issues may affect the community correction agency's ability to provide an array of treatment options. Providing the necessary treatment options, for the extent of mental health issues present in the current study, would require sustained funding. However, sustained funding is required in order to prevent gaps in services or stall one's treatment progress (CSC, 2012b). Thus, inadequate mental health care would affect the residences' stability in corrections and their re-entry into the community.

The story of the male offenders

All of the male participants in the present study resided in the crisis care program at a local community corrections agency's residential facility between the years of 2011 and 2012. Like the women, the ages of the male offenders also varied in the present study and further, most of the men entered community corrections at only 19 years old. The same potential for relationship conflicts in community corrections that was referred to with the female offenders also exists for the male offenders due to the large variability in age.

The pathway to community corrections was similar to that of female offenders, in that male offenders were referred to the agency from a correctional institution or the Canadian Mental Health Association. The major difference, though, was the nature of the crime: a majority of the male offenders who were referred to community corrections committed more crimes against persons. This finding confirms findings reported by Sabol et al. (2007) in a study that concluded that male offenders, compared to their female counterparts, are more likely to be imprisoned for violent offenses. The male offenders are also staying longer in community corrections and have more successful program completion rates, in comparison to female offenders. Future research is needed to explore these important differences.

The education and employment status of the male offenders did not differ significantly in comparison to the female offenders. There was however a larger number of male offenders who did not have their high school diploma and like their female counterparts, it would be extremely difficult for male offenders to obtain employment without a grade twelve education; male offenders also relied on ODSP and social assistance as income sources. The interesting difference between male and female offenders in this study was the higher rates of male offenders who had a private home and/or apartment owned and/or market rent environments prior to and post residency with the agency. The male offenders also had higher rates of

returning to a correctional facility because of a breach of conditions. This finding could be connected to the finding that male offenders exhibit higher rates of antisocial personality disorder; thus, making them more susceptible to re-offend (Laishes, 2002). Future research should also examine why male offenders are able to obtain housing at a higher rate than female offenders.

The male offenders also presented with a variety of issues that needed to be addressed during their stay at the agency. The men also experience high rates of symptoms of mental health and substance abuse and/or addictions, lack of affordable housing, and obtaining financial and legal assistance. The current study uncovered two consistent issues experienced by the vast majority of both male and female offenders: mental health and housing are issues that need to be addressed in corrections.

The mental health profile of the male offenders presented differently in comparison to the female offenders. Even though female offenders presented with relatively higher rates of mental health issues, the present study cannot overlook the fact that male offenders' had overall high levels of mental health needs. The male offenders presented with symptoms that indicated higher rates of disorder of childhood and/or adolescence, and symptoms indicative of mood disorders, anxiety disorders, post-traumatic stress disorder and/or psychotic disorders. Further, the male offenders also presented with more symptoms of personality disorders and impulsivity; this finding further confirms exiting research that found that male offenders have higher rates of antisocial personality disorder (CSC, 2011; Laishes, 2002). Related to this, more male offenders than female offenders also required antipsychotic medications. The researchers of the present study question the high number of male offenders who should be on antipsychotic medications, as the male offenders had lower symptom rates of psychoses and/or schizophrenia in comparison to female offenders.

In terms of substance abuse, while female offenders were abusing cocaine at high rates, male offenders were abusing alcohol at high rates. This finding is in alignment to the study reported by Plourde et al., (2012), which specifically stated that the majority of male offenders abuse alcohol. The present study's results in this regard may also be indicative of the existing literature that posits a relationship between trauma and substance use, in that substance abuse for male offenders is a coping mechanism for the aftermath of trauma. The male offenders presented with different trauma histories in comparison to female offenders. Male offenders presented with a higher rate of a history of emotional abuse and past physical abuse as a child. Thus far, the differences between male offenders and female offenders, including the nature of offense, mental health needs, different methods of substance abuse and trauma histories, indicate that each gender follows a different path in terms of involvement in the criminal justice system. Different paths of criminality may require different treatment and responses to prevent an individual from re-offending.

Limitations

The present study had a number of limitations. The first limitation is the small number of participants in the sample. The researchers of this project collected data on the files that were available at the agency, while trying to maintain an approximate equal ratio between genders. There was a relatively smaller population of male participant files available; therefore, we utilized the 42 male files that were available along with the 48 female files. These two small sample sizes between genders decreases the power of the effect size for the variables in the present study (Cohen, 1992). Further, it is possible that due to the small sample size that the participants may not represent the experiences of all female offenders in community corrections. Further, we were unable to test the relationship between some of the variables as planned, such as, relocation, drug offenses and breach offenses as a result of the small sample size in those

categories, and planned comparisons with substance abuse as a variable, because of the complete lack of variability in the factor, with nearly 100% involvement with substance use among the participants.

The second limitation of the present study is the issue of the generalizability of the sample selection from a medium-sized urban community in southern Ontario. The mental health and substance abuse issues of the participants in the present sample may not be generalized to female offenders in other parts of Canada or even in smaller community correction agencies. For example, there is a higher rate of Aboriginal women (approximately 31%) across Canadian institutions; whereas, the rate of Aboriginal women in the current sample was fewer in comparison (16.7%) (Correctional Service Canada, 2010).

The third limitation of the present study is the subjective nature of the data collected. The present study relied on the agency employees to collect the data from the offenders at intake. The employees are trained effectively in their job to collect the necessary information from the offenders at intake; however, subjectivity may exist when one is trying to determine if mental health symptoms and/or substance abuse issues are present. For example, one employee may fill out the questionnaire on mental health issues based on their knowledge of the DSM-IV (American Psychiatric Association, 2000); whereas, another employee may fill out the questionnaire on mental health issues based on their work experience with individuals with mental health issues. The researchers of the present study are unaware of how individual employees completed the intake forms. Furthermore, offenders self-reported the information on a one-on-one interview at intake; it is possible that some information may have been left out because the offenders may have altered their responses in accordance with what they thought the employees wanted to hear. Also, the nature of the intake questions may have been upsetting for some offenders to want to discuss with a stranger; such as their history of abuse or mental health

concerns. Thus, the results of the current study may not depict the exact extent of the offenders' histories.

A fourth limitation of the current study is the use of the researcher-designed retrieval instrument. This type of retrieval instrument has not been previously utilized; therefore, there is no available psychometric data on the reliability and validity of the instrument. Conceptually, however, the instrument variables were defined in accordance to the LSI-R (Andrews & Bonta, 1995) and the Women's Supplemental Risk/Needs Assessment (Van Voorhis et al., 2010). Those two derived measures, combined, are deemed as effective instruments for the present study's population (Andrews & Bonta, 1995; Coulson et al., 1995; Van Voorhis et al., 2010).

The final limitation of the current study is that of selection bias. The present study includes a participant sample that is biased in that they were purposely selected from a crisis care program. Thus, the researchers were unable to randomly choose the participant selection. Researchers would need to randomly select participants from various types of community correction agencies and/or halfway houses in order to avoid a selection bias in the future.

Strengths

The present study utilized a community corrections sample of offenders. The use of a community corrections sample of offenders is a departure from the widespread research that is available on offenders' mental health needs in federal corrections. The results of the present study provide an overview of issues that face offenders once they are transitioned back into the community. By examining the extent of the issues, such as mental health and/or addictions, which offenders face during their transition back into the community, we can gain more detailed information of what factors may contribute to a successful versus non-successful transition.

Implications

Counsellors

Keeping in mind the limitations of the present study, the following interpretations can be made for counsellors and researchers. The results of this study indicate great variability among the offenders' age. This result indicates that offenders at different ages may require different modalities of treatment programs. The issues facing an offender at 19 years of age versus an offender who is 50 years old will be different. For example, both individuals may have trauma histories; but, the trauma history of an individual who is 50 years old would most likely look different. Another example is in the area of career counselling. A nineteen year old may have little employment experience and require guidance as to career paths to choose; while, the individual who is 50 years old may require guidance on how to re-enter the work force. Community corrections that can address the offenders' program needs for different ages are needed in order to address age based issues.

The results of the present study indicate that offenders are leaving the program very early on in care. Thus, it stands to reason that counsellors should assess whether all individuals in care receive the same treatment programs. Individuals in the first week of care may require a stabilization treatment program for example. Stabilization could provide individuals with tools to address their substance abuse triggers in care or method to stay grounded in their body. Reducing one's trigger towards substances would be a great success in itself, as it would be related to reducing one's potential for recidivism. On the other hand, individuals in the third week of care may require cognitive behavioural therapy to address their negative cognitions and barriers towards a successful reintegration. Even though the pattern of offenders in the present study is to exit early, the first week of the program could provide essential tools such as stabilization which the offenders could carry forward. Thus, counsellors need to be aware of the timing of treatment programs they are providing to the offenders in order to facilitate the probability of success for this population.

A final implication that can be applied from the present study to counsellors is the importance of community corrections to have gender specific programming. Results of the present study indicate that female offenders had higher rates of physical and/or sexual abuse histories, while male offenders had higher rates of emotional abuse as a child and higher rates of past physical abuse as a child. Regardless of gender, it is very evident that trauma is a part of most offenders' lives; therefore, counsellors need to take the time to assess for, and provide a safe and nonjudgmental environment. Also, as counsellors, we have a responsibility to provide mental health programming that addresses the different trauma histories between female and male offenders. Another gender difference found is that female offenders had higher rates of the need to abstain from substances. Therefore, counsellors working with female offenders might spend more time focusing on the substance dependence issues, as one's sobriety facilitates an individual's ability to be receptive to treatment. The results of the present study also indicate that female and male offenders experience different mental health symptoms. Female offenders presented with higher rates of mood disorders; while, male offenders presented with higher rates of disorder of childhood and/or adolescence. As counsellors we need to be attuned to the different mental health issues facing men and women in order to deliver effective treatment.

Community corrections

The present study has important implications for community corrections, including directions for future research. This study is one of few to examine the lives of offenders in community corrections in Canada. Further research is needed to explore the differences and needs among offenders in community corrections. Future research would provide a more accurate depiction of the needs and issues that face offenders during their reintegration into society; which can help researchers generalize findings to community corrections across Canada.

The present study revealed a significant relationship between gender and exit disposition. Given that female offenders were found to be almost six times more likely to withdraw (i.e., walk away) from community corrections, future research should be completed in order to understand why female offenders are more likely to withdraw from care. Furthermore, researchers would have the opportunity to explore further gender differences that may exist among offenders in regard to treatment success.

Finally, the present study also found a significant relationship between the nature of offense and exit disposition. The present research revealed that, regardless of gender, individuals who have committed property offenses are almost seven times more likely to have an early termination from care due to new charges and/or rule violations. Future research is needed to explore why individuals who commit property offenses, including possibly gender differences, are more likely to incur new charges and/or rule violations. Future research on this issue would provide further information on how best to facilitate the long term success of individuals, who commit property offenses, in community corrections.

Conclusions

Mental health and substance abuse issues continue to be a significant issue among offenders in community corrections. The present study sought to increase our understanding of the gender differences of substance abuse and mental health issues on the pathways to criminal convictions with a criminal population in the community setting. An exploratory field study was utilized in order to depict the lives of offenders in community corrections. Unfortunately, we were unable to generate meaningful gender differences, as so little variability existed in terms of substance use. The fact that little variability existed among our sample only reflects the substantial need for corrections to address substance abuse among offenders. The results of the present study indicate a relationship between gender and exit disposition, where female offenders

are more likely to withdraw from community corrections than male offenders. The results of the study also found a relationship between the nature of the offense and exit disposition, where individuals who commit property offenses are more likely to terminate from community corrections due to new charges and/or rule violations. The present study has a number of important implications for community corrections, most notably that gender differences that still exist among offenders. Finally, this study highlights the complex issues offenders face during their reintegration into society; specifically, the multitude of mental health and substance dependence issues that exist in the lives of offenders.

References

Allenby, K., Barrett, M. R., & Taylor, K. (2010). *Twenty years later: Revisiting the task force on federally sentenced women*. Research Report R-222. Ottawa: ON: Correctional Service Canada.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.), Washington, DC: Author.

Andrews, D. A., & Bonta, J. (1995). *Level of Service Inventory-Revised.* North Tonawanda, NY: Multi-Health Systems.

Andrews, D. A., & Bonta, J. (2003). *The psychology of criminal conduct*. Cincinnati, OH: Anderson Publishing Co.

Andrews, D. A., & Bonta, J. (2010). Rehabilitation criminal justice policy and practice. *Psychology, Public Policy, & Law, 16*, 39-55.

Andrews, D. A., Bonta, J., & Hoge, R. D. (1990). Classification for effective rehabilitation: Rediscovering psychology. *Criminal Justice and Behavior, 17*, 19-52.

Andrews, D. A., Dowden, C., & Rettinger, L. J. (2001). Special populations within corrections. In J. A. Winterdyck (Ed.), *Corrections in Canada: Social reactions to crime* (pp. 170 -212). Toronto, Ontario, Canada: Prentice Hall.

Austin, J., & McGinnis, K. (2004). *Classification of high-risk and special management prisoners: A National assessment of current practices*. Washington, DC: National Institute of Corrections.

Belknap, J. (2007). *The invisible woman: Gender, crime, and justice* (3rd ed.). Belmont, CA: Thompson Wadsworth.

Blanchette, K. (1996). *The relationship between criminal history, mental disorder and recidivism*

among federally sentenced female offenders. Carleton University.

Blanchette, K., & Taylor, K. (2005). *Development and field test of a gender-informed security reclassification scale for women offenders*. Report R-167. Ottawa, ON: Correctional Service Canada.

Blanchette, K., & Taylor, K. N. (2007). Development and field test of a gender-informed security reclassification scale for female offenders. *Criminal Justice and Behavior*, 34, 362-379.

Bloom, B., Owen, B., & Covington, S. (2003). *Gender-responsive strategies: Research practice and guiding principles for women offenders*. Washington, DC: USDOJ, National Institute of Corrections.

Bloom, B., Owen, B., & Covington, S. (2004). Women offenders and the gendered effects of public policy. *Review of Policy Research, 21*, 31-48.

Brennan, T., Dieterich, W., & Ehret, B. (2009). Evaluating the predictive validity of the Compas risk and needs assessment system. *Criminal Justice and Behavior, 36*, 21-40.

Brochu, S., Cousineau, M. M., Gillet, M., Cournoyer, L. G., Pernanen, K., & Motiuk, L. (2001). Les drogues, l'alcool et la criminalite: Profil des detenus federaux canadiens. *Forum, 13*, 22-26.

Brochu, S., & Plourde, C. (2012). L'offre de services aux adultes toxicomanes sous le coup de mesures judiciaires: Un jeu de murs et de ponts. In M. Landry, S. Brochu, & C. Patenaude (Eds), *L'intégration des services en toxicomanie* (pp. 107-130). Quebec, QC: Presses de l'Universite Laval

Brown, S. L., & Motiuk, L. L. (2005). The dynamic factor identification and analysis (DFIA) component of the offender intake assessment (OIA) process: A meta-analytic, psychometric and consultative review. Report 164. Ottawa, ON.

Champion, D. J. (1994). *Measuring offender risk: A criminal justice sourcebook.* Westport, CT: Greenwood Press.

Chesney-Lind, M., & Shelden, R. G. (2004). *Girls, delinquency, and juvenile justice* (3rd ed.). Belmont, CA: Thompson Wadsworth.

Christian, J. (2006). *Corrections and conditional release in Canada an overview*. Vancouver, BC: International Centre for Criminal Law Reform and Criminal Justice Policy.

Cohen, J. (1992). A power primer. *Psychological Bulletin, 112*, 115-159.

Corabian, P., Dennett, L., & Harstall, C. (2011). Treatment for convicted adult male sex offenders: An overview of systematic review. *Sexual Offender Treatment, 6*, 1-18.

Correctional Investigator Canada. (2012). *Annual report of the office of the correctional investigator*. Ottawa, ON: Howard Sapers.

Correctional Service Canada. (2009). *Report on plans and priorities - 2009-2010*. Ottawa, ON: Author.

Correctional Service Canada. (2010). *Women offender statistical overview: Fiscal year 2009 -2010*. Ottawa, ON: Author.

Correctional Service Canada. (2011). *Preliminary Results from the Men's Self-Injurious Behaviour Study.* Ottawa, ON: Author.

Correctional Service Canada. (2012a). *Maximum security institutions*. Ottawa, ON: Author.

Correctional Service Canada. (2012b). Towards a continuum of care: Correction of Service Canada mental health strategy. Ottawa, ON: Author.

Correctional Service Canada. (2013). *Report on Plan and Priorities*. Ottawa, ON: Author.

Coulson, G., Ilacqua, G., Nutbrown, V., Giulekas, D., Cudjoe, F. (1996). Predictive utility of the Lsi for incarcerated female offenders. *Criminal Justice and Behavior*, 23, 427-439.

Courtois, C. A. (2004). Complex trauma, complex reactions: Assessment and treatment.

Psychotherapy: Theory, Research, Practice, Training, 41, 412-425.

Covington, S. (2000). Helping women to recover: Creating gender-specific treatment for substance-abusing women and girls in community corrections. In M. McMahon (Ed.), *Assessment to assistance: Programs for women in community corrections* (pp. 171-233). Lanham, MD: American Correctional Association.

Daly, K. (1992). Women's pathways to felony court: Feminist theories of law-breaking and problems of representation. *Southern California Review of Law and Women's Studies*, *2*, 11-52.

Dowden, C., & Andrews, D. A. (2000). Effective correctional treatment and violent reoffending: A meta-analysis. *Canadian Journal of Criminology*, 42, 449-467.

Fortin, D. (2004). *Program strategy for women offenders.* Ottawa, ON: Correctional Service of Canada.

Gibbs, W. (2006). *Day parole and halfway house in Canada*. Vancouver, BC: International Centre for Criminal Law Reform and Criminal Justice Policy.

Gobeil, R., & Blanchette, K. (2007). Revalidation of gender-informed security reclassification scale for women inmates. *Journal of Contemporary Criminal Justice, 23*, 296-309.

Henning, K. R., & Frueh, B. C. (1996). Cognitive-behavioural treatment of incarcerated offenders: An evaluation of the Vermont Department of Corrections' cognitive self -change program. *Criminal Justice and Behavior, 23*, 523-541.

Holsinger, A. M., Lowenkamp, C. T., & Latessa, E. J. (2003). Ethnicity, gender, and the Level of Service Inventory–Revised. *Journal of Criminal Justice*, *31*, 309-320.

James, D. J., & Glaze, L. E. (2006). *Mental health problems of prison and jail inmates*. U. S. Department of Justice. Document NCJ213600.

John Howard Society of Alberta. (2001). *Halfway houses*. Edmonton, AB: Author.

Kairouz, S., Boyer, R., Nadeau, L., Perreault, M., & Fiset-Laniel, J. (2008). Troubles mentaux, toxicomanie et autres problemes lies a la sante mentale chez les adultes quebecois. Enquete sur la sante dans les collectivites canadiennes (cycle 1.2), Quebec, QC: Institut de la statistique du Quebec.

Laishes, J. (2002). *The 2002 mental health strategy for women offenders*. Ottawa, ON: Correctional Service of Canada.

Leschied, A. (2011). *The treatment of mentally disordered women offenders: A synthesis of current research*. Public Safety and Emergency Preparedness Canada. Ottawa, ON.

Lowenkamp, C. T., Latessa, E. J., & Holsinger, A. M. (2006). The risk principle in action: What have we learned from 13,676 offenders and 97 correctional programs? *Crime and Delinquency, 52,* 77-93.

Lurigio, A.J., Rollins, A., & Fallon, J. (2004). The effects of serious mental illness on offender re-entry. *Federal Probation, 68,* 45-52.

Matheson, F.M., Doherty, S., & Grant, B.A. (2009). *Women offender substance abuse programming and community integration*. Research Report. Ottawa, ON: Correctional Service Canada.

Messina, N., Grella, C. E., Cartier, J., Torress, S. (2010). A randomized experimental study of gender-responsive substance abuse treatment for women in prison. *Journal of Substance Abuse Treatment,* 38, 97-107.

Najavits, L. M., Rosier, M., Nolan, A. L., & Freeman, M. (2007). A new gender-based model for women's recovery from substance abuse: Results of a pilot outcome study. *The American Journal of Drug and Alcohol Abuse, 33,* 5-11.

Nee, C., & Farman, S. (2005). Female prisoners with borderline personality disorder: Some promising treatment developments. *Criminal Behaviour and Mental Health, 15,* 2-16.

Olson, D. E., Alderden, M., & Lurigio, A. J. (2003). Men are from Mars, women are from Venus, but what role does gender play in probation recidivism? *Justice Research & Policy*, *5*, 33-54.

Owen, B. (1998). *In the mix: Struggle and survival in a woman's prison.* Albany, NY: State University of New York Press.

Patton, D., & Adlaf, E. (2005). Consommation de cannabis et problemes connexes. Dans E. M. Adlaf, P. Begin, & E. Sawka, (Eds.), *Enquête sur les toxicomanies au Canada (ETC): Une enquête nationale sur la consommation d'alcool et d'autres drogues par les Canadiens: La prevalence de l'usage et les méfait: Rapport détaillé.* (pp. 48-54). Ottawa, ON: Centre canadien de lutte contre l'alcoolisme et les toxicomanies.

Plourde, C., Brochu, S., Gendron, A., & Brunelle, N. (2012). Pathways of substance use among female and male inmates in Canadian federal settings. *The Prison Journal*, *92,* 506-524.

Reisig, M. D., Holtfreter, K., & Morash, M. (2006). Assessing recidivism risk across female pathways to crime. *Justice Quarterly*, *23*, 384-405.

Richie, B. (1996). *Compelled to crime: The gendered entrapment of battered black women.* New York, NY: Routledge.

Ross, S., & Guarnieri, T. (1996). *Recidivism rates in a custodial population: The influence of criminal history, offence and gender factors*. Research Report. Report to the Criminology Research Council.

Sabol, W. J., Minton, T. D., et al. (2007). *Prison and jail inmates at midyear, 2006*. U. S. Department of Justice. Document NCJ217675.

Salisbury, E., Van Voorhis, P., & Spiropoulis, G. (2009). The predictive validity of a gender -responsive risk/needs assessment. *Crime & Delinquency*, *55*, 550-585.

Sanders, J. R., McNeil, K. F., Rienzi, B. M., & Delouth, T. B. (1996). The incarcerated female

felon and substance abuse: Demographics, needs assessment, and program planning for a neglected population. *Journal of Addictions and Offender Counseling, 18,* 51-55.

Sapouna, M., Bisset, C., & Conlong, A. (2011). *What works to reduce reoffending: A summary of the evidence justice*. Research Report. Justice Analytical Services Scottish Government.

Shearer, R. A. (2003). Identifying the special needs of female offenders. *Federal Probation, 67*, 46-51.

Smith, V. C. (2011). *Substance-abusing women offenders as victims: Chronological sequencing of pathways into criminal behavior.* (Doctoral dissertation). Retrieved from ProQuest. UMI#: 3460711.

Smith, P., Cullen, F., & Latessa, E. (2009). Can 14,737 women be wrong? A meta-analysis of the LSI-R and recidivism for female offenders. *Criminology & Public Policy, 8,* 183-208.

Smith, L. A., Harris, A., Wilton, G., Archambault, K., Cousineau, C., Varrette, S., Power, J. (2010). *An initial report on the results of the pilot of the computerized mental health intake screening system (CoMHISS)*. Correctional Service of Canada. Ottawa, ON.

Steffensmeier, D., & Allan, E. (1996). Gender and crime: Toward a gendered theory of female offending. *Annual Review of Sociology, 22,* 459-487.

Van Voorhis, P., Wright, E. M., Salisbury, E., & Bauman, A. (2010). Women's risk factors and their contributions to existing risk/needs assessment: The current status of a gender -responsive supplement. *Criminal Justice and Behavior, 37,* 261-288.

Weekes, J., Moser, A., Ternes, M., & Kunic, D. (2009). *Substance abuse among male offenders*. Ottawa, ON: Correctional Service Canada.

Wright, S. (2002). Women's use of drugs: Gender specific factors. In H. Klee, M. Jackson and S. Lewis (Eds.), *Drug misuse and motherhood*. London, UK: Routledge.

Wright, E. M., Salisbury, E. J., & Van Voorhis, P. (2007). Predicting the prison misconducts of women offenders: The importance of gender-responsive needs. *Journal of Contemporary Criminal Justice*, *23*, 310-340.

Zlotnick, C., Najavits, L. M., Rohsenow, D., & Johnson, D. M. (2003). A cognitive-behavioural treatment for incarcerated women with substance abuse disorder and posttraumatic stress disorder: Findings from a pilot study. *Journal of Substance Abuse Treatment, 25*, 99-105.

Appendix A. Data retrieval instrument.

Item		***Enter***	***Code***
1	Gender		0 = Female 1= Male
2	Age		DOB: calculate age to number of months (rounded)
3	Language		1 English; 2 French; 3 Other; 4 none selected; 5 unknown
4	Aboriginal Status		1: Aboriginal; 2 Non-Aboriginal; 3 Unknown
5	Type of care		1=Crisis
6	Days in Care		Continuous
7	Community Treatment Orders		0= no; 1=yes; 2 = unknown
8	Exit Disposition		1= Successful Completion; 2= Withdrawal (Escape, failure to come back); 3= Early Termination Due to Incurrence of New Charges; 4= Early Termination Due to Lack of Cooperation (Violation of rules) 5=Relocation
	Nature of Offense		1=Yes (code all that appear)
	Violent Crime:		
9	Firearms		
10	Robbery		
11	Common Assault		
12	Domestic Assault		
13	Sexual Assault		
14	Threats/harassment		
15	Other violent Crime		
	Property Crime:		
16	Theft under $5000		
17	Theft over $5000		
18	Theft of motor vehicle		
19	Break and Enter		
20	Possession of stolen property		
21	Fraud		
22	Arson		
23	Other non-violent crime		
	Drug Offences:		
24	Possession		
25	Trafficking		

	Other		
26	Prostitution		
27	Breach		
28	Other violations		
29	Previous involvement in the Criminal Justice System		0=no; 1=Yes (PEST)
30	***Nature of offense***		**0=crimes against persons 1=property crimes; 3=both; 4= drug offences 5=breach of existing order 6=prostitution**
	Baseline Legal Status		1=Yes (code all that appear)
31	None Selected		
32	At Risk for Legal Problems		
33	No Legal Problems		
34	Pre-Charge Diversion		
35	Court Diversion Program		
36	Conditional Discharge		
37	Awaiting Fitness Assessment		
38	Awaiting NCR Assessment		
39	On Bail - Awaiting Trial		
40	Awaiting Sentence		
41	On Probation		
42	On Parole		
43	Unknown or Declined		
44	In Community on own Recognizance		
45	Unfit to Stand Trial		
46	Charges Withdrawn		
47	Stay of Proceedings		
48	NCR		
49	Conditional Sentence		
50	Restraining Order		
51	Peace Bond		
52	Suspended Sentence		
53	ORB - Detained- Community Access		
54	ORB- Conditional Discharge		
55	Incarcerated		
	Current Legal Status		1=Yes (code all that appear)
56	None Selected		
57	At Risk for Legal Problems		
58	No Legal Problems		
59	Pre-Charge Diversion		
60	Court Diversion Program		
61	Conditional Discharge		
62	Awaiting Fitness Assessment		
63	Awaiting NCR Assessment		
64	On Bail - Awaiting Trial		

65	Awaiting Sentence		
66	On Probation		
67	On Parole		
68	Unknown or Declined		
69	In Community on own Recognizance		
70	Unfit to Stand Trial		
71	Charges Withdrawn		
72	Stay of Proceedings		
73	NCR		
74	Conditional Sentence		
75	Restraining Order		
76	Peace Bond		
77	Suspended Sentence		
78	ORB - Detained- Community Access		
79	ORB- Conditional Discharge		
80	Incarcerated		
	Source of Referral		1=Yes (code all that appear)
81	None Selected		
82	General Hospital		
83	Psychiatric Hospital		
84	Other Institution		
85	CMHA - Case Management		
86	Other Community Agency		
87	Family Physician		
88	Psychiatrist		
89	Mental Health Worker		
90	Criminal Justice System - Police		
91	Criminal Justice System - Courts		
92	Criminal Justice System - Correctional Facilities		
93	Criminal Justice System – Probation		
94	Criminal Justice System - Parole		
95	Criminal Justice System - Crisis Beds		
96	Criminal Justice System - Other		
97	Self, Family , Friend		
98	Other		
99	CMHA – Other		
100	SLCS		
101	Lawyer		
	Presenting Issues Addressed		1=Yes (code all that appear)
102	None Selected		
103	Threat to Others/Attempted Suicide		
104	Specific Symptoms of Serious Mental Illness		
105	Physical/Sexual Abuse		

106	Educational		
107	Occupational/Employment/Vocational		
108	Housing		
109	Financial		
110	Legal		
111	Problems with Relationships		
112	Problems with Substance Abuse/Addictions		
113	Activities of Daily Living		
114	Other		
	Diagnoses		0=no evidence; 1 = present
115	**None Selected**		
116	**Unknown or declined**		
117	Adjustment Disorder		
118	Anxiety Disorder		
119	Chronic Illness		
120	Concurrent Disorder		
121	Delirium, Dementia, and Amnestic or Cognitive Disorder		
122	Developmental Handicap		
123	Disorder of Childhood or Adolescence		
124	Dissociative Disorder		
125	Dual Diagnosis		
126	Eating Disorder		
127	Factitious Disorder		
128	Hyper Sexuality		
129	Impulse Control Disorder No Elsewhere Classified		
130	Mental Disorder due to General Medical Condition		
131	Mood Disorder		
132	Personality Disorder		
133	Post-traumatic stress disorder		
134	Schizophrenia or Other Psychotic Disorder		
135	Sexual and Gender Identity Disorder		
136	Sleep Disorder		
137	Somatoform Disorder		
138	Substance Related Disorder		
139	Highest level of education		None Selected 1 No Formal Schooling 2 Some Elementary/Jr. High 3

			Some Secondary/High School	4	
			Some College/University	5	
			Unknown/Declined	6	
			Secondary/High school	7	
140	Current Educational Status		None Selected	1	
			Unknown or Declined	2	
			Not in School	3	
			Elementary/Junior School	4	
			Trade School	5	
			Vocational/Training Centre	6	
			Adult Education	7	
			Community College	8	
			University	9	
			Other	10	
141	Baseline Living Arrangement		None Selected	1	
			Self	2	
			spouse/partner	3	
			spouse/partner/other	4	
			Children	5	
			Parents	6	
			Relatives	7	
			Non-Relatives	8	
			Unknown or declined	9	
142	Current Living Arrangement		Code as above		
143	Baseline Residence Type		None Selected	1	
			Approved Homes and Homes for Special Care	2	
			Correctional/Probation Facility	3	
			Domiciliary Hostel	4	
			General Hospital	5	
			Psychiatric Hospital	6	
			Other Speciality Hospital	7	
			No Fixed Address	8	
			Hostel/Shelter	9	
			Long Term Care Facility/Nursing Home	10	
			Municipal Non-profit housing	11	
			Private Non-Profit Housing	1213	
			Private House/Apt-Owned/Market Rent	14	
			Private House/Apt – Subsidized	15	

			Retirement/seniors home	16
			Rooming/Boarding Home	17
			Supportive Housing – Congregate	18
			Supportive Housing - Assisted Living	19
			Other	20
			Unknown or Declined	21
144	Current Residence Type		Code as above	
145	Baseline Employment Status		None Selected	1
			Unknown or Declined	2
			Independent/Competitive	3
			Assisted/Supportive	4
			Alternative Business	5
			Sheltered Workshop	6
			Non-Paid Work Experience	7
			No Employment	8
			Casual/Sporadic	9
			No Employment of Any Kind	10
			No Employment - Other Activity	11
146	Current employment Status		Code as above	
147	Baseline Primary Income Source		None Selected	1
			Employment	2
			Employment Insurance	3
			Pension	4
			ODSP	5
			Social Assistance	6
			Disability Assistance	7
			Family	8
			No Source of Income	9
			Other	10
			Unknown or Declined	11
148	Current Primary Income Source		Code as above	

Drawing from the Program Eligibility Screening Tool			
Psychiatric Symptoms			1=Yes (code all that appear)
149	Abuses alcohol/drugs		
150	Agitated		
151	Anger management issues		
152	Anger/aggression outbursts		

153	Antisocial personality disorder		
154	Anxiety		
155	Attention deficit disorder		
156	Auditory hallucinations		
157	Autism spectrum disorder		
158	Compulsive spending		
159	Conduct disorder		
160	Cravings		
161	Delusions		
162	Depression		
163	Deteriorating mental health		
164	Developmentally delayed		
165	Difficulty reading/ writing		
166	Disorganized speech and thinking/ incoherent thoughts		
167	Dissociation		
168	Dizziness		
169	Drug addiction		
170	Fear		
171	Feeling triggered		
172	Fetal alcohol syndrome		
173	Fixates on problems		
174	Frustration		
175	Gambling addiction		
176	Grandiose ideas		

177	Grief		
178	Homicidal ideation		
179	Hopeless		
180	Impulsive		
181	Inappropriate social interactions		
182	Irrational		
183	Irregular sleeping patterns		
184	Irritable		
185	Lack of cooperation		
186	Lack of energy		
187	Low motivation		
188	Mania		
189	Memory/ intellectual impairment,		
190	Migraines		
191	Mood swings/bipolar/ instability		
192	Nausea		
193	Negative affect		
194	Nervous breakdown		
195	Nightmares		
196	No Appetite		
197	Nymphomaniac		
198	Obsessive compulsive disorder		
199	Oppositional defiant disorder		
200	Pacing		

201	Panic		
202	Panic attacks		
203	Paranoid		
204	Physically aggressive		
205	Poor concentration		
206	Poor memory		
207	Postpartum depression		
208	Preoccupation of religious beliefs		
209	Previous hospitalization (for mental instability)		
210	Previous suicidal ideation		
211	Previous suicide attempts		
212	Psychosis		
213	PTSD symptoms		
214	Racing thoughts		
215	Rapid eye movements		
216	Rapid Speech		
217	Schizophrenia		
218	self-esteem issues		
219	Self-harm		
220	Sexual frustration		
221	Social anxiety disorder		
222	Stressed		
223	Substance induced psychosis		
224	Substance misuse		

225	Suicidal ideation		
226	Threat to others		
227	Verbally assaultive/ use of disrespectful language		
228	Violence		
229	Visual hallucinations		
230	Withdrawal symptoms		
231	Withdraws/isolates self		
232	Worries constantly		
Psychiatric History			Any indication of the length (number of years) since onset
	Time		
Past Treatment			Drug name
233	Med 1		
234	Med 2		
235	Med 3		
236	Med 4		
Current Treatment			Drug name
237	Med 1		
238	Med 2		
239	Med 3		
240	Med 4		
Past Use of Substances			No use for at least 3 months (don't include periods of incarceration)

241	Used in the past		0=no; 1=yes; 2=unknown
242	Duration history		Time (in years) used
243	Oxycontin		1=yes
244	cocaine		1=yes
245	alcohol		1=yes
246	Marijuana		1=yes
247	Other		1=yes
248	Treatment in past		1=yes
Current Use of Substances			1=yes
249	Oxycontin		
250	Cocaine		
251	Alcohol		
252	Marijuana		
253	Treatment currently		
254	Other		
255	Other		
Risk Factors			1=yes
256	Maltreatment as a child		
257	Physical abuse as a child		
258	Sexual abuse as a child		
259	Emotional abuse as a child		
260	Neglect as a child		
261	(adult) Intimate partner violence		(look for Changing Ways, LAWC,

			WCH, Second Stage)
262	Sexual violence as adult		(look for SACL, Trauma Program at St. Joes's)
263	Child welfare as a child		
264	Children removed from care (adult)		
Client Presentation on Admission			0=no evidence; 1=poor/negative; 3=good/positive
265	Physical wellness		
266	Agitated		
267	Angry/aggressive		
268	Appearance		
269	Wounds		
270	Preoccupation		
271	Thoughts		
272	Cooperation		
273	Confused		
274	Logical		
275	Disassociation		
276	Other cognitive		
277	Other Physical		
278	Other Emotional		
Goals			

279	Housing		
280	Connection with other services		
281	Goal 1		
282	Goal 2		
283	Goal 3		
284	Goal 4		

Appendix B. Psychiatric Symptom Clusters.

Cluster	Symptoms
Substance Dependence	Abuses alcohol/drugs
	Cravings
	Drug addiction
	Feeling triggered
	Substance induced psychosis
	Substance misuse
	Withdrawal symptoms
Anxiety	Agitated
	Anger/aggression outbursts
	Anxiety
	Dizziness
	Fear
	Fixates on problems
	Frustration
	Irritable
	Inappropriate social interactions
	Migraines
	Nausea
	Obsessive compulsive disorder
	Pacing
	Panic
	Panic attacks
	Social anxiety disorder
	Stressed
	Worries constantly
Impulse Control Disorder	Anger management issues
	Compulsive spending
	Gambling addiction
	Impulsive
	Physically aggressive
	Threat to others
	Verbally assaultive/ use of disrespectful language
	Violence
Personality Disorder	Antisocial personality disorder
Schizophrenia	Auditory hallucinations
	Delusions
	Disorganized speech and thinking/ incoherent thoughts
	Grandiose ideas
	Homicidal ideation
	Paranoid
	Preoccupation of religious beliefs

	Psychosis Rapid eye movements Schizophrenia Visual hallucinations
Disorder in Childhood	Attention deficit disorder Autism spectrum disorder Conduct disorder Developmentally delayed Difficulty reading/ writing Fetal alcohol syndrome Lack of cooperation Oppositional defiant disorder
Mood Disorder	Depression Hopeless Irrational Irregular sleeping patterns Lack of energy Low motivation Mania Mood swings/bipolar/ instability Negative affect Nervous breakdown No Appetite Poor concentration Poor memory Postpartum depression Previous hospitalization (for mental instability) Previous suicidal ideation Previous suicide attempts Racing thoughts Rapid Speech self-esteem issues Self-harm Withdraws/isolates self Suicidal ideation
Cognitive Disorder/ Delirium	Deteriorating mental health Memory/ intellectual impairment
Dissociative Disorder	Dissociation
Grief	Grief
Post-traumatic Stress Disorder	Nightmares PTSD symptoms
Sexual Identity Disorder	Nymphomaniac Sexual frustration

Appendix C. Treatment/Medication Clusters.

Cluster	Med #	Medications
Antidepressants	Med 4	Amitriptyline (Elavil, tricyclic antidepressant)
	Med 6	Apo-Fluvoxamine (Luvox, SSRI)
	Med 8	Apo-nortriptyline (tricyclic)
	Med 17	Bupropion
	Med 22	Citalopram (SSRI)
	Med 24	Clomipramine (trycyclic)
	Med 36	Escitalpram (SSRI)
	Med 39	Fluoxetine (SSRI)
	Med 57	Mirtazapine (Remeron, Avanza, Zispin)
	Med 59	Nabilone (Also Analgesic)
	Med 68	Paroxetine
	Med 79	Sertraline HCL (Zoloft)
	Med 85	Trazodone (i.e., Desyrel, Oleptro, Trazorel)
	Med 90	Venlafaxine
Stimulants	Med 3	Adderall (ADHD)
	Med 27	Clonodine
	Med 50	Lisdexamfetamine Dimesylate (i.e., Vyvanse)
	Med 54	Methylphenidate (i.e., Ritalin, Concerta)
Antipsychotics	Med 10	Aripiprazole (atypical antipsychotic)
	Med 40	Fluanxol
	Med 45	Hydroxyzine (Antihistamines)
	Med 63	Olanzapine (i.e., Zyprexa – anti-psychotic)
	Med 67	Paliperidone (i.e., Invega)
	Med 72	Quetiapine (i.e., Seroquel)
	Med 75	Risperidone (i.e., Risperdal – antipsychotic)
	Med 91	Ziprasidone
Mood stabilizers	Med 51	Lithium (i.e., mood stabilizer for bipolar)
	Med 89	Valproic acid – (i.e., mood stabilizer)
Anxiolytics	Med 25	Clonazepam
	Med 55	Metoprolol
	Med 82	Temazepam (i.e., restoril, insomnia)
Depressants	Med 16	Benzodiazepines (Benzodiazepine anticonvulsants)
	Med 31	Diazepam (Benzodiazepine anticonvulsants)
	Med 47	Imovane (i.e., zopiclone)
Analgesics	Med 1	Acetaminophen (novo-gesic forte)
	Med 2	Acetylsalicylic acid
	Med 32	Diclofenac
	Med 62	Novo-Gesic (acetaminophen)
	Med 66	Oxycodone (i.e., Percocet)
	Med 87	Tylenol #2
	Med 88	Tylenol #3
Antibiotics/antineoplastics	Med 5	Amoxicillin

	Med 12	Azithromycin
	Med 19	Cephalexin
	Med 21	Ciprofloxacin
	Med 23	Clarithromycin
	Med 26	Clindamycin
	Med 42	Fuciclin Ointment
	Med 43	Garamycin
	Med 56	Metronidazole (i.e., antibiotic)
	Med 70	Polysprin (antibiotic)
	Med 84	Tetracycline (i.e., antibiotics)
Anti-addictive	Med 53	Methadone
Muscle relaxants	Med 13	Baclofen
	Med 30	Cyclobenzaprine
Nonsteroidal anti-inflammatory agents	Med 11	Arthrotec
	Med 35	Stool Softener
	Med 46	Ibuprofen (i.e., antiplatelet drug)
	Med 60	Naproxen (i.e., anti-inflammatory)
Treatment for stomach, GERD, intestinal ulcers	Med 48	Lansoprazole (aka prevacid)
	Med 65	Omeprazole (i.e., Prilosec – for GERD, stomach acid.)
	Med 69	PMS – pantoprazole
	Med 73	Rabeprazole (i.e., Aciphex)
	Med 74	Ranitidine
Treatment for Allergies	Med 14	Beclomethasone (Mylan) - nasal steroids
	Med 29	Corticosteroid nasal spray - nasal steroids
	Med 61	Nasonex
	Med 64	Olopatadine (aka patanol)
	Med 71	Prednisone
Treatment for sexual symptoms	Med 83	Tenofovir/emtricitabine for HIV
Treatment for Parkinson's disease	Med 15	Benztropine
	Med 7	Apo-Levocarb
Treatment for other medical illnesses and symptoms	Med 9	Apo-ramipril for high blood pressure (angiotensin converting enzyme inhibitors)
	Med 28	Clotrimaderm ointment (Antifungals) for skin infections
	Med 33	Diltiazem for hypertension calcium channel blocking agents
	Med 37	Ferrous Phosphate for hypertension calcium channel blocking agents
	Med 41	Fluticasone = Glucocorticoid (Immunological and Metabolic)
	Med 49	Levothyroxine (i.e., levoxyl, synthroid, eltroxin) for Hypothyroidism
	Med 52	Metformin (i.e., diabetic drug) = antidiabetic
	Med 58	Musillium for constipation
	Med 76	Rosuvastatin (i.e., cholesterol)
	Med 80	Soflax (docusate sodium) for constipation

	Med 81	Teva-Telmisartan for high blood pressure
Treatment for Asthma	Med 20	Ciclesonide nasal spray
	Med 38	Flovent
	Med 77	Salbutamol ventolin for Asthma
	Med 78	Sandoz Anuzinc
Treatment for Seizures	Med 18	Carbamazepine
	Med 34	Divalproex
	Med 43	Gabapentin

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