_____ Research Report _____

Resilience Factors Related to Success on Release for Offenders with Mental Disorders

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Resilience Factors Related to Success on Release for Offenders with Mental Disorders

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Executive Summary

Key words: *offenders with mental disorders, protective factors, resilience, desistance, recidivism*

Using a mixed-methodology design, two studies were conducted to examine protective factors related to short-term success in the community for offenders with mental disorders. The first study compared the demographic profiles, offence histories, and static and dynamic risk factors of 297 high risk and high need offenders with a mental disorder who successfully remained in the community for one year to those who returned to custody within the same time period. An additional analysis randomly selected 20 offenders from each of the two groups and conducted a detailed case management file review for the presence of specific protective factors noted in documents describing the offenders while on conditional release.

Results revealed that 25% of the 297 sample succeeded in staying in the community without a return to custody in the first year after their release. Of the 75% who returned to custody, most did so because of technical violations related to non-compliance with release conditions or parole officer assessment of deteriorating behavior; 23% returned with a new offence. Results showed that only two of the demographic factors examined were related to success on release: older age and having had a previous sexual offence. The only static risk indicators that differed between the two groups were related to the more extensive juvenile history of the unsuccessful group. Analysis of the dynamic risk factors that distinguished those who succeeded were: social support from families, prosocial partners and friends, involvement in structured activities (particularly employment), and the offenders' motivation to stay in the community. Involvement in community programming may also have improved the chances of staying in the community.

In the second study, semi-structured interviews were conducted with four offenders with mental health issues who remained in the community for at least three months. Offenders were asked to provide insight on the factors they believed promoted their success on release. Overall, offenders perceived volunteering and social support to be of the greatest importance in their successful outcomes.

These preliminary results provide guidance for case management regarding which strategies might assist offenders with mental disorders to remain in the community after release, including:

1. Encourage opportunities to form relationships with prosocial community supports. Ideally these opportunities would be established prior to release to help these offenders through their critical first weeks in the community.
2. Ensure offenders can access, and participate in, mental health services.
3. Encourage involvement in structured activities such as volunteerism and upgrading courses, and particularly, community employment.
4. Investigate ways to motivate offenders to maintain themselves in the community. All of the successful offenders indicated that they were keen to stay in the community. Their success was goal-driven in spite of their disadvantages.
5. Ensure participation in community programs; for those with substance abuse problems and symptoms of impulsivity, oversee involvement in community treatment and follow-up or support groups.

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Introduction

There is a large body of correctional research identifying factors associated with offender recidivism (e.g., Andrews & Bonta, 2010; Mulder et al., 2011). This research has contributed to the effective corrections approach that has probably been the single most influential approach to evidenced-based practice in corrections (e.g., Andrews & Bonta, 2010; Smith, Gendreau, & Swartz, 2009). Specifically, research identifying static and dynamic risk factors related to recidivism has elucidated the risk and need principles of the effective corrections framework. While identifying risk factors is key to assessing the extent of service required given the offender's risk for reoffending (risk principle) and the appropriate targets of intervention based on dynamic risk factors related to criminality (need principle), this approach neglects factors and circumstances that promote the success of offenders post-release. The recent shift towards a more positivist psychological approach has also been evident in correctional psychology with seminal works by Farrington (e.g., Farrington & West, 1993; Maruna, 2001), and Ward and Stuart (2003) that point to personal and environmental factors that promote desistance from crime and antisocial behaviour in general. Research specifying what influences offenders' success assists in identifying what services should be the focus of case management and what personal qualities should be fostered to promote offenders' well-being and, ultimately, reduce recidivism.

Desistance

There is no one universally accepted definition of criminal desistance (Laub & Sampson, 2001). Most researchers acknowledge that desistance is a process and not a sudden and complete cessation of all criminal behaviour (Maruna, 2001, p. 17). The process of desistance, whereby an individual decreases and eventually ceases criminal behaviour, involves a variety of internal (e.g., thoughts, self-regulation, long-term goals, motivation) and external factors variables (e.g., family, employment; Serin & Lloyd, 2009). Offenders eventually leave the criminal life, whether through incapacitation, aging, or personal agency. Theoretically, by promoting identified factors, the time-table for desistance from criminal behaviour can be expedited.

A widely-cited theory of criminal desistance proposed by Laub and Sampson (2001) points to key sources of change in the desistance process. The theory states that crime generally

declines with age and that "offenders desist as a result of a combination of individual actions (choice) in conjunction with situational contexts and structural influences linked to important institutions" (p. 48). They found that active participation in the desistance process and major life events such as marriage or work were critical to successful outcomes (Laub & Sampson, 2001). Structured life roles (e.g., father, husband, employee) offer stability and provide meaning in the lives of offenders, which in turn contributes to their inclination to refrain from criminal behaviour. Desistance has a 'knifing off effect', by which being cut-off from an offender environment gives rise to a new prosocial one, allowing for successful rehabilitation into the community (Martens, 2000). While most offenders demonstrate their highest level of criminal activity in late adolescence with a steep decline in offending after age 30, there is a group of offenders described as high level persisters who continue to offend well past middle age (Blumstein & Cohen, 1987; Tracy, Paul, Marvin, Wolfgang & Figlio, 1990; Wolfgang, Figlio, & Sellin, 1972). In one Dutch study, minor property crimes were the most common offences of persistent offenders (Blokland, 2005). In countries where rates of violence are higher, however, earlier research indicated that persistent offenders were continuing to commit violent offences (Moffit, 1993). There is evidence, therefore, of distinct lifespan trajectories in offending and desistance.

Resilience and Protective Factors

The terms resiliency and protective factors are often used interchangeably. While these terms are related and share many similarities, a distinction between them should be made. Both resiliency and protective factors are related to desistance and contribute to the maintenance of a crime-free lifestyle; however, while protective factors shield individuals from risk, resilience is understood as the individual variation in response to risk (Rutter, 1987). Resilience is described as "a dynamic process encompassing positive adaptation within the context of significant adversity" (Luthar, Cicchetti, & Becker, 2000, p. 543), or an invulnerability requiring the exhibition of two critical conditions: a significant threat or severe adversity (e.g., chronic illness, poverty, maltreatment) and the achievement of positive adaptation despite this adversity (Luthar et al., 2000). Multiple protective factors are implicated in resiliency development, including those involving the self, the family, and the wider social environments (Luthar et al., 2000).

While the concept of resilience has traditionally been employed in the context of child

development or mental health (e.g., Davydov, Stewart, Ritchie, & Chaudieu, 2010; Luthar et al., 2000), it has a clear application in corrections among offenders. Indeed, in recent years, research has focused on the factors associated with an increased likelihood of successful reintegration in the community despite past criminal history and other disadvantages (de Vogel, de Ruiter, Bouman, & de Vries Robbe, 2011; de Ruiter & Nicholls, 2011; Ullrich & Coid, 2011). Some researchers now recommend that, in addition to a consideration of risk factors, a comprehensive case formulation should include the assessment of strengths and protective factors (de Ruiter & Nicholls, 2011; Farrington, 2007). There is consensus among forensic researchers that the presence of protective factors serves to mitigate the effects of risk factors and reduce the likelihood of recidivism (e.g., de Vogel et al., 2011; Lodewijks, de Ruiter, & Doreleijers, 2010). This relationship could explain why some high risk offenders, against the odds, do not recidivate.

Research has identified multiple factors that are consistently associated with the reduction of recidivism among offenders (e.g., Bahr, Harris, Fisher & Armstrong, 2010; de Vogel, de Ruiter, Bouman, & de Vries Robbe, 2009; Ullrich & Coid, 2011). Commonly identified protective factors include education (Ford & Schroeder, 2011; Lockwood, Nally, Ho, & Knutson, 2012), community employment (Aresti, Eatough, & Brooks-Gordon, 2010; Bahr et al., 2010; Berg & Huebner, 2011; Lockwood et al., 2012; Nolan, Wilton, Cousineau, & Stewart, 2014), social and family support (Bahr et al., 2010; Bersani, Laub, & Nieuwbeerta 2009; Giordano, Seffrin, Manning, & Longmore, 2011; Ullrich & Coid, 2011), including being a parent (Losel, 2012 ; Walker, 2010), involvement in religion (Farrell, 2009; Giordano, Longmore, Schroeder, & Seffrin, 2008; Kenemore & Roldan 2005; Schroeder & Frana, 2009;.Ullrich & Coid, 2011), participation in community-based programs (Bahr et al, 2010; Celinska, 2000; Kesten et al., 2012; McGuire, 2000), and positive attitudes/goals (Bahr et al., 2010; Kenemore & Roldan, 2005; Serin & Lloyd, 2009). There is also some support, though more limited, for the value of volunteering (Taylor, 2008). Although there is little research on protective factors specifically relevant to offenders with a mental disorder, one would expect them to mirror those of offenders in general. For example, there is empirical support for the importance of social ties in improving the quality of life of offenders with mental health disorders (Jacoby & Kozie-Peak, 1997). Specialized programs and intensive case management designed for offenders with mental health issues and substance abuse problems who have been released to the community have shown some promise in reducing reoffending (Farrell-MacDonald & Stewart, in press; Kesten et

al., 2012; Theurer & Lovell, 2008). One measure cited in the literature provides a systematic assessment of protective factors. The Structured Assessment of Protective Factors for violence risk (SAPROF; de Vogel et al., 2011) is a tool that assesses a combination of internal, motivational, and external items reflecting those identified in Laub and Sampson's (2001) theory of criminal desistance that has been used in the assessment of forensic psychiatric patients and violent offenders. Items identified as protective include work, leisure activities, positive attitudes toward authority, and positive social and intimate relationships. To date, there is limited research on the psychometric properties of the tool, but early studies show promise for the measure's potential for enhancing current risk assessment tools (e.g., de Vries Robbé, de Vogel, & de Spa, 2011).

Overall, it appears that provision of a combination of services (e.g., housing support, education, employment training, and clinical attention to mental health and substance abuse issues) may improve outcomes among offenders with mental health problems.

Offenders with Mental Disorders

Although the reasons are unclear, offenders with major mental disorders constitute an increasingly significant proportion of the offender population across jurisdictions (Fazel & Danesh, 2002; Diamond, Wang, Holzer, Thomas, & Cruser, 2001) with recent estimates of the prevalence of major mental disorder among Correctional Service of Canada (CSC) offenders as high as 40% even when substance abuse disorders and antisocial personality disorder are not included (Beaudette, 2013), and considerably higher when they are (Brink, 2005; Brink, Doherty, & Boer, 2001; Motiuk & Porporino, 1991). Given their increased presence in offender populations, it is important to gain an understanding of the factors related to their success on release.

Recently, cumulative evidence from several large scale international studies examining the relative risk posed by individuals with mental disorders has affirmed that, while the absolute amount of crime committed by individuals with mental disorders is small (see Fazel & Grann, 2006), having a diagnosis of a serious mental disorder does indeed increase the risk for violence and other types of recidivism, even when controlling for key covariates (Brennan, Mednick, & Hodgins, 2000; Stewart, Wilton, & Cousineau, 2012). There is evidence that substance abuse, in combination with an antisocial orientation, plays a key role in explaining violent reoffending in

this population (Bonta et al., 1998; Eaton & Kessler, 1985; Hodgins & Müller-Isberner, 2000; Monahan et al., 2001; Wilton & Stewart, 2012). Based on their important meta-analysis, recently updated, Bonta and his colleagues (Bonta et al., 1998; Bonta, Blais, & Wilson, 2013) concluded that the risk factors for criminal and violent recidivism among offenders with mental disorders are the same as for offenders without a mental disorder; namely, factors related to the extent of the criminal history, antisocial personality, substance abuse, unemployment, and family dysfunction. While research has established that many of the risk factors for criminal recidivism may be similar for offenders with and without a mental disorder, it is unknown whether the protective factors are also the same.

The Present Research

The literature identifies a number of protective factors that contribute to the successful reintegration of offenders and facilitate the process of desistance from crime. Much less is known, however, about what facilitates criminal desistance among offenders with a mental disorder.

The present research used a mixed-methodological approach to examine protective factors related to short-term success in the community for high risk, high need offenders with mental disorders. Two studies were conducted. The first study looked at a group of high risk and high need offenders with mental disorders, and compared the demographic profiles, offence histories, and static and dynamic risk factors of those who successfully remained in the community for one year to those who returned to custody within the same time period. It should be noted that only offenders rated as high risk and high need were selected because these individuals are considered highly disadvantaged and, therefore, remaining offence free for a one-year period would signal a level of resilience. An additional analysis involved randomly selecting a subset of 20 offenders from each of the two groups and conducting a detailed case management file review to determine the presence of established protective factors.

Following in the tradition of researchers who have approached this area through qualitative research, a second study conducted an examination of the narratives of four offenders with a mental disorder who have been crime-free since their release from a federal penitentiary.[1]

[1]See Maruna (2001) for a description of the narrative approach in studying desistance from crime.

Study 1: Method

Participants

Participants for this study were taken from federal offenders who had been accepted or were waitlisted referrals to the Community Mental Health Initiative (CMHI). The dates of the referrals ranged from May 2007 to March, 2011, and follow-up data were collected to January 2012. For a referral to CMHI to be accepted, an offender must have either had a diagnosis of one or more Axis I disorders, or a diagnosis of a personality disorder, organic brain dysfunction, acquired brain injury, developmental disability or intellectual impairment and be assessed as having an impaired level of functioning. Of this group of offenders, all offenders who were rated as overall high need and high risk on the intake assessment tools (described below) and who had a confirmed acceptance to the CMHI were identified. This resulted in a final sample that included 297 offenders (92% men and 8% women; 74% of non-Aboriginal ancestry and 25% of Aboriginal ancestry).

Procedure

Two analyses were used to examine differences between two groups: 1) those who remained in the community for one year without a return to custody and 2) those who returned to custody within the same time period. In the first analysis, the "unsuccessful" group and "successful" group[2] were compared on demographic information, offence history, and dynamic need factors that were assessed at offenders' intake to custody.

In the second analysis, 20 offenders were randomly selected from each of the successful and unsuccessful groups of offenders. Based on the review of the literature, relevant protective factors were identified and a coding manual was developed to record the presence of these factors among the two groups of offenders' (see Appendix A). Coding items were grouped into nine categories: associates, family support, intimate relationship support, community functioning, work, substance abuse, attitude and motivation, programs and interventions, and mental health. Two raters, blind to group membership, reviewed offender files for evidence of these protective factors during the post-release period. Offenders were followed for one year, or

[2] While the successful group had no returns to custody, they may have been suspended during their release. These suspensions, however, did not result in revocations.

until they returned to custody. Information on participation in mental health services was found in psychological and psychiatric reports and on case work records that detail ongoing case management observations during interaction with the offenders. In addition to these records, all other offender files were reviewed (e.g., offenders' correctional plan reports, program performance reports, assessment for decision reports). Inter-rater reliability was not calculated as the two coders worked together, discussed any coding that was ambiguous, and reached a mutual decision on each issue.

Measures

All demographic information, offence history, and dynamic need factors were extracted from components of CSC's Offender Management System (OMS), a comprehensive database containing offenders' background information and case management files. The subset of offender files used for the second analysis was also extracted from OMS.

The proportions of the released offenders who returned to federal custody for any reason, who returned to custody with an offence, and who returned to custody with a violent offence were calculated. Offences categorized as violent included: homicide, sexual offences, robbery, assault, arson, abduction, forcible confinement, kidnapping, hostage taking, and a variety of firearms, weapons and explosives violations. The sample was still under federal warrant during the period of the study, so reoffence of any kind resulted in a return to federal custody.

Risk variables were drawn from the Offender Intake Assessment (OIA) which is a comprehensive evaluation conducted on all incoming offenders in CSC. The static risk factor assessment (SFA) rating is one component of the OIA. The SFA is a 137-item structured professional judgement risk assessment scale (Motiuk, 1997). It has three subscales: Criminal History Record (38 items), Offence Severity Record (71 items), and Sex Offence History Checklist (28 items). Additionally, the items of the Criminal History Record are organized into three sections: Previous youth offences (15 items), previous adult offences (17 items), and current offences (6 items). The Offence Severity Record is organized into 2 main sections: previous offences (36 items) and current offences (35 items). Each item is rated as "present" or "absent." Based on the parole officers' review of all these factors, an overall assessment of low, moderate or high risk is made.

The Dynamic Factors Identification and Analysis (DFIA) component of the OIA assesses seven domains of dynamic criminogenic factors, with each domain consisting of multiple indicators (Brown, & Motiuk, 2005). The domains are employment and education, marital and family, associates and social interaction, criminal attitudes and values, personal and emotional orientation, substance abuse, and community functioning (Brown & Motiuk, 2005; Motiuk, 1997; Motiuk, 1998; Motiuk & Brown, 1993; Motiuk & Brown, 1994). Based on consideration of the indicators for each domain, each domain is rated on a three or four point scale ranging from asset to considerable difficulty. An overall assessment of need by parole officers provides a rating of low, moderate, or high need (CSC, 2007). Although all offenders in both groups in this study had an overall assessment of high needs and high risk, rating on the individual needs domains differed as did the presence of indicators within the domains.

Analyses

Chi-square tests are the most frequent hypothesis test method included in this report. For each analysis, Cramer's *V* effect size values are provided. Cramer's *V* is similar to a correlation indicating the strength of association. Generally, Cramer's *V* values less than .1 indicate negligible associations, values between .1 and .2 indicate weak associations, and values between .2 and .4 indicate moderate associations (Rea & Parker, 2005). It should be noted, however, that ascribing value to the strength of associations is somewhat arbitrary, and that even moderate associations are quite rare when examining outcomes that can be influenced by many different factors, as is the case for most social science research.

Study 1: Results

Comparison of Successful and Unsuccessful Offenders

Three-quarters (*n* = 223) of the sample of high risk and high need offenders with a mental disorder returned to custody within one year, while 25% (*n* = 74) did not. As illustrated in Figure 1 below, more than one-quarter of our sample failed within the first 39 days of release; the majority of those who failed did so within the first six months of release. Further analysis of our sample of offenders with a mental disorder revealed that 23% (*n* = 67) returned with a new offence and 11% (*n* = 32) returned with a violent offence.

Table 1 provides the release outcomes (successful or unsuccessful) of the total sample by Aboriginal ancestry and by gender. Aboriginal offenders were less likely to be successful (17% success rate for Aboriginal offenders and 28% for non-Aboriginal offenders). The rate of return of the women in the sample was comparable to that of the men.

Figure 1. Percentage of returns to custody occurring within various time periods during the first year post-release

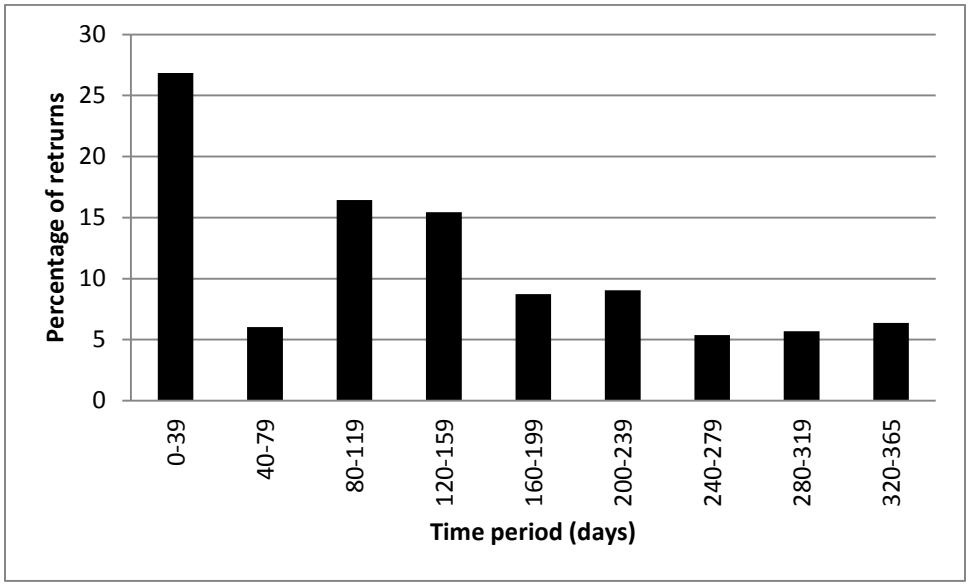

Table 1

Community Outcomes by Gender and Aboriginal Ancestry

	Male (*n* = 274)		Female (*n* = 23)			Aboriginal (*n* = 75)		Other (*n* = 221)		
	%	*n*	%	*n*	*V*	%	*n*	%	*n*	*V*
Outcome					.02 [ns]					.11 [ns]
Successful[†]	25	69	22	5		17	13	28	62	
Unsuccessful	75	205	78	18		83	62	72	159	

*Note: N*s vary because of missing data.
† Successful represents offenders who had no return to custody, whether for technical violations or reoffences, for a one-year period following release.
[ns] not significant.

Table 2 displays the demographic variables associated with outcome on release for the two groups of offenders (i.e., those who successfully remained in the community for one year vs. those who did not). These indicators were assessed at intake and, therefore, may not be as descriptive of the offenders' community circumstances as the data coded from the file review (presented in Table 3). For example, motivation level assessed at intake and presented in Table 2 was not related to outcome, but the motivation rating on release was associated with success on release. With respect to differences in offence histories, successful offenders were more likely to have been sexual offenders (e.g., 55% of sexual offenders were successful for one year after release as compared to 22% of robbery offenders) and there was a small, significant trend for successful offenders to be older. While Aboriginal offenders had lower rates of success on release, the difference between Aboriginal and non-Aboriginal offenders was not statistically significant. The number of women in the sample was too low to establish a reliable trend, but the rates of failure were similar to those of the men.

Further exploratory analyses were conducted to look for differences in risk factors and DFIA indicators between the two groups. A table presenting these results can be found in Appendix B. Given all of the offenders in the two groups had been rated as high risk and high need, and they all had a diagnosis of a mental disorder, it is not surprising that few group differences emerged. Of the static risk factors, only indicators related to the juvenile offence history distinguished the two groups. The unsuccessful group had a greater likelihood to have had a juvenile history (70% versus 54%) and had a higher volume of offences during this period. The adult static risk factors did not differ. With respect to the dynamic risk factors, offenders

from both groups experienced considerable problems in all domains. There is, however, a pattern for fewer of the offenders who succeeded to have had troubled early childhood family experiences (e.g., lacked family ties; paternal relationships problematic as a child; lived in a criminogenic family as a child), to have been involved in drug use to the extent it interfered with employment, to have resided in a criminogenic area, and to have been easily influenced by others. There is a somewhat puzzling result indicating that successful offenders were more likely to have communication problems with the intimate partners and sexual dysfunction problems. This finding may be in part an artifact of their higher rates of involvement in intimate relationships than the unsuccessful group.

Table 2

Profile Comparison of the Successful and Unsuccessful Offenders

	Successful (n = 74)		Unsuccessful (n = 223)		
	%	*n*	%	*n*	*V*
Gender					0.02 ^{ns}
Male	93	69	92	205	
Female	7	5	8	18	
Aboriginal identity	18	13	28	62	0.10 ^{ns}
Major Offence					
Homicide	8	6	6	14	0.03 ^{ns}
Sexual	14	10	4	9	0.17 **
Robbery	33	24	38	85	0.05 ^{ns}
Assault	24	18	19	42	0.06 ^{ns}
Other violent	0	0	3	6	0.08 ^{ns}
Drug	1	1	4	8	0.06 ^{ns}
Other nonviolent	20	15	26	59	0.06 ^{ns}
Motivation Level					0.08 ^{ns}
Low	24	18	31	69	
Medium	70	52	62	138	
High	6	4	7	16	
Release Type					0.09 ^{ns}
Statutory Release	84	62	84	188	
Day Parole	12	9	15	32	
Full Parole	4	3	1	3	
	M	*SD*	*M*	*SD*	R^2
Age at admission	35	10	31	9	.03 **
Aggregate sentence[a]	5	4	6	4	< .01 ^{ns}

[a]Offenders with indeterminate sentences were removed from this analysis; 2 indeterminate offenders were successful and 3 were unsuccessful.

^{ns} not significant, $^{**}p < .01$.

Protective Factors Associated With Success on Release

The following provides the result of the detailed file review conducted on random samples of offenders from the group that failed and the group that succeeded on release. Given the low number of offenders in this portion of the study, the analyses conducted had reduced statistical power. Nevertheless, several significant patterns emerged. More specifically, successful offenders were more likely to have prosocial supports from family and others (including an intimate partner), and to be involved in some form of structured or supportive activity, such as community employment, formal religious activities, volunteerism, or an educational or vocational program. Almost all offenders in both groups participated in mental health interventions, but the successful offenders were more likely to have also participated in correctional or substance abuse programming. All offenders who successfully remained in the community were described in their files as having indicated that they were motivated to stay in the community, compared to 70% of the offenders who returned to custody.

Table 3

Presence of Protective Factors among Successful and Unsuccessful Offenders: File Review

	Successful (n = 20)		Unsuccessful (n = 20)		
	%	*n*	%	*n*	*V*
Interacts with friends	90	17	95	18	0.10
Associates are prosocial[a]	71	10	36	5	0.36†
Family has provided support[a]	89	16	53	9	0.38*
In an intimate relationship	47	9	32	6	0.16
Partner is prosocial	75	6	25	1	0.31
Has children	72	13	78	7	0.06
Verbal communication skills	75	15	65	13	0.11
Involved in organized religion	40	8	15	3	0.28
Involved in organized volunteer work	25	5	10	2	0.20
Involved in any other organized activity	55	11	30	6	0.25
Hobbies	75	15	60	12	0.16
Employed in community[a]	65	13	30	6	0.35*
Education/vocational programs	50	10	25	5	0.26
Financially stable	5	1	5	1	< 0.01
Used alcohol on release	45	9	40	8	0.05
Degree of alcohol use	88	7	88	7	0.00
Used drugs on release	60	12	75	15	0.16
Motivated to be crime free	100	20	70	14	0.42**
Participated in community program	85	17	50	10	0.37*
Medication MH treatment	80	16	85	17	0.07
Counselling MH Treatment	90	18	65	13	0.30
Outpatient MH treatment	10	2	0	0	0.23
Inpatient MH treatment	15	3	5	1	0.17
Other MH treatment	45	9	15	3	0.33
Any MH treatment	90	18	95	19	0.09
MH stability[a]	60	12	65	7	0.25

Note: MH = mental health. Often, information on the variables was not found in the file coding process resulting in missing data. Percentages and statistical tests were calculated using only the valid cases.

[a]These variables were re-coded to form dichotomous groups; none or rarely were combined and some and a lot were combined.

†p < .1, *p < .05, **p < .01, ***p < .001.

Study 2: Method

Participants

Participants were four male federal offenders on supervised release in the Ottawa, Ontario area. Only offenders who had diagnosed mental health issues and had been successful on release in the community for at least three months (i.e., had not committed a new offence or breached their parole conditions) were included. While the follow-up period was limited, evidence suggests that the majority of offenders who recidivate will do so within three to six months (Brown, St. Amand, & Zamble, 2009). Their age at release ranged from 40 to 55 years (M = 44.75), and their time since release varied from approximately three months to three years at the time of the study.

Procedure

Recruitment took place through the parole office and community residential facilities using convenience sampling. Potential participants were asked by their parole officer if they would be interested in participating. Once the offender agreed to participate, he granted the parole officer permission to provide contact information to the researchers. Participants were then contacted and an appropriate time for an interview was scheduled. Participants could choose to conduct the interview in-person or over the telephone.

In-person meetings were scheduled in a private room at the Ottawa Parole Office to ensure confidentiality. Upon meeting, an informed consent form was provided to the participant, along with a verbal description of the content of the form. Individuals were required to provide consent for participation in the study, recording of the interview, and accessing file information via OMS to obtain demographic and criminal history information. Consenting individuals then proceeded with a semi-structured interview designed for this study. Interviews were conducted by the two researchers and were digitally recorded and then transcribed verbatim. Participants were asked a variety of questions about their experiences following release from the institution (e.g., employment, mental health, living circumstances, attitudes, relationships).

Measures

The semi-structured interview schedule composed by one of the authors was developed based on past research on desistance from crime (see Appendix C).

Analysis

A qualitative approach was used in grounded theory methodology (Glaser, 1992; Strauss, 1987). Grounded theory involves developing theoretical ideas throughout the data collection process. As tentative answers to questions were developed and concepts were constructed, these concepts were verified through further data collection. Throughout the data collection process, empirical indicators (recorded events) were constantly compared and themes were distinguished to provide the basis for coded categories (Schwandt, 2007). Coded categories were first developed through the analysis of the original interview protocol. Interview transcripts were imported into NVIVO 7, a qualitative data analysis software which allowed information from the semi-structured interviews to be organized categorically. Commonly occurring themes were derived based on inductive content analysis of the transcripts, through open coding, category creation, and abstraction (Elo & Kyngas, 2008).

Study 2: Results

The following section outlines the themes related to protective factors that were identified in the participants' responses. The findings of each theme are described, and in some cases, illustrative quotes have been provided to emphasize these discoveries.

Employment and Volunteering

Volunteering. Three of the four participants were involved with volunteering in the community and expressed that these activities were an important factor in their reintegration. Specifically, they stated that volunteering provided them with a transition period to employment, a way to give back to the community, and a means through which they could be provided with a pro-social support system:

> P2: I'm doing volunteer work and I love that. It's like "wow" I, it really fulfills me and it's really good and I wanna continue in that kind of field...the poor, the people handicap, or the people off the street, uh, I felt that I've abused the system for a very long time and that it just makes sense for me to give back.

> P3: ...people that I'm meeting, I don't hang around with them or anything but it gives me a chance to go and talk, to talk to them and stuff. And they're doing the same type of thing I am, so chances are, you know, they're law-abiding citizens right? And that's the kind of people I wanna be around...having a support system's big. And I think of people, like people who say they don't have a support system. Now that I've been volunteering and stuff, I don't agree with that. 'Cause everybody can have a support system, everybody can have one. It's just a matter of finding it in the right spots.

Employment. Only one participant was employed at the time of interview, although the remaining three expressed a desire to work sometime in the future. For the man who was employed, he saw his job as a major source of income and a method through which he could stay in the community. Specifically, when asked how he planned to remain crime-free, he stated he would "keep working."

Social Support

Family. Family was considered to be one of the most important resources for successful reentry into the community. Families mainly provided offenders with a form of emotional support, a sense of responsibility, and a means through which they could obtain transportation to attend important appointments:

P3: My mum and my wife and all the kids. All my family's great about me...I'm able to talk to them...I know this sounds different but I'm able to help them now so it kind of makes me have, um, um, uh, like responsibilities.

P4: When I got out at first [my mother] would bring me to my appointments and stuff like that...And after that it was my girlfriend bring me to my appointments and stuff like that...But she always come see me and she come talk to me and she come sometime at...my girlfriend's place...She drink a tea with us and start talking with her mom and, uh, her dad to my girlfriend and me and my girlfriend and you know...she support me good you know. I love my mom.

Friends. Two of the participants no longer associated with their previous friends and believed them to be a bad influence on a successful reintegration. The two offenders saw friends occasionally and found them to be a source of support. Activities involving friends included meeting for dinner on weekends and talking on the phone:

P4: I don't want to see…my friends. Criminals and …alcoholic and druggies…they're all doing drugs and stuff like that. I don't want to be a close to those.

P3: Oh yeah, they're good. They're good. Oh they're great. I talk to them on the phone and that. Um they're looking forward to me coming home so then you know I can see them more often and stuff...they don't do drugs either or nothing like that...they're the type, I'd have them to my house.

Intimate Partner. Three participants were currently involved in an intimate relationship lasting a minimum of three months. Intimate partners were a major source of love and emotional support. Shared beliefs were also expressed as being an important characteristic in their partner:

P2: Well, it's mostly emotional and, uh, you know there's a lot of love. She's a very good Christian woman...been going to church for the last…21 years...falls right into my beliefs and like she's non-smoking and hardworking person and, um, she's very caring and very giving.

P3: ...emotional and, um, like right now I don't have my truck and stuff in Ottawa so like I got a doctor's appointment in [hometown] tomorrow...Usually she comes to take me to my doctor's appointments and you know...so that kind of a support. And of course we love each other.

P4: Yes. A lot of support...she's really a good person…Because I've been with a lot of girls in my life and all of them used to cheat on me and hurt my feelings and everything like that. And her, she never, she never hurt my feelings once.

Children. Some of the participants had children of varying ages (toddlers to grown adults), although only one participant had regular contact with his child. For this offender, his

daughter provided him with the motivation to stay out of the institution and maintain a crime free lifestyle:

> P3: All my time even in jail you know...every time somebody started acting stupid I started thinking about my wife and my daughter and you know? Thinking about them instead of reacting to stuff, right?

Parole Officers. The majority of offenders reported that their parole officers supplied them with an additional form of social support that was beneficial to their successful reintegration. Parole officer's provided advice and were described understanding and honest:

> P3: My parole officer is excellent...You know I, I couldn't ask for a better one. He understands my situation. He's treating me really fair...Some guys that are on parole, they seem to think that they wanna sneak around to do stuff. I don't find that's necessary. If I wanna do something I ask...if he says "no", he'll give me an explanation why, you know, he thinks it's a bad idea and and that's what we go with right? So he's...good with me and I'm honest with him and it's good.

Substance Abuse

All participants had used drugs prior to their incarceration and most would be considered to have had a substance abuse problem. The substances of choice were alcohol and cocaine.

Substance use and criminality. Abuse of these substances was considered a contributing factor to their engagement in criminal behaviour:

> P2: My drug of choice has been crack cocaine. But I haven't always done that. Um, I knew it was my drug of choice, I knew it was a big, big time trouble and, uh, I needed something to function. So, the alcohol was there all my life, it was, I was self-medicating and also the pot. ...when I fell into the cocaine and the crack and that really was my downfall.

Substance Abuse Programs. Some of those with substance abuse issues reported that they were involved in treatment and indicated that this treatment was a major source of support and a way to refrain from returning to drug or alcohol use. It also provided them with an opportunity to support other people who are dealing with the same obstacles. Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) were specifically regarded as valuable programs:

> P1: I was an alcoholic for 25 years. Then I started going to AA meetings and I celebrated 20 years and this June it'll be 25 years without a drink.

> P2: Yeah, I love it. I get so much out of it...In the one of the readings that said, one alcoholic or addict is better suited to help another one...and at the same time, the people

> who are struggling are teaching the old timers, you know...not to go back there again. You know? This, this always an evolution, like we can learn so much from the newcomers and they can learn so much from the people who's been there for a long time and it's constant. It never stops, so it's a life process and I really enjoy going to those meetings and doing this stuff...the best way to help yourself is by giving...

Mental Health

Treatment. Each participant had seen a psychologist or psychiatrist at some point in the institution or following their release on parole. They considered their psychologist or psychiatrist as someone they could talk to, someone who could connect them with other support in the community, and a resource for medication management:

> P1: I seen a...psychologist, one-on-one and she helped a lot

> P2: ...he's taking care of my, uh, medical needs...the [hospital], [doctor]...he's helping me out and then when my supports get a bit lesser because I do have a lot of support right now, he's willing to put me on a case worker there...and then keep on going as long as it will take.

The men also indicated that they were on medication for their mental illness and found this to be a significant contributing factor to their success in the community. It also helped maintain stability in their lives.

Challenges of mental illness. Having a mental illness created additional barriers for these men upon their return to the community. In some cases, the mental disorder itself was a contributing factor to their criminal involvement. The stress of returning to the community was also reported to enhance psychiatric symptoms and make it difficult to successfully return to daily routines:

> P3: ...when I get stressed out then I'll get like voices in my head and, you know, stuff like that going on. So, I don't handle stress very well, but, um, I take my medication regularly...I worked all my life right up to when I went on my disability but...the stress of the job makes it so that it's hard for me to do my job now.

> P4: Caused me to be, uh, to put myself in trouble a lot of time...Some voices tell me go do this, go do that. And you know. And do this, do that, you're gonna be fine...and then I always end up in jail.

Correctional Programs and Interventions

While some offenders had completed their programming while in the institution, others

were involved in community maintenance programming following their release. The men who participated reported that programs were a method that helped them alter their belief systems, cope with mental illness, and interact with others in a social setting:

> P2: I did enjoy a lot of the stuff that I've learned in that program, like ABC's to change my belief. I have borderline personality disorder and my emotions are out of whack a lot, and being able to master them by changing the way I think and the way I believe. So the ABC's that they taught me and made me practice for the 8 weeks that I was there, really helped and I'm using it every day.

> P1: I have two volunteers that take me out…We go to Tim Horton's, we go to movies, we go bowling sometimes...They're really...they're a good organization.

Attitudes

All participants expressed that they respect authority figures and are accepting of the instructions they are given despite not necessarily agreeing with them. Offenders also reported that they take full responsibility for their crimes.

> P1: At one time I didn't like the police, but I changed. I like them now, they're there to help.

> P2: I accept everything that they say. I don't have to agree with it...I'm take full responsibilities for what I've done and take full responsibility of doing my time. And I have to abide by certain rules and I will, but I just don't have to be agreeing to it.

> P3: I did my crime so now I gotta, you know, go along with whatever they tell me to do and you know, so I, I have no problem with it.

Religion

Some participants stated that their religious faith was a significant factor in their success. It provided them with a source of comfort and hope. Reading the bible, going to church, and doing daily devotions were methods they noted as helping them to maintain their faith and stay in the community.

> P2: God....there's no bigger than Him...my belief, my faith, my, you know, it helps me every day, uh it helps me with my struggles, helps me with my thoughts, you know doing my devotion and all, and just feeling that He loves me and shows me the ways. I could sit here for hours and tell you about it but we don't have that time!

> P3: Absolutely makes me feel better myself and you know towards other people and stuff.

Discussion

The purpose of the present research was to investigate protective factors related to resilience for offenders with mental disorders. The first study examined differences between high risk and high need offenders with a mental disorder who successfully remained in the community for a one year period and those who returned to custody within the same time period. In the second study, interviews were conducted with four offenders with a mental disorder who had been released from federal penitentiaries and successfully remained in the community for at least three months. This allowed us to identify factors that the offenders themselves perceived to be beneficial to their success on release.

Results from the first study revealed that very few high risk and high need offenders with mental disorders succeeded in staying in the community without a revocation in the first year after their release. Most of those who returned to custody, however, did so for technical violations and not new offences. This is consistent with earlier research by Porporino and Motiuk (1995) showing that in a two year follow-up, offenders with a mental disorder were more likely to be suspended after release, but less likely to be revoked for an offence than those without a disorder. It is important to note that in our study we did not examine the reasons for violations nor how long offenders remained in custody before the next release. It is therefore possible that revocations were in response to an offender's case supervisor taking action as a crime prevention strategy (i.e., when a breach of conditions occurs or when the parole officer believes an offender's behaviour has deteriorated to the point that public safety could be compromised). Thus, our sample of offenders who met our definition of resilience was quite small (n = 74). It should be noted that the one year follow-up period chosen for the present study was considered a minimum period to demonstrate an offender as having "desisted". This may, however, be merely a period of hiatus from crime until longer term follow-up proves otherwise. For instance, Baskin and Sommers have argued that a two-year period indicates a "temporary cessation", but they contend that it is a long enough period to consider the "processes that initiate and sustain desistance" as underway (1998, p. 143). The factors noted in this research may be those that signal the beginning of desistance (Maruna, 2012) in the same way that the presence of risk factors signals a potential for reoffending.

Findings also indicated that only two of the demographic factors examined related to success on release. Offenders of older ages and sexual offenders were more likely to succeed.

Life course research across cultures has consistently shown that aging is related to a diminution in involvement in criminal activities, with a sharp decline evident beginning in the mid-20s (Farrington, 1986; Sweeten, Piquero, & Steinberg, 2013). Several explanations for this phenomenon have been offered; among them, the decreasing influence of gangs and antisocial peers, more mobility and the means to escape from abuse and witnessing abuse, psychosocial maturity (such as improvement in impulse control and self-regulation), and rational choice (a cumulative realisation of the relative costs and rewards of crime). Declining physical strength and energy and even infirmity may also be implicated. Likewise, the research has established that, in the shorter-term at least, sexual offenders have a lower rate of reoffending relative to other offender groups (Hanson, 2002; Olver, Nicholaichuk, Deqiang, & Wong, 2013). This finding has been attributed to both individual personality factors such as fewer antisocial features among sexual offenders and generally older average age of incarceration, as well as to social factors, such as decreased opportunities to access victims as a result of awareness campaigns focused on child safety.

Results examining static risk factors indicated that the unsuccessful group had a greater likelihood of having a juvenile criminal history and a higher volume of offences, although there were no differences in static risk factors during adulthood. An examination of the dynamic risk factors associated with success on release indicated a pattern for the offenders who succeeded to have reported less troubled early childhood family experiences, to be less likely to have lived in a criminogenic neighbourhood and to have criminal friends, and to be less easily influenced by others. Both successful and unsuccessful offenders were considered impulsive, but those who succeeded were slightly less likely to be described as impulsive and as risk takers. Many of the dynamic risk factors assessed through file coding that distinguished those who succeeded were consistent with what has been noted in the literature. Offenders with more prosocial social support from family, associates, and intimate partners, those involved in structured activities (particularly employment), and those who were rated as motivated to stay in the community were more often desisters. Given that almost every offender in both groups were involved in some form of mental health services and prescribed medication, these factors did not distinguish the successful offenders from those who returned to custody; however, this does not mean that these services were not a critical element in community success. It may be that involvement in mental health services for offenders with a mental disorder is a necessary, but clearly not a sufficient,

condition for success in the community. It appeared that involvement in community programming may have improved the chances of remaining in the community.

A limitation of the first study is that many factors other than the protective factors we assessed in this study could have affected the relative success of offenders with a mental disorder. For example, we did not examine whether there were differences in diagnoses across the two groups. It may be that some diagnoses involve less impairment or are associated with fewer antisocial traits. We did find a slight effect for age with older offenders doing better. Symptoms of some diagnoses remit, or at least the degree of impairment decreases, with age (e.g., Blanchflower & Oswald, 2008; Lang, Llewellyn, Hubbard, Langa, & Melzer, 2011) so it is possible that the offenders who succeeded in our sample were more likely to suffer from these type of disorders. Two groups of offenders with mental disorders have been described in the literature: those referred to as "life course" offenders who are antisocial usually from a young age, and a second group whose antisocial behaviour is limited to a reaction to their illness. For the latter, mental health treatment and other interventions foster remission of the symptoms of the mental disorder would be the primary focus to reduce the risk of future reoffending (see Hodgins & Janson, 2002).

Another potential limitation of the first study is that, due to the study design, we could not say that the factors noted as differences between groups actually influenced the success, or whether those who succeeded had had the opportunity to stay in the community long enough so that involvement with prosocial friends, structured activities, and participation in work and programs could be established.

The results of the second study revealed that recently-released mentally-disordered offenders perceived volunteer activities and prosocial supports to be of the great importance to their success in the community thus far. Additionally, all offenders who were interviewed indicated that they had access to mental health services, making it a likely factor implicated in their success. While qualitative studies add context and insight to research findings, the small sample size in this case (N=4) limits conclusions that can be drawn based on these results.

Although the present research is preliminary, the results suggest some strategies that might assist offenders with mental disorders to remain in the community after release. Interestingly, most of these directions are common to the evidence base on good correctional planning practice for all offenders, not only those with mental health problems:

1. Opportunities to make contact and form relationships with prosocial community supports should be encouraged. For some, this involves promoting family support and intimate relationships, but the benefit of prosocial interaction may also derive from community contacts established through involvement in religious activities, volunteering, or participation in work and upgrading courses. Encouraging a link with prosocial community contacts prior to release may help these offenders through their critical first weeks in the community.
2. Ensure offenders can access and participate in mental health services. Almost all the successful offenders were involved in some form of mental health service, whether it was for psychiatric medication or forms of counselling.
3. Encourage involvement in structured activities such as volunteerism and upgrading courses and, particularly, community employment.
4. Investigate ways to motivate offenders to maintain themselves in the community. All the successful offenders indicated that they were keen to stay in the community. Their success was goal-driven in spite of their disadvantages.
5. Ensure participation in community programs. For those with substance abuse problems in particular, oversee involvement in community treatment, follow-up or support groups and substance abuse monitoring. Skills taught in correctional programs may help offenders manage their impulsivity.

Conclusions

High risk and high need offenders with a mental disorder have high rates of return to custody within a one year period. Those who are able to remain in the community for this period of time may be benefitting from the positive effects of participation in employment and other structured social and religious activities, community programs, established relationships with prosocial family and friends, and from a generally positive attitude towards remaining in the community. Almost all successful offenders, as well as those who failed on release, were involved in mental health services. This group of high risk and high need offenders with mental disorders requires close supervision and support to successfully remain in the community. Establishing these supports and links prior to release may help them remain in the community through their critical first weeks of release.

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Appendix A

Coding Manual[3]

Name of Coder: _____
Date: _____
FPS: _____
DOB [DD.MM.YYYY] _____
Release date: _____
Date of most recent DFIA: _____

ALL QUESTIONS REFER TO POST-RELEASE UNLESS OTHERWISE STATED. THESE QUESTIONS ARE MARKED **

99 = Missing Data (unknown)
88 = N/A

Associates

1) On release, does the offender have a network of friends/peers that he sees/interacts with? (frequent is defined as weekly interaction and short-term girlfriends would considered under associates)

0. No interaction
1. At least infrequent interaction
2. Frequent interaction

2) Has the offenders friends/peers provided support after release? (regular contact, emotional, financial, accommodations – focus on the quality and frequency)

0. Receives no support
1. Rarely receives support
2. Receives some support
3. Receives a lot of support

3) Are the offender's friends/peers prosocial? (prosocial defined as not having a criminal history, no serious substance abuse, is productive, financially stable, a positive influence on the offender, etc).

0. No
1. Some
2. Yes

[3] The formatting and spacing of the coding manual was altered to reduce the number of pages in this publication.

Documentation Log Title, Date, and pg#	Notes

Family of Origin

4) Have members of the offenders family provided support after release? (regular contact, emotional, financial, accommodations)

0. Receives no support
1. Rarely receives support
2. Receives some support
2. Receives a lot of support

Documentation Log Title, Date, and pg#	Notes

Intimate Relationship(s)

5) While on release, is the offender in an intimate relationship? (spouse, common law, partner) (not enough to be a girlfriend, needs to be proof of commitment)

0. No
1. Yes

6) Has the offender's spouse, common law, partner provided support after release? (regular contact, emotional, financial, accommodations)

0. Receives no support
1. Rarely receives support
2. Receives some support
3. Receives a lot of support

7) Is the offender's spouse, common law, partner prosocial? (prosocial defined as not having criminal history, no serious substance abuse, is productive, financially stable, a positive influence on the offender, etc).

0. No
1. Yes

8) Does the offender have a child/children (either biological or from partner)?

0. No
1. Yes

Documentation Log Title, Date, and pg#	**Notes**

Community Functioning

9) Is the offender hygienic/groomed/presentable?

0. No
1. Yes

10) Does the offender have good verbal communication skills?

0. No – poor/limited verbal communication skills
1. Somewhat –basic/fair or has limited verbal communication
2. Yes –good verbal communication skills

11) Does the offender engage in organized activities?

0. Sports teams
1. Religious community or spiritual activities
2. Volunteering
3. Other Specify_____
4. No organized activities.

12) Does the offender have hobbies? (ex things he enjoys doing on his own, solitary activities etc.)

0. No
1. Yes

13) What is the offender's living arrangement?

0. Family of origin
1. Spouse, common law, intimate partner
2. Spouse, common law, intimate partner and children
3. Spouse, common law, intimate partner family
4. Sharing an apartment, house, or rents a room with a friend(s)
5. Living alone in an apartment, house, or rents a room
6. Institution (e.g., CCC)
7. Unstable accommodation – homes of various friends' and family
8. Unstable accommodation – hostel, hotel, shelter, itinerant, on the street

Documentation Log Title, Date, and pg#	Notes

Work

14) Since release, has the offender found employment in the community?

0. No
1. Has stable work
2. Has unstable work

15) Since release, has the offender enrolled in education/vocational program (s)?

0. No
1. Yes

16) On release, what can the offender afford?

0. Relies heavily (solely) on social assistance/welfare/ Disability (ODSP)/CCC accommodations
1. Slightly relies on social assistance/welfare/disability (ODSP)/ CCC but with some external income
2. Basic necessities (food and accommodations)
3. Financially independent (able to afford food, accommodations, leisure on their own)

Documentation Log Title, Date, and pg#	Notes

Substance Abuse

17) Has the offender used alcohol while on release?

0. No
1. Yes

18) If yes, to what degree:

0. Used, but neither breached nor abused alcohol
1. Breached alcohol conditions
2. Abused alcohol

19) Has the offender used substances while on release?

0. No
1. Yes

20) If yes, to what degree:

0. Used, but neither breached nor abused substances
1. Breached substance conditions
2. Abused substances

Documentation Log Title, Date, and pg#	**Notes**

Attitude/Motivation
(Summary of entire release to WED or return to custody)

21) Is the offender motivated to maintain a crime-free lifestyle? (actively avoiding criminogenic influences, negative peers, abstaining from substance use, develop prosocial behaviours, etc.)

0. No – shows no interest in maintaining a crime-free lifestyle
1. Somewhat - shows some interest in maintaining a crime-free lifestyle
2. Yes – is highly motivated to maintain a crime-free lifestyle

Documentation Log Title, Date, and pg#	**Notes**

Programs/Interventions
(make sure not to code for vocational/work related programs)

22) Offender has participated in one or more interventions while on release?

0. No
1. Yes

23) If yes, has the offender performed well or successfully completed at least one intervention post-release?

0. No
1. Yes

24) What interventions has the offender participated in (AA, NA, John Howard

Society programs, etc.)

_____

Documentation Log Title, Date, and pg#	**Notes**

Mental Health

25) Has the offender received mental health treatment /services post-release?

0. No
1. Medication
2. Counselling
3. Mental Health programs (external to correctional programs)
4. Group therapy (external to correctional programs)
5. Outpatient Mental Health Centre/Hospital
6. Inpatient Mental Health Centre/Hospital (include transfer to treatment center)
7. Other Please specify_____

26) Is the offender's mental health status stable? (Summary from release to first return)

0. No episodes of mental instability
1. May have some episodes of mental instability
2. Serious or frequent episodes of mental instability

27) Is there a diagnosis on file?

0. No
1. Yes

28) If yes, specify _____

29) Does the offender have mental health issues that require treatment?

0. No
1. Yes

30) If yes, how compliant with mental health treatment is the offender? (Is the offender following medication regimen attending counselling/MH programming, etc.)

0. Not at all (is not at all compliant to MH treatment)
1. Partially (follow some parts of MH treatments)

2. Yes (fully complies to MH treatment)

Documentation Log Title, Date, and pg#	**Notes**

Appendix B

Differences on Risk Factors between Groups

Table B1

Dynamic Risk Factors: Differences (DFIA) between Groups

Domain Indicators	Successful (n = 74)		Unsuccessful (n = 223)		V
	%	n	%	n	
Employment Domain	70	49	75	158	.04
Less than grade 8	39	27	39	80	.001
Less than grade 10	62	43	65	135	.02
High school diploma	16	11	13	26	.05
Finds learning difficult	47	31	55	108	.07
Learning disabilities	36	22	41	73	.04
Memory problems	40	28	37	75	.03
Concentration problems	61	43	55	113	.06
Problems with reading	36	25	39	81	.03
Problems with writing	40	28	42	87	.02
Lacks a skill area/trade/profession	73	51	82	171	.10
Physical problems interfere with work	25	17	16	34	.09
Unemployed at arrest	84	59	84	174	.007
Unemployed 90% or more	67	46	69	143	.02
Unemployed 50% or more	91	62	87	180	.06
No employment history	24	17	30	63	.06
Difficulty meeting workload requirements	31	21	19	38	.13*
Lacks initiative	41	27	38	78	.02
Lacks employment benefits	51	35	54	111	.03
Job lacks security	54	37	57	117	.02
Difficulty with co-workers	4	3	8	16	.06
Difficulties with supervisors	9	6	12	23	.04

Domain Indicators	Successful (n = 74)		Unsuccessful (n = 223)		V
	%	n	%	n	
Marital/Family Domain	53	37	46	97	.06
Childhood lacked family ties	26	18	46	96	.18**
Mother absent during childhood	24	17	28	60	.04
Maternal relations negative as a child	41	29	36	76	.05
Father absent during childhood	44	37	50	104	.05
Paternal relations negative as a child	46	32	62	128	.14*
Parents relationship dysfunctional during childhood	55	36	68	140	.12*
Spousal abuse during childhood	39	26	47	94	.07
Sibling relations negative during childhood	24	17	16	33	.10
Family members involved in crime	30	20	45	89	.13*
Currently single	80	56	80	168	.004
Has been married/CL in past	76	53	63	132	.12*
Dissatisfied with current relationship	19	13	7	15	.16**
Communication problems affect relationship past/present	62	42	37	76	.22***
Has been a victim of spousal assault	14	10	14	28	.01
Has been a perpetrator of spousal assault	40	27	33	67	.07
Has no parenting responsibilities	77	54	71	149	.06
Unable to handle parenting responsibilities	13	9	12	25	.01
Family unable to get along as a unit	17	12	16	34	.01
Has been arrested for child abuse	1	1	1	2	.02
Has been arrested for incest	0	0	0	0	----
Associates Domain	60	42	69	146	.08
Socially isolated	47	33	48	101	.006
Associates with substance abusers	846	56	90	189	.09
Has many criminal acquaintances	71	47	81	168	.10†
Has mostly criminal friends	52	35	58	122	.06

Domain Indicators	Successful (n = 74)		Unsuccessful (n = 223)		V
	%	n	%	n	
Has been affiliated with a gang	7	5	16	33	.11†
Resides in a criminogenic area	31	20	46	91	.13*
Unattached to any community groups	82	56	81	171	.01
Often victimized in social relations	23	16	30	63	.07
Easily influenced by others	50	35	65	134	.13*
Has difficulty communicating with others	41	28	43	91	.02
Substance Abuse Domain	86	60	92	195	.09
Began drinking at an early age	59	41	60	124	.002
Drinks regularly	48	33	51	104	.02
History of drinking binges	54	37	59	123	.04
Combined use of alcohol and drugs	58	40	58	120	.003
Abuses alcohol	69	48	68	143	.004
Drinking has resulting in law violations	48	33	58	120	.09
Began using drugs at an early age	75	51	75	156	.004
Uses drugs on a regular basis	74	50	78	164	.05
Gone on drug-taking sprees	67	45	75	152	.08
Abuses drugs	86	59	90	189	.06
Drug use interferes with employment	48	32	63	128	.13*
Drug use has resulted in law violations	72	49	80	167	.08
Drug use interferes with health	49	33	49	98	.004
Has completed substance abuse treatment	46	31	46	94	.0003
Community Functioning Domain	39	27	49	104	.09
Unstable accommodation	57	40	69	144	.11†
Residence is poorly maintained	9	5	21	32	.13†
Poor self-presentation	15	10	20	42	.06
Poor hygiene	5	3	11	22	.09
Physical problems	44	30	31	65	.12†
Difficulty meeting bills	62	41	67	139	.04

Domain Indicators	Successful (n = 74)		Unsuccessful (n = 223)		V
	%	*n*	%	*n*	
Outstanding debts	40	28	37	63	.03
Problems writing	29	20	30	62	.02
Unable to express verbally	7	5	15	31	.10†
No hobbies	58	39	62	128	.03
Does not participate in organized activities	81	54	83	171	.03
Has used social assistance	77	54	86	176	.10†
Personal/Emotional Domain	97	68	98	208	.03
Feels especially self-important	4	12	18	38	.01
Family ties problematic	59	41	61	127	.02
Gang member	2	1	4	9	.07
Difficulties solving interpersonal problems	91	63	92	195	.02
Unaware of consequences	56	39	58	121	.02
Goal setting is unrealistic	40	27	46	94	.05
Disregard for others	86	89	84	177	.02
Impulsive	93	65	98	207	.13*
Incapable of understanding feelings of others	56	39	52	107	.04
Narrow and rigid thinking	59	41	66	137	.06
Aggressive	67	47	74	156	.07
Copes with stress poorly	90	63	93	194	.05
Poor conflict resolution	91	64	92	192	.001
Gambling is problematic	5	3	8	16	.06
Low frustration tolerance	64	45	76	158	.09
Hostile	43	29	45	95	.02
Worries unreasonable	35	23	39	79	.03
Takes risks inappropriately	75	52	87	181	.13*
Thrill-seeking	37	25	43	88	.06
Not conscientious	56	39	65	133	.08
Manipulative	70	47	66	135	.04

Domain Indicators	Successful (n = 74)		Unsuccessful (n = 223)		V
	%	n	%	n	
Difficulty performing sexually	14	8	4	7	.17**
Mentally deficient	19	12	21	43	.03
Diagnosed as disordered in the past	52	36	62	129	.09
Diagnosed as disordered currently	46	31	51	108	.04
Prescribed medication in the past	77	53	81	167	.05
Prescribed medication currently	62	42	57	117	.04
Past hospitalization	57	39	54	108	.02
Current hospitalization	13	9	14	29	.01
Past programs participation	46	32	50	103	.03
Current programs participation	13	9	17	35	.05
Attitudes Domain	74	52	75	159	.007
Negative attitudes toward law	69	48	77	163	.09
Negative towards police	54	38	59	123	.04
Negative towards corrections	39	27	46	96	.06
Negative towards community supervision	56	39	66	140	.10
Negative towards rehabilitation	30	20	37	77	.06
Disrespectful of personal belongings	57	39	64	132	.06
Disrespectful of public property	33	23	53	110	.17**
Disrespectful of commercial property	50	35	64	134	.13*
Supportive of domestic violence	34	23	21	41	.14*
Supportive of instrumental violence	69	46	70	146	.01
Lacks direction	86	60	86	181	.001
Non-conforming	83	58	81	171	.02
Community Employment					.20**
Employed	56	42	34	75	
Student	1	1	1	3	

$^{\dagger}p < .1$, $*p < .05$, $**p < .01$, $***p < .001$.

Table B2

Static Risk Factors: Differences between Groups

SFA Indicator	Successful		Unsuccessful		*V*
	%	n	%	n	
Previous youth court	54	37	70	148	0.14*
15 or more convictions as a youth	9	6	19	39	0.11†
10 to 14 convictions as a youth	25	16	30	61	0.05
Five to nine convictions as a youth	38	24	46	93	0.07
Two to four convictions as a youth	48	31	62	126	0.12*
One conviction as a youth	52	33	68	138	0.15*
Previous adult court	93	63	93	200	0.01
15 or more convictions as an adult	53	36	58	124	0.05
10 to 14 convictions as an adult	65	44	70	148	0.05
Five to nine convictions as an adult	82	56	83	175	<0.01
Two to four convictions as an adult	91	62	92	195	0.01
One conviction as an adult	93	63	93	198	0.01
Less than 6 months since last incarceration	35	24	42	90	0.06
No crime free period $\geq$ one year	26	18	38	81	0.11†
15 or more current convictions	6	4	5	11	0.01
10 to 14 current convictions	12	8	13	28	0.02
Five to nine current convictions	35	24	41	88	0.05
Two to four current convictions	75	51	84	180	0.10†
One current conviction	100	68	100	214	-

†p < .1, *p < .05, **p < .01, ***p < .001.

Appendix C

Semi-structured interview protocol

Education

What is the highest level of education you have completed?

Do you believe this education has helped you?

- In what way?

Employment and other activities

Since your release have you found a job in the community? Where?

- Is it full time, part-time, or casual?
- How long have you worked there?

Does your job provide most of your income?

- Do you receive other financial assistance?
- Are finances a problem for you?

What duties does your job require?

Do you find your job enjoyable?

- What do you like most about your job?
- What do you dislike most about your job?

Do you get along with the people you work with?

How do you spend your time?

Do in you participate in any organized activities? (i.e., sports, volunteering)

Do you affiliate yourself with any religious group?

- How has this contributed to your life?

Programs and Intervention

Following your release have you been enrolled in any programs?

- Which program(s)?
- Did you successfully complete the program? Is it ongoing?

Do you enjoy participating in these programs?

- Why or why not?

How often are the sessions held?

- How often do you attend?

Do you believe these programs have assisted you upon your release?

Living Situation and Social Support

Where do you live?

- Whom do you live with?

Family

What was your living situation growing up? (foster home, both parents, single parents, relatives)

Are you (were you) close with your parents/person who raised you?

Did you experience any abuse as a child?

Do you have any siblings?

- How many? What is your relationship with them like?

Do you have contact with your family now?

Has your family provided you with any support since your release?

- What kind of support?

How has this support helped you?

Intimate Relationships

Are you currently involved in an intimate relationship? (e.g., boyfriend, girlfriend, partner, spouse).

- For how long?

What is the longest relationship you have been involved in?

What type of support does your partner provide for you? (emotional, financial etc.)

Do you have any children?

- How many?
- What ages?
- Who has custody?

Associates

Do you have friends that you see?

How do you know them?

How much to do you see them?

Have these people given you support since your release?

- In what way?

Do you think they are a positive influence?

Do they drink a lot? Use drugs?

Have they been in trouble with the law?

Mental Health

Have you ever been diagnosed with a mental disorder? What was the diagnosis?

Do these mental health problems interfere with your daily functioning? How?

What kind of challenges do you face with your illness?

What treatment have you received for these issues? (e.g., counselling, medication)

- Is the treatment ongoing?
- How did you first get treatment? (e.g., got help yourself, someone else wanted you to go)
- What forms of therapy/medications have you been involved in?
- Are you planning to continue with your treatment? Do you find it helpful?

Have you ever been admitted to an outpatient or inpatient mental health centre? For how long?

Substance Abuse

Do you have a history of substance abuse?

- What is your biggest problem?
- Is it still an issue for you?

Attitudes

How do you view authority in the criminal justice system? (e.g., courts, police, parole officers)

Do you accept the decisions and instructions they give you?

Have you been treated unfairly by authority?

Motivation/Goals

What would you like to accomplish in the future? How do you plan to accomplish this?

Do you think you'll stay out of the institution? How do you plan to do this?

Overall

What do you believe to be the most important factors contributing to your success?

What are the greatest challenges you face?

Is there anything else you would like to add?