Examining the Effectiveness of a Mental Health Awareness and Recovery Program

in a Maximum Security Prison

by

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DEDICATION

Tiffany, you are amazing. You have completely and always supported me in my schooling even when it meant that I had to spend more time with it than with you. I love you Forever And A Day Always.
ABSTRACT

The number of adult male offenders in Canadian penitentiaries, who have a mental illness, has been increasing. Due to this increase, new treatment programs have been developed to target the needs of this offender population. Since these programs are new many have not yet been studied to determine their effectiveness. The Mental Health Promotion, Recovery, and General Wellness program is one such treatment. The present study was conducted to evaluate how effective a condensed version of the program was at increasing offender’s mental health knowledge and general wellness. It was hypothesized that the program would be found effective since it holds many key similarities in common with pre-existing treatment programs that have been shown to be successful. To evaluate this program a scale was created, tested for reliability, and then used in a pre- and post-testing procedure by four offenders who participated in the treatment. A manual for the program was also created to aid future program facilitators in providing consistent treatment. The results of the testing, in the area of general wellness, support the hypothesis since three out of four participants showed an increase in their test scores. However, in the knowledge portion of the scale, little improvement was found suggesting that more time may need to be spent on the psychoeducational aspects of the treatment. This study was the first to examine the effectiveness of this mental health program and recommends that future research be done to better analyse the full version of the program.
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Chapter I: Introduction

Due to the increasing number of offenders who suffer from a mental illness, within Canadian penitentiaries, mental health has become a principal focus for treatment programs. Having a mental illness does not render a person incapable of doing most tasks but rather can greatly diminish the person’s ability to do them. Mental illnesses can hamper a person’s capacity to do such things as manage their emotions, think rationally, have pro-social interactions, participate in recreational activities, organize daily routines, manage medication, and properly groom themselves (Kopelowicz & Liberman, 1994). However, people who have a mental illness and are incarcerated in a federal penitentiary tend to exhibit more severe problems in addition to the ones previously mentioned. Offenders with mental illnesses are often branded as outsiders in the hierarchical subculture of a prison which has led to them becoming “the most victimized and exploited group of offenders” (Correctional Services Canada, n.d., p. 8). In addition to being the most victimized minority group, these offenders also make up the largest number of people who commit suicide (Correctional Services Canada, n.d.). There is undoubtedly a major need for mental health treatment in federal penitentiaries. This need is made clearer by the results found in a recent study by Correctional Services Canada (CSC) in 2009. This study reported that from 1997 to 2008 there was an increase of 86% in the number of newly incarcerated offenders who had mental health problems. To help guide mental health services, CSC has identified key principles for mental health treatment. Three of these principles are: to increase mental health awareness and knowledge, to develop the offenders’ interpersonal and life skills, and to ensure that recovery is the main focus of treatment (CSC, 2009). The recently developed Mental Health Promotion, Recovery, and General Wellness program is a group treatment that was created with the intent to incorporate these three principles. The purpose of the program is to deliver mental health education and skill building activities to offenders with the goal of improving the offenders’ daily lives. Since this is a new treatment program it is crucial to evaluate its effectiveness. The purpose of the present study is to establish whether the Mental Health Promotion, Recovery, and General Wellness program produces a significant increase in the participants’ mental health knowledge and general wellness.

To facilitate a more comprehensive understanding about what makes a mental health program effective and how to evaluate its effectiveness, the present report includes an in depth literature review. An ensuing chapter also includes an explanation of the study’s methodology via a description of the treatment program and the assessment procedures. Following this an examination of the results, including visual analysis, has been provided. A discussion section presenting an interpretation of the results, an explanation of the strengths and limitations of the study, and recommendations for future research concludes this thesis.
Chapter II: Literature Review

Recovery, for people with a mental illness, can be a great but daunting desire and yet those who receive effective treatment may be able to reach this goal. A mental illness can weaken a person’s ability to perform everyday tasks, leading to an increase in daily problems and a decrease in general wellness. While having a mental illness can cause difficulties, having a mental illness and being incarcerated tends to increase the amount and the severity of problems experienced by an individual (CSC, 2009). However, there are a number of treatment programs that have shown to be helpful for people who have a mental illness (MacKain & Mueser 2009; Mueser et al., 2006; Mueser & MacKain, 2005). These treatments, along with the recently developed Mental Health Promotion, Recovery, and General Wellness program, have certain key features in common and these similarities may support the newer program as being an effective treatment program.

Mental Illness

Although there are many different types of mental illnesses and even different levels of severity within each illness, all mental illnesses can cause difficulties for the individuals who have them. Mental illnesses affect people in many different ways and can cause problems for them in virtually every aspect of their life. According to the Ontario Human Rights Commission (2009), about 20% of Canadians have or have had a mental illness.

A person can experience the manifestation of a mental illness in numerous ways; in other words, there are many symptoms a person may exhibit due to having a mental illness. People who suffer from psychotic disorders may be unable to distinguish between reality and fantasy (Haro et al., 2003). For people with personality disorders common symptoms experienced are dichotomous thinking, impulsivity, and feelings of abandonment (Croft, 2009). Frequent problems that people with anxiety disorders experience are intense fear, frequent panic attacks, and even a variety of physical discomforts or pains (Croft, 2009). Some symptoms are very characteristic to specific illnesses, such as the ones previously mentioned; however there are many symptoms, such as anxiety and depression that may be experienced by anyone with a mental illness. In a study by Clark, Cook, and Snow (1998) it was found that people with a mental illness are three times as likely to experience symptoms of depression as people without a mental illness. The results of the study indicated that 6% to 15% of people with a mental illness also suffer from depression.

The difficulty of having a mental illness is not only the many different symptoms a person can experience but also that these symptoms affect all areas of the person’s life. According to Kopelowicz and Liberman (1994) symptoms of mental illnesses can cause people to have difficulties with interpersonal skills, daily activity skills, and personal growth. In the area of interpersonal skills a person, due to a mental illness, may have difficulties expressing them self to others or understanding what others are trying to express. This may be due to a lack of communication and social skills or due to a distrust of other people. Daily activities can be difficult for people with a mental illness. They may have a hard time organizing daily routines, remembering how to perform certain tasks, staying focused, or understanding why certain tasks like grooming or taking medication need to be done. Personal growth can become difficult because of a lack of self discipline, a lack of knowledge about mental illnesses, frustration due to past failures, and even because of fear of being seen as incapable or lesser in some way. Many
people with mental illnesses fear that if they let people know they have a mental illness they could lose relationships or even job opportunities. An individual’s entire life is affected by having a mental illness and in many ways the symptoms of the illness can make life more difficult.

**Mental illness in the penitentiaries.** Offenders with mental illnesses exhibit similar but more severe symptoms, leading to similar but more severe skill deficits, than those with mental illnesses who are not incarcerated (Mueser & MacKain, 2005). Since offenders with mental illnesses tend to have severe problems they are a noticeable minority group in the prisons. Therefore, these offenders are more likely to be victimized by other offenders (MacKain & Mueser, 2009). Compared to offenders without mental illnesses, these offenders have a harder time understanding and following orders and this can lead to being disciplined by staff more often. While being disciplined, these offenders are more likely to worsen the situation since they may lack the understanding of why they are being punished. Also offenders with a mental illness are more likely to commit suicide. It was found that in Canada 90% of the suicides in federal penitentiaries were committed by individuals with mental illnesses (CSC, n.d.). To determine the numbers of offenders with mental illnesses a study by Fazel and Danesh (2002) surveyed 18,530 male inmates from 12 different countries. This study found that out of those surveyed 3-7% had a psychotic illness, 10% had major depression, and 65% had a personality disorder. According to a study that CSC completed in 2009, the ratio of individuals with a mental illness to individuals without a mental illness is 3.7 times higher in penitentiaries than that of the general Canadian population. It was also found that 84% of newly incarcerated persons have had or still had a mental illness at the start of their imprisonment (Brink, Doherty, & Boer, 2001). There is a significantly larger proportion of people with mental illnesses in the Canadian prison population than there is in the Canadian general public. Also, offenders with mental illnesses tend to have more intense problems than people with mental illnesses but are not imprisoned.

**Treatment Programs**

There are a number of successful treatment programs that have been developed for people with mental illnesses. This paper makes a comprehensive review of three such programs that have been widely used, studied, and shown to be effective. The Illness Management and Recovery (IMR) program is examined first. After this, the Wellness Recovery and Action Plan (WRAP) treatment is studied. The UCLA Social & Independent Living Skills (SILS) intervention plan is also reviewed in this thesis. The key similarities of these programs have been analysed and compared to the Mental Health Promotion, Recovery, and General Wellness program.

**Illness Management and Recovery program.** In 1997 the Robert Wood Johnson Foundation in collaboration with the Substance Abuse and Mental Health Services Administration identified the need for a single standardized treatment design (Mueser et al., 2006). This standardized treatment would combine information from many specialized interventions to create one general program that could address many of the needs of people with mental illnesses. Mueser and Gingerich designed the IMR program with the intent to fulfill this need (Mueser et al., 2006).
The IMR program was developed to teach people with mental illnesses how to manage their illness and to help them recover balance in their life (Mueser et al., 2006). The program accomplishes these goals through psychoeducational and skill building techniques. While teaching about mental illnesses and how to manage symptoms, the program also focuses on having the clients create personal definitions of what recovery is to them and working on individualized goals that will lead them to their recovery. Common themes of recovery include control over one’s illness, building social and intimate relations, pursuing recreational activities, taking on adult responsibilities, building a positive identity, and having hope for the future. This program was designed to address the specific needs of people with mental illnesses while also being flexible enough to encourage personal development.

By design, the program has a very clear and sequential progression of the material so that a treatment facilitator can deliver the information in a step-by-step manner or modify it to fit their clientele (Mueser et al., 2006). Either way, the program is delivered to ensure that the process becomes very individualized since it promotes personal definitions of recovery and the progression that leads to it. IMR is based on two main theoretical models: the trans-theoretical model and the stress-vulnerability model. The trans-theoretical model emphasises the need to continually motivate clients since their motivational levels changes depending on which stage of change they are in. According to this model there are five stages of change in which the client’s level of commitment to the treatment will change; hence the need to continually motivate the client. In the stress-vulnerability model the focus is on the relationship between stress, vulnerability, and coping. It is believed that extended periods of stress can lead to increased vulnerability to physical health problems, mental health problems, and relapses. To decrease vulnerability a person needs to learn to cope with stress. A part of the IMR program is devoted to teaching clients coping techniques that will decrease the amount of stress they experience. These two principles can be seen throughout the progression of the program.

The program also employs five treatment strategies to increase its effectiveness (Mueser et al., 2006). The program is heavily founded on psychoeducation to teach clients about mental illnesses in general, specific mental illnesses, available treatments and medications, and how specific skills can help lead to recovery. The second technique used is a cognitive behavioural approach specifically aimed at improving clients’ medication adherence. Next, the development of a relapse prevention plan is focused on to decrease the likelihood of symptom deterioration, psychosis, or illicit drug use. The last two strategies focus on social skills and coping skills development. Social skills are meant to help client reach their personal ideas of recovery and to help prevent relapses by having a stronger support network. Coping skills focus on stopping or decreasing the severity of problems when they occur. This also helps prevent relapses by preventing problems from increasing to a crisis. These strategies are all connected but also address specific areas in the process of recovery.

There are 10 subject areas that the IMR program covers during the course of treatment (MacKain & Mueser, 2009). The subject areas are: recovery, practical facts about mental illnesses, stress and stress management, social support, using medications effectively, drug and alcohol use, reducing relapses, coping techniques for stress, coping with problems and persistent symptoms, and getting your needs met in the mental health system. The program facilitators may choose to allocate more time to certain topics based on the needs of their clients. Therefore, the program is flexible and meant to be tailored to the individuals receiving the treatment.

The IMR program has been used in many environments and with many client populations with results that continue to support it as an effective program (Mueser et al., 2002).
program has been also successfully delivered by a number of different people with varied backgrounds, areas of expertise, and levels of training. It has been shown that social workers, nurses, and case managers have been equally as successful in facilitating the treatment as psychologists.

Mueser and associates (2006) conducted a study to analyse the effectiveness of the IMR program. Their study focused on two treatment groups; one in the United States and another group in Australia. The United States group had nine participants and the program in Australia had 10 participants. The study employed a pre-, post-, and three month follow-up testing procedure. Both programs covered the same material and used a similar group format. There were eight measures used to assess the effectiveness of the IMR program. The measures were: the Brief Symptoms Inventory (BSI), the Coping Skills Scale, a compressed version of the Client IMR Scale, the Knowledge Questionnaire, the Recovery Assessment Scale (RAS), the Multidimensional Scale of Perceived Social Support (MSPSS), The Global Assessment of Functioning scale (GAF), and a 6-item satisfaction survey. Since the study found that the clients in both countries were similar in all demographic and functioning variables the results of the tests were combined together. The results of the measures were averaged into a mean score for the pre-, post-, and follow-up testing results. The results for the BSI and the Coping Skills Scale both decreased from the pre- to post-test by a mean of .11 and 1.43, respectively. The scores of the Client IMR scale, Knowledge Questionnaire, RAS, MSPSS, and GAF all increased by a mean of 8.85, 3.8, 1.17, 1.83, and 7.74, respectively. By follow up, the scores from of all the measures had lessened in positive change with the exceptions of the BSI and RAS results which continued to improved after the post-testing. For the satisfaction survey 02% of the clients thought the programs were overall not helpful. However, 62.67% of the clients found the treatments to being helpful, and another 35.88% of the clients believed that they were very helpful.

These results support the IMR program as being effective and found that the clients retained much of their knowledge and skills over the three month follow-up. However, not all of the measures showed significant change. The results from the Knowledge Questionnaire, RAS, and Multidimensional Scale of Perceived Social Support are three scales that did not show significant change. A limitation of this study was that the program facilitators had previously little to no experience with the program and it is possible that with more experience they could have provided a more effective treatment. Also most of the clinicians trained in Australia were at first unsure and unenthusiastic about the IMR program. This may also have decrease the effectiveness of the program. Another issue was that the formats of the groups were not as similar as possible. The United States group used one hour sessions while the Australian sessions had an hour and a half of program time with an additional half an hour as a break in the middle of the session. Having an extra half an hour and a break in each session could have led to differences in their results. However since the study combined the results and did not show them separately it is not know whether or not the results from the two countries differed.

**Wellness Recovery and Action Plan program.** The WRAP program was created by Copland and has been used extensively throughout the whole of the United States (Mueser & MacKain, 2005). The program was designed to help people with recurring physical, emotional, or mental health problems build a healthier, more rewarding life. The program prompts the clients to build personal written plans for what they believe to be successful living. To help the
clients achieve their goals and become more independent in their path to a healthier lifestyle, the program emphasises skill building, self assessment, and self-monitoring techniques.

The delivery of the program is divided into seven segments that use both lecture and discussion formats to educate the clients (Mackain & Mueser, 2009). The sections are: developing plans for daily maintenance, recognizing triggers and warning signs of possible problems or crises, making a plan for crises, creating a healthy lifestyle, building support systems and learning self advocacy, improving self esteem, and decreasing tension and stress. However, before the first lesson begins clients are encouraged to identify people, skills, and anything else that they already have that will be helpful to them throughout their recovery process. Throughout all of the segments clients are encouraged to write down their individual plans so they can refer back to their goals and note their improvements.

To evaluate the WRAP program Cook and colleagues (2009) conducted a study which included 80 clients receiving group treatment. The groups met once a week for eight weeks with the sessions lasting two and a half hours. To determine the amount of change in the participants the study conducted a pre- and post-test procedure. The measures used were the BSI, RAS, Hope Scale, Patient Self-Advocacy Scale (PSAS), Empowerment Scale, Medical Outcomes Study Social Support Survey, and the Medical Outcomes Study-Short Form. The results of the BSI, RAS, Hope Scale, PSAS, and the Medical Outcomes Study-Short Form all illustrated improvements made by the program participants. Significant improvements were also noted in the areas symptoms severity, recovery, self-advocacy, feelings of hopefulness, and a more positive personal view of physical health. However, the results from the Empowerment Scale And the Medical Outcomes Study Social Support Survey did not support the program. There were significant decreases in the clients’ feelings of empowerment and no notable changes were found in the area of social support. Overall these findings support WRAP as an effective program yet some changes to the program may need to be made to improve the program in the two areas where the results were not supportive. To further support the WRAP treatment it was noted that there was a positive correlation between high group attendance and increased improvements. Other studies that have been conducted provide supporting evidence for the WRAP treatment as being an effective program for persons with a mental illness (Cook et al., 2010).

UCLA Social & Independent Living Skills program. Limberman, Wallace, and associates developed the SILS program as a set of treatments that could address a variety of needs that people with mental illnesses may have (MacKain & Mueser, 2009). The program can be seen as a bank of multiple subprograms that can be chosen from to help tailor the treatment of individual clients (MacKain & Messer, 2004). To determine which subprogram a client could benefit from a functional assessment of the client is typically done before treatment starts. This program was designed so that anyone could be trained as a treatment facilitator and so that the program could be adapted for any clientele in any environment. It was also designed to encourage transfer of skills and continued development.

The program is designed with eight subprograms called modules (MacKain & Mueser 2009). Each module covers a number of different skills that the facilitator can tailor to the specific needs of the clients. The eight subprograms are: basic conversational skills, recreation for leisure, friendship and intimacy, community re-entry, substance abuse management, workplace fundamentals, medication management, and symptom management. Since clients tend
not to experience problems in all of these areas facilitators determine which modules best suit their client’s needs.

Information in each module varies but each follows the same seven-step process for providing the information (MacKain & Streveler, 1990). The first step involves introducing the topic and the benefits the clients may gain from the information. Next a video is shown that models the target behaviours. The third step is having the clients role play the behaviours. After this there is an open discussion about problems that may occur while preparing to use the skills being learnt. The fifth step focuses on discussing problems that may occur while using the skills and learning problem solving techniques to determine the best course of action once a problem does occur. The next step is practicing the behaviours outside of the treatment setting with the facilitator there for support. The last step is the same as the previous one but without the facilitator being present. Each of these steps are followed in each module and for every skill taught in each module. This helps ensure that the clients fully learn each skill taught in the program. The problem with this is that it takes a long time to teach each skill. This can be translated into the program being not overly time or cost efficient.

MacKain and associates (1998) did a study to demonstrate the effects of the Community Re-entry module. The study consisted of 44 subjects who had completed the 16 session program. The study used a pre- and post-test method with three scales. The scales were: the Scale for the Assessment of Positive Symptoms (SAPS), the Scale for the Assessment of Negative Symptoms (SANS), and the Community Re-Entry Program (CREP) test. The results for the SAPS was paired $t= 6.13$, $df= 30$, $p < .001$. The results for the SANS was paired $t= 2.25$, $df= 30$, $p < .04$. The results for the CREP test was paired $t= -6.64$, $df= 43$, $p < .001$. These results show a statistically significant increase for the CREP test and a decrease in both the SAPS and the SANS tests which indicates that the program was an effective treatment.

This program has been widely used around the world and has been shown to be successful in teaching clients new skills that help improve their lives (Mueser & Mackain, 2005). Other modules have also been studied with results indicating that they are also effective treatments (Eckman et al., 1992; MacKain & Streveler, 1990).

**Treatment program key similarities.** The IMR, the WRAP, and the SILS differ in many aspects but they also do share some key similarities. There are six similarities that will be discussed in this section.

The first key similarity is that the purpose of each program is to help clients along the path of recovery. Since recovery can mean different things to different people, the programs encourage the clients to build individual and unique definitions and goals for recovery.

The second similarity found in these programs is their focus on psychoeducation. The programs employ techniques such as lectures, discussions, and handouts. These treatments are based on the theory that knowledge is power and that the more clients know the more they can recover.

Also each of these programs included skill building elements. The techniques employed by these programs include modeling, role playing, and practicing skills outside of the program environment. The types of skills that are focused on include interpersonal skills, daily activities, problem solving, and relaxation techniques. These skills are seen as essential to any one’s recovery.

A fourth key similarity is teaching clients about the importance of medication and the dangers of drug and alcohol abuse. Understanding the benefits and side effects of medication
helps clients become more able to be involved in deciding what medication is right for them. Learning about drug and alcohol use allows clients to understand how it can affect their illness, medications, and how it can lead to a relapse.

Another similarity is the importance put on relapse prevention. Clients are encouraged to create plans to prevent relapses as well as to stop a relapse once it occurs. Being able to identify warning signs is also covered by these programs.

The sixth similarity is found in the designs of these three programs. The programs are all designed to be user friendly by the facilitator, flexible enough to be tailored to the needs of the clients, and able to be used in a group or individual setting. Each program includes a step-by-step manual that has all the information needed to successfully run the treatment. They are also flexible in that not all of the information needs to be covered. Some information can be left out if the client group is already knowledgeable in the specific area or if the clients need to focus more on another topic.

**Relationship of the Present Thesis to the Literature**

The Mental Health Promotion, Recovery, and General Wellness program shares many of the similarities found in the previously mentioned programs. The goal of the Mental Health Promotion, Recovery, and General Wellness program is to improve offenders’ daily lives and to help them reach a state of recovery. This program also utilizes similar psychoeducational and skill building techniques that were described in the above programs. The treatment program also covers similar topics such as interpersonal skills, daily activities, problem solving, relaxation techniques, mental illness knowledge, substance use knowledge, and medication management. While this program has incorporated many of the key features found in pre-existing programs a major difference is that the Mental Health Promotion, Recovery, and General Wellness program has been designed specifically for people in prison. The IMR, WRAP, and the SILS programs have been successfully used with incarcerated persons; however, none of them have been developed exclusively for offenders. Another key difference is that the Mental Health Promotion, Recovery, and General Wellness program was also designed to benefit offenders without a mental illness while the other programs were developed to focus on people with a mental illness. This thesis examines the effectiveness of a program that is similar to other successful programs but that has been designed for a specific client population.
Chapter III: Methodology

Participants

Five offenders participated in the Mental Health Promotion, Recovery, and General Wellness group program. These offenders also consented to being a part of the evaluation of the program. Another 10 offenders participated in the reliability testing of the Mental Health Awareness, Recovery, and General Wellness (MARG) Scale, which was the scale developed to examine the effectiveness of the treatment and a copy can be found in Appendix A. All 15 offenders were given random numbers which were used instead of their names or their identifying Finger Print System (FPS) numbers. This was done so that their identities would be kept confidential. The offenders who were members of the treatment and evaluation of the program were given numbers from one to five and will be referred to as Participant One, Participant Two, Participant Three, Participant Four, and Participant Five. The offenders who took part in the reliability testing of the scale were randomly assigned numbers from 10 to 19.

Program participants. At the time of the program these five offenders were all living on the same subpopulation range. The offenders were all within the age range of 30 to 40 years with the possible exception of Participant Two, whose information was not recorded. Participant One was incarcerated for robbery, possession of property obtained by crime under 5000 dollars, forcible confinement, uttering threats, assault with a weapon, and possession of illegal substances. For these crimes he had a sentence of four years. He had also been diagnosed with substance abuse disorder and borderline personality disorder. Participant Two withdrew from the study due to not having enough time left in his sentence to complete the evaluation of the program. Therefore, information about him is not recorded in this paper. Originally Participant Two did have enough time to complete the study but due to security issues the program was delayed by a month which meant that the offender no longer had the time to finish the program. Participant Three was sentenced to eight years for robbery, uttering threats, assaults, robbery with violence, possession of stolen property, and trafficking illegal substances. Participant Three had no diagnosis of a mental illness. Participant Four was sentenced to eight years in prison for manslaughter, failing to comply with his probation, assault with the use of force, and aggravated assault. He had not been formally diagnosed with schizophrenia but did report that he had been suffering from hallucinations for his entire adult life. He was, however, in the process of being formally assessed for schizophrenia. Participant Five was sentenced to seven years for robbery, using an imitation firearm while committing robberies, forcible confinement, and assault. As a child he was diagnosed with having attention deficit hyperactivity disorder but he believed that he had been misdiagnosed.

Reliability testing participants. The 10 offenders who participated in the reliability testing process came from various ranges within penitentiary. These offenders were also randomly assigned numbers, ranging from 10 to 19, so their identities would be kept private. Offenders 10, 15, 16, and 18 were from different general population ranges. Offenders 11, 12, 13, 14, and 19 were from two different segregation ranges. Lastly, offender 17 was from a subpopulation range. In total six different ranges were represented by these 10 offenders for the reliability testing of the MARG Scale.
Selection Procedures and Informed Consent

Program participant selection procedure. The selection procedure used to determine which offenders would participate in the treatment program consisted of having the offenders meet four criteria. The first criterion was living on the specific subpopulation range that the treatment was being provided to. Second, being considered as having minimal to moderate mental health needs. Having minimal needs referred to having a history of mental health problems but now functioning relatively well. Having moderate needs referred to exhibiting mild symptoms of a mental illness but being able to function at a satisfactory level. The third criterion was being seen as compatible with the other offenders. This would ensure that the participants could interact with each other in a group setting. The final criterion was having enough time left in their sentence to complete the program. The institution’s registered mental health nurse, who was also the main program facilitator, created a list of offenders that fit these criteria. The list was then sent to the head of security and the correctional investigator to ensure the offenders on the list were compatible. When the compatible offenders were identified they were individually asked if they would participate in the program. The first five who consented to the program became the program participants. The criterion to participate in the evaluation of the program was simply being a treatment member; however there was a separate consent form for participating in the evaluation process.

Reliability testing participant selection procedure. Selecting offenders to participate in the reliability testing was done using two criteria. First, the offender could not be receiving any treatment or be participating in any programs during the testing process; with the exception of receiving medical treatment. During this process, treatments were not denied to the participants but the participants were not at that time scheduled for any treatments. The second criterion was that the principal investigator needed be allowed to interact with the offenders. To ensure that the principal investigator was allowed to administer the tests to the offenders a list of offenders who met these three criteria was made and the first 10 names randomly drawn were asked to be participants.

Informed consent. The offenders, participating in and evaluating the treatment program, were required to sign a Correctional Services Canada consent form (see Appendix B) to participate in the group. In addition, to participate in the evaluation of the group the offenders were required to sign a St. Lawrence College consent form (see Appendix C). The offenders participating in the reliability testing signed a separate St. Lawrence College consent form (see Appendix D). Before the offenders provided informed consent, the program and the evaluation process was explained to them as well as their right to withdraw at any time without affecting the other services offered by the institution. Confidentiality was also explained to the offenders and that they would be given a random number in place of their name and Finger FPS numbers for the evaluation process. This would ensure privacy of their results. The offenders participating in the program were told that only the lead program facilitator and the principle investigator would know their results. The offenders participating in the reliability testing were informed that no one, with the exception of the principal investigator, would know their personal results. The test-retest procedure was explained to them so they understood that the expectation was for them to complete the same scale twice with a week’s time between the two sessions.
Design

**Program evaluation design.** The evaluation of the program was done using a pre- and post-test design. The data gathered from the MARG Scale was analyzed using a comparison between the pre- and post-test results. Before the program started, each offender was brought individually into a private interview room in which they were given as much time as they needed to complete the scale. The instructions given to them were; to be as honest as possible, mark a check, an “x”, or circle the answer they believe to be correct, and if any help is needed the principal investigator will read or restate the item on the scale. The data from the evaluation of the program are presented in tables and bar graph figures. The tables will show the exact scores each member had on their pre- and post-tests. The figures will illustrate the amount of change for each member. Originally it was planned to compute a Wilcoxon test but since Participant Two withdrew the test was not conducted since a minimum of $n=5$ is needed for a Wilcoxon test.

**Reliability testing design.** The reliability testing procedure employed a test-retest design. Three Pearson Correlations were conducted. The first correlation was to determine the reliability of the entire MARG Scale. The second and third correlations were used to evaluate the reliability of the two subscales within the scale. To conduct the Pearson Correlations a statistical computer program was used.

**Setting and materials.** The program took place in a classroom within the institution. The testing for both the evaluation of the program and the reliability testing of the scale were conducted in an interview room where only the principal investigator and offender were. The materials used in the program were; the Mental Health Promotion, Recovery, and General Wellness manual, handouts, folders, pens, a chart board, chart paper, markers, and a clock.

Procedures

**Treatment program.** The program was designed to be a time-limited group treatment that focused on psychoeducation and skills building. There are a total of 11 sessions that are one to two hours in length and are delivered twice weekly. However, due to delays in starting the program it was compressed into six sessions that were delivered one to three times a week. The group utilizes group discussions, modeling, practicing skills, and homework assignments to build the knowledge and skills being taught in the program. The program was held in a classroom inside the institution. The program facilitators were the institution’s registered mental health nurse, a behavioural science and technology psychology staff member, and this study’s principal investigator, a student in the Bachelor of Applied Arts in Behavioural Psychology program at St. Lawrence College.

**Program outline.** The program was designed to be 11 sessions. The following provides a brief description for each session. However, for more detail refer to the program manual (See Appendix E).

1. Introduction: Group members meet each other and the facilitators, other topics covered in the program are introduced, and ground rules and expectations of the program are discussed.
2. Stigma: Members are taught what stigma is, how it develops, and how it can be stopped. The stigma of having a mental illness and of being incarcerated is the main focus.
3. Mental Illnesses: Participants educate each other by making and presenting informative posters that are about various mental illnesses commonly found in offenders.
4. Mental Illnesses continued: This is a continuation of the third session and is meant to allow participants to present their posters without pressures of a time limit.
5. Recovery: Making Changes and Activities of Daily Living: This session focuses on what recovery is and how to attain it. It also focuses on the importance of daily activities.
6. Stress Management: Members are taught to use diaphragmatic breathing, progressive muscle relaxation, and mindfulness meditation to decrease their stress.
7. Communication Skills: This session focuses on building pro-social communication skills.
8. Problem Solving: Offenders learn how to examine a problem and determine the best course of action.
9. Emotion Regulation/ Anger Management: In this session members are taught how to decrease and control their anger and aggression.
10. Assertiveness: Participants learn how to become more assertive in their communication and behaviour styles.
11. Final: This session recaps previous session lessons that members may need extra instruction on and examines how to transition learnt skills into everyday life.

Since the program was changed for this study the program was delivered with the following outline:
1. Introduction: This session covers the material meant for sessions one, two, and part of three.
2. Mental Illnesses: This session focuses on material from the original sessions three and four. However, the program facilitators presented the information about mental illnesses instead of having the members teach each other.
3. Recovery and Stress Management: This session combines the original Recovery and Stress Management sessions. The principal investigator led this session.
4. Communication Skills: This session is the same as the original Communication Skills session. The principal investigator of this study also led this session.
5. Problem Solving: This session also was the same as the original Problem Solving session.
6. Anger Management and Assertiveness: This session focused on the information from the original ninth, tenth, and eleventh sessions.
Chapter IV: Results

The purpose of this study was to examine the effectiveness of the recently developed Mental Health Promotion, Recovery, and General Wellness program in a maximum security prison. To determine the effectiveness of the treatment program a scale, the MARG Scale, was developed to measure changes in participants’ mental health knowledge and their general wellness. Since this scale was newly made it was tested to ensure its reliability. To determine the reliability of the scale a series of Pearson Correlations were conducted. To determine if there was clinically significant change found in program members a visual analysis of the results was conducted.

Results of the MARG Scale

Scale design and scoring process. The MARG Scale is a 36-item measure designed specifically for evaluating changes made in participants during the program. The scale is divided into two subsections. Subsection A uses a series of 24 multiple choice questions to analyse mental health knowledge. To determine the results of this section the number of correct answers is divided by 24 and then multiplied by 100 to determine the percentage of correct answers. Subsection B focuses on measuring general wellness and uses a Likert scale for its 11 items. Items 25 to 32 have a 5-point scale, item 33 includes a 6-point for a not applicable answer, and items 35 and 36 use a 4-point scale. The points on the scale range from A to F and have the following score attached to each: point A corresponds with a score of one, point B corresponds with a score of two, point C corresponds with a score of three, point D corresponds with a score of four, point E corresponds with a score of five, and point F corresponds with the answer not applicable. When determining the results each answer is given its corresponding score value and a sum is calculated. Then the sum is divided by the number of items answered. If an item is not answered then it is not included in the division. However, if a participant answers F on item 33, indicating the question is not applicable to them, then the item is scored as if it was not answered. Also, item 34 is scored differently and so is not included in determining the results. The results of Subsection B can range from 0 to 4.82. In this scale, high scores in both sections are desirable. Since the scale utilizes both multiple choice questions and Likert scale items two sets of scores are calculated and not one total score to show changes from pre- to post-testing.

Reliability of the scale. To determine the reliability of the MARG Scale the computer program SPSS PASW Statistics 18.0 was used to calculate three Pearson Correlations. A Pearson Correlation was calculated for the entire scale and then for each of the scale’s subsections. For the entire scale the correlation was significantly strong with \( r = .917, p < .01 \) two-tailed test. The correlation for Subsection A was also significant with \( r = .824, p < .01 \) two-tailed test. Subsection B again was very significant with \( r = .986, p < .01 \) two-tailed test. Each participant’s test-retest answers are viewable in Appendix F.

Validity of the scale. The MARG Scale has good Face validity. The content of the scale is valid since it is based on three pre-existing mental health knowledge and overall wellness measures. One of the scales was developed by the National Alliance for the Mentally Ill and was called Test Your Mental Health Knowledge (1997). Another measure was created by the Canadian Mental Health Association and was named Test Your Mental Illness Knowledge (n.d.).
The third measure that the MARG Scale was based on was the Outcome Measure: Client Version Illness Management and Recovery Scale: Client Self-rating which was developed for the IMR program (Singer et al., 2006). In addition, the developer and facilitator of the Mental Health Promotion, Recovery, and General Wellness program as well as the participants in the program reported that the test covered relevant material to the treatment. Therefore, the MARG Scale has been to be both reliable and valid.

**Results of the Treatment Program**

The answers that each participant gave for each question in the pre- and post- test can be found in Appendix G. These answers were scored and the results of their scores are discussed in this section. The Subsection A results were calculated and can be found in Table 1.

<table>
<thead>
<tr>
<th>Participant</th>
<th>Pre Test</th>
<th>Post Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>79.2</td>
<td>79.2</td>
</tr>
<tr>
<td>3</td>
<td>58.3</td>
<td>62.5</td>
</tr>
<tr>
<td>4</td>
<td>58.3</td>
<td>58.3</td>
</tr>
<tr>
<td>5</td>
<td>70.8</td>
<td>75</td>
</tr>
</tbody>
</table>

It should be noted that Participant One and Participant Four did not show any change in knowledge however both Participant Three and Participant Five did improve their scores by 4.2 percent each. This can be translated into an average positive change of 2.1 percent. These results are also illustrated in Figure 1.

*Figure 1. Results of Pre- and Post-Test for Subsection A*
These results clearly depict that little to no change was found in the participants in the area of mental health knowledge. However, none of the participants’ scores decreased from the pre-to the post-test.

The results for Subsection B were calculated and the results compiled into Table 2. Again these scores can range from 0 to 4.82.

Table 2

*Pre- and Post-Test Results for Subsection B*

<table>
<thead>
<tr>
<th>Participant</th>
<th>Pre-test</th>
<th>Post-test</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>3.09</td>
<td>3.09</td>
</tr>
<tr>
<td>3</td>
<td>3.7</td>
<td>4.2</td>
</tr>
<tr>
<td>4</td>
<td>2.18</td>
<td>2.82</td>
</tr>
<tr>
<td>5</td>
<td>4.36</td>
<td>4.73</td>
</tr>
</tbody>
</table>

Again Participant One’s results did not changed from pre- to post-testing suggesting that no change was made in Participant One during the course of the program. However, Participant Three’s score increased by .5, Participant Four’s score increased by .64, and Participant Five’s score increased by .37. This results in an average increase of .38. From these results it is clear that the treatment program was more effective in improving participants’ general wellness than it was in increasing their mental health knowledge. The following figures illustrate at which level each member showed change in Subsection B. In this section of the scale an improvement in general wellness and recovery is shown by the amount of the participants’ answers increasing from A towards E. Figure 2 shows Participant One’s results.

![Figure 2](image)

*Figure 2. Participant One’s Answers for the General Wellness Section*

This graph shows that Participant One did show some change. During his post-test he answered A and D once more but also answered B and C once less than he did in his pre-test. This shows that his general wellness improved in some areas but worsened equally as much in
other areas which resulted in no change in overall general wellness. This next graph, Figure 3, shows the change in levels for Participant Three’s Subsection B answers.

![Figure 3. Participant Three’s Answers for the General Wellness Section](image)

These results illustrate that Participant Three’s scores decreased in the amount of A and C levels reported while increased in the amount of D and E levels reported which supports finding of Participant Three’s improvements. It should be noted that although item 34 is not included in the calculation of these results Participant Three did changed his answer on this question from the pre- to the post-test. He scored him selves as having an Aggressive communication style on the pre-test and that he improved to an Aggressive-Assertive communication style by the post-test. He also answered F on item 33, indicating the question is not applicable to him, and so this question was also not calculated into his results. Participant Four’s results are illustrated in Figure 4.

![Figure 4. Participant Four’s Answers for the General Wellness Section](image)
This figure shows drastic changes in the level of scores. The more notable change is a substantial decrease in A scores and an equally substantial increase in C scores. This suggests that Participant Four improved in the area of general wellness. Again it should be noted that although item 34 is not included in the calculation of these results Participant Four also changed his answer from having an Aggressive communication style to an improved Aggressive-Assertive communication style. This last graph, Figure 5, shows the changes made in Participant Five.

![Figure 5. Participant Five’s Answers for the General Wellness Section](image)

This illustration shows a great improvement in Participant Five. His lower scores of Cs and Ds decreased and his higher scores of Es increased. Out of all the members Participant Five had the highest post-test score in Subsection B, however, he also had the second lowest change from the pre- to the post-test.

Overall these results show that three of the four members in the Mental health Promotion, Recovery, and General Wellness program showed improvement. The participant that did not show and overall improvement in mental health knowledge or general wellness also did not show any deterioration. These results show that the most improvement was found to be in the area of general wellness while little improvement was noted in the area of mental health knowledge. Since a Wilcoxon test was not conducted it cannot be said whether or not the change was statistically significant but it can be said that significant clinical change was found in three of the participants. This suggests that the Mental Health Promotion, Recovery, and General Wellness treatment program may be effective for male offenders in a maximum security facility.

**Program Manual**

The manual was created for the Mental Health Promotion, Recovery, and General Wellness program. It is a 228 page document that provides program facilitators with an introduction to the program, instructions for conducting the pre- and post-testing, and an explanation of how to use the manual and provide the treatment. Each session chapter has a summary of the session objectives, materials needed, and homework assignments to be given to the program participants. Session chapters also provide step-by-step questions and information to discuss with the offenders so that the facilitator can simply follow the progression in the chapter.
Some sessions also provide group activities that tie into the lesson being taught. Some of these activities build skills that are aimed at improving the participants daily functioning and interactions. All of the handouts and homework assignments are also included in the manual for the facilitator to copy and give to the program members.
Chapter V: Discussion

Summary

Individuals who are incarcerated and have a mental illness are more likely to have difficulties in terms of interpersonal relations and overall wellness than offenders who do not have a mental illness. For this reason the Mental Health Promotion, Recovery, and General Wellness program was developed. Its goal is to aid offenders in this demographic by educating them and building their skills which should translate into improved daily lives. However, since this program was recently created there have been no previous studies examining the effectiveness of the treatment. This thesis was conducted to help determine whether or not this program produces significant improvements in the mental health knowledge and life skills of offenders with a mental illness.

To examine the treatment program a pre- and post-testing procedure was conducted with four offenders who completed the program. The MARG Scale was developed specifically to assess the effectiveness of the program. To ensure that the results of the testing were accurate, reliability testing of the scale was also conducted using 10 offenders from throughout the penitentiary. The results of this testing found very strong correlations within the scale and thus supported the scale as being reliable. This means that the results from examining the program are reliable.

The principal investigator of this study also designed and produced a manual for the program, developed two of the program’s sessions, and co-facilitated the treatment sessions. The manual was developed to assist future facilitators in providing the treatment in a consistent manner. This will also be beneficial to future studies done on this program.

Following in this chapter, there is an interpretation of the results of the study and the study’s connection to the current literature, an examination of the strengths and limitations of this study, an analysis of the multilevel challenges brought up by the treatment program, an explanation of the contributions this research has to the field of behavioural psychology, and recommendations for future research.

Interpretation of Results and Connection to the Literature

Overall the results of this study support the hypothesis that the Mental Health Promotion, Recovery, and General Wellness program is an effective treatment program. Individually, Participant Three and Participant Five both improved their test scores in both mental health knowledge and general wellness. Participant Four showed improvement in general wellness but not in knowledge and Participant One did not show any improvements. This could be due to him only attending three sessions which equalled half of the treatment. However, in a study by MacKain and Streveler (1990), which examined the effects of the SILS program, it was noted that participants who attended half of the scheduled sessions did show improvements. The difference could be due to the number of session that half equals for each program. In the treatment this study evaluated half of the session, as mentioned, was three while half of the SILS program sessions was 18. This means that half of the SILS program sessions were six times the amount of sessions as was half of the Mental Health Promotion, Recovery, and General Wellness program.
The results of this study also indicate that the greatest improvements were made in the area of general wellness, which includes recovery and coping skills. Similar results were found by studies of the IMR, WRAP, and SILS programs (Cook et al., 2009; MacKain et al., 1998; Mueser et al., 2006). Each of these programs indicated that overall wellness in patients had increased. Each treatment program also emphasized the use of psychoeducation and skill building exercises which may account for the similarities in effectiveness. However, this examination of the Mental Health Promotion, Recovery, and General Wellness program also found that minor improvements were found in the area of mental health knowledge. Only the results of the IMR program were paralleled to these since Mueser and associates (2006) did not find significant increases in knowledge either. While the Mental Health Promotion, Recovery, and General Wellness and the IMR programs are well structured they are also more flexible than the WRAP and SILS programs. This flexibility is seen as beneficial in many ways yet it may also result in less information retention on the part of the treatment members. More research needs to be done to analyse why some program produce more increases in knowledge than others.

In the field of mental health in a correctional environment the literature has made several suggestions that may promote increased improvements. Mueser and MacKain (2005) found that treatment programs available on a volunteer basis may develop a more cohesive group in a prison setting. MacKain and Streveler (1990) also suggest that a program given to offenders should be tailored to the activities available to them and to be situation appropriate. An example of this would be prompting the members to use privileges such as going out to the yard and using the phone when teaching them pro-social communication rather than teaching them that a shopping center is a good place to interact with new people. A third suggestion found in the literature is to have the program facilitators play an active role in skill building aspects of a treatment (MacKain & Streveler, 1990). This includes having the facilitators modeling and prompting skills and then consistently reinforcing members for their attempts at using the skill. The Mental Health Promotion, Recovery, and General Wellness program includes the use of all three of these ideas. The members in the program were all volunteers, the material was congruent to the environment, and the treatment facilitators used modeling, prompting, and positive reinforcement throughout the duration of the program.

Strengths and Limitations

There were several strengths to this study. Foremost, the flexibility and determination of the three program facilitators made the study possible. Although the program was delayed by almost a month the program facilitators were able to condense the program into six sessions that occurred up to three times a week. A second positive point is that there were three program facilitators. This meant that if one or even two of the facilitators were unavailable for one of the sessions the remaining facilitators could continue the program. The offenders’ willingness to participate in the program and evaluation process was another strength that aided this study.

Throughout the study a number of limitations noted. The most notable restriction was the delay in starting the program. This was due to security concerns yet it resulted in the compression of the treatment. This also lead to Participant Two not being able to complete the program which sequentially lead to the study not being able to conduct a Wilcoxon test to determine statistical significance. Another limitation was that only one measure was used to analyse changes in the participants. Using more scales could provide a clearer and more accurate description of the effectiveness of the treatment. Since the general wellness subscale was a Likert
scale it is also possible that the participants may not have accurately reported their improvements due to a possible response bias. Since the principle investigator of this study was also a program facilitator it is possible that these interpretations may be biased. However, the investigator’s involvement in the program may also have better enabled him to interpret the findings. Finally, the classroom was small, often overheated, and not oriented in a way that would promote group discussions.

**Multilevel Challenges**

Simply getting the treatment program started was a challenge because it was directed towards offenders on a subpopulation range. Offenders who live on a subpopulation range, like the four members of the group, are considered to be incompatible with all other offenders from the other ranges. Due to this incompatibility, it is difficult to move these offenders around the institution without them interacting with other offenders. This meant that more preparation had to go into determining when and where the program could be held. Unfortunately, this need for more planning led to the delay in starting the program.

**Client level.** Although the program was compressed into a fewer number of sessions the members were still taught and expected to learn the same material and skills. The shortened schedule made the program more intensive for the program participants.

**Program level.** The challenge at the program level was to provide the entire treatment to the offenders while still having enough time to complete this evaluation of the program. This meant reducing the number of sessions and yet by doing so the results of this study may not fully represent the program’s effectiveness.

**Organizational level.** At the organizational level the difficulty was being able to safely move the group members to the treatment location. Moving any number of subpopulation offenders around the institution could potentially compromise the security within the penitentiary.

**Societal level.** The problem faced at this level is the safety of the community. Offenders who receive less treatment may be more likely to re-offend once released. This can be interpreted into a possible increase in crime and decrease in public safety.

**Contributions to the Behavioural Psychology Field**

It is crucial to study the effects of all treatment programs so that the best practices for specific populations can be known. This thesis has contributed to the field of behavioural psychology by being the first study to provide empirically based data about the effectiveness of the Mental Health Promotion, Recovery, and General Wellness program. This study has found evidence to suggest that this treatment may be effective in increasing offenders’ mental health knowledge and general wellness. Also, this study has compiled the program information into a user-friendly manual that will assist future studies by ensuring consistent treatment is given across groups.


Future Research

It is recommended that further research be done on this program so that more evidence can be compiled to determine the effectiveness of the program. It would be beneficial for future studies to be conducted on the complete 11 session version of the program and for the studies to utilize other evaluation measures in addition to the MARG Scale. It is also recommended that the program continue to use the pre- and post-test procedure while providing the treatment. This could reinforce the results found in this and future studies.
References


Appendix A

Mental Health Awareness, Recovery, and General Wellness Scale

Date: ___________________________  ______

When completing this scale please be as honest as possible so that the results are reliable. This test will not be used against you in any way but rather is meant to evaluate the Mental Health Awareness, Recovery, and General Wellness program. To choose an answer you may put a check mark or an “X” on the blank space beside your answer, or circle the answer that you believe to be correct or that best describes you. Some questions may not apply to you. If you need help reading the questions, I will be available to read them to you. Thank you for your time and help. If you have any questions about the test feel free to ask at any time.

Mental Health Awareness Section

1) Mental health is defined as:
   _____ a) a constant feeling of contentment
   _____ b) a balance in all areas of your life (social, physical, spiritual, mental)
   _____ c) achieving a period of 12-18 months without a psychotic episode

2) Mental illness is:
   _____ a) a single, rare disorder
   _____ b) being crazy or out of your mind
   _____ c) a broad classification for many disorders

3) Severe mental illnesses can be caused by:
   _____ a) bad parenting
   _____ b) a physical and/ or chemical problem in the brain
   _____ c) severe mental illnesses can only be passed down genetically by parents
   _____ d) being infected by a person who already has a severe mental illness
4) Mental illness can disrupt a person’s ability to do all of the following except:
   _____ a) plan and schedule their time
   _____ b) relate to others and their environment
   _____ c) be a unique individual

5) What percentage of homeless people have severe mental illness:
   _____ a) 5%
   _____ b) 17%
   _____ c) 25%
   _____ d) 33%
   _____ e) 58%

6) How many people who have severe mental illnesses get treatment:
   _____ a) 15%
   _____ b) 30%
   _____ c) 60%
   _____ d) 85%

7) Who is most likely to get a mental illness:
   _____ a) poor and uneducated people
   _____ b) only those who have a parent with a mental illness
   _____ c) mental illness can affect anyone, regardless of intelligence or social class

8) Depression and Bipolar disorder are categorized as:
   _____ a) anxiety disorders
   _____ b) mood disorders
   _____ c) personality disorders
9) Panic attacks and Phobias are categorized as:
   _____ a) anxiety disorders
   _____ b) mood disorders
   _____ c) personality disorders
   _____ d) fear-based conditions

10) Schizophrenia refers to:
    _____ a) a mental illness that results in split personalities
    _____ b) a mental illness that may include symptoms of hallucinations, delusions, social withdrawal, and thought disorders
    _____ c) a mental illness that causes people to become dangerous and unpredictable
    _____ d) Schizophrenia is not a real disorder, it was made up to medicate uncooperative people

11) Post-traumatic stress disorder refers to:
    _____ a) a one-time reaction to a very difficult experience
    _____ b) an anxiety disorder that only affects people that are in the army
    _____ c) a recurring anxiety disorder resulting from an unexpected and traumatic event

12) A Phobia is:
    _____ a) a strong dislike for something or some activity
    _____ b) an irrational, illogical fear that has a powerfully intrusive effect on a person’s life
    _____ c) always being frightened easily or surprised by things

13) What is Cognitive-Behavioural Therapy, or CBT:
    _____ a) a form of treatment that looks at how thoughts and behaviours effect each other
    _____ b) lectures that give people detailed information about their mental illness and how they should behave
    _____ c) talking to people about your feelings so that you can get what you want
14) Clinical depression is:
_____a) severe feelings of worthlessness, sadness, and emptiness that lasts for weeks and begins to interfere with a person’s work and social life
_____b) sadness or disappointment
_____c) depression brought on by frequent trips to a dental clinic or hospital

15) Stigma refers to:
_____a) societal prejudice against certain people that can prevent them from speaking out or seeking help
_____b) a plan of treatment agreed to by a patient and doctor
_____c) what most people think about others that is typically based on some truth

16) The anxiety disorder involving persistent thoughts, ideas, or images and repetitive behaviours is called:
_____a) repetitive syndrome
_____b) panic disorder
_____c) persistent mind disorder, or PMD
_____d) obsessive-compulsive disorder, or OCD

17) The exact cause of ADHD is not known but the following are all considered to be possible causes except what:
_____a) chemical imbalance in the brain
_____b) poor parenting skills
_____c) genetic factors
_____d) smoking during pregnancy
18) What does it mean to be assertive:
   _____ a) getting what you want by any means possible
   _____ b) getting your needs met without violating anyone else’s rights or needs
   _____ c) being assertive is the same thing as being aggressive but just a nicer way of saying it
   _____ d) finding a way to stay out of the way

19) It is safe for women to drink alcohol early in their pregnancy as long as they stop during the last two or three months:
   _____ True
   _____ False

20) Although the exact cause of ADHD is not known, a major role in children developing ADHD is sugar, food colouring, and other food preservatives:
   _____ True
   _____ False

21) Studies indicate a genetic link to brain disorders:
   _____ True
   _____ False

22) The medical term for split personal is Schizophrenia:
   _____ True
   _____ False

23) Violence is often associated with mental illness:
   _____ True
   _____ False
24) There are not many treatments out there for mental illness:
   _____ True
   _____ False

Recovery and General Wellness Section

25) In the past 3 months I have come up with:

<table>
<thead>
<tr>
<th></th>
<th>a)</th>
<th>b)</th>
<th>c)</th>
<th>d)</th>
<th>e)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No personal goals</td>
<td>A personal goal but have not worked on it</td>
<td>A personal goal and worked on it a little</td>
<td>A personal goal and have worked on it quite a bit</td>
<td>A personal goal and have finished it</td>
<td></td>
</tr>
</tbody>
</table>

26) How much do you feel like you know about your symptoms, treatment, coping strategies, and medication: (if you do not have a mental illness then this refers to any ongoing problem such as anger, racing thoughts, or negativity)

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<thead>
<tr>
<th></th>
<th>a)</th>
<th>b)</th>
<th>c)</th>
<th>d)</th>
<th>e)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not very much</td>
<td>A little</td>
<td>Some</td>
<td>Quite a bit</td>
<td>A great deal</td>
<td></td>
</tr>
</tbody>
</table>

27) On average how much time do you spend doing ADL’s (Activities of Daily Living) such as exercise, cleaning, grooming, working, hobbies, socializing, and spirituality:

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<th>a)</th>
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<th>e)</th>
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</thead>
<tbody>
<tr>
<td>2 hrs. or less a week (20 min. or less a day)</td>
<td>3 – 5 hrs. a week (30 – 45 min. a day)</td>
<td>6 – 15 hrs. a week (50 min. – 2 hrs. a day)</td>
<td>16 – 30 hrs. a week (2 hrs. &amp; 15 min. – 4 hrs. &amp; 30 min. a day)</td>
<td>More than 30 hrs. a week (more than 4 hrs. &amp; 30 min. a day)</td>
<td></td>
</tr>
</tbody>
</table>

28) How much do your symptoms bother you: (if you do not have a mental illness then this refers to any ongoing problem such as anger, racing thoughts, or negativity)

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<th>a)</th>
<th>b)</th>
<th>c)</th>
<th>d)</th>
<th>e)</th>
</tr>
</thead>
<tbody>
<tr>
<td>They bother me a lot</td>
<td>They bother me quite a bit</td>
<td>They somewhat bother me</td>
<td>They bother me very little</td>
<td>They do not bother me at all</td>
<td></td>
</tr>
</tbody>
</table>
29) How much do your symptoms get in the way of you doing the things that you want to or need to do: (if you do not have a mental illness then this refers to any ongoing problem such as anger, racing thoughts, or negativity)

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<td>b)</td>
<td>c)</td>
<td>d)</td>
<td>e)</td>
<td></td>
</tr>
<tr>
<td>They get in my way a lot</td>
<td>They get in my way quite a bit</td>
<td>They somewhat get in my way</td>
<td>They get in my way very little</td>
<td>They do not get in my way at all</td>
<td></td>
</tr>
</tbody>
</table>

30) Which of the following would best describe what you know and what you have done in order to avoid having a relapse: (if you do not have a mental illness then this refers to any ongoing problem such as anger, racing thoughts, or negativity)

<p>| | | | | | |</p>
<table>
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<tbody>
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<td>a)</td>
<td>b)</td>
<td>c)</td>
<td>d)</td>
<td>e)</td>
<td></td>
</tr>
<tr>
<td>I do not know how to prevent a relapse</td>
<td>I know a little but I have not made a relapse prevention plan</td>
<td>I know some things I can do but I do not have a written plan</td>
<td>I have several things I can do but I do not have a written plan</td>
<td>I have a written plan that I have shared with others</td>
<td></td>
</tr>
</tbody>
</table>

31) How well do you feel you are coping with your mental or emotional issues from day to day:

<p>| | | | | | |</p>
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<tbody>
<tr>
<td>a)</td>
<td>b)</td>
<td>c)</td>
<td>d)</td>
<td>e)</td>
<td></td>
</tr>
<tr>
<td>Not well at all</td>
<td>Not very well</td>
<td>Alright</td>
<td>Well</td>
<td>Very well</td>
<td></td>
</tr>
</tbody>
</table>

32) How well do you feel you are coping with your stress, anger, and frustration from day to day:

<p>| | | | | | |</p>
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<th></th>
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</thead>
<tbody>
<tr>
<td>a)</td>
<td>b)</td>
<td>c)</td>
<td>d)</td>
<td>e)</td>
<td></td>
</tr>
<tr>
<td>Not well at all</td>
<td>Not very well</td>
<td>Alright</td>
<td>Well</td>
<td>Very well</td>
<td></td>
</tr>
</tbody>
</table>

33) How often do you take your medications as prescribed:

<p>| | | | | | |</p>
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<thead>
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</thead>
<tbody>
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<td>a)</td>
<td>b)</td>
<td>c)</td>
<td>d)</td>
<td>e)</td>
<td>d)</td>
</tr>
<tr>
<td>Never</td>
<td>Occasionally</td>
<td>About half the time</td>
<td>Most of the time</td>
<td>Every day</td>
<td>I do not have prescribed medication</td>
</tr>
</tbody>
</table>

34) How would you describe your communication style:

<p>| | | | | | |</p>
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<thead>
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</thead>
<tbody>
<tr>
<td>a)</td>
<td>b)</td>
<td>c)</td>
<td>d)</td>
<td>e)</td>
<td></td>
</tr>
<tr>
<td>Aggressive</td>
<td>Aggressive and Assertive</td>
<td>Assertive</td>
<td>Assertive and Passive</td>
<td>Passive</td>
<td></td>
</tr>
</tbody>
</table>
35) When you have a problem with someone else how often do you think of different ways to deal with the problem:

<table>
<thead>
<tr>
<th>a)</th>
<th>b)</th>
<th>c)</th>
<th>d)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never I always go with the first thing that comes to mind</td>
<td>Occasionally I will think about a few solutions</td>
<td>Often I think about different solutions to the problem</td>
<td>I always first think about different ways to fix the problem</td>
</tr>
</tbody>
</table>

36) When I am angry I do deep breathing, try to relax, write about it, or do something that calms me down:

<table>
<thead>
<tr>
<th>a)</th>
<th>b)</th>
<th>c)</th>
<th>d)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never I focus on what made me angry</td>
<td>Sometimes I try to but it normally does not work</td>
<td>Most of the time I do and it tends to help</td>
<td>I always calm myself down before dealing with the issue</td>
</tr>
</tbody>
</table>

Created By:
Kaleb J. Verk
B.A.A. Behavioural Psychology
St. Lawrence College

Adapted from:


Appendix B

Correctional Services Canada Consent Form

<table>
<thead>
<tr>
<th>Correctional Service Canada</th>
<th>Service correctionnel Canada</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROTECTED</td>
<td>ONCE COMPLETED</td>
</tr>
</tbody>
</table>

NOTE: Reference documents
- CSC/SCC.4000-18e (2006-06) (Word Version)
- Correctional Services Canada Consent Form

PERSONAL INFORMATION BANK
- PUT AWAY ON FILE
- Original = Offender PY file

PPS Number

Family name

Given name(s)

Date of birth

CONSENT TO PARTICIPATE IN INSTITUTIONAL OR COMMUNITY MENTAL HEALTH SERVICES

Institution / Parole Office

Region

Completing Operational Unit

I consent to participate in:

☐ Clinical Discharge Planning Services

☐ Community Mental Health Specialist Services

☐ Individual therapeutic intervention (specify)

☐ Group therapeutic intervention (specify)

The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me. I understand that I am free to withdraw from participation in this service at any time that I choose.

Limitations of Confidentiality

I understand that professional confidentiality regarding my mental health files will be maintained by my health services team. However, there are certain limitations to that confidentiality which are set out below. I understand that mental health staff will consult with my Case Management Team and with other members of the Mental Health Care Team throughout my involvement in this process. I understand that formal reports will be copied to the Psychology File, Health Care File, the Case Management File, National Parole Board and on the Offender Management System (OMS).

I understand that there are specific and limited exceptions to confidentiality which include the following:

A) When there is a risk of imminent danger to myself or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.

B) Where any disclosure is made by me to a member of my health services team regarding any previously unreported offence, the clinician is legally required to inform the appropriate authorities.

C) When there are suspected cases of child abuse the clinician is legally required to inform the proper authorities.

D) In some cases, the clinician may be required by federal or provincial legislation to release personal information from my mental health or other files.

Signature of Offender

Date (YYYY-MM-DD)

Witness (print name)

Witness signature

Date (YYYY-MM-DD)

Distribution

Copy

Offender HC file
Appendix C

Consent Form: Evaluating the Treatment Program

**TITLE:** Examining the Effectiveness of a Mental Health Awareness and Recovery Group in a Maximum Security Prison

**STUDENT:** Kaleb Verk

**COLLEGE SUPERVISOR:** Marie-Line Jobin

**Invitation**

I am a student in my 4th year in Behavioural Psychology at St. Lawrence College and I am currently on placement in the Psychology Department here at Kingston Penitentiary. As a part of this placement I need to complete a project called an Applied Thesis and I am asking for your assistance to complete this project. The information in this form is intended to help you understand my project so that you can decide whether or not you want to participate. Please read the information below carefully and ask any questions you have before deciding if you want to participate.

**WHAT IS THE PURPOSE OF THE PROJECT?**

The purpose of this project is to help determine how effective the Mental Health Awareness, Recovery, and General Wellness Group is for teaching information and building skills.

**WHAT WILL YOU NEED TO DO IF YOU TAKE PART?**

You will be asked to regularly attend the group sessions, which are scheduled for Tuesdays and Thursdays at 1:00 pm. The sessions will be one to two hours in length. You will also be asked to complete the Mental Health Awareness, Recovery, & General Wellness Scale at the beginning and at the end of the group. For this you will be given as much time as needed to complete. Also you will be asked to complete small homework assignments between group sessions, for the next session.

**WHAT ARE THE POTENTIAL BENEFITS TO YOU BY TAKING PART?**

The potential benefits of participating in the group include learning about various mental health needs and building skills that will help in the process of recovery and overall wellness. This group is made to benefit those with or without a mental disorder; since most of us at least know someone who has mental health needs and we all can improve our general wellness.

**WHAT ARE THE POTENTIAL BENEFITS TO OTHERS BY YOU TAKING PART?**

Your participation will not just benefit yourself but also others. The results of this project may indicate that the group is helpful and so the group will be more likely to continue and become helpful to other offenders. If the results show that this group is not effective then the group can be modified to become more beneficial.
**WHAT ARE THE POSSIBLE DISADVANTAGES AND RISKS TO YOU BY TAKING PART?**

There are only minimal risks of participating in this project. You may feel uncomfortable in the group setting or experience frustration when practicing the skills taught in the group.

**WHAT HAPPENS IF SOMETHING GOES WRONG?**

Since everyone is different it is possible you may experience some emotional responses to the group or the test. If this happens you may talk to myself or one of the staff leading the group. If you no longer want to participate in the group, complete the questionnaires, or homework you may withdraw from the project. If you withdraw from the project, this decision will not in any way be held against you and will not affect the services provided to you by Kingston Penitentiary.

**WILL MY TAKING PART IN THIS PROJECT BE KEPT PRIVATE?**

Your participation in this project will be kept private unless required by law. However it will be recorded on your file that you did participate in this project but your results will not be. To ensure that your name or FPS number will not be recorded on the tests and certain homework assignments I will assign a random number to you. This will also enable me to compare your results without other people knowing your results. A copy of this consent form will be given to you for your own purposes. A copy will be kept in your file in a locked filing cabinet, in a locked file, in the psychology department. Another copy of this consent form will be kept in the locked office of the principal investigator of this project, in a locked filing cabinet. Any information kept on a computer will be password protected. All data will be kept for 7 years. Every attempt to keep your information private will be made.

**DO YOU HAVE TO TAKE PART?**

It is up to you to decide whether or not to take part. If you do decide to take part, you will be asked to sign this consent form. If you do decide to take part, you are still free to withdraw at any time, without giving any reason, and without having the services given to you by Kingston Penitentiary affected in any way. If you decide to not participate in this study or decide to withdraw you may still participate in the group.

**CONTACT FOR FURTHER INFORMATION.**

This project has been approved by the Research Ethics Board at St. Lawrence College. The project will be developed under the supervision of Marie-Line Jobin, my supervisor from St. Lawrence College. I really appreciate your cooperation and if you have any additional questions or concerns, feel free to ask me, Kaleb Verk, or you can contact my College Supervisor at mjobin@sl.on.ca. You may also contact the St. Lawrence College Research Ethics Board at appliedresearch@sl.on.ca.

**CONSENT**

If you agree to participate in the project, please complete the following form and return it to me as soon as possible. A copy of this signed document will be given to you for your own records. An additional copy of your consent will be retained at the agency and in a secure location with the Research Ethics Board at St. Lawrence College.
CONSENT

By signing this form, I agree that:

- The study has been explained to me.
- All my questions were answered.
- Possible harm and discomforts and possible benefits (if any) of this study have been explained to me.
- I understand that I have the right not to participate and the right to stop at any time.
- I am free now, and in the future, to ask any questions about the study.
- I have been told about the limits of confidentiality that apply to my personal information.
- I understand that no information that would identify me will be released or printed without asking me first, with the exception of notes made for my record.
- I understand that I will receive a signed copy of this consent form.

I hereby consent to participate.

Signature: ____________________________  Date: ____________

Printed Name: ________________________

SLC Student Signature: ________________  Date: ____________

Printed Name: ________________________
Appendix D  

Consent Form: Assessing the Scale

**TITLE:** Assessing the Reliability of the Mental Health Awareness, Recovery, and General Wellness Scale

**STUDENT:** Kaleb Verk

**COLLEGE SUPERVISOR:** Marie-Line Jobin

**Invitation**

I am a student in my 4th year in Behavioural Psychology at St. Lawrence College and I am currently on placement in the Psychology Department here at Kingston Penitentiary. As a part of this placement I need to assess the reliability of the Mental Health Awareness, Recovery, and General Wellness Scale. The information in this form is intended to help you understand my project so that you can decide whether or not you want to participate. Please read the information below carefully and ask any questions you have before deciding if you want to participate.

**WHAT IS THE PURPOSE OF THE PROJECT?**

The purpose of this project is to assess the reliability of the Mental Health Awareness, Recovery, and General Wellness Scale. The reliability of a test refers to how consistent it is. This means one person should get the same results on the test every time they take it, as long as the person has not changed. If the test is found to be reliable then it can be used to help determine how effective the Mental Health Promotion, Recovery, and General Wellness group is.

**WHAT WILL YOU NEED TO DO IF YOU TAKE PART?**

You will be asked to complete the Mental Health Awareness, Recover, and General Wellness Scale twice. You will be asked to complete the scale at this time, if you sign this consent form, and to complete it once again in a week from now.

**WHAT ARE THE POTENTIAL BENEFITS TO BY TAKING PART?**

You will have helped in the process of determining the reliability of the scale.

**WHAT ARE THE POSSIBLE DISADVANTAGES AND RISKS TO YOU BY TAKING PART?**

There are no known risks to you by completing the scale.

**WILL MY TAKING PART IN THIS PROJECT BE KEPT PRIVATE?**

Your participation in this project will be kept private unless required by law. However it will be recorded on your file that you did participate in this project but your results will not be. To ensure that your name or FPS number will not be recorded on the tests and certain homework assignments I will assign a random number to you. This will also enable me to compare your results without other people knowing your results. A copy of this consent form will be given to you for your own purposes. A copy will be kept in your file in a locked filing cabinet, in a locked file, in the psychology department. Another copy of this consent form will be kept in the locked office of the principal investigator of this project, in a locked filing cabinet. Any information
kept on a computer will be password protected. All data will be kept for a 7 years. Every attempt to keep your information private will be made.

**DO YOU HAVE TO TAKE PART?**

It is up to you to decide whether or not to take part. If you do decide to take part, you will be asked to sign this consent form. If you do decide to take part, you are still free to withdraw at any time. If you withdraw you do not need to give any reason and the services provided to you by Kingston Penitentiary will not be affected by this in any way.

**CONTACT FOR FURTHER INFORMATION.**

This project has been approved by the Research Ethics Board at St. Lawrence College. The project will be developed under the supervision of Marie-Line Jobin, my supervisor from St. Lawrence College. I really appreciate your cooperation and if you have any additional questions or concerns, feel free to ask me, Kaleb Verk, or you can contact my College Supervisor at mjobin@sl.on.ca. You may also contact the St. Lawrence College Research Ethics Board at appliedresearch@sl.on.ca.

**CONSENT**

If you agree to participate in the project, please complete the following form and return it to me as soon as possible. A copy of this signed document will be given to you for your own records. An additional copy of your consent will be retained at the agency and in a secure location with the Research Ethics Board at St. Lawrence College.
CONSENT

By signing this form, I agree that:

- The study has been explained to me.
- All my questions were answered.
- Possible harm and discomforts and possible benefits (if any) of this study have been explained to me.
- I understand that I have the right not to participate and the right to stop at any time.
- I am free now, and in the future, to ask any questions about the study.
- I have been told that my personal information and test results will be kept confidential.
- I understand that no information that would identify me will be released or printed without asking me first.
- I understand that I will receive a signed copy of this consent form.

I hereby consent to participate.

Signature: ____________________________ Date: ____________

Printed Name: _______________________

SLC Student Signature: ________________ Date: ____________

Printed Name: _______________________


Appendix E

Mental Health Promotion, Recovery, and General Wellness Manual

In other document
### Appendix F

Reliability Testing Answers for Each Participant

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<tbody>
<tr>
<td>Q1</td>
<td>B</td>
<td>B</td>
<td>B</td>
<td>A</td>
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Note: A blank space= no answer given to specific question, More than one letter in a space= more than one answer given to specific question, Q= question, 10.T= Participant 10 test, 10.RT= Participant 10 re-test, 11.T= Participant 11 test, 11.RT= Participant 11 re-test, etc.
Appendix G

Pre- and Post-test Treatment Answers for Each Member

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Note: Q= question, 1 Pre= Participant One pre-test, 1 Post= Participant One post-test, 3 Pre= Participant Three pre-test, 3 Post= Participant Three post-test, etc.