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THE IMPACT OF INSIGHT, PSYCHOLOGICAL FUNCTIONING, AND TREATMENT RESISTANCE ON COMPLETION OF DIVERSION PROGRAMS

By

Şeniz Warner, MS

A Dissertation Presented to the College of Psychology
of Nova Southeastern University
in Partial Fulfillment of the Requirements
for the Degree of Doctor of Philosophy

NOVA SOUTHEASTERN UNIVERSITY

2022

Statement of Original Work

I declare the following:

I have read the Code of Student Conduct and Academic Responsibility as described in the *Student Handbook* of Nova Southeastern University. This dissertation represents my original work, except where I have acknowledged the ideas, words, or material of other authors.

Where another author's ideas have been presented in this dissertation, I have acknowledged the author's ideas by citing them in the required style.

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Şeniz Warner, MS

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Date

Approval Page

This dissertation was submitted by Şeniz Warner under the direction of the Chairperson of the dissertation committee listed below. It was submitted to the Center of Psychological Studies and approved in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Clinical Psychology at Nova Southeastern University.

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Abstract

The Impact of Insight, Psychological Functioning, and Treatment Resistance on Completion of Diversion Programs

By

Şeniz Warner, MS

Doctor of Philosophy, Nova Southeastern University, 2022

Offenders are three to five times more likely to struggle with mental health challenges compared to that of the general population. As such, mental health is a major concern for individuals within the criminal justice system (Bronson & Berzofsky, 2017; Desmond & Lenz, 2010; Fazel & Seewald, 2012; Gonzalez & Connell, 2014; Hall et al., 2019; Linhorst & Dirks-Linhorst, 2015). Despite the significant number of offenders who are reportedly struggling with mental health, there is difficulty providing inmates with mental health treatment in general. Within correctional facilities, various treatment programs are available for inmates; however, there is limited access due to limited resources, limited staff, or lack of awareness of these programs. Similarly, there are mental health treatment programs in the community, including mental health diversion programs, that offenders may be referred to for mental health treatment. Offenders who participate in diversion programs may exhibit difficulties completing the programs due to lacking insight, experiencing deficits within their psychological functioning, or being resistant to treatment.

The purpose of this study is to examine how an offender's level of insight, psychological functioning, and treatment resistance may impact their ability to complete a mental health diversion program. A sample of 106 participants in an outpatient mental health diversion program was utilized. A binary logistic regression was conducted to

analyze the data from the archival database. Notably, insight, psychological functioning, and treatment resistance were not found to significantly impact their ability to complete the program.

Keywords: insight, psychological ability, treatment resistant, diversion programs

Chapter I

Statement of the Problem

Over the past few decades, the criminal justice system has been changing their aim from a retributive approach to a rehabilitative approach. As such, diversion programs have been entering the criminal justice system and have played a significant role in offender rehabilitation. Research has demonstrated that criminal behavior encompasses deficits within an individual's cognitive, emotional, and behavioral functioning (Wormith et al., 2007). Additionally, insight has been hypothesized to contribute to an individual's treatment adherence (Reimer, 2010). These deficits have created significant challenges for offenders due to the lack of support they have within the community and within themselves (Andrews et al., 2011).

These challenges and deficits that offenders experience have assisted in the development of the foundation for mental health services within the criminal justice system. Community corrections, which encompasses as diversion programs, were implemented to provide mental health services that help offenders understand and identify their risks and needs. Overall, the goal of most diversion programs comprises of providing various services for offenders with mental illness while also reducing their risk of recidivism. More specifically, diversion programs provide an intervention that is intensive, providing offenders with a structured system where they can develop specific coping skills (Taxman et al., 2006). Nevertheless, the effectiveness of diversion programs have been faced with criticisms by many researchers (Schlager, 2009).

Treatment within correctional facilities and diversion programs demonstrate improvement in an individual's ability to display stable cognitive, affective, and

behavioral functioning (Cardarelli et al., 2015; Wormith et al., 2007) even if an offender has limited insight into their challenges (Jacob et al., 2014; Lien et al., 2018; Yen et al., 2005); however, research has demonstrated that an offender's insight has a significant influence on their ability to complete mental health programs, including diversion programs (Yen et al., 2005). With a significant portion of offenders being placed in correctional facilities, they do not receive the appropriate services they need, hindering their ability to improve their insight into their mental health symptoms, their need for treatment, and their risk for potential violence (Lien et al., 2018). Unfortunately, research on the impact of an offender's insight and how being able to successfully complete diversion programs is scarce. As such, the purpose of this study is to examine how risks, such as insight, psychological functioning, and treatment adherence can impact an offender's ability to complete a mental health diversion program.

Chapter II

Literature Review

Mental Health in Offenders

Mental illness continues to be a challenge amongst offenders both in community and correctional settings. Based on recent reports, 16-24% of the inmates struggle with mental illness in both federal and state prisons, while approximately 13% struggle within local jails (Alia-Klein et al., 2007; Bewley & Morgan, 2011; Linhorst & Dirks-Linhorst, 2015; Judd & Parker, 2018; McNeil & Binder, 2007). Further, offenders are three to five times more likely to meet criteria for a mental health disorder than the general population (Bronson & Berzofsky, 2017; Desmond & Lenz, 2010; Fazel & Seewald, 2012; Gonzalez & Connell, 2014; Hall et al., 2019; Linhorst & Dirks-Linhorst, 2015). Given the significantly higher rate of mental illness amongst offenders, mental health treatment is essential for this population. Over time, mental health treatment has significantly grown in correctional settings; however, for offenders within the community, there has been limited access to mental health services. Generally, reports focus primarily on offenders within correctional settings. Thus, limited information exists on the impact that mental health has on offenders within the community setting (Cardarelli et al., 2015).

Moreover, over the recent decades, there has been a significant decrease of offenders with serious mental illness that enter psychiatric or forensic hospitals. Many forensic psychiatric hospitals have been closing down, resulting in limited placement for offenders with serious mental illness. As these hospitals have been closing as a result of deinstitutionalization within the criminal justice system, many offenders with serious mental illness are placed in correctional settings (Desmond & Lenz, 2010; Linhorst &

Dirks-Linhorst, 2015; Winick, 2003). As a result, in the early 2000s, Lurigio and Swartz (2006) found that approximately 900,000 offenders with serious mental illness entered jails across the country annually. Research suggests this number has been increasing asa result of limited access to mental health facilities, substance use programs, stricter civil commitment laws, or homelessness prior to arrest or at the time of their arrest. Nevertheless, research has demonstrated that hospitalizing offenders is not as effective for offenders due to the need for the comprehensive treatment programs to account for specific factors, such as substance use, homelessness, and criminal behavior (Linhorst & Dirks-Linhorst, 2015).

Offenders with serious mental illness who are found within a correctional setting face multiple challenges, including access to appropriate mental health resources. With so many offenders entering correctional settings, though, many have fallen through the cracks and have not received appropriate services or assistance (Judd & Parker, 2018). This, in return, significantly impacts an offender's functioning and may impact their ability to function in an institution. As such, mental health treatment is essential for offenders upon entering a correctional setting. Notably, according to a report from 2005, approximately 24% of state prisoners and 21% of jail inmates received some form of mental health treatment within the past year; however, the majority of this treatment comprised of psychotropic medications, usually prior to entering a correctional facility (Constantine et al., 2012).

Mental Health amongst Offenders

With the additional stress of mental health challenges on an offender and the criminal justice system, serious mental illness has been found to impact the outcome of

the criminal case for the offender (Hall et al., 2019). For instance, if an offender's mental illness interferes with their competency to stand trial or if the offender is deemed not guilty by reason of insanity (NGRI), the outcome of their criminal case will be considered in light of their mental illness. In specific states, such as New York, an offender who has been charged with a misdemeanor may have their charges dismissed if their mental illness was involved and they were found incompetent to proceed to trial (Hall et al., 2019). As such, across the majority of states, mental illness may be viewed as a mitigating factor in an offender's case due to their inability to make appropriate decisions and to the potential of the offender being in a vulnerable state during incarceration.

Conversely, mental health may be viewed as an aggravating factor due to offenders with mental illness being viewed as more dangerous. Given this sense of dangerousness, this may increase the chance of an offender with serious mental illness being prosecuted and incarcerated to keep the public safe (Hall et al., 2019). In previous decades, offenders who were deemed to be a danger to others were hospitalized; however, due to the closure of a significant number of forensic psychiatric hospitals, offenders have been placed in correctional facilities instead without the necessary mental health treatment. Despite this sense of dangerousness, there is contradicting research regarding whether severe mental illness and violence are connected (Alia-Klein et al., 2007; Bronson & Berzofsky, 2017). Some research indicates that offenders with SMI are not violent, especially to others; however, some studies have found that offenders with serious mental illness are more likely to display violent behavior that is not intentionally targeted at other individuals (Alia-Klein et al., 2007).

Mental health challenges, regardless of severity of violence, are a common problem among offenders within the justice system. As previously mentioned, between 16-24% of prison inmates and 13% of jail inmates struggle with mental health challenges (Alia-Klein et al., 2007; Bewley & Morgan, 2011; Linhorst & Dirks-Linhorst, 2015; Judd & Parker, 2018; McNeil & Binder, 2007). Of these inmates with mental health challenges, based on a report completed in 2005, approximately 24% of state prisoners and 21% of jail inmates received a form of mental health treatment. The treatment provided to inmates primarily comprised of psychotropic medications. Prior to entering the correctional facility, inmates were prescribed psychotropic medications; however, upon entering the correctional facility, they did not receive their medications consistently throughout incarceration. This resulted in a disruption of their limited treatment. Moreover, while receiving psychotropic medications, inmates did not always receive individual or group therapy, further limiting their mental health treatment (Constantine et al., 2012).

With less than a quarter of the inmates with mental health challenges receiving any form of mental health treatment, correctional facilities experience difficulty in working with mentally ill inmates. Moreover, many correctional employees do not have the appropriate training when working with this population. Nevertheless, based on their job responsibilities as a correctional employee, they are forced to work with inmates with mental illness. For example, some correctional employees may be required to participate in case management, appropriately identify mental health symptoms, utilize de-escalation techniques, and provide adequate referrals to treatment specialists or other individuals (Lurigio & Swartz, 2006). With limited access to mental health services and limited

training amongst correctional employees, inmates who struggle mental health challenges experience significantly elevated symptoms of mental health and are more at risk of reoffending following their release from the correctional facility.

Risk Factors

Understanding risk factors for offending is complex due to the difficulty in explicitly defining risk (Woods et al., 2003). Many researchers have provided their own definition of risk, demonstrating the fluid nature of risk. Nevertheless, the general concept of risk indicates that there is a particular aspect in one's life that results in a negative consequence (Woods et al., 2003). These types of risks can develop prior to birth or throughout a person's entire life and can comprise of a variety of components.

One of the most prominent risk factors that an individual may have develops through developmental challenges (Harris, 2011; Hirschbritt & Binder, 2017; Moore et al., 2018; Yen et al., 2005). For example, a person may have a history of experiencing childhood abuse or neglect or experiencing a traumatic event. These events may result in an individual experiencing difficulty developing specific life or social skills needed throughout their life (Fox et al., 2015). Further, without these skills, an individual may experience difficulty regulating their emotions and behaviors, such as aggression (Harris, 2011; Moore et al., 2018), and may be at risk for reoffending.

In addition to developmental risks, educational and occupational challenges may pose an increased risk for individuals (dos Santos et al., 2016; Jacob et al., 2014). An individual who has not completed school may be at risk for experiencing more negative behaviors or reoffending (dos Santos et al., 2016). These risks may arise when an individual does not attend or complete school due to the inability to learn proper skills or

awareness related to functioning needed throughout their lives (Harris, 2011). Specifically, social skills may be impacted as well as the ability to adhere to rules or regulations. Additionally, if individuals are surrounded by delinquent peers within their school environment or their neighborhood, they may be at risk of learning negative behaviors, such as criminogenic behaviors. Overall, without proper education or through the observation of delinquent peers, individuals are more at risk with not developing an understanding of "right from wrong" and having difficulty with developing appropriate social skills (Hill et al., 2018; Moore et al., 2018; Vernham & Nee, 2016).

Mental health and substance use have also been viewed as significant risk factors that may result in increased symptom severity, difficulty adapting to social norms, and increased risk of engaging in negative behavior (Jacob et al., 2014; Moore et al., 2018; Taxman, et al., 2006). These risk factors can develop through early childhood all the way through adulthood. Mental health alone can create significant challenges for individuals, often leading to negative self-perceptions and increased vulnerability (Moore et al., 2018). Even though they may be experiencing these insecurities, individuals may resort to using substances, which subsequently decreases treatment adherence (Hill et al., 2018; Taxman et al., 2006).

Without proper treatment, it is likely that individuals will have significant difficulty controlling their emotions. As such, substance use has been utilized as an unhealthy coping skill, often times leading to criminal or negative behavior. Using substances has been a way for individuals to decrease their distress related to the symptoms, albeit temporarily. Specifically, individuals within the criminal justice system who struggle with mental health challenges disclosed utilizing substances as a means to

self-medication and ignore any emotional pain. As such, the prevalence rate of substance use is significantly high amongst individuals within the criminal justice system (Jacob et al., 2014; Taxman et al., 2006).

Approximately 65% of the prison population have been diagnosed with a substance use disorder and an additional 20% have a history of substance use without a diagnosis (National Institute on Drug Abuse, 2020). For many individuals, including those within the criminal justice system, mental health challenges and substance use significantly decreases treatment adherence (Hill et al., 2018; Taxman et al., 2006). Due to the temporary but repeated relief, many individuals will not seek mental health treatment. Particularly, individuals have utilized substances as a means to ignore their mental health challenges, resulting in increased adherence to substances and decreased willingness to move towards treatment.

Mental health challenges, along with other risks, pose significant problems for individuals, which can lead to increased risk of suicidal behavior. In the United States, suicide is a leading cause of death for the general population. Within the offender population, suicidal behavior is more often reported and has been significantly increasing (Cardarelli et al., 2015). Through research and psychological autopsies, researchers have found various risk factors linked to increased suicide risk, including substance use, mental health challenges, and a lack of treatment (Cardarelli et al., 2015; Hill et al., 2018; Jacob et al., 2014; Taxman et al., 2006). Due to the increased risk of suicide, mental health treatment is essential amongst the offender population; however, many offenders do not seek treatment because they do not understand their need for treatment, may not

have access to treatment, or may be deterred by the stigma surrounding mental health and offenders.

Mental Health and Violent Behavior

Mental health and the relationship with violent behavior has been an ongoing debate for decades (Elbogen et al., 2016; Harris & Lurigio, 2007; Silver et al., 2008). The research surrounding mental health and violent behavior has been contradictory (Van Dorn et al., 2012). According to Nederlof and colleagues (2013), the operational definition of violence has been difficult to identify within the field of mental health as a result of the contradictory information. This has posed significant difficulty in effectively researching the relationship between mental health and violent behavior, and identifying effective treatment programs (Hiday et al., 2001; Lurigio & Harris, 2009; Nederlof et al., 2013; Swanson et al., 2015).

Research on the relationship between mental health and violence is contradictory for a variety of reasons. Following a review of the literature, some of the research comprises of an evaluation of specific, yet different forms of violence (i.e., assault, use of weapons, threats, aggressive behaviors, homicide) committed by offenders (Ahonen et al., 2019; Hicks et al., 2010). Other research does not provide a description of the types of violence they evaluated but rather focuses on a broad definition of violence (Bowes & McMurran, 2013; Howells et al., 2004). Moreover, the research that focuses on violent behavior and mental health focus on aspects related to the individual's mental health. For instance, research focused on the cognitions and non-violent behaviors that may increase an individual's risk of engaging in violent behavior (Bowes et al., 2020; Hicks et al., 2010; Warren et al., 2002).

In addition to the studies identifying specific forms of violence or examining violence in a generic light, there are other factors that may result in the research being contradictory. As Ahonen and colleagues (2019) explained, the base rate of individuals with mental illness engaging in violent behavior is "too low to effectively predict violence." Furthermore, Van Dorn and colleagues (2012), along with a great deal of other researchers, examined violence in a broad sense due to the significantly small base rate. As such, it has been difficult to examine the base rates of those who engage in violent behavior compared to those who do not (Ahonen et al., 2019; Elbogen & Johnson, 2009; Van Dorn et al., 2012; Walji et al., 2014).

When examining the different forms of violence, research and social media has identified mental illness as a significant risk for serious violence. For instance, Ahonen and colleagues (2019) identified numerous mass shootings that occurred until 2016. Notably, of these mass shootings, the offenders were those who were diagnosed with a serious mental illness. Furthermore, Ahonen and colleagues (2019) focused primarily on gun violence and mental health. Throughout their study, they found that those with schizophrenia or bipolar disorder were at elevated risks of engaging in violent behavior. Nevertheless, despite this elevation, the link between mental illness overall and violent behavior is relatively weak.

Furthermore, research has described that individuals with mental illness who engage in violent behaviors are less likely to engage in serious violent acts (Elbogen et al., 2016). Mental health has been viewed as a risk factor that may increase an individual's risk of engaging in violent behaviors; however, some research suggests that mental illness may reduce an individual's risk of engaging in violent behaviors while

other risk factors may present elevated risks (Elbogen et al., 2016; Van Dorn et al., 2012). For instance, research has identified childhood abuse (Van Dorn et al., 2012), substance abuse (Rueve & Welton, 2008; Varshney et al., 2016), and violent victimization (Monahan et al., 2017) as risks of engaging in violent behavior.

The earliest research regarding the relationship with mental health and violent behavior resulted from patients being discharged from psychiatric hospitals. Through the use of clinical observation and evaluation regarding a patient's risk for engaging in violent behavior, it was determined whether the patient could be released based on their level of threat to society and themselves (Lidz et al., 2007). As research continued to develop on this topic, research has proven how difficult it is to determine the risk of engaging in violent behavior. Specifically, some research suggests that individuals with severe mental illness (i.e., psychosis, major mood disorders, personality disorders) are more likely to engage in violent behaviors (Bowes et al., 2020; Ford et al., 2012; Lidz et al., 2007; Lurigio & Harris, 2009; Nederlof et al., 2013; Thomson et al., 2009); however, other research did not find any significant links between mental health disorders and violent behavior (Elbogen et al., 2016; Hiday et al., 2002; Lurigio & Harris, 2009; Nederlof et al., 2013; Pozzo et al., 2021; Silver et al., 2008; Thomson et al., 2009). As research has emerged regarding the lack of a relationship between mental illness and violent behavior, the research indicates that those who may engage in violent behavior may not always exhibit violent behavior (Elbogen et al., 2016) Notably, if an individual with mental health challenges has utilized substances, a substantial portion of literature suggests that substance use increases their risk of engaging in violent behavior (Lidz et

Despite the lack of consistent research regarding the relationship between mental health disorders and violent behaviors, there appears to be a preconception that most offenders who engage in violent crimes have a mental health disorder (Varshney et al., 2016). According to a study conducted by Gallup Inc. (2011), almost half of the respondents (48%) suggested that the lack of availability of mental health resources for individuals resulted in the 2011 shooting in Tucson. Furthermore, according to Swanson et al. (2015), while the media and public health experts focused on violent acts itself, society has been focused on the mental health concerns of offenders. As such, research has identified a stigma placed on offenders with mental health, stating they are more violent than offenders with no mental health concerns (Chan & Yanos, 2017; Swanson et al., 2015).

Regardless of the preconception that there is an elevated prevalence rate of violent behavior amongst offenders diagnosed with mental health disorders, the prevalence of violent behavior among offenders is relatively low but varies amongst the diagnoses of different mental health disorders (Rueve & Welton, 2008). Specifically, mental illness only encompasses approximately 4% of violent behavior; however, rates are significantly higher amongst individuals with psychotic disorders (Pozzo et al., 2021). Based on research, approximately 6.7% of individuals who were diagnosed with a psychotic disorder engaged in violent behaviors, despite receiving treatment and 4.3% of the individuals engaged in serious violent acts (Chang et al., 2015). Moreover, those with psychosis and comorbid trauma are at higher levels of risk for violent behaviors (Ford et al., 2012; Grattan et al., 2019). These elevated risks may be a result of the significant incidents (i.e., traumatic events, psychotic episodes) hindering an individual's ability to

develop the necessary life and social skills (Bowes et al., 2020; Ford et al., 2012; Pozzo et al., 2021).

In addition to psychosis, offenders who are diagnosed with substance use disorders were found to have significantly higher rates of violence or were found to exhibit higher risks of engaging in violent behavior (Rueve & Welton, 2008; Varshney et al., 2016). Further, individuals diagnosed with comorbid substance use and other disorders were at elevated risks of engaging in violent behaviors (Rueve & Welton, 2008; Steadman et al., 199). As such, despite the stigma that exists regarding mentally ill offenders being more violent, the overall prevalence rate is lower. Nevertheless, due to the varying rates of violent behavior amongst different disorders, it is essential that offenders continue to receive the necessary treatment to decrease their risk of engaging in violent behavior.

Clinical Insight

In addition to violent behavior, an offender's level of insight needs to be evaluated when considering treatment plans and the treatment outcomes. Before examining an offender's level of insight, one must know what insight is. There are various forms of insight; however, when examining an individual's level of insight, research tends to focus on the concept of clinical insight. Clinical insight was first considered through psychodynamic therapy (Bradley, 1987) and the psychoanalytic theory (Glucksman, 1993). According to Glucksman (1993), through the psychoanalytic approach, the goal of reaching "clinical change" was to improve an individual's insight while also developing strong therapeutic rapport. If the therapeutic relationship is not strong, the client would not demonstrate significant changes in their symptomatology and

quality of life. Similarly, the psychodynamic approach relies heavily on examining the individuals' relationships with themselves as well as with others (Messer, 2013). Through identifying the relationships as well as transference that may occur, an individual's level of insight is more likely to improve throughout the course of treatment (Johannson et al., 2010).

During the earlier decades, insight-oriented treatment was found to be effective in improving an individual's overall symptomatology. Insight-oriented treatment through the lens of psychodynamic therapy began to be compared to behavioral therapy to identify effective forms of treatment for individuals with poor insight. Through the research, both forms of therapy were found to be effective at improving insight. Notably, though, behavioral therapy demonstrated improved results on insight and quality of life in a shorter timeframe for clients (Cross et al., 1982; Liberman & Eckman, 1981). Recently, more research has been published on examining whether cognitive-behavioral therapy (CBT) is, in fact, effective for improving insight amongst individuals (Rosmarin et al., 2019; Visser et al., 2015). As Visser and colleagues (2015) found, those with poor insight demonstrated significant improvement in their obsessive-compulsive behaviors throughout the course of their treatment utilizing CBT. Moreover, Rosmarin and colleagues (2019) found that CBT was effective in improving individuals' insight for those diagnosed with depression and anxiety.

While the view of insight and mental health treatment transitioned and grew over the decades, clinical insight has become challenging to define. It has undergone numerous changes over the course of the century, especially within the field of psychology (Van Camp et al., 2017). Originally, insight was characterized as an

individual's understanding of their need for change due to a mental illness (Lewis, 1934). Over time, it grew to become a broad, yet all-encompassing concept comprising of three aspects: "(a) the awareness of the illness, (b) treatment compliance, and (c) the attribution of symptoms to the disease" (David, 1990). More recently, clinical insight has been defined as an individual's ability to recognize their mental illness or symptoms, identifying how the symptoms impact their quality of life, and understanding their need for treatment (Ekinci & Ekinci, 2013; Ohayon et al., 2008; Williams & Collins, 2002). It is possible, though, for individuals to understand that they have a mental illness and to comply with treatment; however, they may not fully understand the consequences or impact of their mental illness and the benefit of treatment (Reimer, 2010; Van Camp et al., 2017). As such, insight continues to be a complex concept that is essential for the mental health treatment of individuals.

For treatment to be effective, an individual must be able to understand their mental illness, how their symptoms impact their quality of life and daily living, and the risks they may have that increases their chances of increased symptoms or potential to offend. Clinical insight rose to become an essential part of treatment by providing psychoeducation of the mental illness, exploring the individual symptoms, and defining the needs of the individual. Of note, clinical insight originated with individuals who have been diagnosed with psychotic disorders (Van Camp et al., 2017). Over time, though, researchers have begun to evaluate insight among individuals with various other disorders, such as anxiety, personality, and mood disorders (De Assis da Silva et al., 2015; Dias et al., 2008; Jacob et al., 2014; Yen et al., 2005; Yen et al., 2007). For instance, Yen et al. (2005) found that individuals with major depressive disorder had

higher levels of insight into their need for treatment compared to other mood disorders. As such, even though clinical insight has been considered to be an important component for treatment (Karow et al., 2008), there is contradictory research that indicates whether insight is beneficial for treatment (Ohayon et al., 2008).

Overall, insight appears to be essential for treatment adherence, regardless of whether an individual has higher levels of insight or poor levels of insight. For instance, those with higher levels of insight are more likely to have a better understanding of why something occurred, what symptoms they may be experiencing, how their symptoms impact their quality of life, and why treatment is (or is not) working (Reimer, 2010). On the other hand, some researchers found that some individuals with limited insight may adhere to treatment despite not understanding their mental illness because they find the treatment beneficial in some form. Even though limited insight may prevent someone from understand these components, individuals with limited insight may still view treatment as beneficial because they are able to identify some form of progress (Reimer, 2010). Nevertheless, limited insight poses a challenge for encouraging treatment adherence.

Working with an individual with limited insight can create challenges when trying to engage them in treatment (Reimer, 2010; Yen et al., 2005), especially with individuals diagnosed with psychotic disorders (Atoui et al., 2018; Van Camp et al., 2017). Based on research, "positive, negative, and especially disorganized symptoms have significant impacts on insight; however, it is only a small impact" (Atoui et al., 2018; Carroll et al., 2004). Fortunately, there are psychotropic medications that assist in improving an individual's overall functioning by decreasing their symptom severity. Thus, they are

able to gradually increase their insight through medication compliance and discussions with their primary psychiatrist.

Nevertheless, higher levels of insight have been linked to a lack of pharmacological treatment compliance (de Assis da Silva et al., 2015), resulting in lower levels of self-esteem (Karow et al., 2008; Ohayon et al., 2008). This lack of treatment compliance and the lower levels of self-esteem may be due to an individual's overall functioning level. Specifically, when an individual with some insight understands what is occurring, they may be more resistant to treatment due to the negative effects that treatment may bring about in the beginning (Reimer, 2010). Furthermore, Karow et al. (2008) found that individuals with increased self- or expert-rated insight into their illness may experience a lower quality of life compared to those with lower insight due to their understanding of the impact their mental health has on their thoughts and behaviors. Overall, this lower sense of self or quality of life may result in an individual putting limited to no effort into treatment (Jacob et al., 2014).

In addition, research demonstrates that higher levels of insight are linked to increased suicidal ideation or great stigmatization (Carroll et al., 2004; de Assis da Silva et al., 2015; Karow et al., 2008; Mervis et al., 2022). If an individual has more insight, they may experience self-stigma, increased levels of sadness, hopelessness, and may report more challenges with their overall psychological functioning (Carroll et al., 2004; de Assis da Silva et al., 2015; Donohoe et al., 2009; Lien et al., 2018). As a result, these individuals may report a lower quality of life because they have a better understanding of how their mental health challenges impact their daily lives (Karow et al., 2008; Lien et al., 2018). Conversely, despite these negative effects of higher levels of insight, research

also suggests that increased levels of risk and insight have a significant relationship, demonstrating that increased levels of insight are linked to more awareness of their mental health and its effects on their functioning (Woods et al., 2003) and treatment adherence (Reimer, 2010).

On the contrary, poor insight has demonstrated to negatively impact an individual's treatment adherence. When an individual has poor insight, they have limited information into their mental health or need for treatment. As a result, they are more likely to experience an increase in their symptomatology and the levels of their symptoms (Jacob et al., 2014). As such, they may tend to discontinue treatment. Notably, research has demonstrated contradicting information related to lower levels of insight and how it impacts treatment adherence. These lower levels of insight are important to understand because offenders were found to have decreased levels of understanding of their mental health challenges. Prior research has found that individuals who offend, especially those that commit violent acts, are more likely to have lower levels of insight into their actions (Buckley et al., 2004; Margetić et al., 2012; Mohamed et al., 2009). Subsequently, this means that they may be more unaware of their need for treatment and may resist treatment recommendations. Despite the contradicting information regarding insight and its impact on treatment adherence, individuals will adhere to treatment if the benefits of treatment outweigh the consequences or negative side effects (Reimer, 2010).

While there is a great deal of research on insight in the general population or on specific mental health disorders, there is limited information on insight among the offender population. The abovementioned information is essential for clinicians to work with individuals with insight; however, when working with the offender population, it is

necessary to consider that the offender population may require additional treatment or support.

Furthermore, insight is challenging to measure through the use of psychological assessment. Currently, the Historical Clinical and Risk Management 20, Version 3 (HCR-20-V3) allows a clinician to examine an individual's level of risks and recent problems into their insight. Even though this is a widely utilized measure for examining an individual's violence risk and clinical risks (Douglas et al., 2013), this measure is subjective due to the clinician completing this measure. Insight can also be measured through other assessments; however, they are not explicitly defined, nor are they the focus of the measure. For instance, the Personality Assessment Inventory (PAI) is a self-report measure that examines and individual's severity of psychopathology (Morey, 1991). As such, the measure will comprise of some form of evaluation of an individual's level of insight by examining how well the individual understands their mental illness and symptoms associated with their disorder. Nevertheless, the PAI does not explicitly examine an individual's level of insight.

Psychological Functioning

The goal of mental health treatment is to reduce an individual's symptom expression and improve their quality of life. An individual's psychological functioning tends to significantly impact their quality of life. Notably, there is research that focuses on psychological functioning in the general population suggesting that mental health treatment is significantly effective in improving an individual's overall functioning and quality of life. Notably, there is limited research on the offender population, which may be due to the vulnerability of conducting research on this population. Nevertheless, the

research that does exist focus primarily on juvenile offenders and targeting psychological functioning earlier on (Wareham & Dembo, 2007). Intervening earlier on provides the individual the ability to obtain the necessary skills to improve their functioning and their quality of life. Moreover, it reduces their risk of reoffending significantly while improving their knowledge – or insight – into their mental health challenges and their behavior.

Different interventions have been evaluated to identify the most effective forms of treatment for improving psychological functioning. Mindfulness-based interventions have been demonstrated increased psychological functioning amongst those with depression and anxiety (Bowlin & Baer, 2012; Kaemmerer et al., 2022; Kriakous et al., 2021). Moreover, studies examined the impact of CBT on improvement of an individual's psychological functioning. According to the results of the studies, CBT has demonstrated significant improvement in psychological functioning (Barrowclough et al., 2006; von Brachel et al., 2019; Driessen et al., 2017; McCloskey et al., 2008; Pukay-Martin et al., 2021), including among men who demonstrate violent behavior (Lawson, 2010).

In addition to mindfulness and cognitive behavioral therapy, the effectiveness of psychodynamic therapy was examined on the improvement of an individual's psychological functioning. Psychodynamic therapy demonstrated significant improvement in clients that exhibited depressive symptoms (Driessen et al., 2017; Halstensen et al., 2021), posttraumatic stress (Rice et al., 2021) and other disorders (Fisher et al., 2016). As Driessen and colleagues (2017) found, psychodynamic therapy has demonstrated effectiveness in improving an individual's psychological functioning

similar to that of CBT, providing support that psychodynamic therapy can be utilized as an alternative treatment orientation for individuals where CBT may not be as effective.

Mental Health Treatment in Offenders

There are various mental health treatment programs available for offenders within correctional facilities. Specifically, the treatment interventions adhere to the Risk-Needs-Responsivity (RNR) model, which has shown to significantly reduce recidivism rates through identifying the risks and criminogenic needs that offenders have while developing an effective response to the offender's risks and needs (Andrews et al., 2011). Through the utilization of the RNR model, treatment within correctional facilities comprise of cognitive-behavioral orientations (Barranger et al., 2020). The RNR model not only aims to reduce recidivism, but it aims to assist an offender with their mental health recovery by targeting their maladaptive behaviors. Mental health recovery is the act of "changing one's attitudes, values, feelings, and goals in order to lead a satisfying life, contribute to society, and develop new meaning and purpose in life" (Barranger et al., 2020).

An individualized treatment method is essential to one's recovery; however, there are numerous external conditions that are just as important. Through the use of the RNR model, an individualized treatment method can be developed for the offender by utilizing a variety of steps. First, through the use of a risk assessment for the offender's risks and severity of the risks, the clinician can identify which topics need to be focused on through treatment (Andrews et al., 2011). Following the risk assessment, the clinician and offender can then identify a treatment plan that will target these risks. This will then provide the clinician with the specific needs the offender has by identifying specific skills

that the offender may need to develop and utilize. Furthermore, once the offender's risks and needs are identified, the clinician can then identify the best form of treatment for the offender. Throughout treatment, the offender's risks and needs would continue to be assessed to determine what areas of growth the offender continues to have. As treatment continues, the risks and needs would continue to be assessed and responded to, while other challenges the offender has would also be addressed.

While an offender goes through treatment, they would benefit from the support of others (i.e., family, friends). If a person does not feel supported, they are more likely to disengage from treatment. Additionally, there needs to be access to mental health services. Without the appropriate resources, individuals would not have the opportunity to begin their mental health recovery (Barranger et al., 2020; Monahan et al., 2016).

Forms of Mental Health Treatment for Offenders

When providing mental health treatment, the correctional settings in both the community and the facilities have utilized cognitive behavioral therapy (CBT) through the RNR model. Cognitive behavioral therapy has demonstrated significant improvement in an offender's mental health symptoms while also showing significant reductions in risk of recidivism (Blonigen et al., 2018; Dafoe & Stermac, 2013; Landenberger & Lipsey, 2005; Walters, 2017). According to the American Psychological Association (2017), CBT is "a form of psychological treatment that has been demonstrated to be effective for a range of problems" and is based on several core principles, to include identifying maladaptive thinking and behaviors, and identifying positive ways to cope with their maladaptive thoughts and behaviors. This, in return, relieves their mental health symptoms and improves their quality of life (APA, 2017). The use of CBT within the

criminal justice system aims to target the maladaptive thoughts and behaviors to reduce an offender's mental health symptoms while also providing them with the sills necessary to cope with their symptoms in the future and also reduce their risk of recidivism (Landenberger & Lipsey, 2005; Walters, 2017).

There has been an ongoing debate on whether other treatment modalities are as effective for offenders as CBT (Dafoe & Stermac, 2013); however, there has been limited research to provide support for the significant impact that other treatment modalities have on reducing an offender's mental health symptoms and risk of recidivism. Dialectical behavior therapy (DBT), which falls under the cognitive behavioral orientation, has been on the rise in correctional setting. DBT provides offenders with treatment on emotional regulation, including aggressive behavior, and other challenges with their behavior (Byrne & Ghrada, 2019; Shelton et al., 2011). Under the DBT model, clinicians utilize mindfulness-based interventions to help offenders develop the necessary skills for anger management, behavioral challenges, or other mood disruptions (Byrne & Ghrada, 2019; Himelstein, 2010). Furthermore, according to Dafoe & Stermac (2013), mindfulness meditation, outside of the scope of DBT, has been found to improve an offender's self-regulation, which reduces their impulsivity while becoming more in tune with their needs and risks.

Due to the correctional setting, many researchers and clinicians have argued that a time-limited approach to treatment, such as CBT, is the most necessary treatment for offenders. Studies have demonstrated that CBT is effective and beneficial for offenders. Notably, though, there has been recent debate about whether offenders need a treatment that is not time limited. Recently, research has argued that psychodynamic therapy is

beneficial for offenders, especially for those with psychosis, mood disorders, and anxiety; however, the research on psychodynamic therapy within the correctional settings is limited. Through an extensive review of the literature, Mulay and colleagues (2017) found that psychodynamic therapy has been found to be effective for treating offenders. Despite these findings, others have indicated that although psychodynamic therapy is effective at reducing symptoms for offenders, CBT appears to be more effective in the settings (Lawson, 2010).

In addition to psychodynamic therapy, Acceptance and Commitment Therapy (ACT) has been introduced to offenders in correctional settings, (Berta & Zarling, 2019) especially for those struggling with substance abuse (Twohig et al., 2007). In 2017, 27.9% of incarcerated offenders met criteria for a substance use disorder while 32% of incarcerated offenders met criteria for co-occurring mental health and substance use disorders (Butler et al., 2022). Based on research, ACT has been identified as somewhat beneficial for offenders and treatment (Twohig et al., 2007).

Other approaches, to include psychodynamic therapy (Mulay et al., 2017) and Acceptance and Commitment Therapy (Berta & Zarling, 2019; Towhig et al., 2007) have been found to be effective in treatment of offenders; however, they have either been utilized in conjunction with CBT methods or have been difficult to implement in correctional settings for a variety of reasons. The research that exists does suggest that the other modalities are effective at reducing the severity of symptoms as well as the risk of recidivism. Notably, though, when compared to other treatment modalities, CBT continues to demonstrate more improvement on both facets compared to other modalities (Dafoe & Stermac, 2013; Landenberger & Lipsey, 2005; Walters, 2017).

As previously mentioned, the RNR model has been widely utilized within the criminal justice system to provide offenders with mental health treatment. (Andrews et al., 2011; Barranger et al., 2020; Blonigen et al., 2018; Dafoe & Stermac, 2013). Overall, the RNR model has demonstrated effectiveness in reducing risk of recidivism amongst offenders while also improving their mental health symptoms and ability to utilize healthy coping skills. This has been done through the use of primarily CBT approaches and continues to be utilized across various community settings and correctional facilities (Blonigen et al., 2018).

Most CBT programs within correctional facilities are manualized treatments (i.e., Moral Reconation Therapy, Thinking for a Change) and are easier for offenders with limited insight to follow (Blonigen et al., 2018). Poor insight has been linked to difficulty adhering to treatment recommendations (Reimer, 2010; Yen et al., 2005). As such, with more complex or less structured treatment modalities, offenders may have difficulty following treatment guidelines provided by their clinicians. This, in turn, has provided support for CBT as an effective form of treatment compared to other treatment modalities.

Availability of Treatment

Correctional facilities have been viewed as the largest provider for mental health services for offenders (Gonzalez & Connell, 2014). As a result, offenders may have access to psychotropic medications, case management, individualized treatment, and other mental health referrals that provide support (Bewley & Morgan, 2011). Nevertheless, research has demonstrated that correctional facilities are not optimal for treatment because many forms of treatment, to include the cognitive-behavioral

interventions that are utilized, have not been fully adapted for correctional facilities (Bewley & Morgan, 2011; Gonzalez & Connell, 2014). Furthermore, due to the limited treatment staff available in correctional facilities, availability of resources is sporadic and limited (Gonzales & Connell, 2014), posing difficulty in providing mental health treatment to all individuals in need of treatment.

With the limited availability of resources for offenders, it may be difficult for offenders to receive the necessary treatment. Specifically, if an offender with severe mental illness does receive mental health treatment, they are more likely to have difficulty adapting to life in confinement and adhering to the rules and policies of the correctional facilities (Lurigio & Swartz, 2006). Despite the severity of need for mental health treatment for some offenders, research has found that prison administrators would push to keep mental health classifications low to ensure that there is space for inmates within the correctional facilities and to reduce the need for placement in specialized programs (Gonzalez & Connell, 2014).

Over the years, though, there have been many mental health treatment programs that have been developed for offenders both within the community and correctional facilities. As previously mentioned, treatment in correctional facilities has followed the RNR model, which encompasses the cognitive-behavioral orientation. Similarly, treatment within community corrections for offenders have incorporated cognitive behavioral therapy (CBT) as well. Based on research, CBT appears to be the most effective form of treatment for offenders that clinicians have utilized due to the ability to not only reduce recidivism but target an individual's level of insight into their mental

illness (Bewley & Morgan, 2011; Cardarelli et al., 2015; Dafoe & Stermac, 2013; Jacob et al., 2014; Lawson, 2010; Landenberger & Lipsey, 2005; Walters, 2017).

Treatment Adherence. Mental health treatment does not solely focus on reducing symptoms or recidivism. Rather, it also aims at increasing an individual's insight into their mental health diagnosis, which results in significant improvements in symptoms and quality of life (Bewley & Morgan, 2011). In order for treatment to be effective, though, it is essential for an individual to adhere to the treatment plan. Within the criminal justice system, many individuals have difficulty adhering to treatment. This could be a result of a lack of resources in the system or a lack of motivation to maintain consistent treatment (Gonzalez & Connell, 2014). Furthermore, if an offender feels as if a specific form of treatment is being forced upon them, they are less likely to adhere to treatment guidelines (Blonigen et al., 2018). Those who do not receive adequate or consistent treatment may be at risk for treatment failure and increase risk of reoffending (Gonzalez & Connell, 2014).

According to Alia-Klein et al. (2007), an individual's level of insight and their level of treatment adherence had independently impacted their level of other-directed violence. This suggests that the level of insight an individual has and their likelihood of engaging in treatment is largely impacted by other individualized characteristics. For instance, an individual's age of their first arrest, cultural and/or ethnic background, childhood trauma and/or abuse, or socioeconomic status may significantly influence their treatment adherence. As such, clinicians need to ensure that treatment programs are implemented early on and are appropriate and readily available for the offender in order to reduce the negative influences of mental health on insight (Atoui et al., 2018).

Mental Health Courts

Over the recent decades, correctional facilities have replaced psychiatric hospitals, which has significantly reduced the number of offenders housed in hospitals. Specifically, due to deinstitutionalization, the number of offenders being hospitalized went from approximately 500,000 to approximately 50,000 offenders (Barr, 2003; Monahan et al., 2016; Winick, 2003). Concurrently, this has resulted in a significant increase in offenders being incarcerated within jails and prisons across the United States (Monahan et al., 2016), subsequently increasing the amount of mentally ill offenders within the correctional facilities (Butler et al., 2022). This has posed a significant challenge of housing mentally ill offenders in the correctional facilities as they were not yet equipped with the resources to treat mental illness.

In order to help offenders with their mental health challenges, diverting offenders with serious mental illness was described to be more beneficial than incarcerating them. The use of mental health courts provides a unique take on how to implement a form of punishment that is necessary for offenders (Winick, 2003). Notably, those who also display violent behavior may attend specific programs within the correctional facilities that target these behaviors. For those without a violent charge, though, one way to avoid incarcerating offenders with mental illness is to divert them from the criminal justice system and provide them with services they need within the community (Barr, 2003; Monahan et al., 2016). With the help of enrolling an offender to outpatient treatment, offenders are provided with the opportunity to attend treatment within the community as their form of punishment (Winick, 2003). To help an offender maintain treatment compliance, the court may require preventive commitment that aims at providing

offenders with services they need rather than punishment through incarceration (Monahan et al., 2016).

When an offender is incarcerated, they may view mental health treatment negatively due to other inmates or the media. This negative perception, or stigma, within correctional settings has made it difficult to ensure offenders receive proper mental health treatment. As a means to provide offenders with treatment, offenders may be court ordered to mental health treatment through an outpatient program or a mental health court, subsequently diverting them from a correctional facility (Monahan et al., 2016). Over time, as research has demonstrated the benefits of mental health treatment compared to incarceration, courts began utilizing therapeutic approaches within their supervision, such as probation or parole, of offenders to help decrease recidivism rates and improve insight into offender's mental health challenges (McNeil & Binder, 2007). Due to the effectiveness of these types of supervision and programs, mental health courts and diversion programs were developed to aid in supervision, decrease incarceration of offenders with mental illness, and increase an offender's ability to manage mental health challenges (Monahan et al., 2016).

Development of Mental Health Courts

In 1998, the Mentally Ill Offender Criminal Reduction Act (MIOCR) was developed in California to help encourage mental health treatment for offenders while also working on decreasing recidivism rates (Cosden et al., 2005). When MIOCR was first developed, mental health courts were in the initial stages and focused primarily on offenders with misdemeanors; however, over time, mental health courts began to expand to allow offenders with specific felony charges to participate in this specialty court

(Goodale et al., 2013). The purpose of this expansion was due to the increase of offenders struggling with a mental health disorder (Judd & Parker, 2018) and the need for the accessibility of mental health treatment. As such, mental health courts have started mental health treatment for many offenders who may not originally have the access to treatment or may not fully understand their need for treatment (Goodale et al., 2013).

Notably, mental health courts were developed as a form of problem-solving courts, taking after drug courts, and expanded quickly across the nation with the first of the mental health courts starting in the 1990s (Christy et al., 2005; Goodale et al., 2013; Hughes & Peak, 2012; Judd & Parker, 2018; Linhorst & Dirks-Linhorst, 2015; Palermo, 2010; Schneider, 2010) to help with providing access of services to offenders through correctional settings (Gonzalez & Connell, 2014; Richardson, 2019; Schneider, 2010). Specifically, in 1997, the first mental health court originated in Broward County, Florida (Casey & Rottman, 2000; Hughes & Peak, 2012; Ryan & Whelan, 2012). Since the Broward County Mental Health court opened its doors, approximately 250 mental health courts opened across the nation by 2005 (Hiday & Ray, 2010; Hughes & Peak, 2012; Ryan & Whelan, 2012). Currently, there are over 300 mental health courts across the country and the number of these specialty courts continue to increase (Judd & Parker, 2018; Schneider, 2010).

For offenders with specific charges and mental health challenges, jails and prisons have been viewed as “hospitals of last resort” due to the impact that incarceration can have on mental health. There has been a need for additional mental health services within the criminal justice system (Christy et al., 2005). As such, mental health courts were developed to help fills gaps and eliminate the “treatment compliance obstacles” that are

present in various settings, including correctional facilities (Hughes & Peak, 2012), especially since the traditional courts do not have adequate resources to deal with mentally ill offenders (Moore & Hiday, 2006).

Components of Mental Health Courts

Most mental health courts comprise of specific components that traditional courts do not have, which allow them to function. First and foremost, a specialized docket and criteria is developed to determine an offender's eligibility into the program. Throughout the shearing and interdisciplinary contacts, a specialized judge and specialized court staff monitor the cases. As a team, the judge and court staff consult to develop appropriate treatment and punishment recommendations for offenders to provide them with the essential mental health treatment they need along with the ability to complete the program to which they are mandated (Bond et al., 2010; Boothroyd et al., 2003; Christy et al., 2005; Desmond & Lenz, 2010; Goodale et al., 2013; Linhorst & Dirks-Linhorst, 2015; McNeil & Binder, 2007; Richardson, 2019; Schneider, 2010). With the consideration of these components, the overall goal of the mental health court is to divert individuals from a correctional facility and provide them with the treatment they need (Bond et al., 2010; Boothroyd et al., 2005). Notably, the goal of the mental health court should always be aligned with the treatment goals of the offenders to increase the likelihood of completion of the program as well and the reduction of recidivism risk (Hughes & Peak, 2012; Palermo, 2010).

Therapeutic Jurisprudence

Within the criminal justice system, mental health courts have been developed to ensure that offenders with mental illness are provided with the necessary services both within the community and correctional facilities (Carpenter & Spruiell, 2011). As such, the criminal justice system utilized therapeutic jurisprudence as a means to incorporate a rehabilitative approach. Overall, therapeutic jurisprudence has been an underlying major concept of mental health and drug courts (Boothroyd et al., 2003; Carpenter & Spruiell, 2011; Judd & Parker, 2018; Lim & Day, 2016; Palermo, 2010; Ryan & Whelan, 2012). The concept of therapeutic jurisprudence arose in the 1980s to provide an interdisciplinary approach to the criminal justice system. Specifically, therapeutic jurisprudence aims to provide a therapeutic agent to the court system to provide mental health services to offenders with mental illness (Kawalek, 2020; Lynch & Perlin, 2017; Winick, 2003).

Over the recent decades, experts have debated on the effectiveness of therapeutic jurisprudence due to the difficulty identifying therapeutic jurisprudence as one singular concept. In other words, the arguments that researchers have provided range from therapeutic jurisprudence being a philosophy to a practice. As a result, there has been significant debate about whether therapeutic jurisprudence is advantageous due to the difficulty of identifying which singular theory or practice. Nevertheless, therapeutic jurisprudence has been identified as "clear enough to be understood and distinguished in theoretical terms" (Kawalek, 2020). Despite this debate, the theory of therapeutic jurisprudence suggests that the strict use of law and policies impact the overall well-being of an offender (Kawalek, 2020). As such, the theory promotes the need for the law to

value mental health and to limit any anti-therapeutic method of imposing punishment to offenders whenever possible (Lynch & Perlin, 2017; Winick, 2003).

Through the use of therapeutic jurisprudence, the criminal justice system can determine the level of therapeutic services an individual needs (Boothroyd et al., 2003; Hughes & Peak, 2012; Schneider, 2010). Overall, the theory of therapeutic jurisprudence acknowledges that when an individual with mental illness is involved with the justice system, their symptoms and functioning are more likely to be impacted by the system (Kawalek, 2020; Ryan & Whelan, 2012). With this, therapeutic jurisprudence provides courts, judges, and clinicians with the opportunity to identify various forms of treatment for offenders with mental illness to avoid harmful effects of retributive justice and increases the rehabilitative approach to punishment (Kawalek, 2020; Winick, 2003) without violating the standards of court (Casey & Rottman, 2000). This ensures that offenders who are in need to be held accountable for their actions are receiving the most appropriate punishment while also receiving the mental health services needed (Winick, 2003).

Using therapeutic jurisprudence assists in providing offenders with a "deferred prosecution" to ensure they receive mental health treatment while being supervised by the courts through court appearances for status hearings (Judd & Parker, 2018) to avoid the negative impacts the system has on offenders with mental illness. The development of various problem-solving courts, to include mental health courts, has allowed for an easy implementation of therapeutic jurisprudence in various courtrooms. Due to the various concepts that therapeutic jurisprudence emphasizes, such as empathy, dignity, respect for mental health, and a supportive environment, the courtroom can be seen as a therapeutic

atmosphere that aims to provide both rehabilitation and retribution to an offender while minimizing the negative effects of retributive justice (Casey & Rottman, 2000; Kawalek, 2020; Lynch & Perlin, 2017).

Adding to the importance of the interdisciplinary team, the theory of therapeutic jurisprudence draws upon the behavioral sciences to provide therapeutic value to the criminal justice system (Kawalek, 2020; Winick, 2003). As such, therapeutic jurisprudence acknowledges the judges and lawyers "as therapeutic agents" who are part of the interdisciplinary team that develops an individualized treatment plan for the offender (Kawalek, 2020; Lynch & Perlin, 2017; Ryan & Whelan, 2012; Winick, 2003). Rather than focusing on punishment, the role of the judges and lawyers become a more clinical role (Hughes & Peak, 2012; Kawalek, 2020). For judges, specifically, their role in court transitions to the "managers of treatment programs" to ensure offenders are being held accountable for their actions while ensuring they are receiving the required treatment (Kawalek, 2020). Notably, many researchers believe that effectively implementing therapeutic jurisprudence in the court system is a challenge because the courts and judges are expected to recognize and acknowledge their new role as a therapeutic agent as well as the differences between therapeutic and anti-therapeutic consequences. Fortunately, many judges have been viewed to already utilize the concepts of therapeutic jurisprudence in their sentencing (Casey & Rottman, 2000).

With the implementation of therapeutic jurisprudence, mental health courts develop treatment goals and provide a link to mental health services for offenders with mental illness (Hughes & Peak, 2012). As such, the long-term goal of mental health courts through the lens of therapeutic jurisprudence is to reduce recidivism risk by

providing a rehabilitative approach to criminal behavior (Lim & Day, 2016). Moreover, therapeutic jurisprudence aims to provide offenders with insight into what actions related to the law may be harmful or beneficial (Palermo, 2010).

Importance of Mental Health Courts

Due to the importance of providing a rehabilitative approach to offenders, there has been a significant increase in the need for mental health courts (Butler et al., 2022). Approximately 14% of federal prisoners and 26% of jail inmates reported experiencing mental health challenges that met diagnostic criteria. Additionally, approximately 37% of prisoners and 44% of jail inmates have been professionally diagnosed by a mental health provider (Bronson & Berzofsky, 2017). Tied in with the varying levels of insight amongst offenders, these numbers demonstrate the need for offenders to receive mental health treatment while under the supervision of the courts rather than solely serving a punishment.

Mental health courts attempt to reduce the number of inmates within correctional facilities by providing offenders with mental illnesses an opportunity to receive mental health services (Hughes & Peak, 2012). Due to the differences of mental illness between offenders, mental health treatment within mental health courts is individualistic and dynamic, allowing for the flexibility of the intervention (and punishment) (Barranger et al., 2020; Desmond & Lenz, 2010; Hughes & Peak, 2012). When having a general program for offenders, it poses the problems of applicability and appropriateness of treatment. This then reduces the offenders' interest in treatment. As such, it is important to identify relevant goals for each offender to increase their ability to complete mental health treatment. Moreover, it is essential to utilize psychoeducational and

psychotherapeutic approaches when providing treatment to provide ample opportunity for an offender to improve their insight into their own mental health and behavioral challenges (Carrol et al., 2004).

Goals of Mental Health Courts

As previously mentioned, the main goal of mental health courts, including diversion programs, is to decrease an offender's time spent in a retributive setting (e.g., correctional facility) and increase their access to mental health services. For mental health courts, the overarching goal is to "promote the mentally ill offenders' engagement in treatment, to increase their quality of life and to decrease recidivism" (Palermo, 2010). Even though treatment within a mental health court is individualistic and dynamic to target an individual's level of insight and mental health challenges, there are common generic goals that are presented to improve understanding of the criminal justice system as well as their own mental health challenges (Barranger et al., 2020; McNeil & Binder, 2007; Schneider, 2010).

Mental health courts aim to provide "hope for the future," improve relationships with others, assist offenders in developing a new sense of self, instill power, and provide meaning and worth to their life. Additionally, within the criminal justice system, mental health treatment provides a "sense of safety and security or freedom." Furthermore, it provides the ability for an offender to understanding the consequences of their actions, accept their criminal behaviors, and address the specific risks of recidivism while providing a rehabilitative approach to these behaviors (Barranger et al., 2020; Schneider, 2010).

Not only are mental health courts aiming to provide a rehabilitative approach to increase insight in offenders, they also aim to provide public safety to the community. Specifically, mental health courts attempt to ensure that the community is protected against social nuisances (e.g., disruptive behavior) while ensuring that offenders within society are receiving the appropriate services. To reduce the disruption in the community, mental health courts have set rules and regulations that offenders must abide by. As such, it is essential that offenders involved with these courts receive direct assistance through defense attorneys or public defenders to ensure they are not misunderstanding the court system, especially if they have limited insight (Hughes & Peak, 2012).

Effectiveness of Mental Health Courts

Limited evidence is available to determine the overall effectiveness of mental health courts; however, research has demonstrated that mental health courts in Washington and Seattle have been effective in reducing crime and rearrests (Boothroyd et al., 2005). Notably, there is contradicting evidence suggesting that defendants on probation and parole with increased case management or services are more likely to be rearrested due to noncompliance with the probation and parole requirements as well as their noncompliance with mental health treatment recommendations (Henrickx et al., 2005). The noncompliance with treatment recommendations amongst offenders who are on probation or parole may be due to limited access to mental health treatment. This provides support that even though there is limited research on the effectiveness of mental health courts, the need for services due to mental health being a risk of reoffending is essential, requiring the need for MHCs (Lim & Day, 2016).

Over time, mental health courts have demonstrated a significant decrease in recidivism while increasing an offender's insight into their mental health and behaviors (Goodale et al., 2013). Overall, the primary findings within research on mental health courts look at short-term criminal recidivism, thus making it difficult to fully understand the extent to the effectiveness of mental health courts at reducing recidivism and mental health symptoms while increasing insight (Hiday & Ray, 2010; Hughes & Peak, 2012). Moreover, there has been research to suggest that depending on the severity of the problem, mental health courts may not be as effective as another treatment program. Notably, despite the severity of symptoms, if the quality and range of services are available within a mental health court, they may show significant improvement in offenders' behaviors (Cosden et al., 2005).

Unfortunately, there are mental health courts that still pose problems in demonstrating effectiveness. According to a study conducted by Boothroyd et al. (2005), offenders within the mental health court did not demonstrate a reduction in symptoms. This may have been a result of limited resources or resources that were not appropriate for the population. Additionally, a study completed by Steadman et al. (2011) compared offenders within a mental health court and offenders within a jail treatment program. They found that many offenders within the mental health court were less likely to be rearrested; however, they also found that there was not enough information to identify the specific reasons as to why the offenders' recidivism rates decreased. Specifically, they noted that there was no evidence to suggest that an offender's insight or "clinical outcome" significantly improves though a program in a mental health court compared to a jail treatment program (Steadman et al., 2011).

Notably, mental health courts may not be as effective due to not including the necessary components to account for comorbidity or other factors (Linhorst & Dirks-Linhorst, 2015). These factors may include homelessness, race, inadequate funding, and a lack of services. As such, this proves difficult for courts to ensure that the offenders receive adequate assistance and services while being supervised.

Furthermore, there have been some concerns about offenders who enter mental health courts due to determining whether offenders were competent or stable when volunteering to participate in a program (Ryan & Whelan, 2012). In addition to these concerns, some researchers have believed that since offenders must accept the stipulations of the program, they may be coerced into a program if they do not have enough insight into their need for treatment, resulting in a lack of treatment adherence (Ryan & Whelan, 2012); however, other researchers supporters of mental health courts and diversion programs have demonstrated that offenders are able to opt out at any time if they want to, especially if they are able to develop the insight needed. As such, they would not feel coerced into participating in a program (O'Keefe, 2006; Poythress et al., 2002). Nevertheless, it is essential that mental health courts and programs ensure that maximum efforts are utilized to reduce risk of coercion (Ryan & Whelan, 2012).

Many studies have been able to show improvement in offender's mental health symptoms and their behaviors if an offender completed a program (Linhorst & Dirks-Linhorst, 2015; Moore & Hiday, 2006). For instance, Cosden et al. (2005) found that offenders within mental health courts and in the control group both demonstrated improvement in functioning, symptoms, quality of life, and a decrease in substance use.

Additionally, Desmond and Lenz (2010) found that recidivism rates in offenders decreased significant after participating in a program through a mental health court.

While looking at those who completed mental health court programs, offenders were less likely to list any disadvantages of the program in a short timeframe; however, offenders who participated in mental health courts longer were more likely to identify significant disadvantages of these programs (Hughes & Peak, 2012). This may be due to an offender feeling a lack of support, feeling micromanaged, or not understanding the situation to its fullest. As Steadman and colleagues (2011) have demonstrated through their study, the importance of determining whether a mental health court is effective is to look at the participants. It is not a matter of whether the program is effective but rather than the participants are appropriate for the program.

Even though research is conflicting on the effectiveness of mental health courts, Constantine and colleagues (2012) found that offenders who received outpatient services were less likely to be rearrested in the "immediate future" compared to those who received inpatient services where their arrest rates increased. This demonstrates that entrance into mental health court increased the defendant's access to treatment while those in regular court – regardless of mental health diagnosis – are a significant disadvantage when it comes to accessing mental health services (Boothroyd et al., 2005; Henrickx et al., 2005). Furthermore, with a decreased risk of recidivism, diversion programs and mental health courts are more effective than simply housing an offender with mental illness in a mental health unit at a correctional facility. Overall, mental health courts provide the offenders with the ability to place offenders in settings where they are supported by individuals within the mental health field (Lurigio & Swartz, 2006).

Diversion Programs

As part of mental health courts, diversion programs were developed and have become widespread across the United States over the past two decades (Parker et al., 2009). Overall, similar to mental health courts, the goal of diversion programs is to reduce an offender's amount of time within correctional settings with the hope that they will not need incarceration during their sentence. Rather, they would be provided with treatment to help them obtain insight and skills necessary to improve their mental health functioning and behavior (Parker et al., 2009; Ryan & Whelan, 2012).

The benefit of diversion programs is that it diverts offenders from a correctional facility at any time of the criminal justice process, eliminating the negative impact the facility may have on their mental health. They can be diverted prior to being charged with their crime, prior to trial, or prior to sentencing after conviction if they are recommended for mental health treatment (Ryan & Whelan, 2012). As a result of when an offender can be diverted form the process, various forms of diversion programs have been developed to increase mental health awareness and management of symptoms.

When an offender is first arrested, the arresting law enforcement official may recommend an offender to participate in mental health treatment through a pre-booking jail diversion program. Typically, the pre-booking jail diversion program is available for offenders who do not have a violent history. Moreover, the actions that led to the arrest are a result of mental health challenges and can be managed through the aid of mental health treatment rather than incarceration. Prior to being charged with a crime, law enforcement officials may recommend an offender to these types of diversion programs

to help with reducing incarceration and recidivism rates of offenders (Parker et al., 2009; Ryan & Whelan, 2012; Steadman et al., 2001).

The next form of diversion programs are the post-booking jail diversion programs. Most diversion programs follow the post-booking jail diversion program process, which comprises of offenders who have been charged with a crime and are incarcerated. During the screening process, they have been found to have a mental health disorder or substance use challenge. As such, they are recommended for mental health treatment rather than incarceration (Parker et al., 2009; Steadman et al., 1995).

Lastly, mental health courts are specialized courts that were developed for offenders with mental illness. Participants in these courts are those who have been charged and typically convicted of their crime. Offenders who are found in mental health courts are often referred to community-based services that allows offenders to receive mental health treatment while under the supervision of the court and probation officers. Over time, mental health courts have changed to include other forms of diversion programs as well to ensure offenders are provided with the opportunity to obtain the necessary services rather than being incarcerated (Parker et al., 2009). Upon completion, many mental health courts provide incentives for the offenders, including expungement of their current criminal case.

The development of mental health courts was almost imperative due to the significant number of mental health facilities (e.g., forensic hospitals) shutting down or reducing their limit of patients that can be admitted (Palermo, 2010). Without the appropriate services for offenders with mental illness, it was difficult to provide offenders with appropriate treatment that could improve their insight into their actions and

behaviors. As such, this resulted in offenders not understanding the consequences that were a result of their actions and behaviors. As such, this resulted in a continuation of engaging in these behaviors that lead to negative consequences (e.g., incarceration). To help fight against recidivism rates while improving their mental health symptoms, many courts developed these specialized mental health courts to provide a more rehabilitative approach when working with offenders with mental health challenges (McNeil & Binder, 2007; Palermo, 2010; Ryan & Whelan, 2012). A rehabilitative approach allows courts to provide offenders with the ability to develop skills to improve insight, and change their attitudes and behaviors (Palermo, 2010).

Broward County Mental Health Courts

As we have reviewed, there is contradictory research regarding mental health courts across the nation since the first mental health court opened. While programs are being evaluated, new programs have the ability to develop with the feedback that is provided to improve mental health courts and their effectiveness. This growing and improvement of mental health courts started in Broward County, Florida in June of 1997 when the first mental health court in the United States opened (Boothroyd et al., 2003; Boothroyd et al., 2005; Henrickx et al., 2005; Hughes & Peak, 2012). When the Broward County Mental Health Court opened, it began providing the offender with the access to treatment and other various forms of support (Boothroyd et al., 2003; Boothroyd et al., 2005). After the development of this mental health court, other mental health courts sprang into action across the nation to help reduce the involvement of offenders with mental illness in the criminal justice system (Henrickx et al., 2005).

The Broward County Mental Health Court, a diversion program for non-violent felony offenders, classifies itself as a treatment court that provides ample opportunities for its offenders and has "adopted a supportive, instructive, and problem-solving style" that will help offenders with their mental health challenges (Boothroyd et al., 2003; Boothroyd et al., 2005). Moreover, the Broward Mental Health Court was developed to allow for quicker evaluations for offenders with mental illness, identification of mental health disorders, and quicker access to mental health services (Boothroyd et al., 2005). These evaluations allow the court to ensure that offenders are provided with the appropriate treatment (Boothroyd et al., 2005).

Overall, mental health courts, just like the Broward County Mental Health Court, all utilized various evaluations to determine the best form of treatment for offenders (Boothroyd et al., 2003). To do this, the court or judge may require an offender to complete a specific treatment program to best fit their needs. Nevertheless, the type or quality of treatment provided are not controlled or filtered by the court system (Boothroyd et al., 2005). As such, this further provides evidence that research on mental health courts and diversion programs are essential for the improvement insight, mental health, and functioning of offenders.

Purpose

Through the limited research on insight within individuals and offender treatment, it has been difficult to identify evidence on how insight, psychological functioning, and adherence to treatment impacts an individual's ability to complete a treatment program. Some evidence suggests that poor insight leads to poor treatment outcomes (Lien et al., 2018; Yen et al., 2005); however, other evidence suggests that lower levels of insight

may lead to poor treatment outcomes (de Assis da Silva et al., 2015; Jacob et al., 2014) or that higher levels of insight may lead to lower levels of treatment compliance for a variety of reasons (Donohoe et al., 2009). Furthermore, there has also been limited research on the evaluation of psychological ability and completion of mental health diversion programs. As such, this study aims to examine how an offender's psychological ability impacts their ability to complete mental health diversion programs. To help aid in the expansion of this research, this study aims to examine three hypotheses within a mental health diversion program.

Hypothesis 1

An individual who has entered a diversion program may exhibit poor insight into their mental health, their need for treatment, and their risk for potential violence. When an individual has low insight, they typically experience difficulty adhering to specific program requirements and treatment recommendations. Overall, research has focused on how insight impacts various types of mental health disorders. Based on what the researchers have found, mental health does impact insight; however, the information about how mental health may impact an individual's ability to complete a treatment program is limited (Lien et al., 2018; Yen et al., 2005). Furthermore, due to the limited research on insight among offenders within the criminal justice system, it is unknown how insight may impact completion of treatment programs. It is predicted that individuals with higher levels of insight are more likely to complete mental health diversion program.

Hypothesis 2

Behavior (Harris, 2011; Moore et al., 2017), cognition (Atoui et al., 2018; Donohoe et al., 2014), and affection (Atoui et al., 2018) can influence an individual's

ability to complete a treatment program. However, there has been limited research on an individual's psychological functioning regarding to their affective, behavioral, and cognitive functioning and how this can influence their ability to complete a mental health diversion program within the court system. It is predicted that individuals with higher psychological functioning are more likely to successfully complete a mental health diversion program.

Hypothesis 3

Lower levels of insight may lead to lower levels of treatment adherence (Jacob et al., 2014; Yen et al., 2005); however, this research has not been conclusive and does not consider the psychological functioning of an individual. As a result, it has been difficult to identify whether insight and psychological functioning plays a significant role in resistance to treatment. Furthermore, there is conflicting information regarding how treatment resistance impacts an offender's ability to adhere to treatment recommendations and complete treatment (Gonzalez & Connell, 2014). After accounting for insight and psychological functioning, it is predicted that offenders who are more open to treatment are more likely to successfully complete a diversion program.

Chapter III

Methods

Participants

For this study, data was gathered from an existing database from a 12-month outpatient mental health adult offender diversion program the Broward Regional Health Planning Council, Incorporated (BRHPC). All data was de-identified to maintain the confidentiality of the participants. The database comprised of 230 participates who reside in South Florida. In order to participate in the program, individuals must meet the following criteria: (a) be arrested and charged with a third-degree felony, (b) must be at least 18 years or older, (c) must be diagnosed with a mental health disorder or experience mental health symptoms, and (d) must not have a severe violent offense. Notably, some offenders were referred to the program with a violent offense (i.e., Battery of a Law Enforcement Officer) but under the discretion of the state attorney's office or the program staff. Participants were referred by their public defender or attorney through a referral process. The study obtained approval through the Institutional Review Board (IRB) at Nova Southeastern University.

Procedures

Approval to conduct archival research using the existing BRHPC diversion database has been approved by the licensed clinician of BRHPC. Additionally, approval was obtained through the Institutional Review Board (IRB) at Nova Southeastern University to conduct this study. As previously mentioned, the data was de-identified to ensure confidentiality of the participants. To gather the data from the participants, the participants participated in an extensive initial evaluation a battery of assessments were

administered; however, only relevant measures were selected for the purpose of this study.

Recruitment to program

In order to participate in the 12-month diversion program, participants were referred by their public defender or private attorney. They must have been previously diagnosed with a mental health disorder, must be experiencing symptoms, or have been observed experiencing symptoms. If an offender was diagnosed with a mental health disorder according to the DSM-V or ICD-11, they were referred to the program for evaluation. Moreover, if the participant endorsed any mental health symptoms (e.g., anxiety, depressive symptoms, psychotic symptoms, etc.) or if they were observed experiencing symptoms by others (i.e., family members, defense attorney, doctors), they were referred to the program. Of note, the offender did not need to have a diagnosis of a mental health disorder at the time of the referral. As such, they would only need to be experiencing symptoms prior to referral.

Once referred, the Broward County State Attorney's Office (SAO) reviewed the referrals for approval of the participant's eligibility for the program. Following the SAO approval, the participant underwent an extensive evaluation comprising of a biopsychosocial interview and the administration of a complete battery (See appendix A for the list of the full battery). The evaluations were conducted by second year practicum students that are enrolled in a doctoral training in a clinical psychology program and are under the supervision of a licensed psychologist. Once the evaluation is complete, the evaluator then determined whether the participant met further criteria for the program, including the participant's risk for violence, cooperation with the program requirements

and treatment recommendations, and the presence of mental health challenges. If a participant did not meet criteria, they were excluded and referred back to the participant's public defender or private attorney. If a participant was found eligible for the program, they were assigned a case manager and began participation in the 12-month diversion program.

Administration of Battery

For the administration of the battery, trained practicum students conducted the evaluation at the office of BRHPC or via a Health Insurance Portability and Accountability Act of 1996 (HIPAA) approved telehealth platform. At the beginning of the evaluation, participants were provided with the limits of confidentiality and were given the option to participate in the evaluation. Once consent was obtained, the evaluation was conducted. The evaluations lasted at least three hours and consisted of the biopsychosocial interview as all as the administration of a complete battery. Two additional evaluations, at six months and at the end of the program at 12-months, were conducted throughout the individual's participation in the program (See Appendix B for a projected timeline of the program). From this complete battery, specific measures were identified for the purpose of this study.

Completion of the Diversion Program

Once a participant has completed the initial evaluation and has been accepted into the program, they began participation in the 12-month cognitive-behavioral treatment program that comprises of individual and group therapy. As part of the program requirements, offenders were required to complete a 12-module self-help book. Upon

completion of each module, they presented their work in their weekly group therapy. After the offender completes the initial 12-module book, they were provided additional self-help books to work on and are required to present them once a month in group therapy. If they adhere to the program requirements, they will be evaluated at the 6-month mark. When a participant has completed the treatment, they completed a 12-month evaluation, indicating that the individual has completed the program. Of note, some participants required an extension of the program for individualized reasons. As such, for the purpose of this study, completers also included those who completed the program both within the 12-month time frame and with the extension. If they maintained a clear record for one year following their completion of the program, the participant's case will be under review for expungement.

Measures

The participants in the diversion program and study were administered a series of measures within a battery during the initial evaluation. Additionally, participants were examined at their 6- and 12-month marks to determine program status. From this battery, the Historical Clinical Risk Management 20, Version 3 (HCR-20-V3) and the Personality Assessment Inventory (PAI) were utilized for this study.

Historical Clinical Risk Management 20, Version 3 (HCR-20-V3).

The HCR-20-V3 is a structured clinical interview that evaluates an individual's violence risk to help determine how their risk can be managed. This tool provides a comprehensive set of professional guidelines that include and emphasize the Structured Professional Judgement (SPJ) model that identifies 20 key risk factors and their impact on the individual. Within the HCR-20-V3, there are three domains, including: (a)

historical static risk factors; (b) clinical dynamic risk factors that are observed throughout the clinical interview; and (c) risk management factors (Douglas et al., 2013).

This study utilized two scales from the HCR-20-V3 to examine insight and psychological functioning. Each scale is broken down into three facets, creating a total of six facets that were utilized, including: (a) recent problems with insight into their mental disorder; (b) recent problems with insight into violence risk; (c) recent problems with insight into their need for treatment; (d) recent problems with instability with affective functioning; (e) recent problems with instability with behavioral functioning; and (f) recent problems with instability in cognitive functioning (Douglas et al, 2013).

Personality Assessment Inventory (PAI).

The PAI is a 344-item comprehensive self-report measure that examines an individual's severity of psychopathology, various personality characteristics, and behavioral tendencies. This measure comprises of four validity scales that assess an individual's level of malingering, random responses, or carelessness. The PAI is broken down into 11 clinical scales, five treatment consideration scales, and two interpersonal scales based on the examinee's responses on the items. The measure comprises of four responses options: "false, not at all true," "slightly true," "mainly true," and "very true." This study utilized the treatment rejection (RXR) scale to examine a participant's ability to adhere to treatment requirements (Morey, 1991).

Statistical Analyses

Descriptive statistics were calculated for all key variables. For hypotheses 1-3, the data analysis consisted of a binary logistic regression analysis predicting success of the

program (0 – failure of program; 1 – completion). For a participant to be considered as a completer for this study, they must have completed the program in its entirety, including if they completed the program longer than the 12-month timeframe. If the participant dropped out of the program or was kicked out of the program, there were entered in as "failure of program." The binary logistic regression also included eight key variables, including (a) insight into need for treatment, (b) insight into potential for violence, (c-e) psychological functioning, (f) treatment resistance, (g) age of offender, and (h) number of years of education completed. This analysis was conducted using IBM SPSS Statistics software (V. 27; IBM Corp., 2020). The level of significance was set to .05.

Assumptions of Logistic Regression

The following key assumptions that underly logistic regressions were evaluated, including: (a) little to no multicollinearity (correlation among predictors); (b) observations are independent of one another; (c) the dependent variable must be binary (i.e., 1 = successful completion, 0 = failure of the program); and (d) do not include outliers that are strongly influencing model results (Stotlzfus, 2011). Outliers are data points that appear to be inconsistent with the majority of the data (Zijlstra et al., 2007). Notably, seven of the eight variables utilized in the dataset are dichotomized (e.g., categorical). Examining outliers for categorical variables has been the subject of an ongoing debate (Zijlstra et al., 2007). As such, when examining the data for outliers, a scatter-and-leaf plot was utilized for the continuous variable.

Chapter IV: Results

Demographic Statistics

The full database included 230 participants; however, due to the PAI not being administered to part of the sample, the sample for this current study comprised of 106 participants in the program. Of the 106 participants, 52.8% (*n*=56) of the participants were male and 47.2% (*n*=50) were women. Moreover, the majority of the sample identified as non-Hispanic White (36.8%, *n*=39) and non-Hispanic Black (31.1%, *n*=33). As we can see in Table 1, the demographic distribution of the subsample is similar to the demographic distribution of the full sample. Furthermore, demographic distribution was evaluated for both those who completed the program and those who did not complete the program for both the full sample and the subsample (see Table 1). Notably, those who were referred to the program or currently enrolled were not included in the analysis. Furthermore, descriptive statistics of demographic and other key variables are displayed in Table 2.

This study only evaluated the participants who completed the program and those who were terminated from the program. For the purpose of this study, the category for those who completed the program comprised of participants who completed within the 12 months and participants who completed following a delay. As we can see in Table 1, 76 participants out of 230 successfully completed the program within 12 months while 37 participants completed the program longer than 12 months.

Evaluation of Assumptions

In order to assess for multicollinearity amongst the predictor variables, the correlations of the predictor variables were examined within the correlation matrix (see

Table 3). When examining the correlation matrix, Recent Problems into Insight into Mental Health and Recent Problems into Insight into Need for Treatment exceeded a correlation of ± .80 (r = -.826). This suggests that the two predictor variables may be examining similar construct. As such, following a review of the variables, the variable of Recent Problems into Insight into their Mental Health was not included in the data analysis as the information in the variable of Recent Problems into Insight into their Need for Treatment included similar information.

After a review of the variable utilizing a scatter-leaf plot, there were no true outliers observed within this model. As such, all datapoints were retained for the purpose of this study. Overall, the statistical data analysis provided support that the assumptions for the logistic regression model were acceptable.

Table 1.

Sample Demographic Distribution (N = 230; n = 106)

Demographic	Full Sample		Subsample	
	Frequency	Percentage	Frequency	Percentage
Program Outcome*				
Failure of Program	44	19.1%	30	28.3%
Successful Completion	76	33.0%	76	71.7%
Delayed Completion	37	16.1%	-	-
Referred to Program	28	12.2$	-	-
Currently Enrolled	45	19.6%	-	-
Gender				
Male	124	53.9%	56	52.8%
Female	106	46.1%	50	47.2%
Ethnicity				
White (non-Hispanic)	84	36.5%	39	36.8%
Black (non-Hispanic)	90	39.1%	33	31.1%
Other (non-Hispanic)	1	0.4%	6	5.7%
White (Hispanic)	26	11.3%	17	16.0%
Black (Hispanic)	4	1.7%	2	1.9%
Other (Hispanic)	25	10.9%	9	8.5%
Employment at time of Evaluation				
Employed	84	36.5%	39	36.8%
Unemployed	146	63.5%	67	63.2%

*Those who were currently enrolled or referred not included in the analysis

Table 2.

Descriptive Statistics for Subsample (n = 106)

Variable	Range	*M*	*SD*
Age	18-60	31.37	10.865
Education	8-20	12.61	2.045
PAI			
Treatment Rejection	20-75	40.26	12.768
HCR-20-V			
Insight into Mental Health	0-1	.4057	.49335
Insight into Potential for Violence	0-1	.7925	.40748
Affective Functioning	0-1	.3208	.46898
Behavioral Functioning	0-1	.4340	.49797
Cognitive Functioning	0-1	.6509	.47894

Table 3

Correlation Matrix of Predictor Variables

Variable Name	1	2	3	4	5	6	7	8	9
1. Age	1.000	-.238	.142	-.213	-.064	.193	-.222	.079	.147
2. Education	-.238	1.000	-.076	-.022	.145	.025	.036	..008	-.033
3. Treatment Rejection	.142	-.076	1.000	-.016	.064	.010	-.183	.120	.014
Recent problems with insight into…									
4. Mental Health	-.213	-.022	-.016	1.000	.040	-.826*	-.086	-.129	-.027
5. Violence Risk	-.064	.145	.064	.040	1.000	-.090	-.216	-.261	-.066
6. Need for Treatment	.193	.025	.010	-.826*	-.090	1.000	.056	.149	-.008
Functioning…									
7. Affective	-.222	.036	-.183	-.086	-.216	.056	1.000	-.210	-.297
8. Behavioral	.079	.008	.120	-.129	-.261	.149	-.210	1.000	-.232
9. Cognitive	.147	-.033	.014	-.027	-.066	-.008	-.297	-.232	1.000

*Correlation exceeds ± .80

Results of Primary Analysis

As previously mentioned, this study utilized the binary logistic regression as a means to estimate the relationship between the predictor variables and the outcome. Specifically, this analysis examined how (a) insight into mental health, (b) insight into potential for violence, (c) affective functioning, (d) behavioral functioning, (e) cognitive functioning, and (f) treatment rejection predicted an offender's ability to complete the mental health diversion program (0 = unsuccessful; 1 = successful). Within this model, these predictor variables were considered along with the following confounding variables: offender's age and education at the time of the evaluation. Utilizing a logistic regression model assists with controlling for these confounding variables by providing the odds ratios. The adjusted odds ratio controls for multiple confounders by adjusting the values while considering each covariate (Pourhoseingholi et al., 2012). Please see Table 4 for the results.

A goodness-of-fit test was conducted to determine whether the current model adequately describes the current data. The goodness-of-fit was conducted through the Hosmer and Lemeshow Test. While examining the logistic regression model, the model demonstrates adequate model to data fit as evidenced by a non-significant chi-square (χ^2 = 6.911; p = .546). This suggests that there is no difference found between the observed data and the model predicted data. Based on the data, 71.7% of the observations within the model accurately classified. Within the model, 30 participants were predicted to complete the program; however, they were unsuccessful in completing the mental health diversion program.

Hypothesis 1. The first hypothesis predicted that individuals with increased recent problems of insight into their mental health and potential to engage in violent behavior are more likely to complete mental health diversion programs. While holding all other predictor variables constant, an offender's recent problems into their insight of their mental health (Odds Ratio = .719, 95% CI [.288, 1.795], p = .480) and insight for violence risk (Odds Ratio = 2.467, 95% CI [.755, 8.062], p = .135) did not yield significant results. Those who have experienced recent problems of insight into their mental health symptoms are 71.9% and recent problems of insight into their violence risk are 146% more likely to complete the program compared to the odds of those who did not have any recent problems into their insight who did not complete the program. Nevertheless, the results suggests that recent problems into any insight did not impact an offender's ability to complete a mental health diversion program.

Notably, to explore the results further, a logistic regression was completed on the full sample of the database for those who fell in either the completer (program completion = 1) or the non-completer category (program completion = 0). Those who were referred to the program or currently enrolled were not included in this analysis. As such, the sample comprised of 150 participants. Similar to the initial analysis, the results suggest that recent problems into insight into mental health (Odds Ratio = .1.462, 95% CI [.688, 3.104], p = .323) and violence risk (Odds Ratio = .595, 95% CI [.236, 1.503], p = .272) did not significantly impact an offender's ability to complete the program.

Hypothesis 2. The second hypothesis for the purpose of this study examined how an offender's adjustment ability increases their ability to successfully complete a program. Specifically, this study examined the affective, behavioral, and cognitive

functioning of an offender. Overall, an offender's affective functioning (Odds Ratio = .696, 95% CI [.225, 2.152], p = .529), behavioral functioning (Odds Ratio = .834, 95% CI [.290, 2.398], p = 736), and cognitive functioning (Odds Ratio = .651, 95% CI [.213, 1.990], p = 451) were not found to impact an offender's likelihood of successfully completing a mental health diversion program when holding all other predictor variables constant. Overall, the offenders who experienced recent problems in their affective functioning were 69.6% more likely to complete the program compared to the odds of those who did not have problems into affective functioning who did not complete the program. Furthermore, compared to the odds of those who did not have problems into their behavioral or cognitive functioning who did not complete the program, those who experienced recent problems in their behavioral functioning were 83.4% more likely to complete the program while those who experienced problems in their cognitive functioning were 65.1% more likely.

When exploring the subsample to the full sample, the analysis did not yield any significant results. Specifically, recent problems into affective functioning (Odds Ratio = .626, 95% CI [.253, 1.547], p = .310), behavioral functioning (Odds Ratio = 1.137, 95% CI [.473, 2.736], p = .774), and cognitive functioning (Odds Ratio = 2.054, 95% CI [.809, 5.218], p = .130) did not significantly impact offenders in completing the mental health diversion program.

Hypothesis 3. The final hypothesis for this study examined how an offender's adherence to treatment increases their likelihood of completing a mental health diversion program. When accounting for all other predictor variables, an offender's adherence to

treatment was found to not impact their likelihood of completing a diversion program (Odds Ratio = .975, 95% CI [.941, 1.010], p = .155).

Table 4

Logistic Regression Coefficients (Subsample, n = *106)*

Variable Name	β	S.E.	*p*	Odds Ratio	95% C.I. for Odds Ratio	
					Lower	Upper
Age	-.003	.022	.908	.997	.954	1.042
Education	.221	.124	.075	1.248	.978	1.592
Treatment Rejection	-.026	.018	.155	.975	.941	1.010
Recent Problems with…						
Insight into Mental Health	-.329	.467	.480	.719	.288	1.795
Insight into Violence Risk	.903	.604	.135	2.467	.755	8.062
Affective Functioning	-.362	.576	.529	.696	.225	2.152
Behavioral Functioning	-.182	.539	.736	.834	.290	2.398
Cognitive Functioning	-.430	.570	.451	.651	.213	1.990

Table 5

Logistic Regression Coefficients (Full, n = *150)*

Variable Name	β	S.E.	*p*	Odds Ratio	95% C.I. for Odds Ratio	
					Lower	Upper
Age	.007	.018	.712	1.007	.972	1.042
Education	.085	.086	.322	1.089	.920	1.288
Recent Problems with…						
Insight into Mental Health	.380	.384	.323	1.462	.688	3.104
Insight into Violence Risk	-.519	.473	.272	.595	.236	1.503
Affective Functioning	-.469	.462	.310	.626	.253	1.547
Behavioral Functioning	.128	.448	.774	1.137	.473	2.236
Cognitive Functioning	.720	.476	.130	2.054	.809	5.218

Chapter V: Discussion

Mental health treatment in offenders has always been a controversial topic amongst researchers and the criminal justice system. Within the correctional facilities, offenders have limited access to mental health treatment programs. Moreover, within the community, finding mental health treatment has also been found to be challenging. Over the course of the decades, the number of mental health diversion programs have been steadily increasing, allowing offenders to receive mental health treatment without entering a correctional facility. Moreover, these programs have aided offenders in developing positive behaviors and changes in thinking (Parker et al., 2009; Ryan & Whelan, 2012), which reduces their risk of recidivism (Parker et al., 2009; Ryan & Whelan, 2012; Steadman et al., 2001).

According to the research on diversion programs and mental health treatment, there are significant benefits from diverting offenders from the correctional facilities. Specifically, diversion programs provide offenders with a structured system that assists in developing coping skills (Taxman et al., 2006) while improving an offender's cognitive, affective, and behavioral functioning (Cardarelli et al., 2015; Wormith et al., 2007). Notably, there has been much criticism related to the effectiveness of diversion programs due to many offenders not being able to complete treatment. The rates of offenders not completing diversion programs may be due to a variety of deficits, to include lack of support or continued engagement in criminal behavior. Additionally, an offender's inability to understand the concepts of treatment may also play a significant role in their ability to complete a diversion program.

Interpretation of Results

While examining insight and an individual's treatment adherence, research has found contradictory evidence for whether insight plays a significant role. This contradiction may be due to individual characteristics of the clients, the types of treatment being offered, or other factors that may not be easily identifiable. Notably, there has been limited to no research regarding insight amongst offenders specifically, which poses significant issues regarding understanding the effectiveness of mental health treatment programs for offenders in general. Furthermore, when examining mental health diversion programs, research has demonstrated the effectiveness of these programs; however, there is no known information regarding how levels of insight may impact offenders.

This study identifies different types of insight, including insight into their mental health and violence risk, which can influence an offender's ability to complete a mental health diversion program. Within the HCR-20-V3, insight is measured by examining the recent problems an offender may have with their insight into mental health and risk of violence (Douglas et al., 2013). Based on the results of this study, an offender's level of insight on these facets did not significantly influence their ability to complete a diversion program.

In addition to insight, the influence of how an offender's psychological functioning and treatment resistance on their ability to complete a diversion program were examined. While looking at an offender's psychological functioning, this study did not find evidence that their affective, behavioral, or cognitive functioning would impact their ability to complete a diversion program in any significant way. After a review of the

results, there could be a variety of reasons as to why an offender's functioning did not significantly impact their completion of the program. For instance, the program provides a great deal of support to the offender through the assignment of a case manager and an individual therapist. As such, even if an offender did experience challenges in their psychological functioning, they may have been provided the support necessary to allow them to complete the program.

Lastly, when looking at an offender's treatment resistance, this study does not suggest that difficulty adhering to treatment significantly impacts their ability to complete a mental health diversion program. This may be due to the fact that the diversion program is a mental health court program that comprises of a great deal of support from a mental health treatment team. Additionally, offenders are provided with the incentive of having their case dismissed following the completion of the program. As such, an offender with higher levels of treatment resistance may not necessarily resist the treatment despite their negative perception to treatment. They may be focused on the incentive and may complete the program by adhering to the minimal guidelines. Notably, completing a mental health treatment program may take longer than the 12 months. As such, with the incentive of having their charge expunged from their records, they may continue to participate in the program to complete it, even with minimal motivation. On the other hand, if an offender has lower levels of treatment resistance, they may not complete the program for a variety of reasons, to include disinterest in the program, lack of motivation, and dismissal of the support provided. Nevertheless, this insignificant result continues to yield crucial factors to consider when working with offenders, by suggesting the treatment team focus on individualizing the treatment recommendations for the offender.

All eight variables that were utilized for this study within the dataset were directionally set were not found to be significant. Notably, according to the results, the recent problems into an offender's insight into their mental health symptoms provided a negative odds ratio. Due to the variables being dichotomized for the purpose of this study (i.e., yes versus no), the "possible" risk of the recent problems into insight of mental health problems may have impacted the results. Specifically, coupling the "possible" and "yes" components of the variable may have impacted the results.

Of the eight variables, the variable for the number of years of education an offender completed was approaching significance (Odds Ratio = 1.248, CI [.978, 1.592], p = .075). The purpose of evaluating the age and education of an offender was to look at different variables that may influence an individual's level of insight, psychological functioning, or ability to adhere to treatment protocols. With education approaching significance, this suggests that an offender's level of education may influence their ability to complete mental health treatment programs.

Limitations

The present study examined how levels of insight, psychological functioning, and treatment resistance influenced an offender's ability to complete a mental health diversion program. The results of the study yielded no significant results that are of importance to the field of forensic and correctional psychology. As such, limitations in this study should be discussed.

First, when examining the literature on the constructs, there was limited research that focus on insight, treatment adherence amongst offenders, and diversion programs. This gap in research poses a challenge when examining the risk of an offender not

completing the program and not receiving appropriate treatment. To further increase this gap, the limited research that exists on insight specifically does not cover the offender population. This may be due to the difficulty of accessing this population for research as the offender population is a vulnerable population.

In addition, the limited research that is present provides a significant amount of contradictory evidence regarding how insight impacts treatment adherence. The contradictory information appears to be related to the different types of insight that were examined along with the lack of a universal definition of insight. Overall, many researchers have utilized insight as an all-encompassing concept while other researchers do not identify what type of insight they are examining. As such, when examining the literature on insight and treatment adherence, the information is not clear as to how insight impacts treatment adherence.

Within the literature of insight and treatment adherence, the samples in the studies comprised of individuals within the community who were primarily diagnosed with schizophrenia or bipolar disorders. Additionally, there was significantly less research on other disorders within this area of literature. Furthermore, the literature on treatment adherence focused primarily on adherence to psychotropic medications. Limited information was found regarding treatment adherence to mental health treatment programs.

Aside from the limited research, there are limitations related to the database that need to be highlights. First, the data that was analyzed for the purpose of this study was derived from archival data that was compiled from the mental health diversion program in South Florida. As such, the data was limited geographically, which impacts

generalizability of the results. Specifically, when considering the location and cultural factors, the results may not be generalized to other mental health diversion programs across the United States.

Furthermore, the participants in the diversion program participated in group Moral Reconation Therapy (MRT). Research has found MRT to be effective primarily for individuals diagnosed with antisocial personality disorder and has not been proven to be as effective for other mental health disorders. Within this current sample, participants were diagnosed with a variety of mental health disorders ranging to major mood disorders to psychotic disorders to personality disorders. As such, the type of group treatment provided may not have been effective for this population.

Due to the use of the archival data, the participants for the purpose of this study were not selected at random. While using the de-identified data, the data that was utilized were the participants who had completed the PAI and had the data for the HCR-20-V3. Without randomizing the data, this provides the possibility that sampling biases increase. Additionally, without a random sample, the external validity may be potentially limited, further decreasing generalizability of the results. The database utilized in this study only comprised of data from participants in the mental health diversion program. There were no comparison groups considered for this study, which further impacts generalizability.

Due to a small sample size, there were significant power issues for this study. Moreover, with the study being a between-subjects design, meaning all of the participants participated in one single treatment (i.e., MRT), the individualized differences may have impacted the results. In addition to power issues, the data in the dataset only comprised of initial data. Due to the ability to only analyze initial data, it is difficult to accurately

evaluate any progress over the course of the treatment. In order to make the results more effective or meaningful, the study would have benefited from initial, during, and post-treatment data as well.

When examining the results, it was essential to consider the potential bias that may be present. Specifically, insight was measured through the HCR-20-V3, which is through the clinician's point of view. Given the clinicians assigned levels of insight and other factors, the assigned levels may be subjective, resulting in some forms of bias being present in the results. Moreover, the clinicians who completed the HCR-20-V3 as well as the interview and the full battery that was administered to the offenders were second year practicum students. Each student was trained on the purpose of the measures, how to administer the measures, and how to interpret results; however, it is still essential to acknowledge that the limited training may impact the results of the study. Furthermore, while assessing insight, the HCR-20-V3 provides essential information into the different types of insight; however, this does not provide extensive data regarding insight. Moreover, utilizing the HCR-20-V3 does not provide true insight data on the offender. Overall, these factors could lead to biases that may be present within the present study, impacting the internal validity.

In addition, the findings of the data analysis were not aligned with the three hypotheses. The findings could have been influenced by a combination of the above-mentioned factors as well as additional factors that were not mentioned. Overall, due to these limitations, this present study has the possibility of being replicated with stronger conditions. This could, potentially, provide more confident results for this area of literature.

Future Directions

When reviewing the limitations above, there is a plethora of opportunity of replicating this study. One opportunity is to provide the ability to a database with a larger sample size. Utilizing a larger sample size can provide researchers with information that may be more applicable to other locations or individual characteristics, increasing the generalizability of the results. Furthermore, including pre- and post-treatment data could increase the significance of the results by evaluating an individual's progress throughout their program.

Moreover, there is ample opportunity to utilize a comparison group to compare mental health diversion programs to community based mental health treatment programs. This would provide information that would assist in understanding what forms of treatment would be more beneficial when considering insight, psychological functioning, and treatment resistance. In addition, it may be beneficial to also examine an individual's level of motivation in engaging in the program. This information would add important data to determine whether motivation and treatment adherence are interconnected while also understanding how to increase or maintain an offender's level of motivation. Given the lack of research that is present within the offender population compared to the general population, having these results could provide researchers with the necessary details of what clinicians can consider when providing treatment to offenders.

The present study assists in filling some gaps within the literature; however, there are significant gaps that still persist and should be the focus of upcoming research. Specifically, when working with offenders, it may be challenging to engage them in treatment. The existing literature provides information related to treatment adherence

related to medications. Despite medications being an essential part of treatment, the lack of literature in the treatment adherence related to mental health treatment programming provides difficulty in identifying alternative modalities of treatment that may be more beneficial for offenders.

In addition, when examining insight amongst the literature, it was challenging to find one definition of insight. There are multiple forms of insight to consider; however, the research provided contradicting definitions of insight, posing a significant challenge for this present study. To alleviate this challenge, it would be beneficial to identify a universal definition of insight for researchers to use.

Not only is it difficult to define insight, insight is difficult to measure. Utilizing the HCR-20-V3 is an essential way of measuring insight through the clinician's perspective. This, however, provides ample room for biases to form. As such, in order to assist in measuring insight, it may be beneficial for a measure to be developed to administer to an individual.

This present study analyzes how insight, psychological functioning, and treatment resistance may impact an offender's ability to complete a mental health diversion program. To increase the literature within the offender population, future studies could examine offenders who are incarcerated and how the three factors impact their ability to complete mental health treatment programs within the correctional facilities. Given that the offender population is a vulnerable population, it may be challenging to obtain the data; however, a significant number of offenders who are either in the community or in correctional facilities require mental health treatment. As such, it is essential to gather

this information and provide supporting evidence to determine what programs are beneficial for offenders.

Implications for Treatment

Insight, psychological functioning, and treatment resistance have been three controversial topics when identifying the best form of treatment for offenders. Based on the results of this study, these three concepts do not necessarily impact an offender's ability at completing a mental health treatment program. Nevertheless, they may pose problems for offenders when adhering to treatment guidelines. As such, it is essential that when working with offenders in a mental health diversion program, clinicians should continue to consider the difficulties these three concepts bring to effective treatment for offenders.

Even though this study did not yield any significant challenges of completing a mental health diversion program posed by problems into insight, it is important to highlight that the different forms of insight (i.e., into mental health, into violence risk, and into need for treatment) differ. An offender may have difficulty identifying their symptoms; however, they may be able to understand their need for treatment. As such, a clinician can adapt their form of treatment and individualize the treatment approach to better suit the offender. Overall, it is important to individualize the treatment goals for an offender along with the treatment approach to produce significant improvements in their symptoms as well as increase their ability to complete mental health treatment programs.

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Appendix A

Broward Regional Health Planning Council Diversion Program Evaluation Battery

Broward Regional Health Planning Council Diversion Program Evaluation Battery

Required Materials	
Name	**Constructs measured**
Biopsychosocial interview	Gathering biopsychosocial and diagnostic information
Beck Anxiety Inventory (BAI)	Anxiety
Beck Depression Inventory – II (BDI-II)	Depression
Beck Hopelessness Scale (BHS)	Suicidality/levels of hopelessness
Brief Cognitive Screening Exam (BCSE)	Assessing cognitive deficits within orientation, time, mental control, planning and visual-perceptual processing, incidental recall, inhibitory control, and verbal productivity
Inventory of Offender Risk, Needs, and Strengths (IORNS)	Measures risks for criminal behavior, their treatment needs, and protective factors
Miller Forensic Assessment of Symptoms Test (M-FAST)	Assesses likelihood of malingering of symptoms
PTSD Checklist for the DSM-5 (PCL-5)	Assesses trauma symptoms
Personality Assessment Inventory (PAI)	Assesses personality and pathology characteristics
Word Choice/Effort Test	Assess performance

Optional Materials	
Name	**Constructs measured**
Level of Service Inventory-Revised (LSI-R)	Assesses risks identified to impact treatment adherence
Minnesota Muliphasic Personality Inventory-3 (MMPI-3)	Assesses personality and pathology characteristics (in lieu of PAI)
Trauma Symptom Inventory – 2 (TSI-2)	More in-depth assessment of trauma symptoms
Wechsler Adult Intelligence Scale-4th Edition (WAIS-IV)	Measures cognitive ability
Note: Additional optional measures were utilized and depended on the client.	