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Therapeutic Alliance and Offender-Staff Relations in Women's Corrections

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2014 Nº R-305

Therapeutic Alliance and Offender-Staff Relations in Women's Corrections

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February 2014

Acknowledgements

The completion of this report is the result of the work and dedication of many people. The authors would like to thank staff from Correctional Service of Canada National Headquarters, the Regional Psychiatric Centre (PRA) in Saskatoon, Grand Valley Institution, and Fraser Valley Institution for their initial feedback regarding methodological development during the preliminary consultation process.

We greatly appreciate the work and effort provided by Kim Allenby, Tammy Cabana, Lysiane Marseille and Alex Yeaman in their assistance with the data collection process. We would also like to acknowledge Ashley McConnell for her role in the data entry and coding process and Dena Derkzen for her feedback on the report and her assistance with data collection. We appreciate the work of Ian Broom in retrieving and organizing the data required and providing initial support in its analysis, and we would also like to acknowledge Shannon Gottschall for her feedback in the preliminary phases of statistical analysis. We would also like to thank Lynn Stewart for her review of the report and editorial feedback.

The authors would also like to thank the staff and wardens of all the women's federal institutions (Fraser Valley Institution, Edmonton Institution for women, Grand Valley Institution, Nova Institution, Joliette Institution and Okimaw Ohci Healing Lodge) for welcoming us and assisting us in our data collection process. Thank you to our site contacts: Virginia Meeds, Carol Miller, Jennifer Flett, Dr. Janine Cutler, Laurie Bernard and Chantal Lanthier for all of their help and support during our time in the institutions.

Finally, we'd like to thank all of the women and staff who participated in our research. Without their invaluable responses and feedback, this project would not have been possible.

Executive Summary

Key words: therapeutic alliance, women offenders, correctional interventions

In recent years, there has been an emerging interest in correctional research in the construct of the therapeutic alliance. Therapeutic alliance has been conceptualized as the collaborative and affective rapport established between a treatment provider and his or her client(s). The quality of this alliance is considered an important variable in the treatment process, affecting client success and rehabilitation across diverse modes of treatment and therapy. It can be argued that the importance of this relationship should therefore be significant when working with the offender population in regards to effective rehabilitative strategies. Research in this area, however, is relatively limited, especially with respect to women offenders. This gap in research exists despite the fact that current rehabilitative initiatives of the Correctional Service of Canada (CSC) emphasize that positive staff/offender interactions should be the foundation for the successful rehabilitation of women offenders.

Using a mixed-methods approach, the current study investigated the extent to which relationships between parole officers, institutional staff and women offenders in CSC are characterized by healthy connections as defined by relational and therapeutic alliance theories. The potential impact of an alliance on women's institutional adjustment was also assessed using alliance ratings as a predictor for institutional misconducts.

Participants were 124 federally-incarcerated women offenders and correctional staff at all six women's federal institutions in Canada. The study employed alliance and relational health measures as well as semi-structured interviews to gather information regarding staff and offender perceptions of therapeutic alliances within the facility as well as the impact of the operational environment (dynamic/static security) on the development of such alliances.

Results of a correlational analysis demonstrated that women's perceived level of bonding with their parole officer was related to their adjustment in that women with higher bond ratings were less likely to be involved in institutional misconducts. Interview responses from both staff and offenders further supported the importance of maintaining relational health and positive alliances within the institutional setting. Women offenders consistently highlighted the importance of communication, interpersonal skills and certain relational qualities that would better facilitate positive, collaborative alliances between staff and women. Staff demonstrated their knowledge of the construct of therapeutic alliance, its meaning, and its application to the job, while also acknowledging the challenges of establishing alliances with such a diverse population within an environment that requires a balance of positive interactions and priorities related to safety and security.

The majority of staff and women indicated that dynamic security was being practiced across all of the women's sites. Both staff and offenders also recognized certain operational barriers and the provision of resources as obstacles in the maintenance of alliances. Results provide evidence for the relevance of strong therapeutic alliances in promoting successful interventions and positive outcomes.

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Introduction

The quality of the rapport between a treatment provider and a client is an integral part of the therapeutic process affecting client success and rehabilitation across diverse forms of treatment. This relationship, which has been termed the 'therapeutic alliance', has long been the focal point of extensive research in clinical settings within the general population. It has evolved into a broad construct that encompasses all potential change-inducing relationships in various contexts (e.g., psychotherapy, psychiatry, substance abuse programming, and even medical treatment). Although there has been a growing interest in the therapeutic alliance in regards to the treatment of offenders, research in this area is still in its infancy. The role of the therapeutic alliance and its impact on offender rehabilitation has not been extensively investigated and is not yet entirely understood within the correctional setting. This paucity in the research is especially prominent when it comes to women offenders.

It has been well established in the correctional literature that the women offender population presents with a diverse range of needs. There is also evidence that women may respond more positively to certain styles of management and intervention (Blanchette & Brown, 2006). Over the years, the Correctional Service of Canada (CSC) has continued to evolve its management of this population, drawing from the Relational Cultural Theory (Miller, 1986) and focusing on positive staff and offender interactions as the foundation for achieving its objectives and priorities. The staff-offender dynamic has been highlighted as playing a crucial role within the institutional setting and emphasis has been placed on the rehabilitation of women offenders via healthy and constructive relationships within a supportive environment (Task Force on Federally Sentenced Women, 1990).

Given the importance placed on successful rehabilitation through positive connections and relationships with criminal justice-involved women, similarities can be drawn between the concept of the therapeutic alliance and current rehabilitative initiatives in corrections with women offenders. The purpose of the current study is therefore to investigate the extent to which relationships between women offenders and institutional staff in the federal correctional system are characterized by healthy connections while exploring the construct of therapeutic alliance.

The literature review that follows provides a theoretical overview of Relational Cultural Theory and its current application to women offenders. The review will also include an overview of the literature on therapeutic alliance and the literature assessing the constructs of

alliance theory within a correctional setting. Gaps in research will also be highlighted.

Relational Cultural Theory

Central to the concept of rehabilitation through constructive interactions is Relational Cultural Theory (RCT; Miller, 1986). Emerging from the work of Miller (1986), RCT provides a gender responsive alternative to the traditional male theories that focus on autonomy and individualism. Rather than focusing on rehabilitation by the realization of one's full potential through independence and self-actualization, RCT posits that self growth and psychological development via healthy and meaningful connections is particularly important for women. The theory holds that healthy relationships which foster growth and change are characterized by five defining aspects: mutual engagement (perceived mutual involvement and commitment of both parties), empowerment/zest (empower to act positively and take action), authenticity (knowledge of self and self-worth), the ability to accept and effectively manage conflict, and finally, the desire for further connection with others.

It is argued that if relational health is not evident, or if there is a rupture or disconnection within a relationship, this can have a negative effect on psychological development (e.g., a diminished sense of self-worth, lack of engagement, lack of pro-social actions, and a decreased ability to effectively manage conflict; Comstock, Hammer, Strentzsch, Cannon, Parsons, & Salazar, 2008; Frey, Beesley, & Miller, 2006; Frey, Tobin, & Beesley, 2004). Although RCT is considered a broad theoretical model applicable to women's developmental trajectories in general, it is also often applied to understanding women's criminality and their potential rehabilitation. It is proposed that the manifestation of these emotional, psychological and social difficulties and the negative effects of social isolation and disempowerment play a role in female offending (Bloom, Owen, & Covington, 2003). For example, women offenders report higher rates of past victimization and abuse in comparison to male offenders and women in the general population (evidence of unhealthy and detrimental relationships;Task Force on Federally Sentenced Women, 1990),and it is argued that abuse can be linked to a later onset of criminal behavior (Kelly & Caputo, 1998). Furthermore, unhealthy and antisocial relationships/associations have frequently been associated with offending behaviour (Andrews & Bonta, 2010; Brown & Motiuk, 2005). Research suggests that antisocial associations are a powerful predictor of recidivism in women and therefore a relevant target for intervention (Blanchette & Motiuk, 1995; Brown & Motiuk, 2005). Research supporting the role of

antisocial associations in offending is typically grounded in the risk-need-responsivity principles of the effective corrections framework (RNR; Andrews & Bonta, 2010) rather than RCT; however, regardless of the theoretical underpinnings considered, there is ample evidence to support a link between procriminal associates and female offending.

Although literature regarding relational issues in women offenders focuses on adolescents and is qualitative in nature, the results support its importance in rehabilitative approaches. Belknap (1997) for example, conducted focus groups with adolescent girls in custody to better understand their experiences. The girls described experiencing relationships with staff characterized by disrespect and poor interpersonal skills which in turn hampered rehabilitation efforts. The girls also emphasized the necessity of an ideal mentor or role model to promote their wellbeing, and the importance of establishing positive interactions between staff and offenders. Another major finding related to the impact of past traumatic events and past dysfunctional or antisocial relationships which they viewed as related to the onset of their delinquent behaviour (Belknap, 1997).

More recently, qualitative assessments of adult women offenders successfully reintegrated into the community support the importance of relationships (Gobeil, 2008; O'Brien, 2001). Gobeil (2008), for example, found that the majority of women perceived that their healthy relationships with their family, children and friends played a significant role in remaining crime-free. In the same study, the majority of women provided positive feedback in regard to their relationships with their community parole officers. Participants highlighted that parole officers who had a positive influence on the women's reintegration were: supportive, encouraging, professional, effective communicators and able to build a rapport with the women. Those officers who could not establish a positive alliance were seen by the women as being unprofessional, authoritarian and unable to positively reinforce behaviours. O'Brien (2001) reported similar findings.

The importance of RCT in the psychology of women has frequently been discussed in the feminist and counseling literature, but the knowledge base is still in the developmental stages and further research is needed. Empirical research examining RCT in a correctional setting is even more limited. Notwithstanding these issues, relational health is still seen as a potential moderator variable of treatment outcome and has been a major influence in the development and planning of correctional programming and gender-informed principles (Blanchette & Brown,

2006; Fortin, 2004). For this reason, it is essential to further investigate the role of RCT in the rehabilitation of women offenders.

RCT and Canadian Correctional Perspectives for Women Offenders. For the reasons discussed above, RCT is regarded as a fundamental part of an effective approach in the treatment of women offenders and has been a core focus in the development of women-centered methods of intervention (Blanchette & Brown, 2006; Fortin, 2004). As outlined in The Program Strategy for Women Offenders in CSC (Fortin, 2004), programs must take into account the psychological development of women and how it relates to the development and maintenance of positive connections. The focus is to encourage change and rehabilitation by increasing a woman's "capacity to engage in mutually empathic and mutually empowering relationships" (Fortin, 2004, p.5) while also emphasizing the importance of staff in engaging with the women in forming and developing these connections. The goal in the development of relationships is to enable change and encourage the psychological growth of women by moving away from past negative and antisocial relationships (e.g., domestic abuse, antisocial peers) towards a more healthy and prosocial lifestyle, thus reducing the risk to reoffend (Bloom et al., 2003).

RCT is also consistent with the established concepts of effective correctional practice, most notably the responsivity principle (Blanchette & Brown, 2006). Responsivity, one of the core principles of evidenced based practice in corrections, relates to the characteristics of program delivery and the way in which the style, format, and approach to treatment fit the learning styles of offenders (i.e., what they are *responsive* to; Andrews & Bonta, 2010). Very similar to RCT and therapeutic alliance theory, which will be discussed shortly, adherence to the responsivity principle notes that the most effective correctional staff are warm, supportive and empathetic (Andrews & Bonta, 2010; Blanchette & Brown, 2006).

Current correctional initiatives are also based on the guiding principles of *Creating Choices*, the report of the 1990 Task Force on Federally Sentenced Women, which recommended the development of a correctional model using a holistic approach to women's corrections. In acknowledging that women's backgrounds, levels of risk and need, and security requirements were often different from their male counterparts, the Task Force outlined correctional goals based on the principles of empowerment, meaningful and responsible choices, respect and dignity, shared responsibility and a supportive environment (Task Force on Federally Sentenced Women, 1990). The Task Force report stated that that women required different

methods of intervention, management, and a dynamic model of security to facilitate rehabilitation, while maintaining the safety of the correctional environment (CSC, 2002). It should be noted, however, that many of the principles outlined in the report could apply to intervening with male offenders as well, although there is less research specifically examining the impact of adherence to these principles with men.

Dynamic security is an integral component in this holistic approach to women's corrections in CSC. As outlined in the Commissioner's Directive 560, the objective of dynamic security is to, "optimize a safe environment for employees, offenders and the public through meaningful interactions between these parties" (CSC, 2006). Dynamic security constitutes any interaction or activity that contributes to the safety of an institution via the establishment of positive, constructive relationships (CSC, 2002). Relationships between staff and women offenders are therefore at the foundation of the practice of dynamic security. The way in which staff and women engage and interact with each other has the potential to develop a positive institutional environment and a 'teamwork' culture, thus contributing to the safety of the institution and reducing the need for the use of force or extensive static security measures (CSC, 2002).

Therapeutic Alliance

The concept of relational health and rehabilitation via healthy connections is not a novel concept. Although research on RCT is scant, therapeutic alliance has been investigated for some time in a multitude of clinical settings. Therapeutic alliance, which has also been referred to more generally as a working alliance, refers to the interdependent and affective bond that is established between therapist and client, and is seen as an integral part of the treatment process (Martin, Garske, & Davis, 2000). Although originally rooted in psychodynamic theory, therapeutic alliance has been reconceptualized into a pan theoretical model which encompasses all potential change-inducing relationships across different therapies and treatments (Bordin, 1979). Bordin (1979) proposed that an alliance consists of three key components: goals, tasks, and bond and that the combination of these components determines the strength and quality of a therapeutic relationship and consequently, treatment effectiveness. The goal component constitutes the mutual agreement between therapist and client regarding outlined objectives that become the target and potential outcome of intervention. A rapport can be difficult to establish if the goals cannot be agreed upon, or if the clients do not feel they have any influence in

determining their goals. Tasks relate to the steps that need to be taken in order to achieve the goals set out for treatment for which both parties endorse and accept responsibility. It is important that the tasks be seen as relevant and beneficial in serving their purpose so that the client is more likely to be engaged in the treatment process. Finally, the bond component, similar to concepts found in RCT, relates to the compatibility of both parties and the nature of the relationship formed. Bonds are characterized by the level of mutual trust, respect, acceptance and shared commitment.

The relationship between the quality of alliance and clinical outcome has been consistently demonstrated across diverse forms of treatment using numerous approaches to measuring alliance (e.g., client, participant and observer scales of alliance) as well as multiple methods of outcome measurement depending on the targets of intervention (e.g., depression, substance abuse, or other mental health issues; Horvath & Symonds, 1991; Lambert & Barley, 2001; Morgan, Luborsky, Crits-Christoph, Curtis, & Solomon, 1982). In a meta-analytic review, Horvath and Symonds (1991) reported that the therapist-client relationship accounted for 25%-30% of the variance in explaining treatment effectiveness. A more recent meta-analysis (Martin, et al., 2000) also reported a moderate effect size between alliance and treatment outcome.

Research has further demonstrated that the quality of the relationship and therapists' interpersonal skills show higher correlations with treatment outcome than specific therapeutic techniques or even type of therapy. Specifically, characteristics such as warmth, flexibility, empathy and understanding have been positively related to healthy alliances (Ackerman & Hilsenroth, 2003) while characteristics of being rigid, judgmental and unsupportive contribute to alliance difficulties (Ackerman & Hilsenroth, 2001). Furthermore, positive or negative patient observations of therapist characteristics are associated with treatment outcome. As demonstrated in a meta-analysis by Horvath and Symonds (1991), clients' perceptions of these therapist characteristics and therapeutic alliance have been found to be more strongly related to treatment outcome than therapists' and observers' assessments. These findings have been supported in other studies (Ackerman & Hilsenroth, 2003; Horvath & Luborsky, 1993; Saunders, 2000), and have been evident irrespective of type of therapy, length of treatment, or treatment format (i.e., group vs. individual), indicating the significance of the alliance and the bond itself (Horvath & Symonds, 1991).

Given that a positive therapeutic alliance has repeatedly been linked to positive treatment

outcome, it is not surprising that a negative or ruptured therapeutic alliance has also been highlighted as a risk for poor treatment outcome and treatment dropout (Safran, Samstag, Muran, & Winston, 2005; Samstag, Batchedler, Muran, Safran, & Winston, 1998). Samstag and colleagues (1998) found that client's perceptions of a problematic or negative alliance were significantly related to increased dropout rates. Negative therapist ratings were also indicative of the increased dropout rates. Although a positive alliance has been shown to be a stronger predictor of treatment outcome (Luborsky, 1994) there is still sufficient evidence to suggest the potentially detrimental impacts of a negative alliance on client retention and rehabilitation.

The quality of the therapeutic alliance plays a prominent role in treatment outcome, and based on the pan-theoretical origins of the theory, one expects that this should be seen across all methods of treatment and all possible settings where a 'helping/change-inducing' dynamic is present. Accordingly, it is expected that the significance of a therapeutic alliance will also be relevant to effective interventions with offenders.

Therapeutic Alliance in a Correctional Environment. There is not yet an extensive amount of research regarding therapeutic alliance in a correctional setting (Ross, Polaschek, & Ward, 2008). There is, however, a substantial body of research on the principles of effective intervention, responsivity, treatment readiness and therapist characteristics that relate to the concept of a therapeutic alliance. Additionally, there are some preliminary research findings on staff and offender interactions.

Numerous researchers (e.g., Andrews & Bonta, 2010; Andrews & Dowden, 2006; Bourgon & Armstrong, 2005; Brown & Motiuk, 2005; Gendreau & Andrews, 1990; Motiuk & Serin, 2001) suggest that correctional programs that comply with principles of risk and need and are responsive to individual learning styles will have a significant impact on treatment outcome. As discussed above, the responsivity principle applies to concepts of therapeutic alliance and relational theory in that it refers to engaging offenders by tailoring treatment based on offender characteristics (e.g., learning styles, goals, motivation; Andrews & Bonta, 2010). In addressing specific responsivity and staff practices, Andrews (2000) points out that matching treatment methods to offender learning styles and abilities while selecting staff who demonstrate strong interpersonal skills (e.g., warmth, respect, flexibility) maximizes offender motivation and engagement. In a meta-analytic review, correctional programs that included these core staff practices and characteristics showed more significant effect sizes in comparison to programs that

did not take therapist skills into account (Dowden & Andrews, 2004). Similar findings have been supported in other correctional research (e.g., Marshall, Serran, Fernandez, Mulloy, Mann, & Thornton, 2003; Serran, Fernandez, Marshall, & Mann, 2003), suggesting that these variables are not only related to offender-staff rapport (i.e., therapeutic bond), but that they are also associated with increased likelihood of offender acceptance and accountability as well as program completion (Serin & Shturman, 2007). Andrews (2000) also acknowledges that although relationship principles are applicable to both male and female offenders, significant emphasis has been placed on the importance of interpersonal connections when working with women offenders. He further argues that additional research in this area is needed.

Beyond the construct of responsivity, the correctional concept of treatment readiness, within an offender context, as outlined by Serin and Kennedy (1997), is also relevant to the therapeutic alliance theory. Readiness can be generally defined as, "the presence of characteristics (states or dispositions) within either the client or the therapeutic situation, which are likely to promote engagement in therapy and that, thereby, are likely to enhance therapeutic change" (Howells & Day, 2002 as cited in Ward, Day, Howells, & Birgden, 2004, p. 647). Similar to the objective of arriving at agreement on tasks and goals as a component of therapeutic alliance, this principle highlights that within a given therapeutic situation, an offender must not only be motivated, but also be engaged in the therapeutic process, perceiving the goals and treatment as being relevant, meaningful and beneficial (Ward et al., 2004).

Given the consistent empirical link between therapeutic alliance and successful outcomes in other therapeutic/rehabilitative contexts, it is plausible that a positive alliance between interveners and offenders is also a significant feature of effective offender intervention. The emphasis placed on offender engagement and staff characteristics in correctional literature highlights the potentially, "critical role of the therapeutic alliance in the development of a collaborative therapeutic relationship in working effectively with offenders to reduce the risk that they will reoffend" (Ward et al., 2004, p.649). If a negative alliance can increase the likelihood of treatment failure or dropout, this is an important issue to assess given the challenge of offender retention in correctional programs, the increased risk of recidivism for non-completers, and the potential for staff burnout (Marshall et al., 2003; McMurran & Theodosi, 2007; McMurran & Ward, 2010). Although offenders can be a challenging population to work with, evidence suggests that neither a confrontational approach, nor one that is unconditionally

positive, will produce a constructive alliance (Marshall & Serran, 2004). Marshall and Serran (2004) emphasize that offenders will be more motivated to change and engage in treatment when a positive, constructive working alliance and supportive environment is provided by institutional staff.

Research assessing working or therapeutic alliances between offenders and institutional staff is not extensive, but some studies have shown promising results and demonstrate similar significant findings. Overall, positive alliances have been linked to potential reductions in offender recidivism (Simon, Wormith, & Nicholaichuk, 2010) and higher levels of treatment performance in correctional programs (Di Placido, Witte, Wong, & Gu, 2006; Polaschek & Ross, 2010). Offenders' negative perceptions of an alliance have also been linked to decreased motivation and program non-compliance, including revocations and new arrests on release (Skeem, Eno Louden, Polaschek, & Camp 2007).

The aforementioned studies show significant results that support the need for further investigation in this area. It is important to note, however, that the above studies consisted of samples that were predominantly male and were only specific to unique or high need offender populations. For example, work by Skeem and colleagues (2007) was on mentally disordered offenders in the community, while work by Di Placido et al., (2006) only assessed gang members and work by Serran et al., (2003) focused on sex offenders. Additionally, the focus has primarily been on alliances with program staff despite the fact that offenders come in contact with a wide range of correctional staff who have the potential to influence their rehabilitation via healthy interactions (e.g., parole officers, correctional officers, behaviour counsellors, elders, chaplains). For example, the parole officer role, which is the primary focus of the current analysis, requires the skills, knowledge related to the key aspects of the therapeutic alliance, specifically those of goal setting, task agreement and the presence of an interpersonal bond. As outlined in the CSC parole officer job description, a parole officer works with offenders to motivate change and rehabilitation, support positive behavioural improvements, and assist in the development of pro-social alternatives. They need to be able to establish a working relationship that involves communication, counselling, mediation, the administration of appropriate consequences for certain behaviours, and consistent support via interpersonal interactions. Parole officers also play a key role in developing a correctional plan with an offender and ensuring that the required and appropriate services and programs (i.e., tasks) are in place in order to meet correctional

requirements and assist the offenders in becoming law abiding citizens (i.e., goal). Similar descriptions exist for other institutional staff, suggesting that widening the lens and exploring alliances with other staff members would be beneficial as well.

Current Study

Despite the emphasis placed on relational health and women, there is a paucity of research on therapeutic alliance specifically among women offenders and correctional staff. Based on the diverse needs of women offenders, the current guiding principles grounded in RCT and the potentially positive impact of a therapeutic alliance on rehabilitation, it is important to explore these constructs within the women offender population.

Using a mixed-methods approach, the current study aims to investigate the extent to which relationships between parole officers, institutional staff and women offenders in CSC women facilities are characterized by healthy connections as defined by RCT and therapeutic alliance. Additionally, the study investigates the construct and relevance of therapeutic alliance and its potential impact on women's institutional adjustment and rehabilitation. This study will also incorporate the assessment of the practice and maintenance of dynamic security, and the way in which the operational environment affects the ability to form healthy and productive working relationships. It is hypothesized that women's ratings of their alliances with their institutional parole officer will be related to their institutional adjustment. More specifically, it is hypothesized that positive alliance ratings will be correlated with a lower number of institutional incidents.

Method

Women Offender Sample

The initial offender sample consisted of 128 federally incarcerated women offenders and 88 institutional staff members. Data quality issues reduced the final sample to 124 offenders. Additionally, five women were not included in the follow up data analysis as they did not consent to the researchers accessing their administrative data. For this reason, only 119 women were assessed for the quantitative analyses, while the full 124 were included in the qualitative results.

During the time of data collection, approximately 500 women were incarcerated in CSC (CSC, 2010), thus the sample represents approximately 25% of available participants (see Table 1 for a breakdown of the sample by institution). The following descriptive characteristics were accessed from OMS and conducted with a reduced sample of 119 women. Thirty-nine percent of the sample was married or common law, while 47% were single and the remaining 14% were separated, divorced or widowed. The women ranged in age from 19 to 69 (M = 37.8 years; SD = 10.83). The breakdown for ethnicity was as follows: 66% Caucasian, 24% Aboriginal, 4% African American and 6% other. Aboriginal women offenders are under-represented in the current sample relative to their presence in the total population of women offenders in CSC (31%).

Table 1

Women Offender Participants by Institution

Institution	%	(*n*/124)
Fraser Valley Institution	13.7	17
Edmonton Institution	18.5	23
Okimaw Ohci Healing Lodge	8.9	11
Grand Valley Institution	13.7	17
Joliette Institution	25.8	32
Nova Institution	19.4	24

The majority of the women (80%) were serving determinate sentences ranging from 2 to 13 years (M = 3.28, SD = 1.56). The women were serving their current sentence for a range of

offences including drug-related offences (27%), homicide (26%), robbery (20%), assault (15%), other violent offences [1](13%) and other non-violent offences[2] (56%)[3]. Forty-three percent were assessed as requiring minimum security, 45% were medium, 9% were maximum security, and for 3% of the sample, the security classification was unknown. Table 2 provides details on the profile of the sample. The majority of women were classified as medium to high risk, and the majority were rated as high need. On a positive note, however, the majority were also rated as having moderate to high reintegration potential and virtually all were rated moderate to high motivation to follow and complete their correctional plans.

Table 2

Women Offenders Sample Profile: Risk, Need, Motivation and Reintegration Level

	%	(*n*/119) [a]
Risk Level		
Low	26.1	31
Medium	42.0	50
High	31.9	38
Need Level		
Low	10.1	12
Medium	34.5	41
High	55.5	66
Reintegration Potential		
Low	28.6	34
Medium	40.3	48
High	31.1	37
Motivation Level		
Low	5.0	6
Medium	52.1	62
High	42.9	51

Note. [a] Results are based on an *N* of 119 due to missing data for 5 cases.

[1] Examples of other violent offences include: kidnapping, abduction, weapons and explosives.
[2] Examples of other non-violent offences include: public order offence, administration of justice, impaired driving.
[3] The number of offences exceeds the number of women because each offender can have more than one offence on file for the current sentence.

Staff Sample

A total of 88 staff participated in the study. Given the number of potential institutional staff participants and the fluctuating number of staff within a given period of time, calculating a response rate was not feasible. As Table 3 illustrates, the majority (60%) of the staff participants were programs staff[4] and primary workers[5]. Among the 88 staff members, the length of experience working in the correction system ranged from 1 month to 23 years (M = 7 years, SD = 5.9 years). Staff experience working specifically with women offenders ranged from 1 month to 15 years (M = 5.2 years, SD = 4 years).

Table 3

Employment Positions of Staff Included in the Sample

Position	%	(*n*/88)
Correctional Program Officer/Facilitator	18.2	16
Social Programs Staff	14.8	13
Primary Worker/Older Sister	17.0	15
Behaviour Counsellor	10.2	9
Parole Officer	9.1	8
Psychologist	8.0	7
Elder	2.3	2
Chaplain	4.5	4
Warden/Assistant Warden	2.3	2
Assistant/Managerial Staff	4.5	4
Other	9.1	8

Recruitment and Data Collection

Data were collected in 2009 at all six federal women's institutions: Fraser Valley Institution, Edmonton Institution for Women, Grand Valley Institution, Nova Institution, Joliette Institution and Okimaw Ohci Healing Lodge. Posters and information sheets outlining the overall purpose of the study were distributed to both the women and staff in each facility one

[4] This included program officers or facilitators for both correctional and social programming.
[5] Primary workers are correctional officers in federal correctional institutions for women offenders.

week prior to the research team's arrival via the assistance of a designated site contact. Signup sheets for both staff and women were provided in advance and participants were also informed that they could approach the team directly upon arrival in order to maintain anonymity. Further face-to- face recruitment efforts were made while on site, and interviews were scheduled accordingly based on staff and offender response.

Procedure

Offender sample recruitment. All federally incarcerated women were eligible to take part in the study. Given the nature of the measurements used and the requirement to read and complete a number of scales, a basic level of reading and writing was required for the women to participate. Interviews and scales were available in both French and English.

The women offender participants were provided with a brief verbal explanation of the project and an informed consent form which described the components of the study and emphasized that participation was voluntary and that confidentiality would be maintained (see Appendix A). Women were told that the process (interview and questionnaires) would take approximately 30-45 minutes to complete. The women were asked to provide their Finger Print System (FPS) number (method of offender identification) and consent to the use of this identifier for additional data collection (e.g., demographics, security level, institutional misconducts) through the Offender Management System (OMS)[6]. Women were given the option to provide consent to participate in the questionnaire and interview portion of the study only and not consent to providing their FPS number or allowing further information to be collected.

Offenders were asked to complete two self-administered questionnaires assessing their interactions with their current parole officer (Relational Health Indices Mentor Subscale and the Working Alliance Inventory Client Version). The parole officer role was selected as the primary focus for the questionnaires based on the job description described above. Offenders were also asked to participate in an interview to discuss the construct of the therapeutic alliance more broadly and to comment on staff interactions outside of those with their parole officer as well as their views on the institutional environment.

Staff sample recruitment. All staff were considered eligible to participate if they self determined that they had enough contact with the women to respond to the questions. Based on

[6] The Offender Management System (OMS) is an offender database monitored and maintained by the CSC. It is used to record, collect and share information on offenders serving federal sentences.

the specific questions and the level of detail needed in order to respond, parole officers, psychologists, behaviour counselors, program officers/facilitators, primary workers, elders, and chaplains volunteered. Other staff who felt comfortable responding to the measures and interview questions participated as well (e.g., teachers, liaison officers).

The staff were informed of the study and instructed that participation was voluntary (Appendix B). Staff were asked to complete one Working Alliance Inventory (WAI) questionnaire based on their interactions with only one woman from their caseload they had been working with recently. In order to assist the staff in the selection of an offender to focus on, the research team ensured that the measures were divided by security level (e.g., minimum, medium *or* maximum) and were randomly assigned to staff members. The staff member was then directed to respond to the questionnaire based on a woman who fit the designated security classification with whom they had most recently interacted. In addition, following the completion of the WAI, the staff member took part in an interview regarding their typical interactions with all women on their caseload. During this interview, their views on dynamic security were also explored.

Although it is common practice in the therapeutic alliance literature to assess the results of a dyadic relationship (i.e., therapist and client rate each other and scores are compared), in the current study this format was not followed for ethical reasons. The collection of scores from both a staff member and an offender on their shared therapeutic alliance would have necessitated that staff be privy to the participants' identities - a situation that would have put undue pressure on the women to participate in the study. Additionally, given the preliminary investigative nature of this study, a more simplistic research design was selected in order to explore the nature of the alliances on a broader level in an institutional setting.

Analytic Approach

A mixed methods approach was used. For the quantitative component, a series of descriptive, reliability and correlation analyses were conducted. A detailed missing value analysis (MVA) was also performed to ascertain the amount and pattern of missing data. Based on the MVA results multiple imputation was selected as the best strategy for addressing missing data (see Appendix C for a detailed overview). Given that multiple imputation essentially generated the same findings as pairwise deletion, it was decided to present the pairwise deletion results for simplicity.

For the qualitative assessment, a thematic content analysis was conducted to interpret the interview results, and identify emerging themes. Responses were grouped and coded into separate categories based on a review of these data. It was ensured that responses within each individual category were of similar content while overlap between the categories was limited. This process was carried out by three researchers, with two of the researchers as principle coders, overseeing all content analysis and coding. Any coding discrepancies were resolved through group discussion. The number and proportions of respondents endorsing each theme are reported in relation to the total number of participants who were asked each question.

Measures/Material

The Offender Management System (OMS) is CSC's automated database containing offender information. Demographic and background information (e.g., ethnicity, marital status, risk, need, security level, offence type, sentence length) were extracted from this system along with outcome data such as major and minor institutional incidents

Demographic and sentence characteristics. Several demographic and incarceration characteristics were accessed from OMS to provide an overall description of the sample. Ethnicity was categorized into four main groups: Caucasian, Aboriginal (Inuit, Métis and First Nations), African American, and Other[7]/Unknown. The relationship status variable was divided into three groups: with partner (married, common-law), single, and separated/divorced/widowed.

Offence characteristics. An offender's index offence(s) on her sentence categorized into the following six dichotomous variables: homicide (e.g., murder or attempted murder), robbery, assault, drugs (e.g., drug possession, trafficking and importing), other violent (e.g., kidnapping, abduction, weapons and explosives, and other non-violent (e.g., public order offence, administration of justice, impaired driving). Aggregate sentence length represents the total length of an offender's sentence in years.

***Offender security level*.** As part of the intake process, offenders are assigned a security classification upon admission into federal custody. The classification is based, in part, on the results of the Custody Rating Scale (CRS; Solicitor Gender of Canada, 1987) which assesses an offender's institutional adjustment and security risk. The measure provides an overall score, with higher scores being indicative of higher classification recommendation. There are

[7] This consisted of several categories collapsed together due to small *n*'s (e.g., East Indian, Hispanic, Chinese, Filipino, Latin American, etc…)

designated score cut-off points which indicate if an offender should be placed in minimum, medium, or maximum security. Although the CRS was originally developed based on male offender samples, it has demonstrated sufficient reliability and validity when used with both women and Aboriginal offenders (Blanchette, Verbrugge, & Wichmann, 2002).

Offender Intake Assessment. Data pulled from OMS included information taken from the Offender Intake Assessment (OIA) database. The OIA is conducted upon an offender's arrival and official admission into the federal correctional system by the institutional parole officer and Case Management Team. The purpose is to assess immediate concerns, levels of static criminal risk (e.g., offence severity, criminal history) and dynamic risk (i.e., criminogenic needs). A core component of the OIA is the Dynamic Factor Identification and Analysis (DFIA), which is comprised of seven dynamic factor domains (Brown & Motiuk, 2005). The DFIA highlights factors that are significantly related to an offender's criminal behaviour and thus identifies targets for correctional intervention. The following ratings were obtained based on offender assessments upon admission and were used for the current analysis: Overall *static risk* was assessed as low, medium, or high risk based on historical factors such as criminal history or age at first offence (CSC, 2007). Overall *dynamic risk* relates to an offender's overall level of criminogenic needs or dynamic risk rating. Offenders are assessed as overall low, medium, or high risk based on the number and severity of identified needs (CSC, 2007). *Motivation level* is rated as low, medium, or high based on an offender's perceived motivation to complete her prescribed correctional plan (CSC, 2007). *Reintegration potential* is assessed as low, medium, or high and indicates the probability of successful offender reintegration back into the community (CSC, 2007).

Institutional adjustment. The criterion variable of institutional adjustment was defined as the number of institutional incidents that occurred within the six months period of data collection (three months prior, and three months post). The six month period was selected to reflect the offender's level of institutional adjustment most proximal to the alliance ratings. Analyses included both major (e.g., assault) and minor (e.g., minor disciplinary) incidents.

Relational Health Indices (RHI).[8] The RHI (Liang, Tracy, Taylor, Williams, Jordan, & Miller, 2002; Appendix D), is based on the foundations of RCT and was developed to assess growth fostering relationships as characterized by engagement, authenticity and

[8] Publicly available measure (http://www.thefindingsgroup.com/groups/measures/wiki/935ea/)

empowerment/zest. Although it was developed with three subscales to assess relationships with one's peers, mentor and community, for the purpose of the current analysis, only the RHI Mentor subscale (RHI-M) was used. The RHI-M is an 11-item self-report scale that assesses the quality of a respondent's relationship with a selected mentor, in this case the participant's parole officer. The scale instructions and structure were modified slightly in order to identify parole officers as the mentors in question and to instruct the women to reply based on their relationships with their current institutional parole officer. Examples of items on the scale include, "My parole officer gives me emotional support and encouragement" and, "I feel comfortable sharing my deepest concerns with my parole officer". Participants were asked to identify the extent to which they agreed with each statement on a 5-point Likert scale (1=never to 5=always). The total score ranges from 11 to 55, with higher scores being indicative of a higher quality of relational health. The RHI has demonstrated adequate internal consistency for the composite scores (Cronbach's *alpha* = .85 to .92), and convergent validity (*r* = .50 to .69) with other measures of relational health (e.g., perceived mutuality in close relationships, support, depth) when used with female participants (Liang et al., 2002).

Working Alliance Inventory (WAI).[9] The WAI (Horvath & Greenberg, 1987) was developed to assess Bordin's (1979) integrative model of the therapeutic/working alliance. The client version (WAI-C), which was administered to the women, is a 36-item, self report scale with three subscales: Bond, Task and Goal, based on Bordin's three key tenets described above. Each subscale is composed of 12 items. Participants are asked the extent to which they agree with each statement based on a 7-point Likert scale (1 = never to 7 = always). Once again, instructions were modified slightly so that the participants would reply based on their current institutional parole officer. Examples of items include, "I feel uncomfortable with my parole officer" and, "My parole officer and I agree on what is important for me to work on".

The therapist version (WAI-T) follows a similar format to the WAI-C. This version was administered to staff and instructions were modified to direct the participants to reply based on their interactions with the woman offender they most recently met with. Examples of items include, "This woman and I agree about the steps that need to be taken to improve her situation" and, "We agree on what is important for this woman to work on".

Total scores for both the WAI-T and WAI-C range from 36 to 252, with subscales

[9] Permission for use in the current study provided by the author (http://www.sfu.ca/~educwww/alliance/allianceA/)

ranging from 12 to 84. Higher scores on each subscale are indicative of a positive alliance. Reliability (Cronbach's alpha) for the WAI overall has ranged from .84 to .93 while reliabilities for the subscales have ranged from .68 to .92 (Horvath & Greenberg, 1989, 1994). The WAI has also shown strong validity in relation to other measures of alliance (e.g., the California Psychotherapy Alliance Scales; CALPAS) with reported correlations between .83 and .87 for the overall measure, and .72 to .84 for the subscales (Horvath & Greenberg, 1994).

Women offender interviews. A semi-structured interview (Appendix E) was developed by the authors of this report and used to obtain information on the women's views and understanding of the therapeutic alliance[10]. More specifically, interviews allowed for more focus on their perceptions of their relationships with other staff members (i.e., those staff they deal with in addition to their parole officer). This allowed participants to provide their perspectives regarding their strongest and weakest relationships and to point out what made certain alliances work, and what needed to change in order for others to improve. Furthermore, the interview focused on the practice of dynamic security in the institution and the women's perspectives on its implementation and role in the development of therapeutic relationships.

Staff interviews. A semi-structured interview (Appendix F) was also developed and conducted with the staff in order to obtain their views and understanding of the therapeutic alliance. It allowed them to elaborate on their interactions with other women offenders they come in contact with (outside of the woman they focused on when they completed the questionnaires), and how they viewed alliances with women in general. A dynamic security piece was also incorporated to gain staff input regarding the practice of dynamic security in the institution and its impact on the formation of positive alliances.

[10] Given this interview was developed "in-house" for the purposes of this exploratory research, there is no information pertaining to validity or reliability.

Results

Quantitative Results

Table 4 presents the means and standard deviations for the total and subscales scores for the WAI and RHI. Given that the RHI was only administered to the women, the staff results only pertain to the WAI. Staff scores tended to be more positive overall in comparison to the women's, but the mean scores for both measures still fell within moderate to high range, which is consistent with similar research conducted with offender populations (Di Placido et al., 2006; Skeem et al., 2007). Although there are no substantial differences among the mean subscale scores for the WAI, staff scores reflected higher ratings for the measure of bond, while women's scores reflected higher ratings for goal agreement.

Table 4

Mean Scores and Standard Deviations for the WAI and RHI Results

Measure	Women Offender Scores			Staff Scores		
	n[a]	*M*	(*SD*)	n[a]	*M*	(*SD*)
WAI Total	97	168.15	(42.38)	74	195.65	(18.76)
WAI Bond Subscale	101	55.39	(8.99)	76	69.51	(7.09)
WAI Task Subscale	108	54.89	(11.18)	81	60.20	(6.02)
WAI Goal Subscale	108	58.48	(16.89)	83	66.30	(8.14)
RHI Total	102	29.39	(10.56)	N/A	N/A	N/A

Notes. WAI = Working Alliance Inventory. RHI = Relational Health Indices. [a] Sample size fluctuates as a result of missing data

Outcome results. Overall, 39% (46/119) of the sample had incurred at least one prison misconduct during the 6 month follow-up period. Seventy-eight percent (36/46) were minor in nature (e.g., possession of unauthorized item, theft, disciplinary problems) with the remaining 22% classified as major (10/46; e.g., assault on staff or other inmates).

As Table 5 illustrates, only one variable (the bond subscale of the WAI) was significantly associated with major and minor prison misconducts ($r = -.22$, $p < .05$). Results suggest that the offenders' perceived level of bonding with their parole officer was potentially related to their adjustment. Women with higher bond scores were less likely to engage in institutional misconducts. Although the relationship of institutional charges to scores on the other scales did

not reach a level of statistical reliability, trends were in the same direction.

Table 5

Bivariate Correlations between Offender WAI and RHI Scores and Prison Misconducts

Variable	(n^a)	*r*
WAI total score	93	-.16
WAI bond score	97	-.22*
WAI goal score	104	-.15
WAI task score	104	-.09
RHI total score	99	-.11

Note. [a]*n* fluctuates due to missing data. WAI = Working Alliance Inventory. RHI = Relational Health Indices

Qualitative Results

Therapeutic alliance with parole officers – Women offenders' perspectives. The self-report questionnaires completed by the women offenders, specifically the WAI-C, focused predominantly on their assessment of scheduled sessions with their parole officers. In order to assess the perceived influence of these sessions, the women were asked if they felt that their interactions with their parole officer contributed to their daily life in the institution (i.e., if aspects they discuss/work on during their meetings have an impact their actions and decisions on a day to day basis). Data are only presented for those who responded only. Just under half of the women (44%; 55/124) felt that their parole officer influenced their daily lives while almost equal numbers (49%; 61/124) indicated that their parole officers did not. Reasons for women's responses are provided in Table 6.[11]

[11] Three participants (2%; 3/124) indicated they were unsure and five (4%; 5/124) chose not to answer the question because they had not yet met their parole officer or had very limited contact.

Table 6

Women's Perceptions of Parole Officers' Contribution to Life within the Institution

Women's Responses	%	*n*
Reasons for Positive Contributions		(*n*/55)
Clear and efficient communications / expectations	50.9	28
Overall effect of positive and healthy relationships (e.g., support, honesty)	45.5	25
Mutual agreement on goals and objectives to reach while incarcerated	27.3	15
Completion of paperwork	12.7	7
Reasons for Lack of Contribution		(*n*/61)
Limited contact	52.5	32
Focus on administrative / process issues rather than day to day concerns	31.1	19
Poor communication / unclear information	21.3	13
Lack of support in addressing needs	18.7	12
Staff characteristics / issues (e.g., high turnover, inexperience)	18.0	11
Negative relationships (e.g., lack of trust, impersonal, feeling judged)	16.4	10

Therapeutic alliances with other institutional staff – Women offender perspectives. Because women come in contact with multiple staff members on a daily basis and thus have the potential to form other alliances, the remaining interview questions concerned interactions with parole officers and other staff. The women were first provided with a list of different staff positions, including parole officers, primary workers/older sisters[12], psychologists, program officers, elders, and chaplains and were asked to rate their relationship with each one as having a negative alliance, a positive alliance, or a neutral alliance. Results are outlined in Table 7. Overall, women tended to perceive their alliances with staff as positive. Although the parole officers received the largest portion of negative ratings, it was still a relatively small percentage of women who rated them as such. Elders and chaplains received the highest portion of positive ratings.

[12] Older Sister is the term used for staff at the Okimaw Ohci Healing Lodge who perform the same role as a Primary Worker.

Table 7

Women's Perceptions of Alliances by Staff Position

Staff Position	Positive		Neutral		Negative	
	%	(*n*)	%	(*n*)	%	(*n*)
PO's (*n* =115)	54.8	63	27.0	31	18.2	21
PW's/ Older Sisters (*n* = 120)	66.7	80	25.0	30	8.3	10
Psychologists (*n* = 102)	88.2	90	7.8	8	3.9	4
Program Facilitators (*n* = 107)	81.3	87	16.8	18	1.9	2
Elders (*n* = 67)	95.5	64	4.5	3	0	0
Chaplain (*n* = 80)	90.0	72	6.3	5	3.8	3

Note. Percentages may not sum to 100% due to rounding.

Participants were then asked to be more specific and to rate the quality of their therapeutic alliance with each staff position on a scale of one to ten (1 = not at all positive to 10 = extremely positive). While a larger *portion* of the sample selected certain positions as positive in the previous question (e.g., psychologists, facilitators), for this question women perceived a higher *quality* of alliance with elders and chaplains. Essentially, although fewer women maintain regular contact with elders, their views suggest they have a more positive relationship compared to other staff-offender dynamics within the institution. What remained consistent between the two questions was that parole officers received the lowest ratings. Results are provided in Table 8.

Table 8

Women's Ratings of Alliance by Staff Position

Staff Position	Ratings [a]		
	M	(*SD)*	*n* [b]
Elders	9.13	(1.72)	62
Chaplains	8.85	(1.94)	78
Psychologists	8.66	(1.84)	99
Program Officers/Facilitators	7.97	(2.05)	105
Primary Workers/Older Sisters	7.22	(2.60)	120
Parole Officers	6.14	(2.90)	116

Notes. [a] Rating Scale = 1-10. [b] *n* fluctuates based on the number of women who chose to provide ratings. Many did not answer for certain positions due to limited contact with these staff.

Participants were also asked to indicate with which staff position they believed it was most important to forge a strong alliance. The most commonly selected staff positions were the primary workers (44%; 54/123), parole officers (31%; 38/123) and elders (17%; 21/123). Overall, the most common reason for the selection of primary workers was their level of involvement in a woman's correctional plan and institutional experience. The role requires frequent communication, regular contact with the women and continuous availability and visibility. Interestingly, these same themes were endorsed by the women, but to a lesser extent for the parole officers. Instead, the most common reasons provided were more related to administrative/operational function filled by this position (e.g., paperwork support, authoritative figure, decision maker). Additional themes are provided in Appendix G.

Although many women provided positive responses, they were also given the opportunity to offer constructive feedback to highlight where improvements could still be made Recurring issues that emerged as themes for multiple staff positions were to improve their methods of communication, and increase the frequency of contact (see Appendix H for coded responses). Another theme that was raised across all staff roles related to a recommendation to improve interpersonal and relational skills. Participants stated that they would prefer if staff were more personable and more engaged with them. Women also pointed out they would like to see staff become more flexible, understanding, and honest, as well as less judgmental and more women-centered.

With primary workers/older sisters, parole officers and staff in general, numerous women pointed out a need for improvement in the way in which they fulfilled duties related to their positions (i.e., paperwork support, professionalism, provision of resources). In the same vein, women also acknowledged the need for improved staff resources including: more experienced staff, better staff screening and training, a reduction in staff turnover, as well as more manageable caseloads so that staff are able to realistically address their needs.

To take into account staff duties and job requirements which can range from being very static to dynamic (e.g., primary worker vs. elder), one of the interview questions related to whether the development of alliances was role dependent, or individual dependent. The majority of women who answered (82%; 100/122) stated that the development of a therapeutic alliance or healthy relationship is entirely individual rather than role dependent. Women pointed out that the quality of the connection depended on staff personality (37%; 37/100), individual effort (16%; 16/100) and interpersonal skills (13%; 13/100). The few women who stated it was role dependent (7%; 8/122) explained that certain positions dictate the nature and frequency of contact.

Knowledge and experience with the therapeutic alliance – Staff perspectives. Due to the fact that the term 'therapeutic alliance' is not commonly used in a correctional environment, staff were asked whether they had been previously exposed to the concept. A total of 73 respondents out of 88 (83%) indicated that they had come across the term before while 15 (17%) respondents had not. Areas in which staff had been exposed to the concept are outlined in Appendix I, with the most common being during staff training (66%; 48/73) and formal education (31%; 23/73). Although only a small number were not familiar with the term (17.1%; 15/88), the majority of them agreed that it would be beneficial to incorporate therapeutic alliance into CSC training as it would be pertinent to all staff working with women.

Alliances with women offenders – Staff perspectives. Given that the WAI-T contained questions limited to their relationship with individual women, staff participants were asked to elaborate on their interactions with the women in general, and discuss the ways in which they engage with them and the extent to which their interactions vary. When asked if they felt their responses would differ significantly if applied to other women, the majority of staff (71%; 62/88) stated that their alliance rating would vary depending on the woman being assessed. Of the staff noting that the type of relationship depended on the offender, 63% stated this would be due to the

differences in women's personalities and personal effort. This included the women's attitude, level of motivation, and engagement and whether they took responsibility for their actions. Interestingly, 21% (13/62) stated that it would be difficult to rate women equally because of difficulties in engaging some women in setting mutually agreed upon goals, one of the core concepts of the therapeutic alliance. Just over one-quarter of the respondents (26%; 16/62) said that the ability to form a therapeutic alliance varies based on the women's mental health status. Staff noted that the level of need, cognitive ability and comprehension, in combination with mental health issues, vary extensively amongst the women offender population, thus making engagement a continuously fluctuating and challenging process. Those who stated their ratings would not vary (26%; 23/88) perceived themselves to have a consistent approach for all women in terms of their style of intervention and the way in which they set goals and objectives with the women.

An important consideration in the current analysis is the impact a correctional environment has on staff-offender relationships. While staff are mandated to promote offender reintegration, safety and security is also a key correctional objective that needs to be a focus in interactions with the women. In contrast to traditional therapeutic settings, one has to consider the potential impact the institutional environment and dynamic security have on the ability to form therapeutic alliances.

Dynamic Security – Staff and offender perspectives. The second part of the interviews for both staff and women asked the same questions regarding their views on dynamic security. After providing a clear definition of dynamic security[13], participants were asked if it was currently being practiced at their institution and if so, if dynamic security practices had increased, decreased, or stayed the same during their time in the current institution. All of the staff participants responded that dynamic security was currently being practiced in their institution (100%); 82% (100/122) of the women offenders also acknowledged that dynamic security was in place. Nevertheless, as shown in Table 9, staff indicated that practices of dynamic security had decreased since they first began working in the institution, while just over half of the women offenders stated that dynamic security practices had not changed during their incarceration.

[13] See Appendices G and H for the definition of dynamic security provided to participants.

Table 9

Participants' Perceptions of Dynamic Security

	Improved		Same		Decreased	
	%	(*n*)	%	(*n*)	%	(*n*)
Staff (*n*=88)	15.9	14	34.1	30	37.5	33
Women (*n*=100)	12.0	12	53.0	53	21.0	21

For those women offenders who stated that dynamic security had improved, the main explanation provided was a positive shift in staff behavior (67%; 8/12), including more communication, and more attempts to connect with the women. Staff who perceived an increase in dynamic security attributed it to, having both new and energized staff as well as more experienced individuals who are well practiced in working with women (71%; 10/14).

Of the offenders who stated that dynamic security had decreased, the majority explained that it was due to more restrictive security measures and policy changes (62%; 13/21); this was echoed by the majority of staff that answered dynamic security had decreased (52%; 13/33). Forty-two percent of staff also acknowledged changes in the women offender population (e.g., younger, more violent, more difficult to work with as well as negative staffing issues (e.g., high staff turnover, limited training) as reasons for decreases in dynamic security.

In answer to the question about the potential impact of reduced dynamic security, both staff and offenders provided similar responses. As outlined in Table 10, both groups perceived a potentially negative impact on multiple aspects in the institutional environment and viewed increased static security as an ineffective and anti-rehabilitative approach.

Table 10

Perceptions of the Potential Impact of Decreased Dynamic Security

Themes	Staff Responses		Women Offender Responses	
	%	(*n*/88)	%	(*n*/109)
Negative impact on alliances	38.6	34	26.6	29
Division between staff and women (e.g., reinforce the 'us vs. them' mentality and the inmate code)	30.7	27	22.0	24
Non-rehabilitative (i.e., ineffective approach)	11.4	10	17.4	19
Security risk	27.3	24	6.4	7
Negative impact on staff (e.g., staff burnout, staff division)	9.1	8	N/A	N/A
Negative impact on women (e.g., mental health issues, increased frustration, self-harm)	N/A	N/A	21.1	23
No negative impact (e.g., potential positive in having more structure and safety for the women)	5.7	5	8.3	9

Finally, both staff and the women offenders were offered the opportunity to raise any additional issues or concerns related to the capacity to form therapeutic alliances. Common themes in the women's responses reiterated the need to change negative staff behaviours in interacting with them (21%; 26/122) as well as the need to improve staff screening, training and selection and reduce staff workloads (10%; 13/122). Other themes related to operational issues were provided, such as improvements needed in the consistency of operational practices (i.e., dynamic security) and institutional rules and regulations (9%; 11/122).

Staff responses provided three major themes. The most frequent responses (20.5%; 18/88) pertained to staffing problems (e.g., high staff turnover, lack of communication, lack of resources and training, staff division and staff burnout). Staff also pointed out the challenges they face in trying to establish alliances and balance dynamic and static security requirements (14%; 12/88). Finally, responses regarding operational/policy issues involved a broad range of concerns such as having more division among the women based on security levels, the need for more mental health resources, the need for more Aboriginal staff input at the policy level as well as concerns regarding the division between interventions and operational staff and the implementation of the uniform policy (12%; 10/88).

Discussion

The relationship between the quality of therapeutic alliance and positive treatment outcomes has been consistently demonstrated across diverse interventions using different measures of alliance (e.g., client and participant measures) as well as different methods of measuring outcome (e.g., reduced mental health issues, reduced substance abuse; Horvath & Symonds, 1991; Lambert & Barley, 2001). Research has also demonstrated that the quality of the relationship and the treatment providers' interpersonal skills show higher correlations with treatment outcome than choice of treatment techniques or type of therapy. Specifically, intervener characteristics such as warmth, flexibility, empathy and understanding have been positively related to healthy alliances (Ackerman & Hilsenroth, 2003). Limited research, however, has been completed within correctional systems. Given the dynamics between offender and correctional staff, one would expect that therapeutic alliances would be relevant for offenders as well. This would be especially pertinent for women offenders in CSC, given that current rehabilitative initiatives are grounded in theories of relational health and concepts of rehabilitation through mutually respective and empowering relationships (Fortin, 2004). In light of this direction at CSC, this research aimed to determine the extent to which relationships between parole officers, institutional staff, and women offenders are characterized by healthy connections.

It was hypothesized that positive alliance ratings would be associated with a reduced number of institutional incidents within the six month timeframe of data collection. The hypothesis was partially supported as evidenced by the significant association between the strength of the bond (based on the WAI bond subscale) and fewer overall institutional incidents.

Findings from this research suggest that the offenders' perceived level of bonding with their parole officer may be related to their overall institutional adjustment. This is consistent with previous research and highlights that the bond between the client and the intervener is often the most important component of a therapeutic alliance. Although these results are promising it is important to note that they are preliminary in nature. Given that potential differences between offenders who were involved in institutional infractions other than that of the strength of the relationship bond were not controlled (e.g., risk, substance abuse, security level), these initial results should be interpreted cautiously.

Notwithstanding these issues, exploratory qualitative analysis conducted with both staff

and offenders also supported the importance of positive alliances. What was clear in the themes from interviews with all women is that effective communication, clear expectations, support, honesty, and overall positive relationships are critically important to them. Women also expressed that the capacity to achieve strong therapeutic relationships between staff and offenders requires staff to have strong interpersonal/relational skills for effective communication as well as opportunities for increases in frequency of contact. Also noteworthy is that women indicated staff completing their job duties effectively (e.g., paperwork, professionalism, and provision of services) would also contribute to the capacity to build a therapeutic alliance. It is worth noting that the degree of importance placed on operational factors may be unique to working relationships within an institutional environment. This need for correctional staff to adopt a "dual role" to provide both concrete/operational services (i.e., security/case management based) and emotional/personal support (i.e., rehabilitation focussed) has emerged in previous studies with women offenders (e.g., Gobeil, 2008). In turn, it is important to consider what impact the environment itself plays in the capacity to form an effective therapeutic alliance. In a related vein, the women also acknowledged the extent of operational demands placed on staff during a time of fiscal restraint. The women highlighted that increasing the resources afforded to staff would have a positive impact on their capacity to do their jobs effectively, and in turn, work toward establishing stronger therapeutic relationships.

Primary workers were most likely to be identified by the women as the staffing group with whom it is most important to establish a therapeutic alliance. This was due to the role requirements of the position that involve frequent communication and interpersonal interactions with the women while maintaining continuous visibility and availability. Notably, Commissioner's Directive (CD) 560 on Dynamic Security specifies that, "operating procedures shall be established in such a way as to facilitate staff visibility and the highest degree of interaction between employees and offenders". The perspectives of the women are in line with CSC's policy in this regard.

Given the varying roles of staff members, it was speculated by the researchers that different positions afford different opportunities for building therapeutic alliances; however, the women indicated that they felt that developing a therapeutic alliance is individual-based and not role-based. More specifically, the women argued that personality, individual effort, and interpersonal skills were the key qualities that contributed to achieving therapeutic relationships.

These findings are relevant to decisions related to staff recruitment. They emphasize the importance of efficient staff screening and selection for qualities that promote positive interactions with offenders.

Importantly, staff appear to be knowledgeable in the construct of therapeutic alliance, its meaning, and its application to the job. Knowledge of therapeutic alliance was most often gained through training, formal education, or co-workers. That being said, the majority of staff were not familiar with the actual term, but were more informed of the overall concept. Although current training practices focus on relational theory and relational health when working with women, training initiatives could be enhanced by incorporating the broader concept of the therapeutic alliance; emphasizing the potential impact of alliances on offender institutional adjustment. Given CSC's focus dynamic security, knowledge of the role of therapeutic alliance in developing trusting relationships is important given that the two constructs (are inextricably linked. If staff members fail to build therapeutic alliances with the women, their capacity to build "meaningful relationships" (CD 560) is compromised; thereby conceivably affecting their "knowledge-base of the offenders' activities and behaviours", and, in turn, affecting staff capacity to ensure the "safety and security of employees, offenders and the public" (CD 560).

According to both staff and women, dynamic security is being practiced across all of the women's sites and many argue that dynamic security practices have remained consistent since staff began working at the institution and women began their incarceration. Nearly one-third of staff and women, however, argued that there has been a decrease in dynamic security. Decreases in dynamic security were attributed to more restrictive security measures, changes in policy/management practices (e.g., implementation of uniforms for correctional officers), changes in the nature of the women offender population, and negative staff behavior / issues (e.g., inexperience, lack of training and communication, and staff turnover). A smaller portion of staff and women stated that increases in dynamic security were attributed to shifts in staff behaviour, increases in the number of staff on board, improved communication and staff awareness. Staff and offenders also recognize the link between therapeutic alliance and dynamic security, indicating that erosions in dynamic security will inevitably have an impact on therapeutic alliance and vice versa.

Future Research

While this exploratory research contributes to our knowledge in the area; certain

limitations should be acknowledged and potential future directions outlined. Firstly, although it is common practice in alliance research to assess a direct dyadic alliance between the client and the intervener, the methodology used in this study did not follow this format. The current research did not assess dyadic alliances because it would require staff to know participants' identities. Second, the current study relied on a convenience sampling method. Although this is standard practice in applied research, it is important to acknowledge that findings may not be considered generalizable to the women offender population. In this vein, it is also important to note that a comparison group of women incarcerated during the same timeframe was not used. Given that the project was exploratory in nature, providing preliminary results as groundwork for future research, a matched comparison sample was beyond the scope of the current study. A matched comparison sample would have allowed stronger conclusions to be drawn regarding the link between the quality of the alliance and institutional behaviour. Future research, therefore, should utilize a comparison group and control for key covariates related to correctional outcomes (e.g., risk level, need level, security classification, mental health).

Additionally, the measures used in the current study were not developed specifically for use within a correctional environment. Given the dual role of staff in promoting offender reintegration and enforcing security (i.e., both the interpersonal and operational intervention approach), there is the potential limitation that the measures may not have fully captured all the constructs pertinent to an alliance within the prison environment (Skeem et al., 2007).

Finally, it is important to acknowledge that although there is significant emphasis on the role of relational health in women's corrections and the importance of staff interactions, it is likely that a positive rapport between institutional staff and offenders would be pertinent for men as well. It would be useful, therefore, for future research to examine the association of therapeutic relationships between institutional staff and male offenders and institutional adjustment.

In a time in CSC in which we are witnessing increasing numbers of incarcerated women offenders (Women Offender Sector, 2010) with higher levels of mental health needs (CSC, 2009a), and higher static risk attributes (CSC 2009b), it is critical that our intervention and security efforts maximize their effectiveness. This research suggests that effectiveness could be enhanced by creating conditions that foster positive therapeutic alliances between women offenders and staff. This can be achieved through the maintenance of dynamic security and

hiring of staff with the personality qualities that promote positive relationships with offenders within an institutional correctional environment.

References

Ackerman, S. J., & Hilsenroth, M. J. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical Psychology Review, 23,* 1-33.

Ackerman, S. J., & Hilsenroth, M. J. (2001). A review of therapist characteristics and techniques negatively impacting the therapeutic alliance. *Psychotherapy: Theory, Research, Practice, Training, 38*, 171-185.

Andrews, D. A. (2000). Principles of effective correctional programs. In L. L. Motiuk & R.C. Serin (Eds.), *Compendium 2000 on effective correctional programming* (pp. 9-17). Ottawa, ON: Correctional Service of Canada.

Andrews, D. A., & Bonta, J. (2010). *The psychology of criminal conduct* (5th ed.). Cincinnati OH: Anderson Publishing.

Andrews, D. A., & Dowden, C. (2006). Risk principle of case classification in correctional treatment. *International Journal of Offender Therapy and Comparative Criminology, 50,* 88-100.

Belknap, J., Holsinger, K., & Dunn, M. (1997). Understanding incarcerated girls: The results of a focus group study. *Prison Journal, 77(*4), 381-404.

Blanchette, K., & Brown, S.L. (2006). *The assessment and treatment of women offenders: An integrative perspective.* Chichester, UK: John Wiley & Sons Ltd.

Blanchette, K., & Motiuk, L.L. (1995). *Female Offender Risk Assessment: The Case Management Strategies Approach.* Poster presented at the Annual Convention of the Canadian Psychological Association, Charlottetown, PEI.

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

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research, and Practice, 16*, 252-260.

Bourgon, G., & Armstrong, B., (2005). Transferring the principles f effective treatment into a "real world" prison setting. *Criminal Justice and Behavior, 32*, 3-25.

Brown, S.L., & Motiuk, L.L. (2005).The Dynamic Factor Identification Analysis (DFIA) component of the Offender Intake Assessment (OIA) process: A meta-analytic, psychometric and consultative review. *Research Report R-164.* Ottawa, Ontario: Correctional Service of Canada.

Comstock, D. L., Hammer, T. R., Strentzsch, J., Cannon, K., Parsons, J., & Salazar, G. (2008). Relational-cultural theory: A frame-work for bridging relational, multicultural, and social justice competencies. *Journal of Counseling and Development, 86*, 279-287.

Correctional Service of Canada (2002). *Regional women's facilities: Operational Plan*. Ottawa, ON: Office of the Deputy Commissioner for Women.

Correctional Service of Canada (2006) *Commissioner's Directive 560*: *Dynamic Security* Ottawa, ON: Correctional Service of Canada.

Correctional Service of Canada (2007). *Commissioner's Directive 705-6*: *Correctional planning and criminal profile*. Ottawa, ON: Correctional Service of Canada.

Correctional Service of Canada (2009a). *The Changing Offender Population: Highlights, 2009.* Ottawa, ON, Canada: Correctional Service of Canada.

Correctional Service of Canada (2009b). *National Capital Accommodation and Operations Plan (NCAOP) Forecasted and Actual Values 2000-2013.* Ottawa, ON Canada: Correctional Service of Canada.

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

Di PLacido, C., Witte, T. D., Wong, S. C. P., & Deqian, G. (2006). *Relationship between motivation, therapeutic alliance and treatment completion for gang members.* Poster presented at the Annual Convention of the Canadian Psychological Association, Calgary, AB.

Dowden, C., & Andrews, D. A. (2004). The importance of staff practice in delivering effective correctional treatment: A meta-analytic review of core correctional practice. *International Journal of Offender Therapy and Comparative Criminology, 48*, 203-214.

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

Frey, L. L., Beesley, D., & Miller, M. R. (2006). Relational health, attachment, and psychological distress in college women. *Psychology of Women Quarterly, 30*, 303-311.

Frey, L. L., Tobin, J. & Beesley, D. (2004). Relational predictors of psychological distress in women and men presenting for university counseling center services. *Journal of College Counseling, 7*, 129-139.

Gendreau, P.C., & Andrews, D.A. (1990). Tertiary prevention: What a meta-analysis of the offender treatment literature tells us about 'what works'. *Canadian Journal of Criminology, 32*, 173-184.

Gobeil, R. (2008). *Staying out: Women's perceptions of challenges and protective factors in community reintegration*. Research Report R-201. Ottawa, Ontario: Correctional Service of Canada.

Howells, K., & Day, A. (2002). Readiness for anger management: Clinical and theoretical issues. *Clinical Psychology Review, 23,* 319–337.

Horvath, A. O., & Greenberg, L. A. (1987). Development of the Working Alliance Inventory. In L.S. Greenberg & W.M. Pinsof (Eds.), *The psychotherapeutic process: A research handbook.* New York: Guilford Press.

Horvath, A. O., & Luborsky, L. (1993). The role of the therapeutic alliance in psychotherapy. *Journal of Consulting & Clinical Psychology, 61,* 561-573.

Horvath, A. O. & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology, 38,* 139-149.

Kelly, K. & Caputo, V. (1998). *Are federally sentenced women's experiences with family violence a factor in their contact with the criminal justice system? An exploratory study.* (Technical Report TR1998-15e/x), Ottawa, ON: Department of Justice.

Lambert, M. J. & Barley, D. E. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy: Theory, Research, Practice, Training, 38,* 357-361.

Liang, B., Tracy, A., Taylor, C. A., Williams, L. A., Jordan, J. V., & Miller, J. B. (2002). The relational health indices: A study of women's relationships. *Psychology of Women Quarterly, 26,* 25-35.

Luborsky, L. (1994). "Therapeutic alliances as predictors of psychotherapy outcomes: Factors explaining the predictive success" in A. O. Horvath & L. S. Greenberg (Eds.), *The working alliance: Theory, research, and practice* (pp. 38-50). New York: Wiley

Marhsall, W. L., & Serran, G. A., (2004). The role of the therapist in offender treatment. *Psychology, Crime and Law, 1,* 309-320.

Marshall, W.L., Serran, G.A., Fernandez, Y.M., Mulloy, R., Mann, R.E., & Thornton, D. (2003). Therapist characteristics in the treatment of sexual offenders: Tentative data on their relationship with indices of behaviour change. *Journal of Sexual Aggression, 9,* 25-30.

Martin, D. J., Garski, J. P. & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting & Clinical Psychology, 68,* 438-450.

McMurran, M., & Theodosi, E. (2007). Is treatment non-completion associated with increased

reconviction over no treatment? *Psychology, Crime and Law, 13,* 333-343.

McMurran, M., & Ward, T. (2010). Motivating offenders to change in therapy: An organizing framework. *Legal and Criminological Psychology, 9*, 295-311.

Miller, J. B. (1986). *What do we mean by relationships?* Work in Progress No. 22. Wellesley, MA: Stone Center, Working Paper Series.

Motiuk, L.L., & Serin, R.C. (2000). A compendium on "What Works" in offender programming. *Forum on Corrections Research, 12* (2), 3-4.

Morgan, R., Luborsky, L., Crits-Christoph, P., Curtis, H., & Solomon, J. (1982). Predicting the outcomes of psychotherapy by the Penn Helping Alliance Rating Method. *Archives of General Psychiatry, 41*, 33-41.

O'Brien, P. (2001). *Making it in the "free world": Women in transition from prison.* Albany, NY: State University of New York Press.

Polaschek, D. L. L., & Ross, E. C. (2010). Do early therapeutic alliance, motivation, and stages of change predict therapy change for high-risk, psychopathic violent prisoners? *Criminal Behaviour and Mental Health, 20,* 100-111.

Ross, E., Polaschek, D.L., & Ward, T. (2008). The therapeutic alliance: A theoretical revision for offender rehabilitation. *Aggression and Violent Behavior, 13,* 462-480.

Safran, J. D., Samstag, L. W., Muran, J. C., & Winston, A. (2005). Evaluating alliance-focused intervention for potential treatment failures: A feasibility study and descriptive analysis. *Psychotherapy: Theory, Research, Practice, Training, 42,* 512-531.

Samstag, L. W., Batchelder, S. T., Muran, J. C., Safran, J. D., & Winston, A. (1998). Early identification of treatment failures in short-term psychotherapy: An assessment of therapeutic alliance and interpersonal behaviour. *Journal of Psychotherapy Practice and Research, 7,* 126-143.

Saunders, S.M. (2000). Examining the relationship between the therapeutic bond and the phases of treatment outcome. *Psychotherapy: Theory, Research, Practice, Training, 37,* 206-218.

Serin, R., & Kennedy, S. (1997). Treatment readiness and responsivity: Contributing to effective correctional programming. *Research Report R-54.* Ottawa, Canada: Correctional Service of Canada.

Serran, G. A., Fernandez, Y. M., Marshall, W. L., & Mann, R. E. (2003). Process issues in treatment : Application to sexual of offender programs. *Professional Psychology: Research and Practice, 34,* 368-374.

Simon, T. L., Wormith, J. S., & Nicholaichuk, T. (2010). *Effects of learning ability and working alliance on recidivism of offenders in a cognitive behavioural treatment program.* Poster presented at the biennial Symposium on Violence and Aggression, Saskatoon, SA.

Skeem, J. L., Eno Louden, J., Polaschek, D. L. L., & Camp, J. (2007). Assessing relationship quality in mandated community treatment: Blending care with control. *Psychological Assessment. 19,* 397-410.

Solicitor General of Canada (1987). *Development of a security classification model for Canadian federal offenders.* Ottawa, ON: Correctional service of Canada.

Task Force on Federally Sentenced Women (1990). *Creating Choices: Report of the Task Force on Federally Sentenced Women.* Ottawa , Ontario: Ministry of the Solicitor General.

Ward, T., Day, A., Howells, K., & Birgden, A. (2004). The multifactor offender readiness model. *Aggression and Violent Behavior. 9,* 645-673.

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

Appendices

Appendix A: Offender Consent Form

The Therapeutic/Working Alliance Project

Research Branch, Correctional Service Canada

Offender Informed Consent

This consent form is intended to provide you with a description of the research being conducted and to inform you of your right to participate. This form will provide you with information on the research to allow you to make a decision as to whether you would like to participate or not. Please read the following information carefully and sign below if you wish to take part in this study.

The primary objective of this study is to assess the working relationship that is established between institutional staff and women offenders. Further, with the information you provide us, this study will examine the current and long term impacts of such relationships.

The questionnaires will ask you to respond to questions relating to your daily interactions with your parole officer, the way in which you respond to her/his methods of intervention and the level of mutual respect and agreement you feel you have with her/him. Your participation will involve completing one questionnaire package which will take approximately 30-45 minutes. There is also a short 15-20 minute follow up interview with questions regarding your views on the working alliance concept in relation to other institutional staff.

It is important to understand that your participation in this study is entirely voluntary and you are under no obligation to take part. It is also important to note that you will in no way be penalized if you choose not to participate nor you will be rewarded if you choose to take part in this research. You may choose not to answer any of the questions asked and will not incur a penalty for doing so. You may also stop your participation at any point without penalty.

Any information you provide will be kept strictly confidential. Although you are asked to provide your name and FPS number, this information will NOT be attached to your responses as both the questionnaire and interview forms will be given a separate random ID number to ensure anonymity. The information you provide in your consent will be immediately removed from the questionnaire package. Each completed questionnaire will only be dealt with by the research team conducting this study. Individual responses will not be disclosed to your parole officer or any other CSC employee, nor will the information you provide be used to judge your present and/or future performance with the Correctional Service Canada

However, you should know that there are limits on your confidentiality. If you should share information that you pose a threat to your own, or someone else's safety, or other information regarding a threat to someone's safety, the security of the institution, or abuse of a minor child, the interviewer is legally bound to report this information to the appropriate authorities.

Once the study is complete, all the interview and questionnaire data gathered from different respondents will be combined and presented in summary form within a research report.

Giving your consent to participate in this study means that you have agreed to complete the interview and questionnaire for the purposes described above. In addition, your consent also permits us to examine at the present time and for follow-up research, information collected by the Correctional Service of Canada in the Offender Management System regarding assessments completed at intake, as well as program information.

REMEMBER

- Your participation is VOLUNTARY and ANONYMOUS. Do not participate if you don't want to.
- You can STOP your participation any time, or choose NOT TO ANSWER certain questions, without penalty.
- Your responses are CONFIDENTIAL, except under the circumstances listed above.

My signature below indicates that I have read the above, and that I agree to take part in this research regarding therapeutic/working alliances. I fully understand the purpose and objectives of the study as well as my rights in terms of voluntary participation, withdrawal, and confidentiality. I hereby give my consent to participate in this research project. The researcher will also sign to guarantee the conditions stated above.

_____	_____	_____	_____
Date	Participant Name (PRINT)	FPS Number	Participant Signature

_____	_____	_____
Date	Researcher Name (PRINT)	Researcher Signature

Appendix B: Staff Consent Form

The Therapeutic/Working Alliance Project

Research Branch, Correctional Service Canada

Staff Informed Consent

This consent form is intended to provide you with a description of the research being conducted and to inform you of your right to participate. This form will provide you with information on the research to allow you to make a decision as to whether you would like to participate or not. Please read the following information carefully and sign below if you wish to take part in this study.

The primary objective of this study is to assess the working alliance/relationship that is established between institutional staff and women offenders. Further, this study will examine the current and long term impacts of such relationships.

The questionnaire will ask you to respond to questions relating to your interactions with the women offenders, the level of mutual respect and agreement you have with them as well as the way in which they respond to your methods of intervention. Your participation will involve completing one questionnaire package referring to an individual offender which will take approximately 30-40 minutes. There is also a short 15-20 minute follow up interview with questions regarding your views on the working alliance concept in relation to the women in general as well as a brief section on dynamic security.

It is important to understand that your participation in this study is entirely voluntary and you are under no obligation to take part. It is also important to note that you will in no way be penalized if you choose not to participate nor you will be rewarded if you choose to take part in this research. You may choose not to answer any of the questions asked and will not incur a penalty for doing so. You may also stop your participation at any point without penalty.

Any information you provide will be kept strictly confidential. Each completed questionnaire will only be dealt with by the research team conducting this study. Individual responses will not be disclosed to any other CSC employee, nor will the information you provide be used to judge your present and/or future performance with the Correctional Service Canada. Once the study is complete, all the interview and questionnaire data gathered from different respondents will be combined and presented in summary form within a research report.

Giving your consent to participate in this study means that you have agreed to complete the interview and questionnaire for the purposes described above.

REMEMBER

- Your participation is VOLUNTARY and ANONYMOUS. Do not participate if you don't want to.
- You can STOP your participation any time, or choose NOT TO ANSWER certain questions, without penalty.
- Your responses are strictly CONFIDENTIAL.

My signature below indicates that I have read the above, and that I agree to take part in this research regarding therapeutic/working alliances. I fully understand the purpose and objectives of the study as well as my rights in terms of voluntary participation, withdrawal, and confidentiality. I hereby give my consent to participate in this research project. The researcher will also sign to guarantee the conditions stated above.

_____	_____	_____
Date	Participant Name (PRINT)	Participant Signature
_____	_____	_____
Date	Researcher Name (PRINT)	Researcher Signature

Appendix C: Missing Data Analysis

Staff Data

At the participant level, data were minimal ranging from 0% to 14.0% (n = 12) for the total score on the Working Alliance Inventory (WAI). Of the 12 staff members who evidenced missing WAI data, the range of missing data was minimal ranging from one staff member who omitted only one of the thirty-six WAI items to another staff member who omitted five WAI items. A missing value analysis was conducted to determine how the pattern of missing WAI data were distributed across the following continuous variables: length of time working in corrections, length time working in women`s corrections, and length of time in current position. Little's MCAR test was nonsignificant, χ^2 (22, N = 86) = 15.89, p = .821 indicated that overall, the data were most likely missing completely at random (MCAR). All follow-up t-test results failed to reach statistical significance providing further support for the conclusion that the pattern of missing WAI data was not systemically related to any other continuous variables in the dataset.

Similarly, a series of individual chi-square analyses comparing present versus missing WAI total and subscale scores against the following categorical variables: region, exposure to the therapeutic/working alliance concept, whether or not dynamic security is practiced, and whether or not staff would have rated the WAI scale differently if they had been asked to score it for each woman on their caseload also failed to yield any significant differences. Thus, it appears that the pattern of missing data for the staff version of the WAI is most likely missing completely at random (MCAR). Thus, all subsequent analyses involving staff WAI data will be based on casewise deletion rather than imputed data.

Offender Data

With the exception of the Working Alliance Inventory (WAI) and the Relational Health Indices (RHI), missing data were minimal for each variable ranging from 4.0% (n = 5) to 6.5% (n = 8) in the women offender sample. Consequently, a more in-depth examination of the pattern of missing data was reserved solely for the WAI and the RHI in both samples to determine the best course of action for addressing the missing data. Casewise deletion was reserved for all remaining variables.

WAI specific results.

In the women offender sample, missing data were present for each item of the Working

Alliance Inventory (WAI) to varying degrees ranging from 6.5% (*n* = 8) to 12.9% (*n* = 16). At the participant level, 21.8% were (*n* = 27) missing data on at least one WAI item. Of these 27 individuals who evidenced missing data, 8 (6.5%) were missing data for all 36 WAI items, 3 were missing data for 13 to 26 items (36.1% to 72.2%), 4 were missing data for 4 to 9 items (11.1% to 25.0%), and the remaining 12 individuals were missing data for only 1 or 2 items (2.8%).

Next, a missing value analysis was conducted to determine how the pattern of missingness for WAI and RHI scores was distributed against the following variables: offender age, time with current parole officer, aggregate sentence length, marital status, Aboriginal status, motivation level, risk level, need level, reintegration level and security level. Little's MCAR test was nonsignificant, χ^2 (96, N = 124) = 98.32, p = .42 indicating that overall, the data were most likely missing completely at random (MCAR). A series of follow-up t-tests and chi square analyses revealed that the pattern of missingness for the WAI and RHI scores was distributed evenly across all of the aforementioned variables except one—time with current parole officer.

Not surprisingly, women with missing WAI total scores were significantly more likely to have spent less time with their current parole officers (M = 5.37 months, SD = 8.12) versus women who did have WAI total scores present (M = 10.12 months, SD = 8.56), t (49) = 4.0, p < .001. This pattern emerged for all of the WAI subscales. However, the pattern was particularly pronounced for the WAI bond subscale scores (M = 4.13, SD = 5.79) for WAI missing bond scores; M = 10.12, SD = 8.84) for WAI present bond scores, t (49) = 4.0, p < .001 as well as for the WAI task scores (M = 2.97, SD = 3.29) for missing WAI task scores; M = 9.89, SD = 8.86 for WAI present task scores, t(56.1) = 5.8, p < .001). However, the differences just reached significance for the WAI goal scores (M = 4.6, SD = 8.70) for WAI goal scores missing versus M = 9.64, SD = 8.50) for WAI goal scores present, t (19.6) = 2.1, p =.045). These findings coupled with a 22% missing data rate for WAI total scores necessitated the use of multiple imputation (MI) versus casewise deletion as a method for addressing missing WAI data in the women offender sample.

RHI specific results.

Missing data were present for each item of the Relational Heath Index (RHI) to varying degrees ranging from 6.5% (8 items) to 10.5% (13 items). At the participant level, 13.7% were (*n* = 17) missing data on at least one RHI item. Of these 17 individuals who evidenced missing

data, 8 (6.5%) were missing data for each of the 11 RHI items and the remaining 9 were missing data for only 1 or 2 items (7.3%). Again not surprisingly, women with missing RHI scores were somewhat more likely to have spent less time with their current parole officers (*M* = 5.79 months, *SD* = 8.09) versus women who did have RHI total scores present (*M* = 9.66 months, *SD* = 8.66), albeit the differences did not reach statistical significance (30.3) = 2.0, *p* = .058. Although not as problematic as the WAI missing data, for consistency, multiple imputation was adopted as the strategy for dealing with missing RHI scores. In sum, multiple imputation was used to estimate missing values for the RHI and WAI and casewise deletion was used for all remaining variables.

To determine which variables should be used to impute missing values all relevant predictor and criterion variables were correlated with the WAI and RHI scores. Only the following variables were significantly related to WAI and/or RHI scores: misconducts, motivation level, security level, and length of time with current parole officer. Consequently, misconducts, motivation level, security level, and length of time with PO were utilized during the multiple imputation process for both the WAI and RHI. Similarly, the RHI was highly correlated with the WAI total and all WAI subscales scores. Consequently, the RHI was also used during the multiple imputation process for WAI values and the WAI was during the MI process for the RHI missing values. IBM SPSS Statistics 19, 'impute missing data values' was used to conduct the MI. As recommended by Allison (2002), five imputed datasets were generated using the fully conditional specification imputation method with 10 iterations. Constraints were set such that no imputed value could exceed the plausible range of variables. Also, while security and motivation level were used to impute the missing values for RHI and WAI they were used only as predictors; their missing values were not computed. Hence the final analyses are based on a sample size of 119 given that five cases were deleted due to missing information for motivation and security level.

See Tables 1 and 2 for additional imputed calculations for scale descriptive and outcome analyses.

Table A1

Imputed Descriptives for the WAI and RHI in the Women Offender and Staff Samples

Variable	Original Descriptives N [a]		Imputed Descriptives N = 124	
	Original Mean	(*SD*)	Imputed Pooled Mean	(Imputed range)
Offender Scores				
WAI Total	168.15	(42.38)	169.52	(167.37-170.48)
WAI Bond Subscale	55.39	(8.99)	55.81	(55.34 - 56.04)
WAI Task Subscale	54.89	(11.18)	54.85	(54.66 – 54.98
WAI Goal Subscale	58.48	(16.89)	58.92	(58.48 – 59.03)
RHI Total	29.39	(10.56)	29.75	(29.39 – 29.89)
Staff Scores				
WAI Total	195.65	(18.76)	--	--
WAI Bond Subscale	69.51	(7.09)	--	--
WAI Task Subscale	60.20	(6.02)	--	--
WAI Goal Subscale	66.30	(8.14)	--	--

Notes. WAI = Working Alliance Inventory. RHI = Relational Health Indices. [a] Samples fluctuates as a result of missing data

Table B2

Pooled Bivariate Correlations between Continuous Predictor Variables and Prison Misconducts

Variable	Original *r*	(*n*)	Pooled *r* N = 124	(Imputed range)
WAI total score	-.16	(93)	-.17	(-.16 – -.19*)
WAI bond score	-.22*	(97)	-.23*	(-.21* – -.25**)
WAI goal score	-.15	(104)	-.15	(-.13 – -.18*)
WAI task score	-.09	(104)	-.08	(-.06 – -.10)
RHI total score	-.11	(99)	-.13	(-.12 – -.15)

Note. Determinate sentences excluded

Appendix D: Relational Health Indices – Mentor Subscale

Relational Health Subscale Revised Offender Version

Instructions: Please read each of the following statements and select the number that best applies to the relationship you have with your **current parole officer.**

1	2	3	4	5
Never	**Rarely**	**Sometimes**	**Often**	**Always**

1. I can honestly be myself with my parole officer.	1	2	3	4	5
2. I believe my parole officer values me as a person.	1	2	3	4	5
3. My parole officer's commitment to, and involvement in, our relationship goes beyond what is required by his/her professional role.	1	2	3	4	5
4. My parole officer shares stories with me about his/her own experiences in a way that improves my life.	1	2	3	4	5
5. I feel as though I know myself better because of my parole officer.	1	2	3	4	5
6. My parole officer gives me emotional support and encouragement.	1	2	3	4	5
7. I try to share the values of my parole officer.	1	2	3	4	5
8. I feel better and energized after seeing my parole officer.	1	2	3	4	5
9. My parole officer tries hard to understand my feelings and goals.	1	2	3	4	5
10. My relationship with my parole officer makes me want to find other relationships like this one.	1	2	3	4	5
11. I feel comfortable sharing my deepest concerns with my parole officer.	1	2	3	4	5

Appendix E: Offender Interview

Therapeutic/Working Alliance Project
Research Branch, Correctional Service of Canada

SECTION A – DEMOGRAPHIC INFORMATION

DEMO.1. Age (years): _____

DEMO.2. Region: _____

DEMO.3. Institution: _____

DEMO.4. Security Level: _____

DEMO.5. Length of time in current institution: _____

DEMO.6. Length of time with current Parole Officer: _____

SECTION B – THERAPEUTIC ALLIANCE & OTHER STAFF

The following questions will ask you about your understanding of therapeutic/working alliances in relation to your PO and other staff.

1. The questions you just answered were mainly about your *meetings* with your parole officer. Do you find that the time you spend with your parole officer contributes to your daily life in the institution? (e.g., Do the things you work on with your PO help you in other areas of your day to day life in the institution?)

No	Yes	DK	N/A
0	1	88	99
❍	❍	❍	❍

Please explain:

_____

2. With a better understanding of the concept of a working/therapeutic alliance, would

you say you have a positive, negative or neutral relationship with the following staff members:

Staff Title		Positive Alliance	Neutral Alliance	Negative Alliance	Don't Know	N/A
		[1]	[2]	[3]	[88]	[99]
Parole Officers		❍	❍	❍	❍	❍
Psychologists		❍	❍	❍	❍	❍
Correctional Program Officers		❍	❍	❍	❍	❍
Primary Workers		❍	❍	❍	❍	❍
Elder		❍	❍	❍	❍	❍
Chaplain		❍	❍	❍	❍	❍
Other _____		❍	❍	❍	❍	❍

_____

_____

3. On a scale of 1 (*not at all positive)* to 10 (*extremely positive)*, how would you rate the therapeutic/working alliance you have with the following staff positions.

	[1]	[2]	[3]	[4]	[5]	[6]	[7]	[8]	[9]	[10]	DK [88]	N/A [99]
Parole Officers	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
Psychologists	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
CPO's	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍

Primary Workers	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
Elder	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
Chaplain	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
Other _____	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍

_____

_____

4. For those positions that are ranked lower on your list ***[list here]***, what do you feel needs to change in order to improve your working alliance with each one?

_____

_____

[88] DK [99] NA

5. Keeping in mind the definition of a healthy therapeutic/working alliance and all the above staff positions, who is the most important for you in terms of a positive therapeutic/working alliance?

Parole Officers [1]	Psychologists [2]	CPO's [3]	Primary Workers [4]	Elders [5]	Chaplain [6]	Other [7]	DK [88]	N/A [99]
❍	❍	❍	❍	❍	❍	❍	❍	❍

_____

_____

6. Do you find certain roles/positions allow for a better working alliance or does it

depend entirely on the individual? (e.g., an Elder vs. a PW).

_____

_____

[88] DK [99] NA

SECTION C – DYNAMIC SECURITY

******Interviewer Note*** Review *with the women the concept of a Dynamic Security. This definition is for your own understanding. Make sure to simplify:***

Related to the concept of a working alliance is the notion of 'dynamic security' in women's institutions. Dynamic security is defined as the actions that contribute to the development of professional, positive and healthy relationships between staff members and offenders. It has been an important part of changing women's corrections and the purpose of this approach to security is to promote a safe and secure correctional environment through positive and constructive relationships in our institutions. Every interaction has the potential to enhance a secure and positive institutional culture or undo the collective efforts of many others to improve it (Report of the Task Force on Security, CSC (1999).

Simplify: Security environment is present but it is still open enough to allow for interaction and communication between staff and the women. Same aspects of TA (professional, positive and healthy relationships etc…) with a focus on institutional security. Refers more to the <u>overall organization and administration</u> of the institution.

Now that we have discussed 'dynamic security', please answer the following questions.

7. Do you feel that dynamic security is practiced here?

No	Yes	DK	N/A
0	1	88	99
❍	❍	❍	❍

a) **IF YES.** Do you feel the practice of dynamic security has improved, decreased, or

stayed the same during your time here?

Improved	Decreased	Same	DK	N/A
1	2	3	88	99
❍	❍	❍	❍	❍

Please explain:

_____

_____

b) **IF NO.** Do you feel that dynamic security *has* been practiced here before and has gradually decreased or do you feel it has never been practiced in this institution during your time here?

Never been Practiced	Has been practiced	DK	N/A
1	2	88	99
❍	❍	❍	❍

Please explain:

_____

_____

8. How do you think a breakdown in dynamic security would impact the ability for staff and women to form healthy connections? (i.e., An increase in security – moving more towards the male institution environment)

Please explain:

_____

_____

9. Do you have any questions or comments you'd like to address?

_____

_____

Thank you for taking the time to complete this interview.

Appendix F: Staff Interview

Therapeutic/Working Alliance Project
Research Branch, Correctional Service of Canada

SECTION A – DEMOGRAPHIC INFORMATION

DEMO.7. Region: _____
DEMO.8. Institution: _____
DEMO.9. How long have you been working in corrections: _____
DEMO.10. How long have you been working in *women's* corrections:_____
DEMO.11. Position Title: _____
DEMO.12. How long have you been in your current position: _____

SECTION B – THERAPEUTIC ALLIANCE EXPERIENCE & OTHER OFFENDERS

The following questions will ask you about your understanding of therapeutic/working alliances based on experience and in relation to other women.

1. Have you been exposed to the concept of a therapeutic/working alliance during your time working in corrections?

No	Yes	DK	N/A
0	1	88	99
❍	❍	❍	❍

a. **IF YES**. How have you learned of the therapeutic/working alliance?

Staff Training	Formal Education	Co-Workers	On your own initiative	Other: _____	DK	N/A
1	2	3	4	5	88	99
❍	❍	❍	❍	❍	❍	❍

Please explain:

_____

_____

b. **IF NO.** Do you feel it should be a part of staff training so that all staff can be informed of the therapeutic/working alliance concept?

No	Yes	DK	N/A
0	1	88	99
❍	❍	❍	❍

Please explain:

_____

_____

2. The questionnaire you filled out only referred to a specific offender. Do you think your responses would have been significantly varied if you had filled out a questionnaire for each woman you deal with on a daily basis and/or on your caseload?

No	Yes	DK	N/A
0	1	88	99
❍	❍	❍	❍

a) **IF NO.** Why would you *not* rate things differently?

Please explain:

_____

_____

b) **IF YES.** Why *would* you rate things differently?
Please explain:

_____

_____

SECTION C – DYNAMIC SECURITY

*****Interviewer Note*** - This definition is for your own understanding. Don't read word for word. Most staff will know what you're referring to already.** *Related to the concept of a working alliance is the notion of 'dynamic security' in women's institutions. Dynamic security is defined as the actions that contribute to the development of professional, positive and healthy relationships between staff members and offenders. It has been an important part of changing women's corrections and the purpose of this approach to security is to promote a safe and secure correctional environment through positive and constructive relationships in our institutions. Every interaction has the potential to enhance a secure and positive institutional culture or undo the collective efforts of many others to improve it (Report of the Task Force on Security, CSC, 1999).*

Now that we have discussed 'dynamic security', please answer the following questions.

3. Do you feel that dynamic security is practiced here?

No	Yes	DK	N/A
0	1	88	99
❍	❍	❍	❍

a) **IF YES.** Do you feel the dynamic security has improved, decreased, or stayed the same during your time here?

Improved	Decreased	Same	DK	N/A
1	2	3	88	99
❍	❍	❍	❍	❍

Please explain:

_____

_____

b) **IF NO.** Do you feel that dynamic security *has* been practiced here in the past and has

gradually decreased or do you feel it has never been practiced in this institution during your time here?

Never been Practiced	Has been practiced	DK	N/A
1	2	88	99
❍	❍	❍	❍

Please explain:

_____

_____

4. How do you think an erosion/breakdown of dynamic security would impact the therapeutic/working alliances between the staff and the women?

Please explain:

_____

_____

5. Do you have any questions or comments you'd like to address?

_____

_____

Thank you for taking the time to complete this interview.

Appendix G: Women's Perceptions of Most Important Staff Positions in the Facilitation of Therapeutic Alliances

	%	(*n*)
Primary Workers/Older Sisters		(*n*/54)
Good Interpersonal/Relational Skills	37.0	20
Good Communication Skills	37.0	20
Level of Contact/Availability	33.3	18
Parole Officers		(*n/38*)
Authority Figure/Decision Maker	47.4	18
Supportive	21.1	8
Consistent/Reliable	13.2	5
Good Communication Skills	10.5	4
Psychologists		(*n*/20)
Good Interpersonal/Relational Skills	45.0	9
Good Communication Skills	20.0	4
Supportive	51.0	4
Elders		(*n*/21)
Good Interpersonal/Relational Skills	42.9	9
Good Communication Skills	28.6	6
Level of Contact/Availability	23.9	5
Chaplains		(*n*/17)
Good Interpersonal/Relational Skills	17.7	3
Supportive	17.7	3

Appendix H: Women's Perceptions for Areas of Improvement in the Facilitation of Therapeutic Alliance by Staff Position

	%	(*n*)
Parole Officers		(*n*/58)
Interpersonal/Relational Skills	46.6	27
Communication	34.5	20
Frequency of Contact	31.0	18
Parole Officer Duties	20.7	12
Staff Resources	17.2	10
Support	13.8	8
Other (e.g., goal setting, reduce power differential)	13.8	8
Primary Workers/Older Sisters		(*n*/44)
Interpersonal/Relational Skills	60.5	26
Communication	25.0	11
Primary Worker/Older Sister Duties	20.9	9
Other (e.g., reduce power differential)	16.3	7
Frequency of Contact	13.6	6
Staff Resources	11.6	5
Program Officers/Facilitators		(*n*/12)
Other (e.g., More Aboriginal awareness, better understanding of women's mental health issues, more relatable experience)	58.3	7
Interpersonal/Relational Skills	41.7	5
Psychologists		(*n*/13)
Interpersonal/Relational Skills	53.9	7
Staff Resources	23.0	3
Staff in General		(*n*/23)
Work Skills/Duties	56.5	13
Frequency of Contact	43.5	10
Other (reduce power differential, better screening of staff)	21.7	5
Communication	17.4	4
Interpersonal/Relational Skills	13.0	3
Consistency	13.0	3

Appendix I: Previous Staff Experiences with the Therapeutic Alliance

	%	(*n*/73) [c]
Formal Education	31.5	23
Co-Workers	24.7	18
Gained experience within the institution (i.e., part of the job and the institutional culture)	19.2	14
Previous experience outside of CSC (e.g., nursing, counseling)	13.7	10
Own Initiative	9.6	7
Staff Training [a]		
Training Type not specified	37.5	18
Women Centered Training	22.9	11
DBT/PSR [b] Training	29.2	14
Programs Training	10.4	5
Mental Health Training	3.9	3
Parole Officer Training	4.2	2
New Employee Orientation Training	3.9	3

Note. [a] *n*=48. [b] Dialectical Behaviour Therapy/ Psychosocial Rehabilitation. [C] Staff was able to select more than one option.