Mental Health Intake Screening in Correctional Settings:
A Comparison of Normative Data for the Brief Symptom Inventory

by
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DEDICATION
For Uncle Jean and Josh.

You may be gone but you will never be forgotten.

I pray that you have found peace.

For death is no more than a turning of us over from time to eternity. ~William Penn
ABSTRACT

With increasing numbers of offenders coming into the correctional system with various mental health concerns, there is a demand for assessment measures that are quick to administer and will accurately target offenders that need assistance. The Correctional Service of Canada developed Computerized Mental Health Intake Screening System (COMHISS) to assist frontline staff in assessment units across Canada in the early identification of mental health concerns among the offender population to help target those offenders who require immediate services at the time of admission. COMHISS combines two self-report measures tapping psychological problems, the Brief Symptom Inventory (BSI) and Depression Hopelessness and Suicide Screening Form (DHS), with the Paulhus Deception Scales (PDS). This study focused on the BSI, a 53-item self-report symptom inventory, with a 5-point Likert-type scale ranging from 0 (not at all) to 4 (extremely). The BSI is scored and profiled using nine symptom dimensions and three global indices of distress. The BSI published norms (cut-off scores) were developed using a sample comprised of non-patients adults, adolescents, and adult psychiatric in- and out-patients; these are not representative of an offender population. This study sought to develop and test some offender appropriate norms (Stewart et al., 2010), using the current norms and scores, with respect to the offenders’ needs. However after testing the generated offender norms on a sample of 46 federal offenders we found that there was a minimal difference between Derogatis (1993) norms and the offenders’ norms (Stewart et al, 2010) in terms of predicting which offenders would require psychological assistance. Future studies should seek other potential mental health screening tools that may be a better fit for an offender population.
ACKNOWLEDGMENTS

I would like to direct my most heartfelt appreciation to my thesis supervisor, Dr. Geris Serran, for her enduring support and guidance during the progress of this thesis. Her commitment to this project was remarkable, and very much appreciated. I would to thank Dr. Brian Farrell, my on-site supervisor, for his tremendous support in the early stages of the development to the final product of this thesis. Also, I would like to thank you to Dave Villeneuve, who fulfilled the role of second reader, for his attentive review of this thesis.
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Chapter I: Introduction

Currently, the challenges faced by mental health service providers in most federal institutions have been the same for the past two decades; they can be summarized as follows: (1) many individuals with severe mental illness come into the criminal justice system, (2) These inmates can present a risk of hurting themselves or others and (3) can also present management challenges for staff (Felthous, 2009). Even with the available “in-house” services, there are still some challenges involved in delivering mental health services in custody, such as heightened levels of distress related to being incarcerated, lack of resources, and institutional procedure challenges. Altogether, these factors make it difficult to provide wide-ranging mental health services to individuals in custody.

The prevalence of mental disorder is increasing amongst offenders; between March 1997 and March 2008 the percentage of in-custody male offenders, identified at intake, with past mental health concerns almost doubled from 10% to 18% (CSC Report, 2008). Likewise, the percentage of offenders with a current diagnosis increased from 7% to 13% and the number of those currently taking medication for mental health issues increased from 9% to 21% (CSC Report, 2008). With such indications, Correctional Service of Canada (CSC) required tools that could provide an efficient and consistent method to assess offenders who may require mental health intervention. The large numbers of offenders coming into assessment units demanded an automated system that would allow administrators to gather institutional, regional and national statistics and give accurate profiles of offenders who are showing significant symptoms of distress.

To address this need came the development of the Computerized Mental Health Intake Screening System (COMHISS). COMHISS is, a screening protocol that employs several instruments, used in institutions across the Canada. This standardized process was put in place by Correctional Services of Canada to identify offenders with psychological distress who require further assessment or intervention (assistance). Early identification of mental health concerns helps target those offenders who require immediate services, while also giving some insight in the development of a rehabilitation strategy for offenders throughout their sentence. COMHISS combines two self-report measures tapping psychological problems, the Brief Symptom Inventory (BSI) and Depression Hopelessness and Suicide Screening Form (DHS), with the Paulhus Deception Scales (PDS). The screening process ideally occurs in 3-14 days (up to 90 days) from the offender’s admission to the institution and follow-up assessments can occur shortly after that depending on his mental health needs and main concerns (COMHISS National Guidelines, 2008). The follow-up assessment involves a structured interview with a behavioural technician for offenders who flagged on the BSI to determine if they need referral to psychological services.

The development of a mental health screening tool for offenders entering the federal correctional system was needed to ensure that offenders who required mental health services were appropriately identified and referred. Screening for mental health problems through COMHISS is an initial component of the continuity of care established for federal offenders with mental health needs. Those offenders who met a specified cut off score on the mental health screening instruments were referred for a follow-up session with a mental health professional. The assessment information allows the psychologist to prescribe the level of mental health intervention and services required to meet the offender’s need with respect to their risk levels.
The Brief Symptom Inventory (BSI) is a 53-item self-report symptom inventory, with a 5-point Likert-type scale ranging from 0 (not at all) to 4 (extremely) and can typically be completed within 8 to 10 minutes, designed to reflect psychological distress (Appendix A). The BSI is scored and profiled using nine symptom dimensions and three global indices of distress. The primary symptom dimensions are: 1) Somatization 2) Obsessive-Compulsive; 3) Interpersonal Sensitivity; 4) Depression; 5) Anxiety; 6) Hostility; 7) Phobic Anxiety; 8) Paranoid Ideation and; 9) Psychotism. The three global indices provide a general score on the subject’s well-being based on the entire assessment. The global indices are: 1) Global Severity Index; 2) Positive Symptom Total; and 3) Positive Symptom Distress Index.

The BSI current norms (cut-off scores) were developed by Derogatis (1993) using a sample comprised of non-patients adults, adolescents, and adult psychiatric in- and out-patients. However this sample does not represent an offender population in federal custody. It is therefore important to develop some offender appropriate norms, using the current norms and scores, with respect to the offenders’ needs.

Between February 2008 and April 2009 over 1,300 male newly sentenced offenders completed the measures at various federal assessment units across Canada. Those assessments showed that cut-off scores based on psychiatric patient norms predicted that less than 3% of the federal male population would be screened in for further service or evaluation; however, using non patient norms almost 40% of the population would be screened in (Stewart et al, 2010). Stewart et al., (2010) added that further research was required to develop CSC specific norms and appropriate cut off scores for an offender population. Without appropriate screening, inmates may not receive needed services and treatment, leading to behavioral deterioration, safety concerns, management crisis, and a failure to integrate successfully into the community on release.

To address the above issues, this study tested and compared offender norms (Stewart et al., 2010) and Derogatis (1993) norms for the BSI using offenders’ test scores on the BSI. This study will help the institutional psychology department’s assessment unit in the intake mental health screening of the offender, thus assuring that all the offenders that require assistance are provided adequate services with respect to their mental health needs. It is essential for the welfare of those being assessed that accurate norms are used in test interpretations. Therefore developing and using offender appropriate norms will bring assurance in the assessment process and help the department provide their service to the offenders with increased confidence. For our purpose we identified Derogatis (1993) norms as the “Old Norms” and Stewart et al (2010) norms as the “New Norms”
Chapter II: Literature Review

For a psychological test to be adequate for clinical use, it must be standardized and reliable, and it should demonstrate validity with respect to the purposes and populations for which it is used (Hunsley & Di Giulio, 2001). Specifically the test should show what it is measuring with respect to the intended population (i.e. Validity). Hunsley and Di Giulio (2001) add that such instruments should have norms or specific cut-off scores to interpret the results obtained from completed assessments. In their development, most tests undergo a series of trials to verify that they are reliable and valid. With no contrasting values, it is difficult to verify the implication of the test results. Hunsley and Di Giulio (2001) conclude that the chosen sample for any given test to be used should address two important questions: Are the test norms evaluating specific scores in the general population or in particular subgroups of the general population, or are the test norms determining a percentile within a category?

Hawthorne, Osborne, Taylor, and Sansoni (2007) advised that it is sometimes essential to have multiple norms for a test, based on the group being assessed and the intent of the assessment. Developing multiple norms for a test provides assessors some freedom to utilize test norms in different population groups or within a sub-scale of a given population groups (e.g., race versus gender). The ideal screening tool should have a balance in specificity and sensitivity which is evaluated by looking at the number of false positives/negatives and true positives/negatives. Meaning that this tool would capture everyone it should be screened and omitting those that should not be capturing. And norms can be adjusted to meet such criteria (increased/decreased cut-off scores).

The BSI Administration, Scoring, and Procedures Manual provides normative data for four different samples, including non-patient adults, adolescents aged 13-17, adult psychiatric outpatients, and adult psychiatric inpatients (Derogatis, 1993). The BSI (Derogatis, 1993) is a 53 item self-report symptom inventory that assesses nine patterns of clinically relevant psychological symptoms. It is a brief version of the Symptom Checklist List 90-R (SCL-90-R). Correlations between the BSI and SCL-R-90 are reported to range from .92 to .99 (Derogatis, 1993). The BSI has been used in a variety of clinical and counselling settings as a mental health screening tool and as a method of measuring symptom reduction during and after treatment. It has been demonstrated to retain its reliability and validity in numerous cross cultural studies. The nine dimensions the scale measures are: Somatization (distress arising from perceptions of bodily dysfunction), Obsession-Compulsion (thoughts and impulses that are experienced as unremittting and irresistible but are of an unwanted nature), Interpersonal Sensitivity (feelings of personal inadequacy and inferiority in comparison with others), Depression (symptoms of dysphoric mood and affect as well as lack of motivation and loss of interest in life), Anxiety (nervousness and tension as well as panic attacks and feelings of terror), Hostility (thoughts, feelings or actions that are characteristic of anger), Phobic anxiety (persistent fear response to a specific place, object or situation that is irrational), Paranoid ideation (disordered thinking characteristic of projective thoughts, hostility, suspiciousness, grandiosity, fear of loss of autonomy, and delusions) and Psychoticism (withdrawn, isolated, schizoid lifestyle as well as first rank symptoms of schizophrenia such as thought control). The BSI also includes three indices of global distress: Global Severity Index (GSI), Positive Symptom Distress Index, and Positive Symptom Total.

The global indices measure current and past levels of symptomatology, intensity of symptoms, and number of reported symptoms, respectively. For offender populations COMHIISS
screening currently uses adult non-patients; meaning that a T-score of 63 or above on the GSI or a T-score of 63 and above on any two dimensions would be considered a “case” worthy of further evaluation. However recent COMHISS reports found that the BSI does not accurately portray the offender psychological distress levels using the current norms since most of our past intake assessment results have shown an increase number of false positives, with respect to their psychological needs. With that in mind we tested offenders’ norms developed by Stewart et al (2010) to determine if they accurately identify offenders in need of assistance.

In a study by Meijer, de Vries, and Van Bruggen (2011) using a short version of the BSI for a prisoners sample, it was found that the only item on which the prisoners scored higher than the patients in the clinical sample was Item 5 (“Feeling lonely”). Furthermore, the item-total correlations for each subscale and for the total scale were high; while still lower than for the clinical sample. This finding shows that offenders responded to item 5 based on their current situation (being incarcerated) which affects their general distress level and also the items they will endorse on the measure. It is possible that the offenders being screened using the BSI simply do not comprehend the language or some of the constructs being portrayed in the assessment (e.g., anxiety, psychoticism).

In Prelow, Weaver, Swenson, and Bowman’s (2005) study, the BSI was administered to a sample of low-income Latina women. They found that the BSI did not accurately address Latina Women’s level of distress; possibly because the original development sample of the BSI was comprised of mainly European Americans; and therefore does not represent a Latina population. Prelow et al. (2005) added that cultural differences and socio-economic status might affect response style in some cases. The BSI has been reported to be accurate for diverse cultures, however there is no evidence as to which cultures were involved in the development sample. When a scale is applied to a population with different characteristics than the original sample the psychometric properties of that scales may vary (Prelaw et al., 2005). This is relevant because there are diverse cultural backgrounds represented in the federal prison system.

As Prelow et al., (2005) stated: “one cannot presume that instruments developed and tested for European American populations or even a minority groups such as African Americans, are consistently applicable for Latino populations; until there is empirical research that support the use of such instruments for that group”. (pg.140)

A report by Hale, Cochran, and Hedgepeth (1984) showed that the BSI norms were not age-appropriate in some cases. They found that the norms by Derogatis (1993) were standardized on a sample with an average age of 46 years. They used a sample with an average age of 73 years and they found that the elderly reported higher levels of distress. However this might not have been the case if age-relevant norms were used for this sample. Age-appropriate norms would be needed in this case to accurately assess the elderly psychological distress using the BSI.

In their study Lang, Norman, Means-Christensen, and Stein (2009) found a higher percentage of false positives; which diminishes confidence in the measure, thus decreasing compliance with screening. False positives also may be problematic for a busy assessment unit since they consume time that could be spent assessing offenders that could actually benefit from mental health services. As a result, individuals in need of psychiatric treatment sometimes go without appropriate care, and can deteriorate to the point of placing themselves or others in danger. While reducing false positives is the goal for most psychological measures, it comes with a cost, which is that some results may be missed. Stewart et al. (2010) conducted a pilot study within CSC’s assessment units across Canada on the COMHISS. Their study looked at the
percentage of offenders who would be screened in based on the cut off scores in use at the time (T-scores 60 and 65 for in-and out-patient norms). This study involved 1209 (about 80% were non-aboriginal and about 20% were aboriginal offenders) federal offenders across Canada, who completed the COMHISS during a 12 month period and provided valid results. Stewart et al. (2010) found that over one-third of incoming federal offenders report significant psychological distress. However such distress might not be accurately portrayed when compared to non-patients or out-patient norms for the BSI, since they are not representative of the offender population (Stewart et al., 2010). Stewart et al. (2010) added that the raw data generated from this study should be used to develop norms using an appropriate cut off score that will decrease false positives.

Nonetheless, the BSI also has some benefits, to name a few; one potential advantage of this measure is that the items are not specific to a particular disorder, so it may be better able to detect anxiety related distress that cuts across disorders. Second, the responses are on a 5-point scale, which may provide more information than other self-report measures. And finally, it offers a briefer and therefore less time-consuming method of assessment (Lang et al., 2009).

Questions have been raised in the past as to why there has not been any development of offender norms, to date, for the BSI. There are no clear answers to this matter; however a few reasons can be speculated (Stewart et al., 2010).

Research in institutions, especially in maximum security institutions, is difficult to implement for reasons such as: institutional lockdowns (logistics) and lack of interview spaces. Furthermore, correctional facilities have relied on an organizational structure that is routine, risk averse, and security focused. Institutional security is important and works effectively for prisons; however, it has limited the inclusion of potentially beneficial functions such as conducting research. Highly structured organizations, such as prisons, are by design risk averse and often resistant to change associated with research (Wakai, Shelton, Trestman, & Kesten, 2009). Despite these challenges there is growing interest for evidence-based research pertaining to mental health services and other aspects of the correctional system.

In due course, we hope that the offender norms (Stewart et al., 2010) will accurately target offenders who need mental health services and the ones who do not require much attention; when compared to the currently utilized norms (Derogatis, 1993). Such an achievement will shorten waiting lists for various health services in the institution. Without appropriate screening, inmates may not receive needed services and treatment, leading to behavioral degradation, safety concerns, management crisis, and a failure to integrate successfully into the community upon release.
Chapter III: Method

Participants
In order to protect the participants’ confidentiality for the purpose of this study no names or other identifying information were used. Participants were 46 adult male federal offenders serving a sentence of at least two years. To be included in this study, participants must have provided consent, completed the COMHISS testing, and flagged on the BSI (i.e. they identified some concerning areas with respect to their psychological state). Participants who did not consent or provided invalid test result (i.e., they do not respond to all questions on the test or miss too many questions) were not included in this study. The author randomly selected the 46 participants who had flagged on the BSI from the national database. Informed consent was obtained at the participants’ arrival to the assessment unit and on the day of their COMHISS testing. All 46 participants in this study provided consent and valid test results.

Design
This study was both quantitative and qualitative; the BSI norms published by Derogatis (1993) and by Stewart et al. (2010) were compared using the same sample to determine which norms provided better outcomes with respect to participants’ levels of distress (i.e., who will be seen for a follow-up interview). The independent variable in this study was the BSI norms (i.e., are they appropriate for an offender population) and the dependent variable was the referral/non-referral rate (i.e., how well does flagging on the new norms determine who is referred on and who is not).

Setting and Apparatus
This study took place in a federal correctional institution’s assessment unit. The participants were given access to the COMHISS test in a designated computer lab in the psychology department. The author and other members of the COMHISS department were involved in the set-up of each participant’s testing station. In case of any learning disabilities, participants had the option to use paper-pencil testing method or request a scribe. The COMHISS test was offered in both official languages. The COMHISS test battery is comprised of the PDS, DHS, and the BSI. This study only focused on the BSI results.

The BSI (Derogatis, 1993) is a 53 item self-report symptom inventory that assesses nine patterns of clinically relevant psychological symptoms. The scale’s nine dimensions are: Somatization, Obsession-Compulsion, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic anxiety, Paranoid ideation, and Psychoticism. The BSI also includes three indices of global distress: Global Severity Index (GSI), Positive Symptom Distress Index, and Positive Symptom Total; which measure current and past levels of symptomatology, intensity of symptoms, and number of reported symptoms, respectively.

Raw scores on the nine subscales and the GSI are calculated by summing the values for the items in each dimension (including four additional items for the GSI) and then dividing by the number of endorsed items in that dimension. The Positive Symptom Total is calculated based on the total count of the number of non-zero items endorsed and reveals the number of symptoms the respondent reports experiencing. The Positive Symptom Distress Index is calculated by summing the values of the items receiving non-zero responses divided by the Positive Symptom Total. This index provides information about the average level of distress the respondent experiences. An individual must answer at least 40 items of the BSI and must not provide the same response for every item on the measure for the responses to be considered a valid administration of the test (Derogatis, 1993).
Procedure and Data Collection

Once a participant read the consent form (Appendix B) and provided consent to take the COMHISS testing, they were instructed to begin the screening and answer each questions based on the current and past (last 7 days) psychological state. They were reminded that they can ask questions about the test at any point, to assure that they accurately respond to each question and complete the test. The participants were also advised that if their testing results showed significant signs of psychological distress; they would be seen by a behavioural technician, from the COMHISS department, immediately or several days after their testing. The above instructions were given to the participants at the time of their testing by members of the COMHISS department. The author accessed the participants’ data from the testing through the national database. The participants’ data were assessed through a descriptive statistical and visual analysis, comparing the offenders’ norms developed in Stewart et al.’s (2010) pilot study to the norms developed by Derogatis (1993), with respect to the participants’ level of distress. (See Figure 1.0 and Table 1.0 & 1.1)
Chapter IV: Results

When we compared the results of the 46 participants who flagged on the BSI, using the current norms developed by Derogatis (1993) (Norm 1) and the offender norms developed by Stewart et al., (2010) (Norm 2); we found that there was no substantial difference between the two norms; with respect to their predictions of which participant would require assistance following their intake assessment. Using Norm 1 (Derogatis, 1993) 26 of the 46 participants (57%) were hits meaning that they were seen for follow-up after they had flagged on the BSI and 20 of the 46 participants (43%) were misses meaning that they did not require assistance even though they flagged on the BSI. With Norm 2 (Stewart et al., 2010) 30 of the 46 participants (65%) were hits and 16 of the 46 participants (35%) were misses. Table 1.1 and Figure 1.0 are displaying the data we generated for both norms. Looking at the numbers, one can see that there is a slight difference between Norm 1 and Norm 2 for this sample, however Norm 2 generated better numbers with respect to the purpose of the BSI; which is to target the offenders who need assistance and avoiding those who do not.

<table>
<thead>
<tr>
<th></th>
<th>Norm 1</th>
<th>Norm 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hits</td>
<td>26</td>
<td>30</td>
</tr>
<tr>
<td>Misses</td>
<td>20</td>
<td>16</td>
</tr>
</tbody>
</table>

Table 1.1. Comparison of the BSI Norms

Figure 1.0. Bar graph of the BSI Norms

Table 1.2 shows a breakdown of the data generated by Norm 2 and were are able to see the hits and misses in terms of true and false positives and true and false negatives. Looking at Table 1.2, Norm 2 generated some promising data with respect to accurate mental health screening in a correctional setting; however we recorded three false negatives using Norm 2 meaning that of the 46 participants three were be missed by the BSI using offender norms. We cannot afford to miss anyone when it comes to assessing offenders who need assistance for various psychological distresses as this would pose an ethical issue with respect to service delivery in a correctional setting.
<table>
<thead>
<tr>
<th>Needed assistance</th>
<th>Flagged on Norm 2</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>YES</td>
<td>True Positive (Hits)</td>
<td>False Negative (Misses)</td>
</tr>
<tr>
<td></td>
<td>23</td>
<td>3</td>
</tr>
<tr>
<td>NO</td>
<td>False Positive (Misses)</td>
<td>True Positive (Hits)</td>
</tr>
<tr>
<td></td>
<td>13</td>
<td>7</td>
</tr>
</tbody>
</table>

Table 1.2. Breakdown of Norm 2 Results

On the other hand we cannot be sure that Norm 1 did not miss any offenders since we do not have similar data portrayed in Table 1.2 for Norm 1; since offenders who do not flag on the BSI are not tracked down for follow-up. Therefore at this point with limited data we cannot attest to our hypothesis that offender norms (Norm 2) best predict which offenders should be seen for follow up. For example if an offender is not seen based on his results on the BSI using Norm 2 and they end up harm someone or themselves; there will be significant liability issues with the decision to use Norm 2 over Norm 1 in this case.
Chapter V: Discussion

Summary
This study compared Derogatis (1993) and Stewart et al (2010) norms for BSI to determine which is more suitable in the assessment of psychological distress in an offender population. The results did not validate our hypothesis, which was that using offender norms for the BSI will generate accurate prediction of offenders’ assessment results. However, the study was still worthwhile since it generated some important questions for future research with respect to assessment measures in correctional settings. The offender norms (Norm 2, Stewart et al. 2010) identified those who needed assistance and was easy to test since we already had access to the population. It had a higher hit rate and fewer false positives than Norm 1. Although Norm 1 is not sensitive to an offender population it is, however, the least conservative option when it comes to capturing all the offenders that need assistance as shown in Table 1.1 and Figure 1.0.

Strengths & Limitations
Some of the limitations to this study were that the BSI results using Norm 2 missed three of the participants in our sample, meaning that three individuals who require services would not be receiving any assistance. Also the BSI is a self-report computerized assessment and much is to be said about the participants’ willingness to provide an accurate profile of their psychological state; primarily because of the setting the testing is delivered in (correctional setting). Most offenders do not want to be seen as having psychological distresses since they assume that it will affect logistical decisions with respect to their pen placement, correctional programming, and parole. Therefore it is safe to say that some of the participants may provide a compromised test to avoid further psychological assessment or they may lack insight into their psychological well-being, or may not understand the questions on the assessment despite staff’s assistance, or let alone know how to operate a computer. All these factors, plus language barriers played a factor in the results of our study. Due to limited data and time we were not able to develop a statistical analysis to portray our findings, as we originally planned.

Some of the strengths of this study were that it brought about new questions for future research such as the importance of using appropriate norms with specific populations. We were able to test offender norms with the appropriate population compared to Derogatis (1993) which were developed with in- and outpatient psychiatric population. Norm 2 provided less false positives than Norm 1 making it just as productive as Norm 1. However is it safe to adopt norms that will save the department time in their assessment process, even though they might miss some participants in need of assistance? This question certainly poses some ethical and professional concerns with respect to service delivery.

Multilevel Challenges to Service Implementation
Client Level
At a client level challenges to service delivery with respect to mental health screening may be the offenders’ willingness to participate in the assessment and be forthcoming with the information they provided. Because the COMHIIISS battery is comprised of multiple self-reports assessment measures, it is difficult to attest as to what information we receive is true unless we have evidence of psychological distress through specific symptomatology during our interactions with the offenders. Some offenders may not mean to withhold information during their
assessment, they may simply not understand the language of the assessment, have limited insight in their psychological state, or they may have difficulties with the materials used the COMHISS testing battery.

**Program Level**

At a program level, participants’ learning styles can be a challenge to service delivery in a correctional setting because some of the correctional programs might be tailored in a way that does not fit the participants in that specific program. Service providers should be flexible and tailor their delivery to fit the majority of the participants’ learning styles and assist those who need more help. This flexibility is especially relevant to offenders with mental health problems as certain issues such as ADHD or anxiety which could impact their ability to participate effectively in correctional programming.

**Organizational Level**

Budget cuts in federal system pose great challenges to service delivery in a correctional setting because without rehabilitation program offenders would not be able to re-integrate into the community with ease. Budget cuts limit the programs available to offenders, due to limited funds, in custody or in the community, as well as assessment measures. On a positive front, increased funding is being made available to address mental health issues in federal institutions which could potentially help mental health staff to better address the needs of these offenders.

**Societal Level**

Society puts a stigma on all offenders, especially if they have been in the system for a very long time or if they have some mental health concerns. Therefore it is hard for some offenders to integrate back into society once their incarceration is over because of such stigma. Some people in the community may view them as hopeless (good for nothing) because of their criminal history; which puts restrictions to what they can and cannot do in the community. Offenders in such situations end up re-offending again because they find no other way out, especially if they have no family support.

**Contribution to the field of Behavioural Psychology**

The field of Behavioural Psychology strives to promote positive behaviour change and successful rehabilitation into the community for individuals in the correctional system. In fact, one of the goals of Behavioural Psychology is to provide facilitators with empirically sound interventions that work to improve clients adaptive functioning and quality of life. This thesis has the capacity to contribute to this goal, since it provides an avenue for further research in mental health assessments within the correctional setting. It is important that we target the offenders’ need areas to improve their functioning in society, and facilitate successful outcomes as they transition back into the community.

In addition, professionals in the field of Behavioural Psychology are continually expanding the literature on various intervention procedures and client populations. This is possible because a hallmark of Behavioural Psychology is its ability to adapt intervention
procedures to meet the needs of a variety of clients. This thesis serves to add to this growing body of literature, by successfully combining and adapting several treatment approaches for use with acquisitive offenders.

**Recommendations for Future Research**

Future research should explore the BSI subscales individually since we noticed an over-diagnosis in our participants; mostly with the psychoticism scale. In other words, an assessment measure should not be looking into dimensions that are not particularly relevant at the time of the testing unless of course the participants presents apparent symptoms of that specific subscales. It might be helpful to explore other assessment measures that may be a better fit than the BSI for an offender population; since the BSI did not yield promising result using offender appropriate norms. Furthermore, future studies could replicate Stewart et al’s (2010) study in order to generate offender appropriate norms for the BSI ensuing the delivery of COMHISS Version II; which was being piloted in some institution across Canada at the time of our study.
References


APPENDIX A: BRIEF SYMPTOM INVENTORY

** Could not be attached to this report for copyright reason.
APPENDIX B: COMHISS CONSENT FORMS

Consent to Participate in the Intake Mental Health Screening Process

You are invited to participate in the Intake Mental Health Screening process offered by Correctional Service of Canada (CSC). It is important that you read and understand the following guidelines that apply to all participants in this project:

a) The Intake Mental Health Screening consists of three tests that help identify possible mental health problems. There are no right or wrong answers on these tests. Rather, the test questions are exploring whether certain statements apply to you. Test results will be used to better understand your needs and to offer assistance should you need it.

b) Information collected during the Mental Health Screening process is made under the legal authority of the Correctional and Conditional Release Act (CCRA). All information gathered or generated is accessible to you upon request and will be stored in Personal Information Bank CSC PPU 070.

c) Participation is entirely voluntary. You have the right to refuse to answer specific questions or to end the process at any time. However, please note that should you complete part of the testing, those responses will be reviewed and when possible, they may be interpreted.

d) Personal information collected during this screening is subject to the provisions of the Privacy Act. Information gathered for this screening process will only be available when necessary to other CSC health professionals. In accordance with the CCRA, a summary or a "get" may also be made available to your case management team and the Parole Board of Canada. Furthermore, if during the course of this screening you are thought to pose a clear and present threat to yourself or someone else or to the security of the institution, that information will immediately be shared with institutional management.

e) Should the screening process indicate that you would benefit from a more complete assessment, this will be offered to you. It will also be voluntary and may include follow up with a psychologist.

f) Information obtained from this process will be used for research and statistical purposes; however, reports generated using this information will not reveal your identity in any way. If you do not want your data used for this purpose, please inform the test administrator.

g) Should you have any questions about the research project or regarding the results after the completion of the project, you can contact:

National Manager, Institutional Mental Health Initiatives
Correctional Service of Canada, Health Services, Mental Health Branch
340 Lauder Avenue West, Ottawa, Ontario, K1A 0P0
Telephone: (613) 995-2942

If I have read the above and understand the mental health screening process, I agree that I have been given the opportunity to discuss all aspects of my participation in this project and the opportunity to ask questions.

[ ] I do not consent to participate in the Intake Mental Health Screening process.

I agree to participate in the above described Intake Mental Health Screening process.

Full Name of Participant (please print) — Nom complet du participant
Participant — Signature — du participant ou de la participant
Date (YYYYMMDD)

Full Name of Witness (please print) — Nom complet du témoin
Witness — Signature — du témoin
Date (YYYYMMDD)


Personal information will be protected under the provisions of the Privacy Act and will be stored in Personal Information Bank CSC PPU 070. Protection of the information requested on this document is voluntary and you may without prejudice decline to respond to any of these questions. — Les renseignements personnels seront protégés en vertu de la Loi sur la protection des renseignements personnels et seront versés au Fichier des renseignements personnels CSC/PU 070. 

La protection des renseignements demandés dans le présent document est une geste volontaire, et vous pouvez, sans préjudice, refuser de répondre.
MILLHAVEN CoMHISS
(Computerized Mental Health Intake Screening System)

Name: _____________________ FPS: _________ DOB:___________

Agreement to be called for the Mental Health Intake Screening Process

The Computerized Mental Health Intake Screening System (CoMHISS) offered at Millhaven Institution by Correctional Service Canada has been explained to me and I was given the opportunity to ask any questions that I may have.

☐ I would like to be called to participate in the Mental Health Intake Screening process. I understand that:
  • I will be called to attend the testing on two (2) occasions when I have not been scheduled to attend other programs.
  • If I do not attend for the testing on either of these times I will automatically be declined.
  • If I am automatically declined and I change my mind, I can submit an Offender Request Form stating that I would like to participate and I will be called for testing.

☐ I do not consent to participate in the Mental Health Intake Screening process. I understand that if I change my mind I can submit an Offender Request Form stating that I would like to participate and I will be called for testing.

Signature: _____________________________________
Witness: _______________________________________
Date: _____________ Date: ________________

☐ Self-identified literacy issues (arrangements to be made to have the test items read).

☐ Language Decline (level of French/English comprehension was not viewed as being adequate for valid administration of the test battery in oral or written format).

☐ Not seen in A&D

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LIMITS TO CONFIDENTIALITY AND CONSENT

You are invited to participate in the Computerized Mental Health Intake Screening System (CoMHISS) offered at Millhaven Institution by Correctional Service Canada.

CoMHISS Mental Health Intake Screening System:

CoMHISS Mental Health Intake Screening will include:
1) A series of short questionnaires designed to understand each individual’s mental health needs and to provide follow-up as needed.
2) A review of Correctional Services of Canada files (including medical, psychological and/or psychiatric files).

CoMHISS Mental Health Intake Screening may include:
1) A personal interview or interviews.
2) Consultation with others on the case management team.

A written report, which may include anything in the test results or that you report on interview, is found in your files, or is obtained from consultation with others on the case management team will be placed on your Psychology file and entered on the computer database.

Participation is Voluntary

Participation is entirely voluntary. You have the right to refuse to participate in the Mental Health Intake Screening System process. You have the right to refuse to answer specific questions or to end the process at any time. If you choose not to participate, or end the process at any time, a report indicating such will be placed on your Psychology file and entered on the computer database.

Limits to Confidentiality

As outlined above, it is your right to refuse to participate in the Mental Health Intake Screening process.

However:

- Once you have participated in the process, a report will be written and you do not retain the right to withhold distribution of this information. A copy will be placed on your Psychology file and entered on the computer database.
If you choose to end the process at any time, the test items you have answered may be reviewed and interpreted if possible. A report indicating such will be placed on your Psychology file and entered on the computer database.

If you choose not to participate, or end the process at any time, a report indicating such will be placed on your Psychology file and entered on the computer database.

The report that is written can be accessed by CSC case management staff, CSC health professionals, the National Parole Board and other CSC staff with the legal authority to do so.

**In any contact with CoMHISS staff members there are significant limits to confidentiality. These are:**

1) if there is a concern that you pose a risk to harm yourself or someone else,
2) if there is a concern that you threaten the security of an institution,
3) if you provide specific information about unreported criminal activity, past or present,
4) if you provide specific information about a child who has been abused or is at risk of being abused.

In these situations, the staff member is required to report this information to the appropriate authorities, including those outside the institution where authorized or required by law.

Information will also be released where authorized or required by law (i.e., court subpoena or production order)

**Supervision**

The MI CoMHISS clinical team consists of qualified Behavioural Technologist(s), Correctional Programs Officer(s) and Offender Counsellor(s). All clinical staff members have experience in administering and scoring Psychological testing material, and interviewing, assessing, and counselling offenders. All clinical work (testing and/or interviews) conducted by the CoMHISS team is carried out under the supervision of, and is reviewed by, Dr. B. Farrell, Psychologist. You may request to have a meeting with Dr. Farrell prior to, during, or after participating in the Mental Health Intake Screening System process, either by submitting a written request through the inmate mail system or by asking any CoMHISS staff member.

**Aboriginal Offenders**

If you are an Aboriginal offender, you may have a culturally competent adviser present if a follow-up interview is required. If you are called for a follow-up interview do you request that an advisor be present:

☐ Yes, I want an advisor present for my interview.
☐ No, I do not want an advisor present for the interview.
Consent

I have read the above, or had it read to me, and I have been given the opportunity to discuss the process and to ask any questions I may have.

Name: _________________________________    FPS: ________________

**TESTING PHASE**

☐ I consent to participate in the initial phase of the *Mental Health Intake Screening System process* which involves the completion of three short questionnaires. I consent to the CoMHISS staff member consulting with others on the case management team and reviewing Correctional Services of Canada files, and medical, psychological and/or psychiatric files.

☐ I do not consent to participate in the *Mental Health Intake Screening process*.

Signature:_________________________________

____

Date: ______________________

Witness:___________________________________

____

Date: ______________________

**FOLLOW-UP INTERVIEW**

☐ I consent to participate in the follow-up interview for the *Mental Health Intake Screening System process*. I consent to the CoMHISS staff member consulting with others on the case management team and reviewing Correctional Services of Canada files, and medical, psychological and/or psychiatric files.

☐ I do not consent to participate in the follow-up interview for the *Mental Health Intake Screening System process*.

Signature:_________________________________

____

Date: ______________________

Witness:___________________________________

____

Date: ______________________

Date tests completed (If different from consent date) ____/____/_______