Service Delivery Guidelines for Offenders with Medium/Moderate Mental Health Needs

By

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The procedures in the best-practice guidelines are meant to be used by agency staff, as part of the broader services they provide, or under supervision of agency staff.
Dedication

This thesis is dedicated foremost to my parents, Tammy and Leigh Knox. I appreciate everything you have done for me and without your constant support these past four years I would not have been able to come as far as I have. I also dedicate this thesis to my incredible partner, Greg, my brothers Tavis and Brady and, of course, my adorable dog, Marley. Your love and enduring support have been astounding and this thesis would not be possible without all of you.
Abstract

Offenders who are diagnosed with a mental illness have various mental health needs, and benefit from different treatment options and levels of service. Individuals who are incarcerated often do not receive the support or services they require to be successful in coping with their mental illnesses. At the time of this thesis, Correctional Service Canada (CSC) lacked mental health care services that met the broad range of mental health needs presented by offenders. In an effort to address the mental health needs within CSC, service delivery guidelines in the form of best-practice guidelines were designed for the institutional mental health staff, focusing on the Moderate Intensity Intermediate Care Unit (MIICU). The goal is to aid in helping address the gaps in services provided to offenders with mental illnesses and who need enhanced services, as well as to provide the institutional mental health staff with guidance regarding delivery of mental health services within the MIICU. The final product for these guidelines combines information regarding the MIICU, including the definition of the MIICU, admission criteria, process, diagnostic assessments, required staff and proposed additional staffing, services available and the required note taking processes. Evidence based practices from the literature were reviewed in order to design guidelines that complemented existing practices within CSC while also addressing the gaps in mental health services. It was hypothesized that, through the use of the service delivery guidelines, the institutional mental health staff will be successful in providing effective mental health services to offenders with medium/moderate mental health needs and who require enhanced services. This thesis focused on the development of the guidelines and not its implementation. This was a major limitation to the thesis; therefore, a recommendation for future research would be the empirical testing of the guideline to determine its efficacy in providing effective mental health services to offenders with medium/moderate intensity mental health needs. The development of the guidelines was guided by empirical literature and changes to the content were made based on feedback from the institutional mental health staff. Further recommendations, limitations, and implications for the field of behavioural psychology are also discussed within the thesis.
Acknowledgements

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Chapter I: Introduction

Overview
Throughout the years, the prevalence of mental illness has increased within the Canadian population (Simpson, Meadows, Faces, & Patten, 2012). In fact, approximately 20% of Canadian individuals will experience mental health issues during their lives (Health Canada, 2002). Wilton and Stewart (2012) report that mental illnesses are more common within correctional settings compared to the general population. The number of offenders with mental illness who enter Canadian federal correctional facilities has doubled over the past decade (Ennis, McLeod, & Watt, 2014).

The high number of offenders diagnosed with a mental illness has led to a demand for more effective and relevant mental health intervention programs (Pomeroy, Kiam, & Green, 2000). Individuals in correctional settings present with a broad range of mental health needs that can be classified as low, medium/moderate, and high intensity, as well as no need. These different levels of intensity create unique challenges to service delivery. Findings from a study conducted by Hunt, Peters, and Kremling (2015) indicate that there is a significant gap between the needs of offenders with mental illnesses and the mental health care they receive or are provided with while in correctional facilities.

Purpose
Federal correctional facilities provide a host of relevant services to address the mental health issues that inmates experience; however, in order to be effective, the treatment being provided should be tailored to each individual’s specific level of mental health needs (Day, Bryan, Davey, & Casey, 2006). Currently, Correctional Service Canada (CSC) provides primary care services, which are geared towards lower need offenders. They also provide treatment in the form of psychiatric hospitalization to inmates who have acute mental health and/or chronic, significant mental health needs through the Regional Treatment Centres (RTC). Historically, treatment has focused on acute and serious mental health needs; however, CSC aims to supplement service delivery in order to meet the needs of those with medium/moderate intensity mental health needs as well.

Previous research shows the benefits of providing health care services to offenders who have mental health issues. However, there is a lack of research demonstrating the benefits of providing health care services that are tailored to the offender’s specific mental health needs. Therefore, in an effort to address these service delivery issues, it was determined that developing best-practice guidelines would be helpful in order to assist and guide the institutional mental health staff. The best-practice guidelines will be designed to complement the existing practices within CSC while also addressing the current gaps in mental health care services. The guidelines will support staff in the delivery of mental health care services provided to offenders with medium/moderate mental health needs. The best-practice guidelines will outline the services provided on the Moderate Intensity Intermediate Care Unit (MIICU) and will contain information regarding the different components within the MIICU. This includes the definition, admission criteria and process, diagnostic assessments, required staff and proposed additional staffing, services available (e.g., general health care services, therapeutic interventions, and psychiatric services), and the required note-taking process.
The following chapter will review the relevant literature regarding offenders with mental illnesses. This review will include prevalence rates of mental illnesses within the Canadian population, as well as within the offender population. It will also explore the literature that demonstrates various treatments shown to be effective within the offender population, as well as what treatments are currently available within institutions for offenders with mental illnesses. Following the literature review section, the method and procedure for creating the manual will be discussed. Next, an overview of the results will include the presentation of the best-practice guidelines manual. Subsequently, the discussion section will include a review of the strengths and limitations, future recommendations, as well as the manual’s contribution to the field of behavioural psychology.
Chapter II: Literature Review

Best Practice Guidelines

Best-practice guidelines have become increasingly well known to clinical practices and health care professionals over the past decade (Woolf, Grol, Hutchinson, Eccles, & Grimshaw, 1999). Best-practice guidelines, also known as clinical practice guidelines, encompass sets of recommendations and “statements to assist practitioner and patient decisions about appropriate health care” (Czaja & Carson, 2015; Woolf et al., 1999, p. 527). They serve as a resource that clinicians and health care professionals can refer to in order to receive advice and suggestions for their practice that is based on the most recent, effective, and scientifically-based evidence (Czaja & Carson, 2015; Woolf et al., 1999). Adhering to best-practice guidelines create potential benefits for both patients and health care professionals. Woolf et al. (1999) mention that the overall benefit for following best-practice guidelines is improvement in the quality of care received by patients. While it is recognized that it is beneficial for health care professionals to utilize best-practice guidelines to provide patients with the best quality of care, the body of scientific literature available continues to grow. As a result, health care professionals struggle to remain up to date with and provide treatments that have been shown to be effective (Czaja & Carson, 2015). Therefore, it is beneficial for health care professionals to utilize best-practice guidelines to provide patients with the best quality of care.

Prevalence Rates

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) defines a mental disorder, or a mental illness, as “a syndrome characterized by clinically significant disturbances in an individual’s cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning” (American Psychiatric Association, 2013, p. 20). According to Arboleda-Flórez (2005), 21% of Canadians are affected by a mental illness at some point in their lives. In Canada alone, various types of mental illnesses have influenced the lives of 11.1% of Canadians over the course of one year (Arboleda-Flórez, 2005).

Mental illness not only affects the general population, but also impairs the lives of incarcerated inmates. Results of a meta-analysis conducted by Fazel and Danesh, in 2002, suggest that offenders are more likely to have a psychotic illness, personality disorder, or major depression than the general population. In 2006, the Bureau of Justice Statistics (BJS) published a report highlighting the mental health problems of prison and jail inmates (James & Glaze, 2006). In 2005, more than 50% of inmates reported a mental health problem. This figure is notable since the BJS stated that only 16% of inmates met the criteria for a mental health problem in 1999 (Ditton, 1999). This reported frequency of mental health issues in prison systems reflects a dramatic increase in the prevalence of mental illness. Ennis, McLeod, and Watt (2014) conveyed that over the past decade, the rate of offenders with mental illnesses entering Canadian federal correctional facilities has doubled, with an increase from 13% to 29% for women and 7% to 13% for men.

Estimates of mental illnesses have been found to be the highest among offenders within the Canadian federal correctional system (Brink, Doherty, & Boer, 2001). Beaudette, Power, and Stewart (2015) suggest that the majority of offenders in Canadian federal correctional
systems meet the criteria for a mental illness. They developed a study to establish the percentage of male offenders with mental illnesses who are newly admitted to CSC. During this study the following disorders were assessed: 1) psychotic, 2) anxiety, 3) mood, 4) substance abuse, 5) borderline personality disorder (BPD), and 6) antisocial personality disorder (APD). According to the results, alcohol and substance abuse disorders accounted for the highest percentage; however, posttraumatic stress disorder (PTSD), BPD and psychotic disorders were roughly similar. These results also showed that about half of CSC offenders met the criteria for a mental illness other than alcohol or substance abuse and APD. Specifically, the national percentage of offenders diagnosed with bipolar disorder, psychotic disorder, and major depression was 12.4%. It was also suggested by Fazel and Danesh (2002) that being diagnosed with schizophrenia is ten times more likely to occur within the prison system than in the general population. Beaudette et al. (2015) concluded that the overall percentage for any type of mental illness occurring within CSC ranges from 78% to 88%. It is rare that offenders who are incarcerated within CSC have only one mental illness diagnosis. Beaudette et al. (2015) suggests that there are a great number of offenders who meet the criteria for concurrent disorders. The term concurrent disorder refers to a combination of mental health and substance abuse problems (Canadian Centre on Substance Abuse [CCSA], 2009). In February 2015, it was said that 33% to 44% of offenders met the criteria for a concurrent disorder (Beaudette, Power, & Stewart, 2015).

These research results and statistics suggest that mental illness is common within prison systems and that the prevalence rates are higher compared to past years. They highlight the presence of multiple diagnoses among offenders within CSC. Therefore, CSC is posed with the challenge to provide the necessary mental health care services to the high percentage of offenders with mental health problems in order to appropriately meet each offender’s mental illness needs.

Equivalence of Care

Individuals who are incarcerated should not be deprived of the same level of access to health care services as is available in the community. More specifically, offenders should have “access to the same quality and range of health services as the general public receives from the National Health Service” (Prison Service & NHS Executive, 1999, p. 5). This quote helps explain the principle “equivalence of care.” Equivalence of care is a principle in which health services within prison systems are required to provide offenders with health care that is equivalent to the quality and assortment provided to the general population (Niveau, 2007). Despite the type of environment, the purpose for delivering mental health services in both community and correctional settings are to empower persons with mental illness or co-occurring disorders to attain their maximum level of crime-free employment, self-care, interpersonal relationships, and participation in the community or prison population (Powitzky, 2011).

Persons who have mental illnesses are over-represented within the prison population (Lamberti et al., 2001). Therefore, it is important to provide offenders with access to high quality and various ranges of mental health services that are tailored to their individual level of mental health needs, and equivalent to the quality of service that they would receive in the general population (Lamb & Bachrach, 2001; Lamberti et al., 2001). At the moment, the literature and available services available focus on offenders with mental illnesses that present
with acute needs or low needs, not offenders with moderate mental health needs. These gaps create difficulty for CSC when attempting to adhere to the equivalence of care principle.

**Mental Health Services**

Currently within CSC, there are appropriate mental health care services for two types of populations (Correctional Service Canada, 2015). The first type of service is for offenders who have acute mental health concerns, reside in a hospital setting, and require a clinical environment that provides 24-hour patient care coverage. The second is for offenders with minimal mental health concerns and who are able to function in a primary care setting. This involves living in the institution’s general population and only requiring some assistance and monitoring. However, CSC has recently identified a gap between the mental health care services that are provided and the mental health needs of offenders. Specifically, there were no services available to offenders whose mental health concerns do not require admission to an institution’s psychiatric hospital (e.g., RTC) but whose needs exceed the services available through primary care. Soderstrom (2007) mentioned that it is common for offenders to be either over treated or undertreated. One reason for this is because of the identified gap in the mental health services provided within prison systems. Because of this identified gap, CSC’s efforts to determine how to maximize the effectiveness of mental health care services are high (Beaudette et al., 2015).

In order to maximize the effectiveness of mental health care provided to offenders, it is important for CSC to adhere to the equivalence of care principle. To achieve this, services provided within institutions are required to match the quality and variety of services provided within the general population (Cohen & Dvoskin, 1992; Niveau, 2007). Both the community and correctional mental health delivery systems serve the same type of population (Powitzky, 2011). Within the institution’s general population, individuals with mental health concerns who require more assistance then provided by outpatient services but who do not meet the requirements to be hospitalized can be assisted through community residences (Cohen & Dvoskin, 1992).

Community residences integrate therapeutic approaches from both services provided within psychiatric hospitals and outpatient facilities. Studies have shown that these residences improve the quality of life for individuals because they allow for them to be housed in a safe environment, as well as provide therapeutic programming (e.g., psychoeducation, medication and symptom management, and pharmacological support) (Cohen & Dvoskin, 1992). Therefore, in order to appropriately adhere to the equivalence of care principle, CSC should provide a service within prison systems that is equivalent to the community residencies in the general population.

Many researchers support the idea of developing ways to provide mental health care services to individuals who are mentally ill by integrating multiple approaches that have been proven effective (Lamberti et al., 2001). The effectiveness of interventions and treatments provided through psychiatric hospitalization and primary care to offenders who are mentally ill has been shown through recent research studies. Common mental health services that are provided through institution’s primary care include medication, individual and group therapy, social skills training, cognitive-behavioural therapy, anger management, and problem solving programming (Blackburn, 2004). Previous studies suggest these interventions are effective when
used with offenders who have mental disorders, given their needs are complex (Martin, Dorken, Wamboldt, & Wootten, 2012). One study conducted by Frances (1996) examined offenders who were diagnosed with schizophrenia. The participants presented with different levels of severity, symptoms, and needs. The results of the study supported Frances’ original hypothesis stating that depending on an individual’s mental health need, they will benefit more from being provided services within a hospital setting or through outpatient services. McGuire (2002) demonstrated the effectiveness of providing psychological interventions to offenders with mental illnesses. The results from this study showed that, by providing various types of psychological interventions to offenders with mental illnesses, their overall mental health improves the likelihood of recidivism decreased by thirty percent.

Offenders are susceptible to experiencing negative feelings including, but not limited to, anxiety, frustration, anger, depression, sleep disturbances, and fatigue during their sentence (Hek, 2006); however, not every offender presents with the same symptoms, level of severity, or level of mental health need. Therefore, a variety of intervention strategies that have been proven effective in the past should be readily available to treat a range of possible mental health symptoms and severities. Findings from Pomeroy, Kiam, and Green’s (2000) study illustrated that, by providing psychoeducational group interventions to inmates who have a mental illness and who also experience additional feelings of anxiety and/or depression, it was effective in reducing the symptoms while also increasing their knowledge of their mental illness.

Persons with serious mental illness in prison are treated through psychiatric hospitalization, which includes treatment plus a protective environment to live in (Sawyer & Moffitt, 2011). The treatment offered within this environment should parallel those found in the general population for individuals who have serious mental illnesses (Sawyer & Moffitt, 2011). Equivalent to services delivered in the community, the ideal role for patient care provided to offenders in this type of environment is stabilization (Sawyer & Moffitt, 2011). There are many services provided to offenders who reside in an institution’s psychiatric hospital that enable them to cope with their mental illnesses. These services include stabilization, medication management, pharmacological support (e.g., psychotropic medication), and crisis intervention. It would be ideal for psychological treatment including skills training, cognitive therapy, and psychoeducation to also be provided within this environment in effort for the offenders to acquire to skills and abilities needed to return successfully to the community upon release (Sawyer & Moffitt, 2011). However, due to the lack of resources available within the institution’s psychiatric hospital (e.g., staffing, funding, and spacing to run interventions), the accessibility of these interventions and treatments are limited (Blackburn, 2004).

It would be advantageous for health care professionals and mental health care systems if every offender presenting with a mental illness were able to live independently; however, no single type of housing environment suits the large number of offenders with mental health concerns (Lamb & Bachrach, 2001). Therefore, it is essential to respond to the living and environment needs of this population type. Many offenders are able to manage their mental illness while living independently; however, many other offenders require a structured environment, with the potential of locked facilities (Lamb & Bachrach, 2001). It is essential that the individuals who require structured environments do not get overlooked.
Summary

The prevalence rates of inmates with mental illnesses in federal correctional facilities are high and the demand for effective and relevant mental health care is increasing. The majority of offenders within Canadian federal correctional systems meet the criteria for a mental illness (Beaudette et al., 2015). It has been well established through recent studies that the prevalence rates of offenders with mental illnesses residing in prison systems compared to those residing in the general population is higher and that these offenders present with a full range of mental health severities and needs (Fazel & Danesh, 2002; Hassan et al., 2011). With the understanding that the percentage of inmates with mental illnesses admitted to CSC has doubled over the past decade, the challenges CSC faces with providing the necessary mental health services to appropriately treat these offenders are considerable (Beaudette et al., 2015; Ennis et al., 2014).

While CSC has a number of programs and services in place to address the various types of mental illnesses, there is still a need for specific approaches to address the individual needs levels of each offender’s mental health. The results of the studies within this literature review demonstrate that individuals who are diagnosed with mental illnesses have different needs levels and benefit from varied treatment approaches. Specifically, offenders with minimal mental health needs may benefit from being provided mental health services through primary care, but offenders with more acute mental illnesses and higher mental health needs may benefit from services provided within a clinical environment. However, gaps in mental health services and within the literature make it difficult to understand what services would benefit offenders who fall in between those specific need levels. Specifically, those who present with chronic or sub-acute mental health conditions with symptoms that are moderate but cannot be addressed through primary care yet also do not require admission to a hospital. Characteristics of treatments that have been shown to be effective for treating offenders who present with mental illnesses are availability, accessibility, high quality and equivalence (Forrester, Maclellan, Slade, Brown, & Exworthy, 2014). These qualities should be utilized in order to effectively treat offenders with mental illnesses.

Based on this literature review, best-practice guidelines will be developed to provide institutional mental health staff with guidance regarding delivery of services that accommodate those offenders who do not meet the requirement for primary care or psychiatric hospitalization. Currently, CSC is calling this type of service the “Moderate Intensity Intermediate Care Unit” (MIICU). The development of the best-practice guidelines will be designed to complement existing practices within CSC, while also addressing the gaps in services but emphasizing the importance of tailoring treatments to individual mental health needs.
Participants

The best-practice guidelines are intended for use by institutional mental health staff within Correctional Services Canada (CSC); however, other staff members are encouraged to utilize it as a reference. It is recommended that the staff using the guidelines have a working knowledge of various types of mental illnesses, cognitive behavioural treatments, and should be familiar with the needs of the offenders prior to using the guidelines.

The best-practice guidelines were designed according to relevant literature; therefore, no human participants were involved in the creation of the guidelines. The best-practice guidelines are designed for implementation with adult, federally sentenced, male offenders (18 years of age and above), who present with chronic or sub-acute mental health conditions with moderate symptoms that cannot be adequately addressed through primary care but do not require admission to a hospital.

The anticipated offenders are identified by mental health staff at their parent institutions. Referral to the MIICU will include the completion of CSC’s Psychiatric Hospital and Intermediate Care Referral form (a modified version of CSC/SCC 1479- regional treatment centre referral form) and a completed Mental Health Needs Scale (MHNS). The referral for admission will be reviewed by the mental health intermediate care team at the receiving institution.

Design

The best-practice guidelines were developed by the author during a 14-week field placement at CSC as part of an applied thesis in the Bachelor of Applied Arts in Behavioural Psychology degree program. The manual contains information regarding the components of the MIICU, including the definition, referral process, admission criteria and process, diagnostic assessments, required staff and proposed additional staffing, services available (e.g., general health care services, therapeutic interventions, and psychiatric services), consent procedures, required note-taking process, the capacity of the unit and specific types of beds available, documentation and tracking services, and the discharge process. Providing these components within the guidelines will aid mental health staff to provide the appropriate amount of support to offenders based on their individual mental health needs. The setting in which the best-practice guidelines may be used is within the MIICU and mental health services. The use of the best-practice guidelines should be based on offenders identified mental health needs indicated through the referral process and completion of the MHNS. It is anticipated that the offenders’ mental health needs will also be identified through on-going supervision from correctional staff, specifically program officers, parole officers, and/or mental health staff. Using the guidelines will act as a supplementary resource to staff within CSC, in an effort to attempt in increasing the effectiveness of treatment by tailoring mental health care services to offender’s specific mental health needs.

Rationale

The purpose of the best-practice guidelines is to provide the institutional mental health staff with guidance and information regarding delivery of mental health care within the MIICU.
The guidelines were designed with the potential for future development depending on the needs of CSC. The guidelines were developed in response to the increased number of offenders who have mental illnesses and who are either being under or over treated within CSC. They serve to address the gaps in mental health care services provided to offenders who are diagnosed with mental illnesses. CSC’s service delivery has, in the past, focused on providing lower need offenders with primary care and providing services to offenders with acute/serious mental health needs through the Regional Treatment Centre (RTC). It is important that CSC redefines their practice of delivering services in order to meet the needs of offenders with medium/moderate mental health needs.

Methodology

The information and services outlined in the best-practice guideline is to be utilized within the MIICU and are intended to be used by the mental health staff working in conjunction with the MIICU. The guidelines outline a number of services available for offenders residing in the MIICU, including correctional programs, educational opportunities (e.g., co-op), psychiatry clinics/consultations, individual counselling sessions, and various types of group counselling sessions. However, depending on the offender’s level of mental health needs, the amount of services that will benefit them will vary. Mental health staff is in charge of identifying which services outlined in the guidelines will best benefit specific offenders. The goal of the best-practice guidelines is to tailor mental health services to the level of mental health needs of offenders. Therefore, not all services outlined in the guidelines will be beneficial for every offender.

Confidentiality and Informed Consent

There is no additional confidentiality and informed consent required for the use of the best-practice guidelines. As noted previously, the developed guidelines are intended to complement existing practices within CSC and should meet the terms of the existing confidentiality and informed consent procedures. Therefore, it is understood that institutional mental health staff are aware of and will abide by CSC’s existing confidentiality and informed consent procedures and policies.

Feedback

Testing the efficacy of the manual was not within the scope of the current project; however, during the process of developing the guidelines the mental health staff at Bath Institution provided ongoing feedback on the design and content in order to create a resource that would best meet the needs of the staff and offenders within CSC. Co-facilitation during group counselling sessions and involvement with the MIICU also served to influence the creation of the manual. Due to time constraints, the efficacy of the resource manual within the agency was not formally evaluated.
Chapter IV: Results

Service Delivery Guidelines for the Moderate Intensity Intermediate Health Care Unit (MIICU) can be found in Appendix A. The service delivery guidelines were compiled in an effort to assist institutional mental health staff with guidance and information regarding delivery of mental health care within the MIICU. These guidelines were created to address the gaps in mental health care services provided to offenders who are diagnosed with mental illnesses. They were designed to complement the practices that currently exist within CSC by serving as a resource for correctional staff.

Various staff within Bath Institution reviewed the service delivery guidelines in order to provide feedback on the design and content. In general, the feedback indicated that the content of the guidelines was meaningful and it would be a useful resource within the institution. Based on the feedback given, minimal changes to the service delivery guidelines were made. Staff mentioned the following concerns after revising the original draft. First, it was suggested that the acronyms frequently used throughout the document should not be used but rather the full titles listed in order for the guidelines to be useful to all staff within CSC. This change would also allow for the guidelines to be presented in a more clear and concise way. In addition, slight changes were made to sentence structures, wording, and layout in order to maximize the guidelines presentation and usefulness.
Chapter V: Discussion

Thesis Summary

In order for offenders who are diagnosed with mental illnesses to receive effective mental health care and treatment within correctional facilities, it is essential that service delivery be tailored to their specific levels of mental health needs. The number of offenders diagnosed with a mental illness entering Canadian federal correctional facilities has increased over the past decade (Ennis, Mcleod, & Watt, 2014). Due to the high number of offenders with mental illnesses, the demand for effective and relevant mental health intervention programs is growing. It was identified through literature, staff, and experience that offenders show various ranges of mental health needs, which create unique challenges to service delivery. Research identifies significant gaps between the needs of offenders with mental illness and the mental health care they receive while in correctional facilities (Hunt, Peters, & Kremling, 2015). Currently, CSC provides primary care services to lower need offenders and care in the form of psychiatric hospitalization to offenders with acute and/or chronic significant mental health needs; however, CSC aims to supplement service delivery in order to meet the needs of offenders with medium/moderate intensity mental health needs.

In an effort to address the presenting challenges within the delivery of mental health care, best-practice guidelines were created. The best-practice guidelines outline the services available to offenders on the Moderate Intensity Intermediate Care Unit (MIICU) and contain the different components of the unit. It was assumed that the guidelines would aid correctional staff in their existing practices and result in delivering mental health care services that meet the mental health needs of offenders. It was hypothesized that, through the use of the service delivery guidelines, the institutional mental health staff will be successful in providing effective mental health services to offenders with medium/moderate mental health needs and who require enhanced services.

Strengths

The first strength of the guidelines is the inclusion of information based on extensive review of the literature on topics related to identifying offenders with medium/moderate intensity mental health needs and service delivery options that will be of benefit to this population. Reviewing of the literature and including essential information into the guidelines also helped increase staff awareness with regards to meeting offender’s level of mental health needs and how to provide mental health care that is tailored to meet those needs. An additional strength of the guidelines is that they will benefit the staff and offenders of the institution. The guidelines will be of benefit to staff because they complement the existing practices within the institution and will help reduce challenges they face while providing mental health services to offenders with mental illnesses. The guidelines will benefit offenders because they will receive mental health care that is tailored to their individual mental health needs. The final strength is that the guidelines will provide staff that are new to the MIICU with a user-friendly guide, as well as provide relevant information regarding how to deliver effective services to offenders residing within the unit.
**Limitations and Challenges**

The service delivery guidelines have the potential to be valuable within the institution; however, there are several limitations that should be considered. The first limitation to be considered is the number of staff currently employed within the MIICU. Providing effective treatment to offender’s residing within the MIICU requires a certain number of staff. Therefore, if the required staff mentioned within the guidelines is not attainable then the guidelines will not be as effective due to the limitations on service delivery. A second limitation was that, due to time constraints, the guidelines were not formally evaluated and therefore the efficacy of the guidelines could not be tested. There were also minimal opportunities to determine the usefulness and value of the guidelines for the staff and offenders within the MIICU. The final limitation was that, due to time constraints, feedback on the final product could only be obtained by staff within the institution. This limitation minimized the opportunity to alter and improve sections of the guidelines, in effort to create a more practical and useful resource.

**Contribution to the Behavioural Psychology Field**

The field of Behavioural Psychology focuses on behavioural changes and increasing the potential for individuals to live productive, meaningful, and fulfilling lives. The research and resulting guidelines indicate that increasing the effectiveness of mental health care and tailoring treatment to the mental health needs of the individual can contribute to creating positive changes in behaviour and increasing individual’s quality of life. The developed guidelines also help increase awareness within CSC about the importance of focusing on individual mental health needs and tailoring treatment and service delivery to those needs.

**Recommendations for Future Research**

Due to time constraints, the guidelines within the current project were not directly implemented. Therefore, recommendations for future research would include applying the guidelines in effort to determine the usefulness within a federal institution. In addition, in effort to improve the content and overall practicality, it is recommended that the guidelines be formally evaluated by staff, as well as making necessary changes to the guidelines based on the results obtained during the formal evaluation. It is also suggested that the guidelines be expanded and modified in order to meet the changing needs of the institution and offender population. Additional counselling groups, manuals, and diagnostic assessments should be added into the guidelines when necessary in effort to expand on its usefulness.
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Appendix A: Service Delivery Guidelines for Moderate Intensity Intermediate Health Care

Service Delivery Guidelines:

Moderate Intensity Intermediate Health Care Unit
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**Moderate Intensity Intermediate Health Care**

The newly developed Regional Integrated Health Unit (RIHU) is a 96-bed unit at Bath Institution. The RIHU building is occupied by the High Intensity Intermediate Mental Health Care Unit and the Moderate Intensity Intermediate Mental Health Care Unit (MIICU).

There are five pillars of the mental health action plan for federal offenders: 1) timely assessment, 2) effective management, 3) sound intervention, 4) ongoing training and development, and 5) robust governance and oversight (Public Safety Canada, 2014). Implementation of the MIICU contributes to meeting these five pillars.

**Definition**

The Moderate Intensity Intermediate Care Unit (MIICU) is a refined model of care that addresses the gaps in services currently experienced within CSC. It is designed to increase safety and security of offenders, improve the delivery of mental health services, increase efficiency and effectiveness of health resources, and improve the success rate of reintegration.

The MIICU houses inmates who present with chronic or sub-acute mental health conditions with symptoms which are moderate but cannot be adequately addressed through primary care but who do not require admission to hospital or high intensity intermediate mental health care. The MIICU provides services to offenders with mental health needs that require enhanced levels of services.

**Capacity**

Within the RIHU there are various types of funded beds:

**Moderate Intensity Care Beds**

There are 38 moderate intensity care beds available within the RIHU and are available on ranges D, E, G, and H. Range D will consist of MIICU beds and preparation, maintenance, and transition (PMT) beds.

These beds are available to offenders who have been accepted to the MIICU.

**High Intensity Care Beds**

There are 36 high intensity care beds available within the RIHU and are available on ranges A, B, and C.
These beds are available for offenders who have been accepted to the Regional Treatment Centre (RTC) High Intensity Intermediate Mental Health Care Unit.

Observation Cells

There are two observation cells available within the RIHU. Both observation cells are available on Range A. They are placed at the end of the range, on each side.

These cells are available to offenders who are in need of direct observation due to suicidal and self-harm behaviour and will be utilized by Bath High Intensity, Moderate Intensity or Bath Primary Care.

Preparation, Maintenance, and Transition (PMT)

There are 20 PMT beds available within the RIHU and are available on ranges D and F. Range D will consist of MIICU beds and PMT beds.

The preparation beds will be utilized by offenders who have been accepted to the MIICU and are waiting for an available bed or admission into the unit. These individuals will be allowed to participate in the enhanced services being offered. This allows for the offenders who are waiting, to be oriented to the unit and Bath Institution.

The maintenance and transition beds will be utilized by offenders who have participated in various enhanced services and meet the criteria for discharge. During the time the offenders utilize the maintenance and transition beds, they will have the opportunity to demonstrate ongoing stability prior to their transfer to general population at Bath Institution or another institution (e.g., a transfer to minimum security).

The PMT beds will also be utilized by offenders who are in various phases of their correctional plan and for those who have been discharged from the MIICU but have become a peer support worker for the unit. The peer support worker will be assigned tasks related to the MIICU (e.g., orientating new offenders to Bath Institution).

* A layout of the RIHU building is available in appendix C.
Admission Criteria

In order for an offender to be considered a suitable candidate for the MIICU, they are required to meet at least one of the following criteria:

1. Have a serious mental illness in sub-acute and chronic phases with moderate impairment (e.g., schizophrenia, bipolar, major depression) who do not require 24-hour care;
2. Diagnosed with a major mental illness, but are compliant with medications and are able to function in most activities of daily living. The offender will benefit from living in a more supportive environment compared to a primary care setting;
3. Diagnosed with a neurological disorder and experience cognitive impairments (e.g., fetal alcohol spectrum disorder, acquired brain injuries, development disabilities) with moderate functional impairment but do not require access to 24-hour nursing and clinical care;

Offenders being considered for the MIICU are required to meet all of the following criteria:

1. Low level or suicide/self-injurious behaviour but is currently stable (e.g., may have expressed suicide/self-harm thoughts, history of suicide/self-injurious concerns, periodic need for enhanced monitoring but is not currently actively suicidal or engaging in self-harm);
2. Willing to participate in treatment/interventions;
3. Demonstrates some insight into mental health issues (may require some instruction or motivational interviewing);
4. Have the ability to self-administer medication (e.g., blister packs) or require some minimal monitoring by a mental health nurse;
5. Does not pose significant security concerns or extreme behavioural problems;
6. Ability to manage in a medium security institution but require a higher level of services due to mental health needs.

Offenders who present with “Considerable Need” based on the Mental Health Need Scale (MHNS) are ideal candidates for the unit. The MIICU will also consider offenders who have been identified on the cusp of “Some Need” or “Substantial Need” on a case-by-case basis. Refer to the Mental Health Need Scale in appendix B for definitions of different types of need.

Referral Process

Referral to the Moderate Intensity Intermediate Mental Health Care Unit requires the completion of CSC’s Psychiatric Hospital and Intermediate Care Referral Form (a modified version of CSC/SCC 1479 – Regional Treatment Centre Referral Form) (Appendix D). All referrals are to be accompanied by a completed Mental Health Needs Scale (Appendix B).
Referrals are to be completed by mental health staff at the offender’s parent institution seeking to admit patients to the unit. All referrals will be submitted to the Regional Mental Health Service Review Committee (RMHSRC).

The inmate must meet the clinical admission criteria to be admitted to the Moderate Intensity Intermediate Mental Health Care Unit. The determination of clinical suitability of the referred inmate is based on all information available (including consultation with the referring institutional mental health staff).

The RMHSRC will process referrals for offenders transitioning between intermediate mental health care levels (high and moderate) within the RICU. If the inmate is transitioning between psychiatric hospital and intermediate mental health care, the inmate is referred using the CSC/SCC 1479 Psychiatric Hospital and Intermediate Care Referral Form.

**Consent Process**

Consent from an offender is not required when admitting them to the Moderate Intensity Intermediate Mental Health Care Unit. However, consent for treatment must always be obtained using the Voluntary Consent to Participate in Psychiatric Hospital or Intermediate Mental Health Care Form (CSC/SCC 1484) (Appendix E). Following the completion of this form, it must be placed on the offender’s mental health file. Offenders who are obtaining subsequent counselling services (e.g., group and individual) are required to complete the Consent to Participate In/Receive Health Services Form (Appendix F). This form will also be placed on the offenders mental health file.

If an offender refuses treatment, he should be kept at the MIICU for at least 30 working days, in effort to engage him in treatment prior to being discharged. In these cases, an Interdisciplinary Mental Health Team, in consultation with the Regional Complex Mental Health Committee (RCMHC) when appropriate, should review efforts to engage him in treatment before discharge.

**Diagnostic Assessment**

Diagnostic assessments are essential devices within the health care system. Knowing what disorder, psychical disabilities, strengths and weaknesses a patient has helps to guide treatment interventions. It can also help predict outcome and prognosis to a certain extent.

Each offender who is transferred to the MIICU is required to have three different diagnostic assessments completed; 1) Mini-International Neuropsychiatric Interview 6.0 (MINI 6.0), 2) World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0), and 3) Brief
Symptom Inventory (BSI). These items are required to be completed at intake by the sending institution.

**Mini-International Neuropsychiatric Interview 6.0 (MINI 6.0)**

The MINI is the most widely used psychiatric structured diagnostic interview instrument in the world. It screens for all major Axis I disorders, including schizophrenia, anxiety and mood disorders, eating disorders, and substance dependence (Sheehan, et al., 1998). It also briefly screens for suicidality. The MINI has a short administration time (approximately 15 minutes) and the questions only require yes and no answers from the patient and are highly comprehensive (Sheehan, et al., 1998).

The MINI has been validated against the much longer Structured Clinical Interview for DSM Diagnoses (SCID-P) and against the Composite International Diagnostic Interview for ICD-10 (CIDI) (Sheehan, et al., 1998). According to researchers the MINI is a fully validated and more time efficient alternative to the SCID-P and CIDI. Studies have also examined the inter-rater and test retest reliability of the MINI. Overall, the results from studies have supported the validity and reliability of the MINI.


**World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0)**

The WHODAS is a practical and generic assessment instrument developed by the World Health Organization (WHO) to provide a standardized method for measuring levels of health and disability across cultures. It is a responsive measure that can show what difference an intervention makes. The WHODAS 2.0 captures the level of functioning in six domains:

Domain 1: Cognition – Understanding and communicating
Domain 2: Mobility – Moving and getting around
Domain 3: Self-care – Attending to ones hygiene, dressing, eating, and staying alone
Domain 4: Getting Along – Interacting with other people
Domain 5: Life Activities – Domestic responsibilities, leisure, work, and school
Domain 6: Participation – Joining in community activities, and participating in society

The WHODAS 2.0 is a reliable measure applicable in different cultures and used in both clinical and general populations. It can be used a general measure across all diseases, including mental and neurological.
Brief Symptom Inventory (BSI)

The BSI is a diagnostic assessment that measures three primary symptom dimensions, including somatisation (SOM), depression (DEP), and anxiety (ANX) (Derogatis, & Melisaratos, 1983). It is designed to provide an overview of a patient’s symptoms and their intensity at a specific point in time (Derogatis, & Melisaratos, 1983). In other words, the BSI gathers patient reported data to help measure their psychological distress and psychiatric disorders. The BSI is easily administered and takes approximately four minutes to complete.

Both test-retest and internal consistency reliabilities are shown to be very good for the primary symptom dimensions of the BSI, and its correlations with the comparable dimensions of the SCL-90-R are quite high (Derogatis, & Melisaratos, 1983). In terms of validation, high convergence between the BSI scale and like dimensions of the MMPI provide good evidence of convergent validity and factor analytic studies of the internal structure of the scale contribute evidence of construct validity (Derogatis, & Melisaratos, 1983).


Assessment and Treatment Planning Staffing Model

For inmates admitted to the MIICU, the assessment and treatment process will follow the *RTC Standardized Assessment, Treatment Planning, and Progress Monitoring Guidelines* (Appendix G), unless a previous assessment is applicable to the inmates’ current needs. In this case, a review of the existing assessment will take place and will be updated if required.

A treatment plan is required to be developed for inmates admitted to the Moderate Intensity Intermediate Care Unit within 60 calendar days of admission and is to be developed using the *Treatment Plan Template*, which can be found within the *RTC Standardized Assessment, Treatment Planning, and Progress Monitoring Guidelines* in appendix G.
**Staffing Model**

**Present Staffing Structure/Role**

* Dedicated Psychologist (Team Leader/PS-03)*

The PS-03 will be in charge of coordinating all incoming referrals and admissions from the RMHSRC. They will also coordinate the different counselling groups and individual sessions, structure the schedules of other MIICU staff members, as well as distribute tasks, referrals, and caseloads. The PS-03 will serve as the MIICU team leader and will liaise with the Regional Treatment Centre (RTC), Bath Institution, health care, security and various referring institutions, as well as the Chief of Mental Health Services (PS-04). Finally, the PS-03 will clinically supervise the nonregistered staff in the MIICU and report to the Chief of Mental Health Services.

* Dedicated Behavioural Science Technician (BST)*

Within the MIICU, the BST will facilitate group and individual sessions, develop group programming, coordinate group programs, and participate on the MIICU multidisciplinary team.

* Dedicated Registered Nurse (Mental Health Specialization)*

The registered nurse will facilitate group and individual interventions, liaise with health care and psychiatry, coordinate group programs, and support and assist patients with psychiatry clinics.

* Psychiatrist*

The Bath Institution psychiatrist will be in charge of psychiatry clinics and consultations.

* Physician and Registered Nurses – Health Services*

The physician and registered nurses in Bath Institution Health Services will be in charge of physical health care management and the distribution of medication.

* Registered Social Worker*

The registered Social Worker will be available full-time on the MIICU and will be in charge of offender discharge planning, specifically those who are being released into the community. They will also be available for consultation and may be involved in facilitating group and individual counselling sessions as well.
Expected Additional Staffing

Dedicated Behavioural Science Technician/Registered Nurse

The dedicated BST/Registered Nurse is required to have mental health experience. They will facilitate groups and individual sessions, develop group programming, and coordinate group programs.

Occupational Therapist (OT)

The OT will be available full-time on the MIICU and will facilitate at least one group per week. These groups may include activities of daily living groups, recreational groups, or leisure groups.

Vocational Therapist

The vocational therapist will be available on the MIICU for 8-12 hours per month and will facilitate at least one group per week, specifically around employment.

Administrative Assistant (CR-04)

The administrative assistant will be available 40 hours per week and will be in charge of various tasks. The CR-04 will plan, organize, and coordinate administrative operations at Bath Mental Health Services Department. They will maintain, update, and safeguard offenders record files consistent with professional practises, complete the mental health tracking system, coordinate and maintain a number of electronic databases, and gather mail/inmate referrals from offenders and staff.

Curriculum/Services

The MIICU houses offenders with a range of mental health needs. The services provided to these offenders are based on their individual level of mental health need, which is determined at intake through diagnostic assessments and the mental health needs scale. Offenders who reside on the MIICU are mainly independent in activities of daily living but need support in identified areas of functioning.

Therapeutic interventions (e.g., group and individual) and structured activities are overseen by staff associated with the delivery of mental health services. These services will be available eight hours per day, Monday to Friday. Services are also available when needed on evenings and weekends through primary care. Offenders residing on the MIICU are expected to participate fully in their correctional plan including educational, employment, and programming.
components. Offenders are also expected to participate in at least one intervention service weekly.

The following are interventions and groups provided to offenders residing on the MIICU:

**Crisis Interventions**

Crisis Interventions is emergency psychological care that is aimed at assisting the offender who is in a crisis situation in an effort to minimize the potential for negative outcomes.

This service is provided when there is an urgent referral from a staff member. This referral will be responded to by Mental Health Services at the MIICU, as well as by Health Care at Bath Institution.

**Enhanced Education**

A modified education plan can be developed for an offender utilizing a multidisciplinary approach. All staff members working with a specific offender should collaborate on the plan for the offender. Engaging the offender in activities that are meaningful to them can increase treatment outcomes (Costelloe & Langelid, 2011). An enhanced education pathway can be developed for an individual who has not been successful in a traditional educational setting in the past. This treatment method is also beneficial for offenders who have minimal or no work experience, either within the community or within the institution. This educational pathway is meant to be highly individualized and can be different for each offender. A combination of the services listed below can be implemented as an enhanced educational pathway for an offender.

**Co-operative Education**

- Directed by educational staff in cooperation with workplace supervisory staff.
- Initial contact made between workplace by educational staff (by guidance counsellor).
- Majority of offender’s time is spent at the workplace gaining skills and applying current knowledge.
- Weekly school assignments are to be completed to receive credit, often related to workplace experience.

**Employability Skills Group**

- Can be directed by multiple staff members. Examples of staff members who could facilitate this group are educational staff, job coaches, social programs officers, correctional program officers, and mental health staff.
- Group setting: up to 8 members.
• Utilize multi-media presentation such as smart board, video, flip chart discussion, work sheets and verbal discussion.
• Learn skills such as problem solving, communication, self-regulation, and time management.

Employment
• Implement skills learned in the employability skills group.
• Can be also attending weekly structured classroom instruction to further education level.
• Workplace accommodations.
• Stigma awareness; staff information and increased knowledge to limit negative effects for offender in the program.
• Once offender has completed other areas of program and achieves highest possible education level available, employment is expected to occupy the majority of their time.

Structured Classroom Instruction
• Directed by an educational staff.
• Small groups, about eight offenders.
• Can be working on different subjects and at different levels within the group.
• Close availability of teacher for extra attention and assistance if needed.
• Scheduled library sessions can be utilized by offenders for extra help with school in a less structured environment as well as for access to computer programs to further computer literacy.

Peer Support
• Orientation to the workplace.
• Orientation to the institution.
• Job shadowing.
• School work support: tutoring.
• Workplace support: point of contact.

An example of what an offender’s schedule could look like in the program is listed below.

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AM</strong></td>
<td>Structured</td>
<td>Library</td>
<td>Structured</td>
<td>Employability</td>
</tr>
<tr>
<td></td>
<td>Classroom</td>
<td>Classroom</td>
<td>Skills Group</td>
<td>Classroom</td>
</tr>
<tr>
<td></td>
<td>Instruction</td>
<td>Instruction</td>
<td></td>
<td>Instruction</td>
</tr>
<tr>
<td><strong>PM</strong></td>
<td>Employment</td>
<td>Employment</td>
<td>Employment</td>
<td>Employment</td>
</tr>
</tbody>
</table>
Individual Interventions

Individual interventions are provided to offenders as needed. They are based on individual requests and offenders who are in need of individual sessions are expected to fill out a request form. The scheduling of individual sessions will occur during specific block hours.

Group Interventions

Orientation Group

The orientation group is a type of therapy group that focuses on checking in with participants, inquiring about concerns or questions and reviewing the participant’s mood, as well as providing brief psychoeducation of various topics including emotions, goal setting, mental illnesses, stigma, change, self care, suicide and suicide prevention, symptom management, boundaries and harassment, stress, emotion regulation, and sleep hygiene.

The group is an ongoing and closed group that all offenders who have been admitted to the MIICU are required to attend. The group is expected be run twice a week. The orientation group description and manual can be found in appendix H.

Process-Oriented Group Psychotherapy

Process oriented group psychotherapy is a type of therapy group that focuses on interactional patterns of individual group members in the here and now (Morgan & Winterowd, 2002). Process oriented group psychotherapy has been shown to be effective across a variety of presenting problems (Morgan & Winterowd, 2002). This type of group may not reduce recidivism on its own but if integrated with other treatment programs (e.g., recreational training, vocational and career training, and education) offender’s prosocial behaviour may increase (Morgan & Winterowd, 2002).

This group is an ongoing and closed group that all offenders who have been admitted to the MIICU are required to attend. The group is expected to be 12 sessions long and there is no set curriculum or agenda.

Psychoeducational Group

The focus of this group is to provide offenders with information about specific topics in effort to give them additional resources or information. These groups are structured and participants are provided with specific topics or modules to discuss. The intention of the group is to enhance offender’s knowledge about the following topics:
• Depression and anxiety disorders
• Schizophrenia and bipolar disorders
• Posttraumatic stress disorder and substance use disorder
• Goal setting and time management
• Problem-solving
• Stress/mood management
• Recreation and leisure
• Sleep hygiene
• Self-care

The psychoeducational group is expected to be held every week; however, offenders who are admitted to the MIICU are not required to attend. Therefore, it is an optional/open group.

Medication Management Group

The focus of this group is to provide offenders with information regarding managing their medication. Providing offenders with a therapy group to help manage their medication can assist in improving their overall quality of life. The medication management group sessions focus on the following:
• Compliance
• Patient education
• Interacting with health care professionals
• Intentional non-adherence
• Side effects/management
• Health beliefs

The medication management group is expected to be held once a week for six consecutive weeks; however, offenders who are admitted to the MIICU are not required to attend. Therefore, it is an optional and voluntary group. The medication management group manual can be found in appendix I.

The following groups are to be run if offenders living on the MIICU are in need of it:

Emotion Regulation Group

The focus of this group is to provide offenders with information regarding managing their emotions. Regulating emotions is having the ability to respond to ongoing demands with a range of emotions that are social tolerable and sufficiently healthy. Emotional regulation is a complex process that involves initiating, inhibiting, or modulating one’s state or behaviour in a given situation (Gross, 2002). The goal of the Emotion Regulation Group is to help the participants
understand their own emotions by providing psychoeducation, decrease their frequency of unwanted emotions, decrease their emotional vulnerability, and decrease their emotional suffering.

The emotional regulation group is expected to be held once a week for 10 consecutive weeks; however, offenders who are admitted to the MIICU are not required to attend. Therefore, it is an optional and voluntary group. The emotion regulation group manual can be found in appendix J.

**Grief and Loss Group**

The focus of this group is to provide members with the basic understanding of the bereavement process, as well as to promote health coping strategies in response to loss that can be generalized to other areas of their lives.

The Grief and Loss group is expected to be held once a week for six consecutive weeks; however, offenders who are admitted to the MIICU are not required to attend. Therefore, it is an optional and voluntary group. The Grief and Loss group manual can be found in appendix K.

Following are proposed groups, which would be run each week:

**Activities of Daily Living (ADL) Group**

This program is to be run by an occupational therapist (OT). The following is a list of topics that would be included in an ADL and sensory program:

- Laundry
- Meal preparation and cleaning
- Finances/budgeting
- Hygiene, dress, and grooming
- Navigating the community
- Ontario Disability Support Program (ODSP)

**Vocational Group**

This group is to be run by a Job Coach or an OT. The following is a list of topics that would be included in a vocational group:

- WHMIS aid/training
- Review of work performance evaluations
- Cooperative program
- Computer skills
• Resume writing
• Employment interests and possible career choices
• Volunteer activities. Participation
• Barriers to employment in the community
• Interviewing

Filing, Documentation, Tracking, Monitoring and Reporting Services

All MIICU documentation will be placed on the health care files and/or psychology/mental health files. Weekly services will be tracked on the institutional Mental Health file. The offender’s initial treatment plans and updates to the treatment plan, and their diagnostic assessments and reports are required to be placed on their Mental Health file.

Discharge Process

Discharge from the MIICU will occur no earlier than 30 days in order to engage individuals in treatment. The evaluations at six months will assess for the offenders suitability for transition to Bath Population, and will occur every six months as needed. The readiness for discharge will be evaluated using the Mental Health Need Scale. Offenders presenting with “Some Need” or “Low Need” are suitable candidates for Primary Care in the Bath Population. Refer to the Mental Health Need Scale in appendix B for definitions of different types of need. If an offender is suitable, discharge will be planned in collaboration with Bath Institutions Mental Health Service, Health Services, and Security.
References


Appendix B: Mental Health Need Scale

<table>
<thead>
<tr>
<th>Site:</th>
<th>Region:</th>
<th>FPS Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed by:</td>
<td>Date:</td>
<td></td>
</tr>
<tr>
<td>Reason for referral:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Distribution: Health Care File, Offender Mental Health/Psychology File, Psychiatric File |

The Mental Health Need Scale is completed by a licensed mental health professional, or mental health staff under the supervision of a licensed mental health professional. The scale consists of three main parts:

Part A: Immediate Action Required

Part B: Overall Level of Mental Health Need

Part C: Mental Health Need in Specific Domains of Functioning

There is also a section for adding Comments, if necessary.

### Part A: Immediate Action Required

- Current and significant concerns regarding risk for self-injury or suicide or presenting a danger to others.

### Part B: Overall Level of Mental Health Need

<table>
<thead>
<tr>
<th>Overall Need</th>
<th>Need Indicators</th>
<th>Service Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>Acute/Severe Need</td>
<td>Requires access to 24-hour nursing care; current severe (acute phase) mental health signs and/or symptoms; significantly impaired level of functioning; suicidal and/or actively self-injurious; behaviour might require the application of (Pinel) restraint equipment; serious neurological disorders/cognitive disabilities; totally disorganized; requires stabilization; very severe lethargy; consistent inability to maintain self-care and hygiene; may or may not be medication and/or treatment compliant; certification; urgent need for detox (med collaboration); requires psychiatric assessment and/or specialized assessments.</td>
</tr>
<tr>
<td>High</td>
<td>Elevated Substantial Need</td>
<td>Requires access to 24 hour support; current, sub-acute and/or chronic phase mental health signs and/or symptoms; functioning significantly affected by symptoms; suicidal and/or serious and persistent self-injury; behaviour might require the application of (Pinel) restraint equipment; serious neurological/cognitive impairment/ dementia and/or age-related cognitive and physical disabilities; seriously disorganized thinking; requires stabilization; severe lethargy; self-care and hygiene significantly compromised; may or may not be medication and/or treatment compliant; requires psychiatric assessment and/or specialized assessments.</td>
</tr>
<tr>
<td>High</td>
<td>Substantial Need</td>
<td>May require access to 24 hour support; current significant mental health signs and/or symptoms; major impairment in several areas of functioning; chronic and persistent self-injury; significant cognitive and/or age-related impairments (dementia); some psychotic symptoms (hallucinations, delusion/disorganized thinking); may require some stabilization; may have lethargy-related concerns/complications; self-care and hygiene compromised; may or may not be medication and/or treatment compliant.</td>
</tr>
<tr>
<td>Medium</td>
<td>Considerable Need</td>
<td>Current mental health signs and/or symptoms; moderate impairments in level of functioning; history of suicidal and/or self-injurious behaviour but currently only low-level concerns; moderate cognitive impairment affecting ability to function in a regular institutional environment; may have some psychotic symptoms/disorganized thinking; may have lethargy-related concerns/complications; self-care and hygiene compromised; generally medication and/or treatment compliant.</td>
</tr>
<tr>
<td>Low</td>
<td>Some Need</td>
<td>Current mental health signs and/or symptoms; some impairment in level of functioning; may have a history of presenting a danger to self related to mental health problems, but no current concerns; noticeable cognitive impairment but able to function in a primary care setting with some assistance and monitoring; little, to no, evidence of disorganized thinking; may have some self-care and hygiene concerns; generally medication and/or treatment compliant.</td>
</tr>
<tr>
<td>Low</td>
<td>Low Need</td>
<td>History of mental health problems but no current concerns; within normal range of functioning; may have a history of presenting a danger to self related to mental health problems, but no current concerns; minor cognitive impairment but able to function in a primary care setting but may require some assistance or monitoring; little evidence of disorganized thinking; may have self-care and hygiene concerns; generally medication and/or treatment compliant; may need monitoring/assistance.</td>
</tr>
<tr>
<td>No</td>
<td>No Need</td>
<td>No history or current mental health signs and/or symptoms; no impairments in functioning; no history of suicidal or self-injurious behaviour; no evidence of disorganized thinking; no problems with self-care or hygiene; promotion of well-being.</td>
</tr>
<tr>
<td>Domain</td>
<td>No Need</td>
<td>Low Need</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>------------------------------------------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Suicide Risk</strong></td>
<td>☐ Not enough information</td>
<td>☐ No history of suicide attempts. No indication of current thoughts about suicide.</td>
</tr>
<tr>
<td><strong>Self-Injury Risk</strong></td>
<td>☐ Not enough information</td>
<td>☐ No history of self-injurious behaviour. No current thoughts about self-injuring.</td>
</tr>
<tr>
<td><strong>Aggressiveness</strong> (e.g., intimidation, threats, muscling for medications, destruction of property, assault, sexual impropriety/assault, barricading)</td>
<td>☐ Not enough information</td>
<td>☐ No history of aggressive behaviour.</td>
</tr>
<tr>
<td><strong>Thought Processes/Content</strong></td>
<td>☐ Not enough information</td>
<td>☐ Thought processes and content within the normal range.</td>
</tr>
<tr>
<td><strong>Cognitive Functioning</strong></td>
<td>☐ Not enough information</td>
<td>☐ Intellectually in the normal range. No indication of cognitive deficits.</td>
</tr>
<tr>
<td><strong>Depression/Mania</strong></td>
<td>☐ Not enough information</td>
<td>☐ No evidence of signs or symptoms of depression or mania.</td>
</tr>
<tr>
<td><strong>Anxiety</strong></td>
<td>☐ Not enough information</td>
<td>☐ No evidence of signs or symptoms of anxiety.</td>
</tr>
<tr>
<td><strong>Impulsivity</strong></td>
<td>☐ Not enough information</td>
<td>☐ No evidence of impulse control problems; nearly always thinks before acting.</td>
</tr>
<tr>
<td><strong>Emotion Management</strong></td>
<td>☐ Not enough information</td>
<td>☐ No evidence of problems with emotion management.</td>
</tr>
<tr>
<td><strong>Coping Skills</strong></td>
<td>☐ Not enough information</td>
<td>☐ Good coping skills. Deals with emotions and adverse events and resolves problems effectively and appropriately.</td>
</tr>
</tbody>
</table>

**Indicate the level of need in each domain to assist with case formulation/identify possible targets for intervention.**

<table>
<thead>
<tr>
<th>Overall Level of Mental Health Need</th>
<th>Overall Level of Mental Health Need</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protected ‘B’ when completed</td>
<td>April 2015</td>
</tr>
</tbody>
</table>

**Part C: Mental Health Need in Specific Domains of Functioning**

- ● Indicates the level of need in each domain to assist with case formulation/identify possible targets for intervention.
<table>
<thead>
<tr>
<th>Domain</th>
<th>No Need</th>
<th>Low Need</th>
<th>Moderate Need</th>
<th>High Need</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpersonal Skills</td>
<td>☐ Not enough information</td>
<td>☐ Significant interpersonal strengths. Forms and maintains close relationships.</td>
<td>☐ Some difficulty with social/interactional skills, but level of social functioning is not, or very minimally, impaired.</td>
<td>☐ Very significant problems with social/interactional skills that seriously impair level of social functioning.</td>
</tr>
<tr>
<td>Concurrent Disorders and/or Substance abuse</td>
<td>☐ No history of substance abuse.</td>
<td>☐ Limited history of substance use/abuse, that has a negative impact on medication compliance and/or ability to effectively function, but no evidence of current substance abuse.</td>
<td>☐ Some current abuse of substances, which has a negative impact on medication compliance and/or cause moderate impairment in functioning.</td>
<td>☐ Frequent and/or severe current abuse of substances, causing significant impairment in level of functioning and is related to mental health relapse; drug seeking within institution.</td>
</tr>
<tr>
<td>Psychiatric Medication Adherence</td>
<td>☐ Not enough information</td>
<td>☐ Cooperates well with prescribed medication regime or no need for medication.</td>
<td>☐ Reasonably adherent to medication regime, but may require some prompting and encouragement.</td>
<td>☐ Quite resistant to taking prescribed medication. Intermittent cooperation, may often require significant prompting and encouragement.</td>
</tr>
<tr>
<td>Basic Life/Self-care (Activities of Daily Living) Skills (hygiene, laundry, cell care)</td>
<td>☐ Not enough information</td>
<td>☐ Carries out self-care activities effectively, however, may require some prompting/reminders.</td>
<td>☐ Carries out self-care activities effectively. Engaged in short- or long-term treatment/counselling.</td>
<td>☐ Poor self-care. Unable or unwilling to carry out self-care activities effectively without substantial support.</td>
</tr>
<tr>
<td>Mental Health Treatment or Contact</td>
<td>☐ No need for mental health contact.</td>
<td>☐ Supportive contacts or check-ins to help maintain stability.</td>
<td>☐ Working with MH to address specific issue(s). Engaged in short- or long-term treatment/counselling.</td>
<td>☐ Uninterested in engaging in interventions. Resistant to working with staff.</td>
</tr>
<tr>
<td>Motivation/ Treatment Readiness</td>
<td>☐ Not enough information</td>
<td>☐ Experiences hesitation on some occasions but is usually interested in working with staff and engaged in activities.</td>
<td>☐ Somewhat ambivalent about desire/need to engage in activities. Requires considerable encouragement to participate.</td>
<td>☐ Uninterested in engaging in interventions. Resistant to working with staff.</td>
</tr>
<tr>
<td>Participation in Interventions (e.g., treatment, correctional programs, school, constructive use of leisure time)</td>
<td>☐ Not enough information</td>
<td>☐ Participates well in recommended interventions and/or activities.</td>
<td>☐ Participates reasonably well in recommended interventions/activities, but may require some prompting and encouragement.</td>
<td>☐ Not participate in recommended interventions/activities. Does not respond to prompting and encouragement to do so.</td>
</tr>
<tr>
<td>Discharge Planning</td>
<td>☐ Not enough information</td>
<td>☐ Does not have a pending release date, is not currently seeking a conditional release and/or is not interested in engaging in the discharge planning process.</td>
<td>☐ Pending release date and presents with some mental health and/or community reintegration issues. May be ambivalent about engaging in the discharge planning process.</td>
<td>☐ Pending release date and presents with significant mental health and/or community reintegration issues. Social Worker is assisting with the possible parole application/release of an offender who requires significant assistance.</td>
</tr>
</tbody>
</table>

**Comments**

**Signature of mental health professional completing MH Needs Scale**

**Date**

---

*Protected ‘B’ when completed*  
*April 2015*
Appendix A: Regional Integrated Health Unit Layout

Legend:

Bottom Level: Range _
Top Level: Range _
Observation Cell: Both observation cells are on Range A; at the end of the range, and on both sides.
### Appendix D: Psychiatric Hospital and Intermediate Care Referral Form

<table>
<thead>
<tr>
<th>Level of care for referral – Niveau de soins pour le renvoi:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Psychiatric hospital care – Soins hospitaliers psychiatriques</td>
</tr>
<tr>
<td>☐ Intermediate care – Soins intermédiaires</td>
</tr>
<tr>
<td>Moderate intensity – D’intensité modéré</td>
</tr>
<tr>
<td>High intensity – D’intensité élevé</td>
</tr>
</tbody>
</table>

**Offender has agreed to voluntarily participate in assessment and/or treatment in psychiatric hospital care or high or moderate intensity intermediate mental health care.**

*Le/délinquant(e) a accepté de participer volontairement à l’évaluation et/ou au traitement en soins psychiatriques ou aux soins intermédiaires d’intensité élevé ou modéré en santé mentale.*

- Dans la négative, est-ce-que le/délinquant(e) a été déclaré inapte en vertu d’une loi provinciale en matière de santé mentale ?
- - Oui
- - Non

**Offender’s diagnosis at time of referral – Diagnostic psychiatrique au moment du renvoi:**

- Non
- - Oui
- - Ne sait pas

**Reason for referral – Motif du renvoi:**

- Type/rationale
  - Type/motif

**Currently on medication – Prend actuellement des médicaments:**

- Yes
- No
- Non
- Partial
- Unknown

**Medication compliant – Fidélité aux traitements:**

- Yes
- No
- Partial
- Unknown

**Type of medication(s) (if known) – Type de médicament(s) (si connu):**

**Comments – Commentaires:**
Name – Nom

Physical disabilities/special needs (associated with aging or end of life which requires clinical care and more intensive nursing than a regular institution can provide)

Déficiences physiques/besoins spéciaux (associés au vieillissement ou à la fin de vie, qui nécessitent des soins cliniques et des soins infirmiers plus intenses que ce qu’un établissement régulier peut fournir)

Description (if applicable – s’il y a lieu)

Dementia

Self-injurious history

CRIMP/IMP on file

Type(s) of self-injurious behaviour(s) – Type(s) de comportement autodestructeur

Specify type(s) of self-injurious behavior(s)

Précise le(s) type(s) de comportement autodestructeur

(Note: Please ensure that the “Danger to Self: Self-Injury” and “Danger to Self: Suicide” domains on the attached Mental Health Needs scale are also completed.)

(Nota : Veuillez vous assurer de remplir également les catégories « Danger pour soi-même : automutilation » et « Danger pour soi-même : suicide » dans l’Échelle des besoins en santé mentale ci-jointe.)

Other – Autres

Institutional adjustment concerns

Institutional substance abuse concerns

In segregation at time of referral

Reason for segregation

Date placed in segregation

Assessed degree of urgency of referral

Rationale for degree of urgency – Justification du degré d’urgence

Assessed level of motivation for assessment/treatment

Additional comments – Commentaires additionnels

Staff member name (print)

Nom du membre du personnel (en lettres moulées)

Appendix E: Voluntary Consent to Participate in Psychiatric Hospital or Intermediate Mental Health Care Form (CSC/SCC 1484)

<table>
<thead>
<tr>
<th>Institution</th>
<th>Date of birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I, the undersigned hereby agree to receive psychiatric hospital or intermediate mental health care services at the above noted institution.

- I understand that the services that I will receive (e.g., clinical assessment(s), psychiatric interventions and treatment interventions such as treatment programs and/or individual/counselling sessions with staff) will be based on my clinical need(s) and discussion with me.
- I understand that my treatment plan, various types of treatment options, and the potential benefits and risks of recommended treatment will be discussed with me on regular basis throughout my stay here. I also understand that I can ask questions concerning my treatment at any time.
- I understand that while I will be receiving treatment in a way consistent with professional standards, the degree of improvement in symptoms or problems as a result of treatment varies among patients. I understand that patient cooperation and involvement in treatment is generally associated with better results.

**Limits to Confidentiality and Sharing of Information**

- I understand that confidentiality regarding my mental health/health information will be maintained by my treatment team. However there are limitations to that confidentiality, for example in circumstances where there may be an assessed risk of harm to myself or to others.
- I understand that my treatment team may consult with other CSC staff concerning my treatment throughout my stay at this treatment centre or intermediate mental health care unit as necessary for my care. I also understand that aspects of my treatment information that are relevant to the management of my case and/or institutional or community risk will be shared with case management personnel (e.g., parole officer, correctional staff). Further, I understand that formal reports will be copied to my files (e.g., Psychology, Health Care, Case Management), and also to the Parole Board of Canada, the electronic health care information system and the Offender Management System (OMS) and may be used for decision-making purposes concerning my case.

I have read this Voluntary Consent to Participate in Psychiatric Hospital or Intermediate Mental Health Care form and/or it has been explained to me. I confirm that I understand the contents and that I consent to voluntarily participate in assessment and/or treatment (as described above). I also understand that I can withdraw my consent to participate in these services at any time. The possible clinical and/or operational consequences of my refusal, withdrawal or lack of engagement in treatment were also explained to me.

**SIGNATURES AND DATE**

<table>
<thead>
<tr>
<th>Offender Name (Print)</th>
<th>Signature</th>
<th>Date (YYYY-MM-DD)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Staff Name (Print)</th>
<th>Signature</th>
<th>Date (YYYY-MM-DD)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CSC/SCC 1482e (2015-03) (Word Version) Page 1 of 2

Voir CSC/SCC 1482f pour version française

Information may be accessible or protected as required under the provisions of the Access to Information Act and the Privacy Act.

DISTRIBUTION

Copy= Offender PH file (if applicable)
WITHDRAWAL OF CONSENT

I, the undersigned ____________________________ hereby withdraw my consent to receive Psychiatric Hospital or intermediate mental health care services at ____________________________ .

SIGNATURES AND DATE

____________________________________  ____________________________  ____________________________
Offender Name (Print)  Signature  Date (YYYY-MM-DD)

____________________________________  ____________________________  ____________________________
Staff Name (Print)  Signature  Date (YYYY-MM-DD)
## Appendix F: Consent to Participate In/Receive Health Services Form

### Correctional Service Canada

**PUT AWAY ON FILE**

<table>
<thead>
<tr>
<th>Original</th>
<th>Offender HC file or Offender PY File</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>FPS Number</th>
</tr>
</thead>
</table>

### Family name

<table>
<thead>
<tr>
<th>Given name(s)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date of birth</th>
</tr>
</thead>
</table>

### Completing Operational Unit

**Mental Health Services**

- [ ] Institutional Mental Health Services
- [ ] Clinical Discharge Planning Services
- [ ] Community Mental Health Services
- [ ] Other _Psychiatry, healthcare_
- [ ] Medical/Dental

Please specify the service being consented to in the space below:

______________________________

______________________________

______________________________

### Please note: This service provider is supervised by __________, Chief Institutional Mental Health Services, with whom the particulars of this case will be discussed as part of the supervisory process.

__________ will read and co-sign all notes. The client has the right to request a meeting with __________.

I understand that my participation in this service is voluntary and that I am free to withdraw at any time. I have been provided with a full explanation of the service, including the potential risks and benefits of participating, the potential risks of refusing treatment, and any alternatives to the service. I understand that confidentiality regarding my health information will normally be maintained by my health services team. However, health care professionals must disclose information when there is a legal requirement. For example, health care professionals are required to disclose certain types of information, including:

- a) Information relevant for release decision-making or supervision purposes.
- b) Information suggesting a risk of imminent danger to myself or to another person.
- c) Information that a child is, or may be, at risk and in need of protection.
- d) Information concerning any activity that may breach security.
- e) New information disclosed about offences, if relevant to any of the above.

Other limits to confidentiality specific to this service have been explained to me by the health care professional.

- [ ] I understand and give my voluntary consent to participate in/receive the service.
- [ ] I understand and do not consent to participate in/receive the service.

______________________________

**Signature of Offender/Substitute Decision Maker**

**Date** (YYYY-MM-DD)

**Witness** (print name)

**Witness Signature**

**Date** (YYYY-MM-DD)

*CSC/SCC 4000-18e (R-2014-05) (Word Version)*  
Personal information will be protected under the provisions of the Privacy Act and will be stored in Personal Information Banks CSC PPU 60 and CSC PPU 70.
Regional Treatment Centre Service Guidelines:
Standardized Assessment, Treatment Planning and Progress Monitoring Processes at Regional Treatment Centres

Overview

At a fundamental level, treatment objectives for patients admitted to Regional Treatment Centres (RTCs) should be recovery-focused, facilitate decreased disability and human suffering, as well as increase the individual’s ability to participate in relevant mental health and criminogenic need-based interventions. Corresponding treatment objectives should place focus on the stabilization of mental disorder and an improved capability to use and maintain various internal and external resources to more effectively manage mental health and criminogenic needs. Collectively, such rehabilitative efforts improve independent and pro-social functioning, decrease offence risk and enhance the safety for the individual and others within correctional and community environments.

Professional practice standards suggest that these key treatment objectives are best achieved through an integrated, interdisciplinary assessment and treatment delivery framework. Moreover, assessment processes should inform type and level of client need, as well as identify relevant responsivity considerations to assist in the determination of appropriate interventions.

The purpose of these guidelines is to facilitate consistent assessment, treatment planning and progress monitoring processes across RTCs. The areas addressed in these guidelines include various standardized processes and methods to guide RTC assessment and treatment planning. Also described are the timelines for assessment and treatment planning processes, documentation content guidelines and corresponding distribution and filing requirements.

In preparation of these treatment planning guidelines, a review of Correctional Service of Canada (CSC) Health Services Standards (2010), CD850 “Mental Health Services”, and professional practice literature was conducted as well as consultation with RTC Executive Directors, their clinical designates, and other key stakeholders.

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1 American Psychiatric Association, 2000, as cited in Livingstone, 2009
RTC Treatment Planning Key Principles

The following key principles guide RTC assessment and treatment planning processes.

- **Assessment to Inform Treatment Planning**: Comprehensive assessment is a fundamental component of treatment planning. Assessment processes focus on identifying type and level of need and the determination of relevant responsivity factors, all of which are core considerations in treatment planning.

- **Level of Need and Triage**: Multiple need domains are triaged according to level of need such that various need domains are prioritized and addressed in a timely manner.

- **Holistic Care and Integration of Interdisciplinary Intervention Models**: Reflective of professional practice standards, RTC treatment planning is holistic, client-centered, and interdisciplinary in nature.

  Treatment planning processes are aimed at addressing bio-/psycho-social need domains as well as the patient’s cultural/spiritual needs and personal goals. To the greatest extent possible, treatment goals are determined in collaboration with the patient and are worded/explained in a manner understandable to the patient. Relevant responsivity factors are considered in the determination of interventions.

- **Evidence-Based Interventions**: Selected interventions are based on evidence-based practice and/or clinically informed models of care that are recognized in the literature as having a positive impact on client outcome.

- **Recovery Focused**: Treatment planning acknowledges that recovery from mental disorder is a process, sometimes lifelong, defined and led by the person with the disorder. Recommended RTC interventions assist the individual in achieving greater independence, enhanced self-efficacy and an improved quality of life.

- **Strengths Perspective**: Patient strengths are recognized in treatment planning. Linkages with a broad range of institutional services (e.g., employment, education, cultural/spiritual activities) are made as a means to strengthen pro-social skills and abilities to promote self-efficacy, leading to an enhanced potential for successful community reintegration.

- **Respect for Diversity**: RTCs patients have diverse needs and backgrounds. Accordingly, mental health services are delivered in a flexible and responsive manner to address the unique needs of RTC patients, with an emphasis on women and persons of Aboriginal descent.

- **Individualized Care and Progress Monitoring**: RTC patients’ need areas and responsivity considerations are dynamic and change over time. The efficacy of selected interventions in addressing treatment goals is regularly monitored and treatment plans are modified as required.

- **Information Sharing**: To ensure effective support and monitoring of progress, relevant mental health information and treatment plans are shared with the patient’s interdisciplinary and case management team in a manner consistent with CSC policy and the need to know principle. Relevant information relates to the individual’s risk, need and responsivity considerations (see CD 803 – Consent to Health Services Assessment, Treatment and Release Information and CSC Guidelines for Sharing Personal Health Information).
Assessment, Treatment Planning and Progress Monitoring: Interdisciplinary Roles & Responsibilities

The aforementioned key principles and interdisciplinary framework guide standardized RTC assessment and treatment planning processes. Such processes are based on an integrated, interdisciplinary framework in which all team members share responsibility for effective patient care and treatment.

While all interdisciplinary team members play a role in treatment related processes, to ensure effective patient care, each patient will be assigned a Clinical Case Coordinator (CCC) within 5 working days of patient admission. The CCC plays a leadership role in coordinating and managing patient care. The CCC, or designate, will also assist in ensuring that relevant documentation is completed as required. The CCC can be a nurse, occupational therapist, social worker, psychologist or other clinical professional. Key functions and accountabilities of the clinical case coordinator role are described below.

Clinical Case Coordinator (CCC) - Key Functions and Accountabilities

- The key function of assigning a CCC is to ensure that there is an identified staff member designated to oversee and coordinate care for their assigned patient(s). During absences of the CCC, the clinical leader/supervisor should ensure that an alternate staff member is designated to assume the roles of the CCC.

- As part of an interdisciplinary treatment approach, the CCC assists in coordinating interdisciplinary care to address treatment need domains identified during the assessment process. At case conferences, or on an as needed basis, the CCC liaises with treatment team members regarding patient need areas, treatment goals and planned interventions. The CCC also ensures that the treatment team is updated concerning changes in the patient’s mental health or emotional/behavioural state, along with any relevant contextual information that may be influencing mental state and patient functioning, and/or modifications to the treatment plan.

- The CCC plays an active role in eliciting interdisciplinary feedback for documentation and progress monitoring purposes and, in collaboration with interdisciplinary team members, works toward ensuring that required standarized documentation is completed within stated timelines (e.g., RTC treatment plan, RTC Treatment Plan Summary, RTC Treatment Plan Summary Update(s), RTC Discharge Summary etc.).

Assessment, Treatment Planning and Progress Monitoring

The following sections describe RTC assessment, treatment planning and progress monitoring processes and corresponding documentation requirements.

RTC Assessment Processes:

The gathering and synthesis of relevant mental health/health and criminogenic need information required for treatment planning purposes, involves an interdisciplinary assessment framework and generally includes the following processes:

- File review and patient interviews, with a particular focus on information related to mental health and institutional adjustment concerns. For example a review of: psychiatric treatment/hospitalization history, family history of mental disorders, prior self-injury/suicide attempts; outstanding correctional plan needs; institutional adjustment concerns; previous treatment participation; educational/vocational history; etc.\(^5\)

---

\(^5\) The sharing of patient information is in accordance with CD803: Consent to Health Services Assessment, Treatment and Release of Information.
• Review and synthesis of prior assessment information (e.g., Mental Health Intake Assessment (MHIA), primary mental health care involvement/intervention, etc.).

• Interdisciplinary consultation to determine the potential requirement for additional/specialized assessment (e.g., psychiatry, psychology, occupational therapy, etc.) to further guide treatment planning decisions.

The following list represents various need domains that are often characteristic of RTC patients, and accordingly, should be assessed as part of a systematic and comprehensive assessment process. Additional need domains may also be determined during the assessment process 6.

- Self-Injury/Suicide Prevention
- Mental Health State
- Mental Health Monitoring/Management
- Cognitive Functioning
- Distorted Thought Processes (not influenced by MH disorder)
- ADL/Self-Care
- Interpersonal Skills
- Living Skills
- Physical Health

- Aggressiveness/Violence
- Emotions Management
- Substance Abuse
- Education
- Employment
- Motivation/Treatment Readiness
- Community Discharge Planning
- Continuity of Care/Discharge Planning

As part of the assessment process, a review of the Mental Health Need Scale (MHNS) ratings (which addresses many of the above noted domains) should also be conducted. A completed MHNS will usually be available as part of the RTC referral process.

- The Mental Health Needs Scale (MHNS) will be completed by institutional mental health staff for all offenders who access mental health care at mainstream institutions. Within mainstream institutions, MHNS ratings (i.e., No Need, Low, Moderate or High Need) are used to triage care, such that offenders with highest need are seen by institutional mental health staff on a priority basis. High need domains are those assessed as significantly impacting current functioning.

- MHNS ratings completed at mainstream institutions will also assist in identifying appropriate RTC referrals and included as part of the RTC referral package of information when available. However because mental health need is dynamic in nature and there can be delays between the time of a RTC referral and subsequent admission, MHNS ratings determined at the time of the referral should be reviewed post-RTC admission and any required amendments/changes should be reflected in the developed RTC treatment plan 7.

- Within RTC settings, MHNS ratings are only one component in the RTC assessment process. If a completed MHNS is not available, it is not a requirement that RTC staff complete MHNS ratings (although, they may find this process of benefit) 8. In summary, as part of the assessment process, all relevant, available file information should be considered in treatment plan development.

---

6 As part of the assessment process (e.g., review of the correctional plan), additional need areas may also be identified. Also refer to Appendix A, RTC Treatment Plan Working Guide, for a more complete list of potential need domains.

7 When there have been long delays between the referral and admission dates, prior to admission, it is beneficial to liaise with the referring institution to ensure that the MHNS ratings completed at the time of referral still reflect an accurate clinical picture or are updated as applicable.

8 If a completed MHNS is not available, it is discretionary whether RTC staff choose to rate the MHNS scale. However, consideration of MHNS domains and corresponding descriptors may assist in providing a structured framework to assist with the integration and assimilation of file/interview information.
Treatment Planning Processes

The above noted assessment processes and interdisciplinary case consultation collectively inform the identification of relevant treatment need domains, patient strengths (e.g., protective factors such as effective coping/self-management skills, social support, etc.), as well as responsivity issues which should be considered as part of treatment planning (e.g., the presence cognitive impairment, learning disabilities, resistance to treatment, cultural/gender considerations, etc.).

RTC treatment plans are intended to represent an integrated approach to addressing and prioritizing multiple need areas (e.g., mental health and criminogenic needs) determined through the assessment process. This entails that currently problematic need domains, as well as other less acute or historical needs, be considered in the treatment planning process.

To assist in prioritizing multiple need areas identified during the assessment process, level of need ratings are determined using the scale below: Level of need numbers correspond to: No/N/A, Low, Moderate and High Need. Non-applicable/no need areas will always be rated as 0; ratings of 1 reflect a need area of minimal concern and ratings of 2 and 3 respectively, reflect moderate and highly concerning need areas.

<table>
<thead>
<tr>
<th>Level of Need Rating</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Need</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Need</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate Need</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Need</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

To further assist in developing an integrated treatment plan that prioritizes multiple need domains, in addition to assigning a level of need rating, a determination is also made with respect to whether the need area is currently problematic; or a non-acute/historic concern (e.g., not currently problematic but identified in the correctional plan, etc.); or of both current and historic concern (e.g., currently problematic and also identified on the correctional plan, etc.). This information should be indicated on the treatment plan by placing a tick in the applicable box under the corresponding need domain.

Need domains assessed as currently problematic and high level of need should always be prioritized in treatment.

* As priority/currently problematic need areas (e.g., acute mental health instability) are addressed, non-acute, more historical, or criminogenic need domains identified in the correctional plan, healing plan, etc., may be targeted in treatment. This may occur either subsequently at the RTC, if appropriate/feasible, or alternatively at the time of RTC discharge/transfer to a mainstream institution or other suitable placement.

* In summary, areas that are not assessed as currently problematic, may be targeted for treatment in subsequent RTC treatment plans as appropriate, or alternatively post-RTC discharge, at the parent institution or other suitable placement.

---

9 In the event that available information is insufficient at the time of the initial treatment plan and relevant information becomes available later, the level of need rating should be completed at that time.
* Note: Although the level of need scale used in RTC treatment plans was derived from the MHNS (which is used primarily to triage access to mental health care based on current need), within the context of RTC assessment and treatment planning, there are scale interpretation differences. **Within the RTC assessment and treatment planning process, level of need ratings are based not only on the extent to which the need area negatively impacts/impairs current functioning but are also based on the extent to which the need domain significantly influences the probability of MH relapse or re-offending.**

Example: consider an offender who has ‘high intensity violence prevention programming’ identified as outstanding in their correctional plan but who has not demonstrated any aggressive behaviours during incarceration (e.g., because his/her mental health has been stabilized or due to placement in a structured environment). Based on the MHNS rating scale descriptors alone, because of the absence of any institutional aggression, he/she may be rated on the MHNS as ‘low’ or ‘moderate’ need. In contrast however, RTC treatment plans are to be integrated in nature and also take into consideration need domains identified in correctional plans, etc. In this example, a relapse into violence would significantly influence the probability of re-offending, so despite the absence of violence during incarceration, within the RTC treatment plan, the level of need rating would be assessed as “3” however rated as “not currently problematic”. The RTC Treatment Planning Guidelines specify that “Priority Need Domains” (i.e., those rated as 2 or 3 level of need AND currently problematic) are to be addressed first within RTC treatment plans. As such, in this example, providing directed programming/interventions to address the violence/aggressiveness need domain may not be appropriate /feasible within the RTC.

- In prioritizing multiple need domains, currently problematic need domains, rated as High or Moderate, should always take precedence in treatment planning over more non-acute/historic need domains. Other need domains may be addressed once priority/current need domains have been resolved/stabilized. In some cases, there may be overlap in terms of the impact of interventions on a number of need domains. For example, a treatment plan developed for an acutely ill mental health patient, who also has educational and vocational deficits, would prioritize stabilization of psychiatric symptoms over formal education or vocational interventions. However, there can be significant overlap and linkages between some need domains, such that several need areas can be simultaneously addressed through the same or similar interventions. For example, for a patient with mental health instability, ADL and emotional management needs, which worsen when he/she is medication non-compliant, the provision of interventions that target improved medication compliance would likely result in a positive impact in all of these need areas. It is also acknowledged that there are limits to the number and type of treatment needs that can be addressed at any one time. For example, attempts to address an excessive number of need areas within the same treatment period can be ineffective and overwhelming to the patient.

- In summary, treatment plans should be integrated in nature and reflect level and urgency of need, such that currently problematic domains are addressed first. As priority needs are resolved, lower priority need areas (e.g., areas rated as less severe, non-acute criminogenic needs, etc.), can be targeted for treatment. Not all identified need domains can or should be addressed within a RTC however. **Any outstanding need domains should be highlighted at the time of RTC discharge in order that they can be addressed subsequently at the offender’s mainstream institution or other suitable placement.**
**RTC Treatment Plan Content**

The *RTC Treatment Plan Working Guide* (Appendix A), can be used as an aid in the development of RTC treatment plans. The working guide provides a list of need domains that are characteristic of RTC patients, generic/example treatment objectives that correspond to each listed need domain, example interventions and a list of potential interdisciplinary personnel that may be involved in treatment.

There is flexibility in terms of the format of RTC treatment plans however the content of all RTC treatment plans should include the following key components:

- ✓ Specification of the need domains and level of need ratings identified through the assessment process.
- ✓ Indication of whether identified need domains are currently problematic, historically problematic, or both.
- ✓ Specification of the treatment objectives/goals, which correspond to the need areas currently targeted for treatment. The example objectives can be modified in the development of an individualized treatment plan.
  - Treatment objectives should be individualized in nature, described in concrete, measurable terms and worded or explained in a manner that is understandable to the patient. Also as much as possible, treatment objectives should be congruent with the patient’s personal treatment goals.
- ✓ Specification of relevant interventions that will be used to address need areas. Selected interventions should be based on interdisciplinary consultation and based on evidence-based practice and/or clinically informed models of care that are recognized in the literature as having a positive impact on client outcome.
- ✓ Specification of planned interventions and interdisciplinary personnel that will assist in achieving identified treatment objectives for those need domains currently targeted for treatment.
  - The requirement is that all RTC patients have a treatment plan and an Initial Treatment Plan Summary completed within 30 calendar days of admission. **The exception is emergency/acute admissions. For information pertaining to assessment and treatment planning for highly acute/emergency patient admissions (see below).**

**Emergency/Acute Patient Interim Treatment Plans**

For emergency/acute patient admissions, the initial assessment process is aimed at identifying those need domains that are currently most influencing mental health instability.

- In such cases, an interim treatment plan is developed within 2 working days of admission. Interim treatment plans are limited to addressing only currently critical need areas (e.g., mental health, self-harm). Similar to regular treatment plans, interim plans should similarly specify corresponding treatment objectives, planned interventions and interdisciplinary personnel who will be involved.
- Within 30 calendar days of the stabilization of acute symptoms/behaviours, a regular treatment plan and an initial treatment plan summary should be completed.
Progress Monitoring

Mental health is dynamic in nature. Accordingly, interdisciplinary case conference-based treatment plan reviews are a critical aspect of the treatment process.

- Progress reviews should take into account input from all members of the patient’s clinical team, the patient, as well as other staff involved in the patient’s care and management (e.g., work supervisor, teacher, elder, parole officer, correctional officer(s), etc.).
  - Treatment plans are dynamic in nature and can be modified as required, for example when need areas or treatment goals change. Accordingly, RTC treatment plans should be reviewed/updated on an ‘as needed’ basis (i.e., significant changes, revisions to planned interventions, etc.). At minimum, treatment plans should be reviewed every 90 calendar days to evaluate progress in relation to specified treatment goals/objectives.
  - An internal monitoring process (i.e., a BF system) should be established to ensure that treatment plans are reviewed as specified.

- A lack of progress in relation to treatment objectives signals the need to review the appropriateness of specified objectives and/or suitability of selected interventions. As applicable, updated treatment plans should reflect revised objectives, revised interventions, decreases or increases in level of need ratings as applicable, etc.). In the event that at the time of the progress review, no changes to an existing treatment plan are warranted, a brief rationale indicating that the need domains, treatment objectives, interventions, etc., remain applicable should be noted on the front of the treatment plan.

- An overview of patient progress toward addressing treatment objectives and planned interventions to address outstanding needs for the upcoming treatment period should be documented in a Treatment Plan Progress Update (see description below). A synopsis of any amendments/changes to treatment plans over the course of treatment should be incorporated in treatment plan summary update(s), which are completed every 90 calendar days.

RTC Treatment Plan-Related Documentation

Descriptions of three key RTC treatment plan documents and associated processes are summarized below.

1) RTC Treatment Plan Working Guide

The RTC Treatment Plan Working Guide is designed as an aid to assist in the development of an individualized, integrated treatment plan. As described above, treatment plan design is discretionary and need not replicate the treatment plan working guide format. However, the key elements illustrated in the working guide (i.e., relevant need domains, level/urgency of need, treatment objectives, and anticipated interdisciplinary interventions and personnel must be specified in all RTC treatment plans. The treatment plan working guide illustrates example treatment objective(s), potential interdisciplinary-specific interventions and various professional personnel that could be used to address need domains. The generic/example treatment objectives should be modified as applicable to reflect more individualized/idiosyncratic treatment objectives, which correspond to applicable need domains.
A current treatment plan should be kept on the patient’s treatment centre file. In addition, at the time of discharge from the RTC, a copy of the most current treatment plan should also be filed on the psychology file and health care file.

RTC treatment plans include information such as diagnosis, mental health symptoms, etc. As such, due to privacy legislation regarding specific mental health information, treatment plans cannot be placed on OMS or case management files.

However, in order to ensure that relevant personnel have access to pertinent treatment plan information (i.e., for case or risk management ‘need to know’ purposes), a narrative summary of the initial treatment plan is completed. The Initial Treatment Plan Summary (described below) provides an overview of the initial treatment plan, however complies with privacy legislation as specific mental health information, diagnosis, etc., is excluded.

2) Initial RTC Treatment Plan Summary

The Initial RTC Treatment Plan Summary reflects a narrative overview of key treatment plan information. The Initial RTC Treatment Plan Summary is completed within 30 calendar days of admission and placed on Psychology, Health Care and Case Management files, copied to OMS, share-printed with the Parole Board of Canada (PBC) and shared with the patient. As noted above, due to its distribution and placement on OMS, specific health care information contained in the treatment plan (e.g., diagnosis, detailed symptoms, etc.) is not included in this document.

   The intent of the Initial Treatment Plan Summary is to ensure that relevant personnel can access, on a ‘need to know’ basis, the need domains being addressed while at the RTC, the corresponding treatment objectives and planned interdisciplinary interventions/personnel that will assist in achieving treatment objectives. Such information provides a baseline for subsequent correctional plan progress reviews with respect to progress made while at the RTC (see RTC Treatment Plan Summary Update described below).

The content of the Initial Treatment Plan Summary includes the following key areas:

   o Patient Identification and Reason for Referral
     Provides general patient identification and referral information
   o Relevant Background Information and Assessment
     Provides relevant background information and an overview of the assessment process undertaken in the development of the RTC Treatment Plan.
   o Treatment Need Domains, Treatment Objectives and Interdisciplinary Interventions
     This section of the treatment plan summary is essentially a narrative overview of the treatment plan, specifying the priority need areas (i.e., those assessed as High or Moderate need and currently problematic), as well as lower priority need domains (i.e., those assessed as low need and/or historical/non-acute need, which may/may not be targeted for treatment during RTC placement). For applicable need domains, treatment objectives, planned interventions, as well as the interdisciplinary personnel who will be involved should be described.
Appendix B (RTC Initial Treatment Plan Summary Content Guidelines) provides detailed report content requirements and the filing and distribution processes for the Initial RTC Treatment Plan Summary. An example of a completed RTC Initial Treatment Plan Summary, based on a mock case example, is provided in Appendix C. The corresponding example treatment plan is illustrated in Appendix D.

3) RTC Treatment Plan Summary Update

The Initial Treatment Plan Summary is completed within 30 calendar days of admission. Thereafter, treatment plan progress (including an overview of any significant treatment plan changes) is captured in the RTC Treatment Plan Summary Update report, which is completed every 90 calendar days.

- The RTC Treatment Plan Summary Update is derived from the section in the RTC Initial Treatment Plan Summary entitled “Treatment Need Domains, Treatment Objectives and Interdisciplinary Interventions”. At the time of case review, as applicable, relevant information derived from the initial treatment plan summary can be inserted in the Treatment Plan Summary Update.

- The report content of the Treatment Plan Summary Update includes an overview of the progress made towards achievement of the treatment objectives specified in the Initial Treatment Plan Summary or previous Treatment Plan Summary Updates. In addition, the progress update provides a synopsis of the need domains that will be addressed during the upcoming treatment period, as well as the corresponding treatment objectives and planned interdisciplinary interventions (see RTC Treatment Plan Summary Update - Content Guidelines, Appendix E).

- Treatment Plan Summary Updates are completed every 90 calendar days. To ensure that relevant progress information is available to case management and other stakeholders, the updates are placed on the treatment centre file and copied to OMS, Psychology, Health Care and Case Management files, and shared with the patient. As is the case with the Initial Treatment Plan Summary, specific health information such as diagnosis, etc., are similarly excluded in treatment plan update(s).

Treatment Plan Documentation, Timeframes and Distribution Summary

- Within 5 working days of admission to a RTC, all patients are assigned a clinical case coordinator.

- Within 30 calendar days of admission to a Regional Treatment Centre, the RTC Treatment Plan and Initial RTC Treatment Plan Summary are completed.

* Exception is emergency/acute patient admission. In such cases, an interim treatment/ crisis intervention plan must be developed within 2 working days of admission and placed on the treatment centre file. Within 30 calendar days of the stabilization of acute symptoms/behaviours, a regular treatment plan and an initial treatment plan summary should be completed.

✓ The RTC Treatment Plan is filed on the treatment centre file. At the time of discharge, a copy of the most current treatment plan is also filed on the Psychology and Health Care file.

✓ The RTC Initial Treatment Plan Summary is filed in the Psychology, Health Care and Case Management files, copied to OMS, share-printed with the PBC, and shared with the offender.

✓ Treatment Plan Summary Update(s) are to be completed every 90 calendar days. Treatment Plan Summary updates are filed on the treatment centre file and copied to the Offender Management...
System (OMS), Psychology, Health Care and Case Management files, share-printed with the PBC, and shared with the offender.

✓ At the time of discharge from a RTC, relevant treatment plan summary update information should be reviewed and incorporated as applicable into the RTC Discharge Summary, any outstanding need areas should be highlighted.

Detailed instructions for inputting RTC treatment planning documents to OMS can be found on the InfoNet link http://infonet/Sectors/HealthServices/MentalHealth/Services+and+Initiatives/txcentres.htm - see OMS Step-by-Step Instruction Guide.

The diagram on the following page summarizes the RTC assessment, treatment planning and progress monitoring processes.
Figure 1. RTC Assessment and Treatment Planning Processes & Timelines

- Admission to RTC
- Assignment of Clinical Case Coordinator: To occur within 5 working days
- Assessment Processes: Determination of Type/Level /Urgency of Need & Responsivity Factors
- Treatment Planning: Determination of Treatment Objectives and Interdisciplinary Interventions
- Completion of RTC Treatment Plan & Initial Treatment Plan Summary:
  - Treatment Plan completed and filed on Treatment Centre file
  - RTC Initial Treatment Plan Summary completed and filed on Psychology, Case Mgmt, Treatment Centre, Health Care, OMS, share-printed to PCB and shared with patient
  - To occur within 30 calendar days of admission
- Progress Review
  - Treatment Plan Summary Update: To determine progress in achieving treatment objectives
  - Amendments to Treatment Plan as required
  - Treatment Plan reviews at minimum every 90 calendar days
- Exception – Emergency /Acute admissions - Interim treatment/crisis plan filed on treatment centre file within 2 working days of admission
Appendix A

RTC Treatment Plan Working Guide

A copy of the RTC Treatment Plan Working Guide (treatment plan template) can be downloaded from the following link:

http://infonet/Sectors/HealthServices/MentalHealth/Services+and+Initiatives/txcentres.htm
Appendix B

Regional Treatment Centre (RTC)

Initial Treatment Plan Summary

Content Guidelines

Patient Identification and Reason for Admission
Relevant demographic and referral information addressing at minimum the areas below:

- Patient Name and FPS#
- Security Level
- Date of Admission to RTC
- Reason for Referral (e.g., emergency, assessment, treatment, etc.)
- Date of Report
  *Indicate that the report reflects the views of the patient’s interdisciplinary treatment team (i.e., interdisciplinary professions involved in treatment).*

Background and Referral Information

A. Background Information:

Brief snapshot of relevant mental health history and criminogenic considerations with references to key sources of file information (e.g., psychiatric, psychological, assessment for decision reports, etc.). Example content includes:

- Mental health history (e.g., previous psychiatric treatment or hospitalization, family history of mental disorder, self-harm behaviours, etc.)
- Overview of current mental health/functioning impairments, criminogenic need domains and any current management concerns (e.g., correctional plan progress/outstanding domains, emotional management deficits, impulsivity, interpersonal issues, aggression, etc.).

B. Assessment:

Overview of collective assessment processes used to identify need domains (e.g., file review, patient interviews, observations, review of Mental Health Need Scale (MHNS) and other referral information, interdisciplinary consultation, overview of specialized assessment results, patient’s awareness/insight of mental health (e.g., compliance, independent management of mental health need, etc.).

*Note:* While it is important to describe general mental health symptoms/characteristics impacting current functioning, ensure that the narrative description complies with privacy legislation and does not include mental health or medical diagnoses (Refer to CD 803 - Consent to Health Services Assessment, Treatment and Release Information and CSC Guidelines for Sharing Personal Health Information).

C. Treatment Need, Treatment Objectives and Associated Interdisciplinary Interventions

Specify priority and additional need domains identified in the assessment processes, as well as the corresponding treatment objectives, anticipated interdisciplinary interventions that will be used to address treatment needs, and the interdisciplinary professionals that will be involved.

Example need domains includes:

- Synopsis of mental health state
- ADL functioning (e.g., personal hygiene/self-care, cleanliness of surroundings, living skills, etc.)
- Educational/Vocational/Structured Leisure considerations
- Cognitive functioning & any other responsivity considerations (e.g., motivation, cultural/spiritual factors, language, etc.)
- Emotional Management - Interpersonal Skills - Aggressiveness/Violence
- Substance Abuse - Education - Employment

**See RTC Treatment Plan Working Guide for a more complete list of characteristic need domains.**
Appendix C
RTC Initial Treatment Plan Summary
Case Example

Patient Identification and Reason for Admission

Name: Mr. John Doe
FPS: 000000X
Security level: Medium
Date of admission to RTC: 10/05/2012
Date of report: 31/05/2012

This report reflects the views of Mr. Doe’s interdisciplinary treatment team.

Background Information and Assessment

Relevant Background Information

This represents Mr. Doe’s third admission to RTC. He was referred again due to some re-emergence of mental health instability symptoms. For example, at times he has delusional beliefs (e.g., unsubstantiated beliefs that people are out to get him; that staff members want to hurt and poison him, etc.). In conjunction with mental health instability, he has also been demonstrating seemingly unprovoked anger outbursts that at times, can be quite aggressive in nature (e.g., when asked to comply with routine institutional procedures). A family history of major mental health disorder is also noted on file.

Mr. Doe is currently serving a Life Sentence for Murder. The index offense occurred in 2001. The victim was his roommate at the time. Mr Doe assaulted him with a knife. He claimed that pervasive thoughts he was having about his roommate’s intention to steal all his money triggered the event. Mr Doe was also under the influence of alcohol that day. His criminal history indicates that there were at least two other incidents of alcohol-related violence.

Relevant file background information reveals that Mr. Doe has lived a generally chaotic lifestyle. During his youth, he lived in numerous foster homes and did not complete high school. As an adult, his living arrangements have similarly been quite transient. He has not been involved in any significant intimate relationships and has had only very limited contact with a few relatives. He also had difficulties maintaining stable employment. However, during his periods of incarceration, file information suggests that under structured supervision, Mr. Doe demonstrates a good work ethic and has achieved positive reports from his supervisors.

Mr. Doe has not shown significant progress in addressing his correctional plan. Outstanding criminogenic domains identified in his correctional plan relate to substance abuse and violence/anger management. He has consistently refused to participate in any substance abuse interventions, claiming that this problem was in the past and no longer impacts him. Over the past three years, three random urinalyses have been conducted. The results were negative in each instance. While there have been medication adherence concerns, there has been no evidence of alcohol/drug seeking behaviours during his incarceration. He has tried in vain on two occasions to complete violent correctional programs. In each instance he abandoned the program before completion. The program officer suspected that Mr Doe was hiding some learning deficits behind a wall of indifference. Violence remains an
important dynamic risk factor as he shows aggressive proneness toward others and presents significant institutional adjustment concerns.

Since his current admission, Mr. Doe has generally worked most cooperatively with treatment team members that he is familiar with from his previous RTC stays, he indicates that it will become easier to work with other members of his team “once he gets to know them better”.

**Assessment**

The assessment process currently undertaken to determine treatment need and responsivity issues, included a review of file (e.g., psychology, case management/correctional plan, etc.) and referral information – e.g., Mental Health Need Scale (MHNS) level of need ratings, as well as daily observations and interdisciplinary team interviews since admission (i.e., his psychiatrist, nurse, and clinical coordinator).

Based on Mr Doe’s explanation of the reasons he was encouraged to return to RTC, it seems that his understanding and insight is very limited. During interviews with staff, Mr. Doe has often been preoccupied by his belief that two correctional officers at his parent institution tried to put something in his food for the purpose of making him sick. The explanations given to support these impressions are not well articulated or validated. File and interview information suggests that Mr. Doe’s judgment can be severely impaired by mental state instability. He has agreed to resume a medication regiment that worked well for him during his previous RTC admission, which he did not adhere to when he last left RTC. Although expressing that he will remain compliant with the medication plan this time, he admits that he often worries that his medication may harm him over time. Since his current admission, Mr Doe frequently shows a high level of anxiousness and often seems in a state of vigilance. While at times he claims to feel reassured by his transfer to RTC, the treatment team still observe familiar mental state instability symptoms, such as him refusing to go out for exercise, appearing suspicious at meal times or refusing food at times. Mr. Doe lack of attention to his personal hygiene can be exacerbated during acute mental instability. File reports indicate that at times this area of need can persist even after such episodes.

Throughout his incarceration, Mr. Doe has worked as an institutional cleaner as well as some other types of institutional employment. With the exception of periods of acute mental health instability, when he was unable to attend work, the quality of his work is assessed by his supervisors as positive. Also noted is that Mr Doe is generally receptive to constructive feedback from his supervisors and attempts to improve his performance as requested. File reports suggest that these traits were generally similar to his work characteristics in the community, however untreated episodes of mental health instability and associated de-compensation, resulted in an inability to maintain steady employment . Overall, it appears that Mr Doe values involvement in institutional employment and he is expressing a desire to work again here as soon as possible. At present staff are determining what work options are currently available.

With regard to Mr. Doe’s cognitive functioning information on file (e.g., previous psychological and psychometric assessments, Mental Health Intake Assessment (MHIA) results), suggests limited intellectual capacities and memory deficits. The reports indicate that these issues also likely contribute to impaired judgement and appear to be further exacerbated under stress. During such times, he tends to become more emotionally disregulated and emotional instability can at times heighten the risk of aggressive behaviours directed toward staff and peers. To further understand his needs in this area, during his current RTC admission, further cognitive functioning assessment is planned . Other responsivity considerations include variations in his motivational level toward treatment and a general lack of insight and responsibility for his offences and related criminogenic need domains.
Treatment Need, Treatment Objectives and Associated Interdisciplinary Interventions

Mr. Doe’s need areas, treatment objectives and planned interventions are described below. Priority need domains are those assessed as most contributory to impaired current functioning and/or need areas that most significantly influence the individual’s risk of relapse in the institution or community. Need domains that are currently problematic and assessed as high or moderate level of need are always addressed first as part of RTC treatment planning process. As the highest priority need domains are stabilized or resolved, additional need domains that are less serious, less acute, or more historically problematic in nature, are triaged; these problem areas may be addressed subsequently within the RTC via specialized or modified interventions, or alternatively, highlighted as outstanding need domains that should be subsequently addressed post-RTC discharge (e.g., at the offender’s parent institution or other suitable placement).

Priority Need Domains:
The following need domains have been prioritized in Mr. Doe’s current treatment plan.

Mental Health State and Mental Health Monitoring: Associated treatment objectives are aimed at reducing delusional/paranoid thoughts and related behavioural disturbances (e.g., refusing to go out for walks, suspiciousness at meal times). Progress made toward these treatment objectives will be demonstrated by decreased paranoia/suspiciousness, decreased resistance to mental health treatment, improved medication compliance and improved mental health stability. The interventions in this need domain will be predominantly psychiatry and nursing based. He will have weekly consultations with psychiatrist as well as ongoing individual sessions with his Clinical Case Coordinator (CCC) and other treatment team nursing staff.

ADL/Self Care: Treatment objectives include decreased resistance toward performance of routine personal hygiene routines and improved independent self-care. Daily monitoring and assistance/cueing will be provided regularly by nursing staff and his CCC.

Aggressiveness/Violence: The key objectives are to decrease the frequency and intensity of Mr. Doe’s aggressive behaviours and reactions towards staff and other patients when agitated. One to one counselling, provided by psychology, nursing and his CCC, will initially focus on teaching basic skills/strategies (e.g., time-outs, cell confinement, talking to staff, behavioural agreements, etc.) that will assist Mr. Doe in containing aggressive reactions toward staff and other inmates.

Additional Need Domains:
The following need domains are assessed as not currently problematic and/or are less severe than the aforementioned priority need domains. As applicable, these need domains will also be addressed as part of the current treatment plan due to their overlap with priority need domains and/or that planned interventions for priority need areas also generalize to these domains. Less acute need domains may be addressed in subsequent RTC treatment plans or alternatively, addressed after RTC discharge (e.g., upon return to the patient’s parent institution or other suitable placement).

Motivation/treatment readiness: This need domain is identified in the current treatment plan as motivation impacts engagement in addressing priority need domains. Key objectives include improved engagement in treatment, evidenced by improved insight/acknowledgement of relevant need areas, and increased cooperation with interdisciplinary staff members. Individual sessions with treatment team members (e.g., nurse, clinical case coordinator, psychologist) will incorporate motivational interviewing strategies (e.g., supporting self-efficacy, developing discrepancy between behaviours and personal goals, etc.) as a means to strengthen Mr. Doe’s treatment engagement.
Cognitive functioning/Intellectual capacities: Treatment objectives include an enhancement of Mr. Doe’s problem-solving and judgement skills and an improved ability to cope with cognitive functioning deficits. Once mental health stability is achieved, participation in our “Cognitive Skills Enhancement” group facilitated by the unit psychologist is planned. Other members of his team (e.g., nurses, occupational therapist) will use external cues/prompting and other similar strategies to enhance cognitive capabilities. Additional assessment will also be conducted during his current RTC admission to enhance understanding of cognitive functioning concerns.

Living Skills: This area overlaps with Mr. Doe’s ADL priority need domain. Treatment objectives will focus on assisting Mr. Doe in strengthening relevant living skills such that he can function more independently in institutional environments and subsequently, in the community. Interventions with the occupational therapist, nurse and program officer will initially include involvement in unit cleaning and structured leisure activities.

Substance Abuse: This need domain is not currently problematic and has not presented as an institutional management concern. At this time, we do not offer substance abuse programming/interventions at this facility. As such, this need domain is not targeted for treatment during the current admission. However underlying influences (e.g., improved mental health stability, enhanced emotions management skills) will likely have a positive impact on this need domain. The need for substance abuse-specific treatment, specified in his correctional plan, will be highlighted as outstanding at the time of his RTC discharge. Outstanding need area(s) should be reviewed post-RTC discharge and subsequently addressed as appropriate in the parent institution or other suitable placement.

Emotional management: Treatment objectives are aimed at improving Mr. Doe’s ability to self-regulate anxiety and other emotions that influence mental health deterioration and his offence risk. This will be evidenced by decreased intensity and frequency of acting out behaviours and improved compliance with staff and routines. At this point, interventions with various team members will be mainly on an individual basis (e.g., with psychology, nursing, clinical case coordinator) and focus on anxiety and stress management skill acquisition.

Education: Once mental health is stabilized, Mr. Doe will be encouraged to participate in formal educational activities with the teacher, aided by peer tutoring.

Ms. Smith, Credentials,
Clinical Case Coordinator

Filing/Distribution:
Treatment Centre
Health Care
Psychology
Case Management
Offender Management System (OMS)
Share-printed with PCB
Shared with Offender
Appendix H: Orientation Group Description and Manual

The current group will meet for 90-minute sessions, twice a week. Handouts will be provided to summarize new concepts, and worksheets will be assigned to guide participants in practicing new skills between sessions. The first half of each session will involve checking in with the participants, inquiring about concerns or questions and reviewing the participant’s mood with the traffic light technique. The second half of sessions will involve presenting new material. During the first half of each session, the participants will be asked to rate their level of mood by picking either the colour green (e.g., if they are good to go, feeling fine, ready to learn and engage in daily activities), yellow (e.g., if they feel like they are starting to lose a bit of control, things aren’t 100% right now, they may find it difficult to concentrate on their daily tasks or activities), or red (e.g., if they are feeling bad, upset, irritable, withdrawn, losing control, they may find it very challenging to function in their daily life). Using the traffic light technique allows an opportunity for the participants to engage in and practice the skill of self-monitoring.

• Topic 1 involves psychoeducation to help group members better understand their emotions. Discussions will focus on (a) Self-monitoring using the traffic light technique and why it is important to engage in self-monitoring daily, (b) the thoughts, feelings and behaviours concept, what each of these entail, and why it is important to understand how our thoughts, feelings, and behaviours are connected.

• Topic 2 will focus on goal setting. During this topic, the participants will learn (a) what the definition of a goal is, (b) the purpose of goals, (c) the benefits of setting goals, (d) how to set goals (e.g., using SMART goals worksheets), and (e) how to achieve goals.

• Topic 3 will focus on various mental illnesses; including, anxiety disorders, mood disorders, psychotic disorders, eating disorders, and addiction and impulse disorders. The disorders will be discussed by reviewing what the disorder looks like, the symptoms, causes and the possible treatments available.

• Topic 4 will focus on stigma. This will involve learning (a) what stigma means, (b) what common stigma is faced by people with mental illnesses and criminal histories, and (c) how to manage stigma.

• Topic 5 will focus on change, which involves learning about (a) types of possible changes, (b) the stages of change, (c) how to make change, and (d) how to cope with change.

• Topic 6 will focus on self-care. This includes psychoeducation on self-care and it also involves discussing hygiene and sleep. Specifically what they are and what they involve. Discussions will be held about what a healthy lifestyle is and how to live a balanced lifestyle.

• Topic 7 will focus on suicide and suicide prevention. Specifically, the possible stressors, risks factors, and warning signs for suicide were discussed. It will also involve learning about what to do if you or someone else is suicidal.

• Topic 8 will focus on symptom management. During this topic, the participants will be taught (a) the different strategies to help manage their symptoms, and (b) differences between
healthy and unhealthy coping strategies. They will also have the opportunity to explore/attempt new coping strategies.

- **Topic 9** will focus on boundaries and harassment. During this topic, the participants will learn about the difference between harassment, boundaries and norms. Discussions will be held concerning what acceptable behaviour is and is not. The participants also will have the opportunity to discover and talk about their own personal boundaries.

- **Topic 10** will focus on stress, specifically (a) what stress is, (b) what causes stress, (c) the physical effects of stress, (d) how it affects mood and (e) how it affects behaviour. This topic will also focus on healthy strategies to cope with stress, as well as unhealthy ways.

- **Topic 11** will focus on emotion regulation, specifically how emotions communicate to ourselves, as well as to others, and how they motivate and determine our thoughts and behaviours. This topic will also focus on the model for describing emotions (e.g., vulnerability factors, prompting factors, interpretation, emotional experience and urges, emotional expression, after effects).

- **Topic 12** will focus on sleep hygiene. This will involve discussing what healthy sleep is and 12 tips were reviewed on how to improve one’s sleep.
Orientation Group Manual
Introduction

Session Outline
- Introduction to the MIICU
- Orientation Group
- Starter Strategies: Self-monitoring and Thoughts-Feelings-Behaviours

What is expected of those who live on the MIICU?

Offenders that live on MIICU are expected to exhibit the following:
- Medication compliance
- Participation in therapy and groups based on individual needs/treatment plan
- Motivation to learn and build skills to manage their mental illness
- Implementation of the strategies and skills learned in groups, therapy and programs into everyday life
- Appropriate behaviour/conduct with other offenders and staff
- Participation in institutional programs as needed such as school, chapel, Aboriginal programs

Orientation Group

The purpose of the Orientation Group is to provide you with initial information that will help you begin to learn and be successful on the unit. The group will consist of the following sessions:

1. Introduction
2. Mental Illness
3. Mental Illness continued
4. Stigma
5. Change
6. Self-Care
7. Suicide Prevention
8. Symptom Management
9. Boundaries and Harassment

By the end of this group you will have learned the information you need to participate in other groups offered on the unit, as well as the beginning skills needed to take care of yourself and manage your symptoms.

Group Rules

- **Attendance** - The only reasons not to attend are medical and lawyer appointments. If you are sick, get word to us. You must make up missed sessions.

- **Conduct** – Be polite and respectful, keep swearing to a minimum, one person speaks at a time, wait your turn, stay on topic, listen, etc.
Participation (effort) – Try your hardest and participate as much as possible in the group. The more you put into it, the more you will get out of it. Ask questions.

Complete Homework – the expectation is that you will complete your homework each week. If you do not understand or are unable to complete it on your own, you can ask one of the facilitators to assist you.

Feedback – Feedback is when you tell someone else about how they did. You may provide constructive (helpful) feedback to other group members. The facilitators will provide feedback to each group member.

Disagreements – we will disagree sometimes. That is ok. We will need to discuss it and move on.

Confidentiality – what happens in the group, stays in the group. Do not discuss what is shared in the group on the range. Staff may need to discuss what is shared during group and may end up in reports.

Upon completion of this program you will receive a certificate for your effort!

Starter Strategies

There are some basic concepts that it is essential for you to learn in order to be successful on the unit and in therapy/groups.

Self-Monitoring

Self-monitoring is a tool that we use on the IMHCU to help you identify how you are feeling/managing. This is an important strategy to use because it can help you identify early signs that you are struggling and make it easier for you to address concerns. It is also a great way for you to problem solve and recognize progress. It will help you recognize triggers in your environment so that you can learn to avoid or cope with them.

There are lots of different ways to self-monitor, but the simplest way is to use the Traffic Light model.

- GREEN means GO! When you are self-monitoring and you are GREEN, it means you are good, feeling fine, maybe even excited. You are ready to learn and engage in your daily activities.
- YELLOW means BE CAREFUL. You would say you are YELLOW if you feel like you are starting to lose control; things aren't 100% right now. You may find it difficult to concentrate on your daily tasks and are not able to function fully.
- RED means STOP! You would say that you are RED if you are feeling bad, upset, losing control. You would find it very challenging to function in your daily life. You may be irritable or withdrawn. You would be unable to function in the group setting.
The goal of self-monitoring is to prevent getting to the point of RED. It is really difficult to cope when you get to this point. As you get better at monitoring, you will be able to recognize when you are YELLOW and have strategies you can rely on to help you return to GREEN. It may be helpful to write down the strategies that help you calm down and return to a GREEN state. When we are YELLOW and RED and not fully functioning it can be difficult to think of these things.

In the Orientation group we are going to self-monitor at the beginning and end of each session. It is helpful for other people to know how you are doing so that they can provide support or to give you space if that is what you need.

**Thoughts-Feelings-Behaviours**

Another concept it is important for you to understand is how our thoughts, feelings and behaviours are connected. Below is a diagram of how they relate to each other:

Thoughts: what we think in our head or what we say to ourselves. They can be negative, positive or neutral. Examples of thoughts include:

- I hate that guy.
- I look good today.
- The food here is gross.
- That officer usually follows through on what he says.

Feelings: Our emotions. They can be negative, positive or neutral. Examples of feelings include:

- Angry
- Happy
- Sad
- Excited
- Lonely
- Scared
- Overwhelmed
- Content

Behaviours: What we do or how we act. They can be negative, positive or neutral. Examples of behaviours include:

- Singing
- Sleeping
- Fighting
- Talking
- Pacing
- Eating

Physical reactions are also important to consider when discussing thoughts, feelings and behaviours. Physical reactions are messages from the body. They help us recognize how our body is reacting to a situation. Examples include:

- Heart rate
- Flushed face
- Breathing rate
- Headache
- Energy level
- Body aches
All of these things are interrelated. The way we think impacts the way we feel and act. For example:

If we THINK- I am not good at anything.

Then we FEEL- sad, worthless, depressed, upset

Then we BEHAVE- don’t participate in activities, don’t socialize, sleep all day, self-harm, stop eating

Physical reactions may include: low energy level, headache, body aches

These are all negative. Because our thoughts are negative it results in negative feelings and behaviours. If we can change one of these things then it has a direct effect on the other areas. For example:
Change our THOUGHTS- I can only try my best.

Then we FEEL- Excited, motivated, happy

Then we BEHAVE- try new activities, engage with others, go to yard, eat well
Physical cues may include: energized, alert

This concept is important to implement into your daily life. If you SELF-MONITOR and notice that you are yellow or red then maybe paying attention to your THOUGHTS-FEELINGS-BEHAVIOURS can help you return to green. Understanding how these things are connected will help you stay motivated, engaged and positive in your daily life!
**Homework**

For homework this week complete the following activities and bring them to the next session:

1. List the groups available on the unit you think would be helpful for you or that you are interested in trying. Why?

2. Complete the cognitive triangle worksheet to work on the concept of thoughts-feelings-behaviours.

3. Self-Monitor on a daily basis for the next week. Record your monitoring on the chart provided. In the empty column write down why you think you feel the way you did. If you indicated that you were yellow or red write down the strategies you used to return to green.

   Example:

<table>
<thead>
<tr>
<th>MONDAY</th>
<th>Red</th>
<th>Yellow</th>
<th>Green</th>
</tr>
</thead>
<tbody>
<tr>
<td>L</td>
<td>K</td>
<td>J</td>
<td></td>
</tr>
<tr>
<td>10 9 8</td>
<td>7</td>
<td>6 5 4 3 2 1</td>
<td></td>
</tr>
</tbody>
</table>

   Yellow today because I was supposed to have Rec group and it was cancelled. I was all ready to go and was really disappointed. To return to green I decided that I would do some drawing in my cell to distract myself and make sure to ask one of the staff why the group was cancelled.
### Self-Monitoring Sheet

<table>
<thead>
<tr>
<th>DAY 1</th>
<th>Red</th>
<th>Yellow</th>
<th>Green</th>
<th>Comments:</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>10</td>
<td>9</td>
<td>8</td>
<td>7 6 5 4 3 2 1</td>
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</tbody>
</table>

<table>
<thead>
<tr>
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<th>Yellow</th>
<th>Green</th>
<th>Comments:</th>
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<tr>
<td></td>
<td>10</td>
<td>9</td>
<td>8</td>
<td>7 6 5 4 3 2 1</td>
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</table>

<table>
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<th>Yellow</th>
<th>Green</th>
<th>Comments:</th>
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<tr>
<td></td>
<td>10</td>
<td>9</td>
<td>8</td>
<td>7 6 5 4 3 2 1</td>
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</table>

<table>
<thead>
<tr>
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<th>Yellow</th>
<th>Green</th>
<th>Comments:</th>
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<tr>
<td></td>
<td>10</td>
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<td>8</td>
<td>7 6 5 4 3 2 1</td>
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</table>

<table>
<thead>
<tr>
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<th>Red</th>
<th>Yellow</th>
<th>Green</th>
<th>Comments:</th>
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<tr>
<td></td>
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<td>8</td>
<td>7 6 5 4 3 2 1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
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<th>Red</th>
<th>Yellow</th>
<th>Green</th>
<th>Comments:</th>
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<tr>
<td></td>
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<td>8</td>
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</table>

<table>
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<th>Yellow</th>
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<tr>
<td></td>
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<td>9</td>
<td>8</td>
<td>7 6 5 4 3 2 1</td>
</tr>
</tbody>
</table>
Cognitive Triangle Worksheet

EVENT                   THOUGHTS                      FEELINGS                   BEHAVIOURS

“Something Happens” → “I tell myself something” → “I feel something” → “I do something”
Goal Setting
PERSONAL GOAL SETTING
How to live your life your way

Many people feel that they are adrift in the world. They work hard but don’t seem to be getting anywhere worthwhile.

A key reason that they feel this way is that they haven’t spent enough time thinking about what they want from life and haven’t set themselves former goals.

Goal setting is a powerful process for thinking about your ideal future, and for motivating yourself to turn your vision this future into reality.

The process of setting goals helps you choose where you want to go in life. By knowing precisely what you want to achieve, you know where to concentrate your efforts. You’ll also quickly spot the distractions that can, so easily lead you astray.

Why set goals?

Top-level athletes, successful business-people and achievers in all fields all set goals. Setting goals gives you long-term vision and short-term motivation. It focuses your acquisition of knowledge, and helps you to organize your time and your resources so that you can make the very most of your life.

By setting sharp, clearly defined goals, you can measure and take pride in the achievement of those goals, and you'll see forward progress in what might previously have seemed a long pointless grind. You will also raise your self-confidence, as you recognize your own ability and competence in achieving the goals that you've

Next, complete the Goal Defining Worksheet

Starting to Set Personal Goals

You set your goals on a number of levels:

• First you create your "big picture" of what you want to do with your life (or over, say, the next 10 years), and identify the large-scale goals that you want to achieve.
• Then, you break these down into the smaller and smaller targets that you must hit to reach your lifetime goals.
• Finally, once you have your plan, you start working on it to achieve these goals.

This is why we start the process of setting goals by looking at your lifetime goals.

Then, we work down to the things that you can do in, say, the next five years, then next year, next month, next week, and today, to start moving towards them.

What are life goals?
Life goals are the important things people accomplish that give them a sense of success and satisfaction.

People differ on what is important to them and what will bring them a sense of success and satisfaction.

Examples of Life goals:

- Staying well physically and mentally
- Avoiding unhealthy and dangerous habits
- Getting a job you like
- Completing school or training program that teaches wanted skills.
- Having good relationships with family and friends.
- Having a romantic partner or getting married
- Living in a place that is comfortable and safe.
- Enjoying recreational and social activities
- Having spirituality in your life
- Setting Smaller Goals

List some of your life goals here:
Understanding Barriers That Get in The Way of Achieving Goals

There are many reasons why a person might have a hard time choosing, getting or keeping a goal. The reasons why are called “barriers” because they stand in the way of a person choosing, getting or keeping goals.

Some barriers are directly related to symptoms of a mental health problem.

Some barriers are problems that are associated with having a mental health problem, such as stigma.

Some barriers are just part of what all people face when they make an important change in life.

Accomplishing important goals is not easy. It is not unusual for barriers to get in the way.

Now that you understand what barriers are, brainstorm some examples:

1. Mental Health symptoms get in the way
2. I am afraid to change in case I fail
3. I don’t know how to accomplish my goals
4. I can’t figure out what’s important to me
5. I don’t feel it is possible for me to achieve goals

Understanding Strategies to Overcome Barriers That Get in The Way of Achieving Goals

Overcoming barriers means figuring out what gets in our way and taking healthy and effective steps to deal with it.

What barriers do you see getting in the way of your personal goals and what are some strategies to help you overcome those barriers? Complete the personal Barriers Worksheet

Tips to remember

Goals are not exactly the same as wishes, hopes or dreams.

Our wishes hopes or dreams can be a good starting point to figure out what’s important to us.

We start having goals when we turn our dreams, hopes and wishes into a step by step plan of action.

Next, complete the Goal Setting Worksheet.
FIVE RULES TO SET YOURSELF UP FOR SUCCESS
THE GOLDEN RULES

Have you thought about what you want to be doing in five years' time? Are you clear about what your main objective at work is at the moment? Do you know what you want to have achieved by the end of today?

If you want to succeed, you need to set goals. Without goals you lack focus and direction. Goal setting not only allows you to take control of your life's direction; it also provides you a benchmark for determining whether you are actually succeeding. Think about it: Having a million dollars in the bank is only proof of success if one of your goals is to amass riches. If your goal is to practice acts of charity, then keeping the money for yourself is suddenly contrary to how you would define success.

To accomplish your goals, however, you need to know how to set them. You can't simply say, "I want" and expect it to happen. Goal setting is a process that starts with careful consideration of what you want to achieve, and ends with a lot of hard work to actually do it. In between there are some very well defined steps that transcend the specifics of each goal. Knowing these steps will allow you to formulate goals that you can accomplish.

1. Set Goals that Motivate You

When you set goals for yourself, it is important that they motivate you: this means making sure that they are important to you, and that there is value in achieving them. If you have little interest in the outcome, or they are irrelevant given the larger picture, then the chances of you putting in the work to make them happen are slim. Motivation is key to achieving your goals.

Set goals that relate to the high priorities in your life. Without this type of focus, you can end up with far too many goals, leaving you too little time to devote to each one. Goal achievement requires commitment, so to maximize the likelihood of success, you need to feel a sense of urgency and have an "I must do this" attitude. When you don't have this, you risk putting off what you need to do to make the goal a reality. This in turn leaves you feeling disappointed and frustrated with yourself, both of which are de-motivating. And you can end up in a very destructive "I can't do anything or be successful at anything" frame of mind.

**Tip:**

To make sure your goal is motivating, write down why it's valuable and important to you. Ask yourself, "If I were to share my goal with others, what would I tell them to convince them it was a worthwhile goal?" You can use this motivating value statement to help you if you start to doubt yourself or lose confidence in your ability to actually make the goal happen.
2. Set SMART Goals

You have probably heard of "SMART goals" already. But do you always apply the rule? The simple fact is that for goals to be powerful, they should be designed to be SMART. There are many variations of what SMART stands for, but the essence is this – goals should be:

- Specific.
- Measurable.
- Attainable.
- Realistic.
- Time Bound.

Set **Specific** Goals

Your goal must be clear and well defined. Vague or generalized goals are unhelpful because they don't provide sufficient direction. Remember, you need goals to show you the way. Make it as easy as you can to get where you want to go by defining precisely where you want to end up. Be as specific as you can about your goal.

For example a general goal would be:

"I want to travel to Europe".

A specific goal would be:

"I want to travel to Europe for 4 weeks between September and August 2014. I need $X amount of money to do so."

Set **Measurable** Goals

Include precise amounts, dates, and so on in your goals so you can measure your degree of success. If your goal is simply defined as "To reduce expenses" how will you know when you have been successful? In one month's time if you have a 1 percent reduction or in two years' time when you have a 10 percent reduction? Without a way to measure your success you miss out on the celebration that comes with knowing you have actually achieved something. Establish a means to measure your progress.

For example,

"I need $4000 for my trip that is 10 months away; therefore I need to save $400 a month. One month from establishing these goals and for each month following."
Set **Attainable** Goals

Make sure that it's possible to achieve the goals you set. If you set a goal that you have no hope of achieving, you will only demoralize yourself and erode your confidence.

However, resist the urge to set goals that are too easy. Accomplishing a goal that you didn't have to work hard for can be anticlimactic at best, and can also make you fear setting future goals that carry a risk of non-achievement. By setting realistic yet challenging goals, you hit the balance you need. These are the types of goals that require you to "raise the bar" and they bring the greatest personal satisfaction. When you identify a goal, write it out and make a plan, you are making an attainable goal. You will see opportunities arise that will help you in accomplishing this goal. You will develop a positive attitude working towards an attainable goal and you will develop traits that will give you the strength to see it through.

Set **Realistic** Goals

Goals should be realistic to the direction you want your life to take. By keeping goals aligned with this, you'll develop the focus you need to get ahead and do what you want. Set widely scattered and inconsistent goals, and you'll fritter your time – and your life – away.

Set **Time-Bound** Goals

You goals must have a deadline. Again, this means that you know when you can celebrate success. When you are working on a deadline, your sense of urgency increases and achievement will come that much quicker.

**Next, complete the “SMART Goal-Setting” worksheet**

3. Set Goals in Writing

The physical act of writing down a goal makes it **real** and **tangible**. You have no excuse for forgetting about it. As you write, use the word "**will**" instead of "would like to" or "might."

For example,

“I will write a work book on “**How to add 10 years to your life**” that is at least 150 pages in length and get it completed by June 30th 2008. I will write at least 4 pages every weekday until I complete the book.”

**Not**

I would like to write a book on “How to add 10 years to your life”

The first goal statement has power and you can "see" yourself writing the book, the second lacks passion and gives you an excuse if you get side tracked.
Tip 1:
If you use a To-Do List, make yourself a To-Do List template that has your goals at the top of it.

Tip 2: Post your goals in visible places to remind yourself every day of what it is you intended to do. Put them on your walls, desk, wherever you will remember to look for them.

**Complete the To-Do List Worksheet**

4. Make an Action Plan: Plan it out

This step is often missed in the process of goal setting. You get so focused on the outcome that you forget to plan all of the steps that are needed along the way. By writing out the individual steps, and then crossing each one off as you complete it, you'll realize that you are making progress towards your ultimate goal.

For each goal create a time frame. Write down the day, month and year in which you will complete the goal by. This is especially important if your goal is big and demanding, or longer term.

For each goal write down what you need to achieve that goal including skill, education, career advancement or change, finances, resources, etc.

For each goal write down the actions that you will need to take in order to complete the GOAL and the steps required to complete the actions.

Use one of the worksheets provided. Things to do Today, Daily, Weekly and Monthly Planner worksheets will not only provide direction but are a tangible way of checking how you are progressing towards reaching your goals. A record of your success!

5. Stick With It!

Remember, goal setting is an ongoing activity not just a means to an end. Build in reminders to keep yourself on track, and make regular time-slots available to review your goals. Your end destination may remain quite similar over the long term, but the

**Key Points**

Goal setting is much more than simply saying you want something to happen. Unless you clearly define exactly what you want and understand why you want it the first place, your odds of success are considerably reduced. By following the Five Golden Rules of Goal Setting you can set goals with confidence and enjoy the satisfaction that comes along with knowing you achieved what you set out to do.

So, what will you decide to accomplish today?
Achieving Your Goal

When you've achieved a goal, take the time to enjoy the satisfaction of having done so. Absorb the implications of the goal achievement, and observe the progress that you've made towards other goals.

If the goal was a significant one, reward yourself appropriately. All of this helps you build the self-confidence you deserve.

With the experience of having achieved this goal, review the rest of your goal plans:

- If you achieved the goal too easily, make your next goal harder.
- If the goal took a dispiriting length of time to achieve, make the next goal a little easier.
- If you learned something that would lead you to change other goals, do so.
- If you noticed a deficit in your skills despite achieving the goal, decide whether to set goals to fix this.
Goal Defining Worksheet

What do I want out of life?

What do I enjoy doing?

What am I good at?

What are my positive personality traits?

What gets me motivated?

Who is my role model and why?
<table>
<thead>
<tr>
<th>Personal barrier</th>
<th>Strategy to overcome barrier</th>
</tr>
</thead>
</table>


GOAL SETTING WORKSHEET

Living Environment Goals

1. Move into general population at Bath Institution

2. Be transferred to a camp

3. ____________________________________________

4. ____________________________________________

Employment Goals

1. Learn a new job skill

2. Apply for another job I find interesting

3. ____________________________________________

4. ____________________________________________

Learning Goals

1. Learn a new life skill

2. Earn credits towards my high school diploma

3. Complete my high school diploma

4. ____________________________________________

Leisure/Social Goals

1. Stay in touch with family and friends

2. Make new friends in general population

3. Learn a new sport (i.e., tennis)

4. ____________________________________________
Mental Health Goals

1. Develop new coping strategies to help the symptoms of my mental illness

2. ______________________________________________________________

3. ______________________________________________________________

4. ______________________________________________________________

Short Term Goals

1. ______________________________________________________________

2. ______________________________________________________________

3. ______________________________________________________________

4. ______________________________________________________________

5. ______________________________________________________________

Long Term Goals

1. ______________________________________________________________

2. ______________________________________________________________

3. ______________________________________________________________

4. ______________________________________________________________

5. ______________________________________________________________
SMART Goal-Setting Worksheet

Step 1: Write down your goal in as few words as possible

My goal is to:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Step 2: Make your goal detailed and SPECIFIC

Example: I want to lose 10 pounds in 2 months and i will eat properly and exercise at least 3
days a week to accomplish my goal
HOW will you reach your goal? List at least 3 SPECIFIC action steps you will take:

1. ___________________________________________________________________________
   ___________________________________________________________________________

2. ___________________________________________________________________________
   ___________________________________________________________________________

3. ___________________________________________________________________________
   ___________________________________________________________________________

Step 3: Make your goal MEASURABLE. Add details, measurements and tracking details.

When answering these questions, ask yourself
• How will I know when the goals have been achieved?
• How will I verify the achievement/performance of my goal?

I will measure/track my goal by using the following numbers and methods:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

I will know I have reached my goal when:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
Make your goal ATTAINABLE. What additional resources do you need to achieve your goal?

Items that I need to achieve my goal are:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

I will find time to achieve my goal by:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

The things I need to learn more about in order to achieve my goal are:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

The people I can talk to for support are:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Make your goal REALISTIC.

I want to reach this goal because:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Make your goal TIMELY. Put a deadline on your goal and set some benchmarks

I will reach my goal by (date): __/__/__.
# Things To-Do Today!

Today’s Date is: ______________

My Goal is:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

<table>
<thead>
<tr>
<th>TASKS THAT WILL HELP ME WORK TOWARDS ACHIEVING MY GOAL</th>
<th>HAVE I COMPLETED MY TASK?</th>
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<tbody>
<tr>
<td></td>
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Mental Illness
Mental Illness

Session Outline
• Learn about mental illnesses in general
• Learn the causes, symptoms, and treatment options for different mental illnesses

Mental Illness in General

It is important for us to learn about different mental illnesses while living on the MIIC unit because everyone that lives on the unit has experience coping with one. There are many different types of mental illness, but they can all make it difficult for a person to function in their daily life.

Causes of Mental Illness

The following is a list of some of the common causes or contributors to mental illness:

• Hereditary/runs in families
• Differences in chemicals in the brain
• Differences in how the brain is formed/structured
• Emotional abuse/trauma
• Social environment
• Interpersonal experiences/problems with other people
• Substance use-drugs and alcohol

The list above does not include all of the factors that may contribute to mental illness, but includes the most common.

Types of Mental Illness

There are different categories of mental illness that share common features. The following are some of the more common types of mental illness:

• Anxiety Disorders: response of fear, dread or physical signs of nervousness to an object or situation that is in appropriate, cannot be controlled or interferes with functioning.
• Mood Disorders: consistent feelings of sadness, periods of happiness or fluctuations from extreme happiness to extreme sadness.
• Psychotic Disorders: distorted awareness and thinking that may involve hallucinations and delusions.
• Eating Disorders: Extreme emotions, attitudes and beliefs about weight and food.
• Addiction and Impulse Disorders: inability to resist urges or impulses to do things that could be harmful to self or others.

Again, the list above does not include all types of mental illness, but does include some of the main illnesses that exist on the MIICU.

Effect on an Individual’s Life
The effect that a mental illness has on a person’s life depends on the symptoms that individual experiences and how they cope with them. Common effects include:

- Difficulty dealing with stress
- Difficulty following normal routines
- Dependent on other people
- Feel hopeless and/or helpless
- Difficulty interacting with other people
- Difficulty being in groups

**Types of Treatment**

There are many different ways that people with mental illness can get help. Below are some of the more common treatments:

- Counseling/therapy with a professional
- Medication
- Group therapy programs

**Barriers to Treatment**

Many individuals with mental illness do not get help to manage their symptoms. Below are some common reasons that people do not get help:

- Not sure what is wrong and don’t know that they have an illness
- They think that they are just different
- Think they can beat it on their own
- They are ashamed so try to hide it from others
- Do not have supportive friends and family
MYTH OR FACT?

1. My mom has schizophrenia, this means I will get it too
   - **MYTH**
   - **FACT**

2. The brains of people with mental illness look different and perform differently than other people
   - **MYTH**
   - **FACT**

3. Using drugs may trigger a mental illness episode
   - **MYTH**
   - **FACT**

4. I get nervous when presenting in front of groups, but once I get started I am fine. This means I have an anxiety disorder
   - **MYTH**
   - **FACT**

5. When I am lying in my bed at night I hear voices that tell me what to do. This means I could have a psychotic disorder such as schizophrenia
   - **MYTH**
   - **FACT**

6. I am sad because my dog passed away. This means I have depression
   - **MYTH**
   - **FACT**

7. People with addictions could quit on their own if they really wanted to
   - **MYTH**
   - **FACT**

8. People with mental illness can lead a productive life
   - **MYTH**
   - **FACT**
9. People with mental illness have to take medication for the rest of their life
   
   MYTH
   FACT

10. People with mental illness are often ashamed and do not seek help
    
    MYTH
    FACT

11. People with mental illness always grow out of it as they get older
    
    MYTH
    FACT
Depression

Depression looks like:
- Mood is low (i.e., sad, disappointed, worthless).
- It is severe, lasts several weeks, and gets in the way of your day to day living (i.e., can’t work or be around others)
- The person may think differently (i.e., more negatively)
- The person may act differently (i.e., stay away from people)
- Being depressed could lead to substance abuse, anxiety, heart disease, isolation, relationship problems, family problems, school problems, and even suicide.

Symptoms (things the patient may report experiencing):
- Feeling worthless, helpless, or hopeless
- Feelings of sadness
- Trouble falling asleep and staying asleep
- Sleeping more or less than usual
- Eating more or less than usual
- Physical pain
- Problems focusing and making decisions
- Loss of interest in activities
- Decreased sex drive
- Avoiding other people
- Loss of energy and feeling tired
- Thoughts of death or suicide

Causes of depression include:
- Environment: specific, stressful life events (for example, death of close family member or friend, illness, financial problems)
- Chemical: an imbalance in the brain
- Psychological: thinking negatively
- Genetics/biological: can run in families

Possible treatments for depression include:
- Medication (antidepressants)
- Therapy/counselling (getting educated, focus on motivation, changing negative thoughts)
- Behavioural activation (increasing activity, developing goals)
Bipolar Disorder or Manic Depressive Disorder

Normal moods look like:
- Times of sadness are normal feelings experienced when dealing with difficult events or situations (for example the death of a loved one or losing your job)
- A solution to a problem makes us feel better

Bipolar Disorder looks like:
- Repeated change between 3 different moods
  1. Mania: high state where the person feels on top of the world, unbeatable, full of energy
  2. Depression: low state where the person feels worthless, sad, very little energy
  3. Well: feeling normal and doing well
- The mood swings can range from mild to severe

Symptoms (things the patient may report experiencing)

**Mania:**
- Extremely hopeful
- Exaggerated self-esteem
- Very fast speech
- Very fast thoughts
- Less need for sleep
- Easily annoyed or irritated
- Impulsive and reckless behaviour
- Doesn’t think about consequences

**Depression:**
- Feeling helpless or hopeless
- Feelings of sadness
- Sleeping more or less than usual
- Eating more or less than usual
- Physical pain
- Loss of interest in activities
- Decreased sex drive
- Loss of energy and tire

The causes may include:
- Biological and genetic – Can run in families
- Environment - stressful or traumatic events may trigger an episode
- Personal bad choices – i.e. drug abuse

Possible treatments include:
- Medications (mood stabilizer, antidepressants, antipsychotics)
- Therapy/Counselling (medication compliance, education, and motivation)
Psychotic Disorder: Schizophrenia

**Psychotic Disorder looks like:**
- There is a problem in how the brain works
- The person loses contact with what is real and what is in their imagination
- There are changes in the way the person thinks, believes, perceives (sees) and/or behaves
- The person may be confused and the symptoms are upsetting
- Schizophrenia is the most well known psychotic disorder

**Schizophrenia looks like:**
- Severely problematic thinking, feelings, and behaviours.
- Often appears in cycles of remission (no symptoms) and relapse (symptoms appear)

**Symptoms (things the patient may report experiencing):**
- *Delusions*: holding personal beliefs that are false (for example, the person believes they are famous or like god, believe their spouse is cheating on them when not true, believe that they are being followed or secretly listened to)
- *Hallucinations*: when a person senses (sees, hears, smells, tastes, feels) things that do not exist (for example, hearing voices which tell the person to do something, visual focus on something you cannot see, touching, scratching or brushing things off themselves, sniffing or holding their nose, spitting out food, etc., when there is no apparent reason to do so)
- *Disorganized speech*: what the person is saying no longer makes sense to others (move from one unrelated topic to another)
- *Disorganized behaviour*: trouble doing tasks they used to do (bathing, dressing, making food), stand in bizarre positions, and/or become very aggressive
- *Affect flattening*: do not express emotions

**The cause may include:**
- Unknown but thought to be genetic/biological - run in families

**Possible treatments include:**
- Medications (antipsychotics to reduce hallucinations and delusions)
- Therapy/Counselling (medication compliance, symptom management, relapse prevention)
Anxiety

Normal anxiety looks like:
- Everyone feels anxious/nervous, stressed, and scared at times (job interview, moving to a new cell, review board, public speaking).
- The feelings make you uneasy, but you are able to cope with symptoms.

Anxiety Disorder looks like:
- Stress/nervousness that lasts a long time and that cannot be dealt with.
- Common to have along with another disorder such as depression, an eating disorder or substance abuse.
- The illness affects behaviour, thoughts, emotions, and physical health.

Different types of Anxiety Disorders and their symptoms:
- **Panic Disorder**: panic attacks
  Symptoms: sudden terror, chest pain, racing heart, dizzy, short of breath
- **Phobias** – fears something specific (spiders, flying, open/closed spaces)
  Symptoms: fear, dizzy, instinct to leave, ongoing worry
- **Social Phobia** - fear and avoiding social situations (parties, the mall)
  Symptoms: feel paralyzed (stuck), insecure, muscle tension, shaking
- **Post-Traumatic Stress Disorder** - scary experience where physical harm was threatened or occurred (car accident, war, physical abuse)
  Symptoms: flashback, nightmares, depression, anger, and irritability
- **Obsessive-Compulsive Disorder** - ongoing unwanted thoughts or rituals (contamination, doubting, sexual or religious thoughts)
  Symptoms: repeat thoughts, washing, organizing, and counting
- **Generalized Anxiety Disorder**: repeated and exaggerated worry about routine life events and activities
  Symptoms: worry, nausea, trembling, fatigue, muscle tension, headache

Causes of anxiety disorders may include:
- Biological/chemical imbalance
- Genetics/biology
- Trauma
- Difficult life experiences

Possible treatments include:
- Medication (anti-anxiety, antidepressant).
- Therapy/Counselling (past traumas, motivation, thoughts/behaviour change).
Attention Deficit Hyperactivity Disorder (ADHD)

**ADHD looks like:**
- Difficulty paying attention (gets in the way of learning)
- Difficulty getting organized, sticking to a job, remembering appointments, or getting things done

**Symptoms (things the patient may report experiencing):**

**Inattention:**
- Little attention to detail
- Difficulty focusing on tasks
- Difficulty listening
- Difficulty following instructions
- Difficulty completing tasks
- Difficulty organizing
- Loses items
- Difficulty prioritizing

**Hyperactivity:**
- Impulsive behaviour
- Fidgeting/squirming
- Constantly restless
- Talks too much
- Blurts out answers
- Interrupts
- Trouble relaxing
- Irritated waiting in line

**Emotional responses:**
- Aggressive or violent
- Withdrawal, anxiety, depression
- Low self-esteem
- Mood swings (happy, sad, angry)
- Physical symptoms (headaches)

**Social effects:**
- Bullying
- Avoiding or refusing activities

**The causes of ADHD may include:**
- Not 100% sure what causes it
- Genetics/biology and/or substance abuse (smoking, drugs, and other toxins) may all play a role
- Biological differences in the brain (chemical signals, less activity)

**Possible treatments for ADHD include:**
- Medications (Ritalin)
Addiction

An addiction looks like:
- Any habit/behaviour that is hard to stop.
- Examples include smoking, eating, substances, gambling, and sex.
- The person continues the behaviour even though there are negative consequences/costs involved.
- The behaviour becomes a problem when it interferes with the person’s ability to function (social, work, health)
- Usually try lots of times to break the habit/quit.

Symptoms:
- Tolerance (need more of the substance/behaviour to feel same affect you did when you started)
- Withdrawal (experience unpleasant symptoms when you don't take substance)
- You become obsessed with addiction (starts to control your life)
- Behaviour and mood changes
- Changes in relationships

Causes of addictions may include:
- Environment factors: People around you have addictions (peer pressure, poverty).
- Psychological factors: Going through a trauma or hard time (conflict, tragedy in family, stress).
- Biological factors: Addictions tend to run in families (family history of addictions).

Possible treatments for addictions include:
- Therapy/counseling
- Groups (AA or NA)
- Medication
**Homework**

For homework this week answer the following questions about mental illness:

1. What are the 3 types of eating disorders?

2. List 3 symptoms that a person with depression may experience.

3. A person with bipolar disorder may experience periods of both mania and depression.

   TRUE or FALSE

4. What symptoms may a person with schizophrenia experience?

5. To be diagnosed with an anxiety disorder a person needs to experience anxiety/nervousness that lasts a long time and cannot be dealt with.

   TRUE or FALSE

6. What affect may ADHD have on a person’s life?

7. List two symptoms a person with addiction may experience.

8. What is the cause of fetal alcohol syndrome?

9. Name 3 treatments that will assist in managing the symptoms of mental illnesses.

10. What did you learn about mental illness during the poster presentations?
Stigma
Stigma

Session Outline

• Learn what the word STIGMA means
• Discuss common stigma faced by people with mental illnesses and criminal histories
• Learn how to manage stigma

Stigma

Stigma may be a word that you have not heard before, but it is likely that you have experienced the effects that it can have on a person. The word stigma means:

• When someone judges you negatively based on a quality or trait such as having a mental illness.
• Stigma often results in people being treated differently or being set apart from others.
• Stigma results in bias such as not being hired for a job because you have a criminal history or a mental illness.

Stigma often results from people having a lack of knowledge or understanding about a certain trait and so they make assumptions. They often group people together or make judgments based on what they have seen in the media, what other people have told them or a particular experience they have had.

For example:

• A person may believe that all people with schizophrenia are dangerous because they saw a story on the news about a person with schizophrenia who attacked someone.
• This person is grouping all people with schizophrenia together as people who are dangerous and violent even though most people with schizophrenia are not violent and dangerous.

There are a number of groups that experience stigma, including people of different:

• Race
• Age
• Sexuality
• Gender
• Religion
• Mental or physical illnesses
• Criminal history

Stigma can affect the way we think about and behave toward other people. We have already discussed how our thoughts, feelings and behaviours are all connected so if stigma results in negative thoughts then our feelings and behaviours will also be negative.

Example:

If you THINK people with addictions can’t be trusted and have no will power.
You may FEEL angry, distrustful, suspicious of them.
This may cause you to BEHAVE in a way such as not talking to them, saying that they do not care about their families or they would quit, etc.

If we are able to change our negative thoughts caused by stigma, this will change our feelings and behaviour.

Many people that are stigmatized believe that there is nothing they can do to manage it or be happy again. This is not true. We have little to no control over how others think of us, however, we can learn how to change our own thoughts, feelings and behaviours to help us manage the stigma we are experiencing to limit the impact it has on our life. We can also limit the stigma that we have towards other people by changing our thoughts.

*Example:* Education on different mental illnesses will hopefully help you to recognize that people with mental illness are not weak and ‘crazy’, but need support/treatment to learn to cope with their symptoms.

**Common Stigma**

There are many stigmas that those with a diagnosis of a mental illness and those with a criminal history can face. Below is a list of common stigmas people with *mental illness* often report experiencing:

- Difficulties finding friends and forming lasting relationships
- Being treated like they’re different or that something is wrong with them
- Feeling unloved and unaccepted by family and friends
- Difficulty finding and keeping jobs
- Afraid to ask for help because it means they can’t cope
- Deny that they have a mental illness because they think it is something to be ashamed of
- Start to believe the negative things others/media might say about them
- Starting to think that they are no good
- Denied housing
- Denied bank loans
- Difficulties going to school
- Denied healthcare benefits

Below is a list of common stigmas people with a *criminal record* often report experiencing:

- People don’t treat them fairly
- People judge them and may assume negative things (violent, dangerous, bad person)
- Difficulty forming new relationships
- Difficulty maintaining old relationships
- Problems with getting custody of child
- Difficulty getting and keeping a job
- Embarrassed about people finding out criminal history
- They think they are a bad person
- Begin to feel ashamed and embarrassed
- Don’t think they’re good enough (father, husband...)

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• Denied travelling or immigrating to other countries
• Feeling rejected from society and community
• Restrictions - Unable to attend church because it’s beside a school
• Denied benefits or insurance
• Denied certain medications

As you can see, many of the stigmas faced by both of these groups are similar. People may not experience all of these or they may experience other effects of stigma. It is important to learn about stigma and the common beliefs out there so you can learn to manage and limit the effect it has on your life.

**Managing Stigma**

Although we cannot eliminate stigma in our lives, we can learn different ways to manage and limit the impact it has on our life. Below is a list of things we can do to help us manage the stigma in our lives specifically regarding having a mental illness diagnosis:

• Educate yourself on your disorder
• Read books, come to group, ask questions
• Understand why you may think or act in certain ways
• Accept your illness. It will be difficult to overcome stigma if you’re in denial of your mental illness
• Don’t let embarrassment or shame from stigma get in the way of your treatment needs
• Talk to a doctor or your counsellor to help you get your symptoms under control
• Talk to family and friends about your mental illness
• Explain why you may be acting or thinking differently
• Don’t isolate yourself
• Join a support group
• Know that you are more than your illness
• Instead of saying “I’m bipolar” say “I have bipolar disorder”. Always put yourself first because you are more than a label or mental illness
• Express your opinions of stigma to others. This will not only help yourself but it can also encourage others who are facing similar challenges to speak up

The following is a list of things we can do to help us manage the stigma in our lives specifically regarding having a criminal history:

• Accept your criminal background so you can move forward
• Understand that you can’t change the past but can work towards a better future
• Don’t blame others for your mistakes
• Once you accept your mistakes it will be easier to move forward and get on with your life
• Don’t isolate yourself
• Speak with friends and family members
• Join a support group
• Express your opinions of stigma to others around you. This will help you and encourage others who are facing similar challenges to speak up.

There are many similarities between these two lists. The main ideas for helping manage stigma are to: educate yourself and others, take responsibility for your mistakes and behaviours, accept your illness/criminal history and speak out against stigma.
Change
Change

Session Outline
• Discuss change
• Learn about the stages of change
• Discuss how to make and cope with change easier

Change

Life is full of changes. Some changes are small and easy to cope with while others are large and seem impossible to manage. No matter what the change is, it is a process. Some changes are within our control.

Example: an individual can decide that they want to lose weight.

While other changes are imposed on us.

Example: being told you are moving to a new range.

All types of change result in emotional reactions from individuals such as feeling anxious/nervous, depressed, excited, angry, sad, scared, happy, relieved, etc. It is important to realize how thoughts and feelings about a change impact on behavior. Having positive thoughts will result in more positive feelings and behaviours, which will result in better management of the change.

Stages of Change

As discussed above, change is a process. There are different stages that occur when an individual is going to make a change in their life. The stages of change apply whether the change is voluntary or not. Change can be broken down into 5 major stages.

1. Awareness: The individual becomes aware that a change is needed/going to occur.
2. Determination: The individual decides to make a change/accepts the change.
3. Action: The individual puts a plan to change/cope with the change into action.
4. Maintenance: The individual maintains/adapts to the change over time.
5. Relapse: This may or may not occur. It involves the individual returning to previous negative behaviours. They will need to learn from their relapse in order to have increased awareness to start the stages again.
An individual may go through all of these stages in order, they may skip a stage and then go back to it later or they move back and forth between stages several times before reaching the maintenance stage. As stated before, change is a process so there is always the possibility of movement between these stages.

**Example:**
You have gained 20 pounds since moving to the IMHCU. You are finding it more difficult to get around and are losing your breath easily. You used to enjoy participating in yard and fitness programs, but have been spending most of your time in your cell. You have also been skipping dinner and instead fill your hunger with items you buy from canteen such as chicken wings, chips and pop. Several staff and friends have made comments about your weight gain over the last few weeks, but it hasn’t bothered you and you didn’t think it was a big deal. Now you are starting to feel unwell and tired throughout the day.

The stages of change that this individual may go through include:

1. **Awareness:** You realize that you have gained weight and that it is having an impact on your life. You notice that you are no longer participating in fitness activities and have unhealthy eating habits.

2. **Determination:** You decide that you no longer want to gain weight and you want to feel better/healthier.

3. **Action:** You make a plan to attend some of the fitness groups available to you and to stop buying unhealthy items from the canteen list. You plan to go to yard twice a week. You sign up for the yoga and exercise groups. You start eating dinner and allow yourself one treat per week.
4. Maintenance: You have been going to yard 2-3 times a week for the last two months and have continued to be an active member of the exercise and yoga programs. You are eating better and are sticking to your limit of one treat per week. You are feeling better and have lost 7 pounds!

5. Relapse: You attend an inmate social where the menu consists of fried chicken, poutine, ice cream, cake, pop and other unhealthy food. You indulge yourself and feel really unwell afterwards. Over the next week you have cravings for more junk food so you buy a couple bags of chips from the canteen list. You end up gaining back 3 pounds.

6. Awareness: You realize that you have gained back some weight and re-evaluate your fitness plan because you know you have to make a change to help you when you attend a social or get a craving.

In the scenario described the individual may be able to return to the Action stage or they may need to go through all of the stages again. Either way they need to learn from their relapse and make another change in order to be successful.

**How to Make and Cope with Change**

Change can be a positive thing, but it can also be difficult to do or cope with. In order for a person to make a change in their life they have to set goals. Goals can be either short-term or long-term. Short-term goals are things that can be achieved in the near future (days, weeks, months). An example of a short term-goal is:

I will sign up for the recreation group next week.

Long-term goals are things that usually take longer to achieve (years). An example of a long-term goal is:

I will get my high school diploma.

In order to set a goal an individual has to be aware of the areas in their life that need improvement (weaknesses), but they also need to be aware of the things that they are good at (strengths). An individual’s strengths will assist them in reaching their goals and overcoming their weaknesses. Individual strengths could include:

- Creativity
- Positive outlook
- Determination
- Thoughtfulness
- Curiosity
- Honesty
- Open-mindedness
- Self-regulation
- Modesty
• Self-awareness

There is an endless list of strengths that a person could have, but these are a few examples. Knowing what your strengths are will help you to be successful in achieving your goals and living a satisfying life.

Another important concept for change is hope. Hope is the want or belief that something can and will happen. In order for an individual to successfully make or accept a change, they have to have hope that they can do it. They have to trust in the process and know that they have the skills and support to make the change possible. Without hope, making or accepting a change will be almost impossible.

It can be very difficult to make or accept a change because there are numerous barriers that can get in the way including:

• Change is hard work/ it takes time and energy
• Fear of the unknown
• Doubt that you will be successful/no hope
• Negative attitude
• Difficulty giving up old behaviours and habits
• May involve loss including loss of friends, money, etc.
• Unsure of how to begin the change
• Lack of support from others

In order to successfully make a change an individual needs to make a plan that includes how to overcome any barriers that come up, as well as how to use their strengths to their benefit. A plan should be written down clearly so it can be easily followed and referred to. A plan should include:

• Identify the change
• Set short and long-term goals to make the change
• Identify any barriers that may arise
• Write down how to cope with or manage the predicted barriers
• Identify your strengths and how they can help make the change
• Identify supports such as friends, family, staff
• Identify resources for information/knowledge
• Adapt the plan as the change occurs to make sure that the change is maintained over time

There are also lots of other things that help make dealing with change easier including:
• Knowledge: Getting as much information as possible, asking questions, accessing resources
• Positivity: positive thoughts=positive feelings=positive behaviour
• Support: ask for help from friends, family and staff
• Plan: make a plan of action for the change and how to cope with it including how to manage any barriers or difficulties that may come up
• Coping strategies: use the coping strategies that work best for you when going through a time with instability such as relaxation, music, fitness, reading, groups, therapy, etc.

Making changes is an essential part of living a full and satisfying life!
Homework

Your homework this week consists of answering the following questions:

1. You have just been told that you are being moved to a new unit. Write down what you think may happen in each of the stages of change.

Awareness:

Determination:

Action:

Maintenance:

Relapse:
2. Identify a change that you would like to make in your life and fill in the chart below to make a plan:

3. What is the change:

Identify two goals to make the change:  

1. 

2. 

What barriers may come up:

How will you manage these barriers:

What are your strengths:

What are your supports:

What resources can you access:
Self-Care
Self-Care

Session Outline

- Discuss self-care, hygiene and sleep
- Learn about healthy life balance

Self-Care, Hygiene and Sleep

Self-Care

Self-care is a broad topic that includes many of the activities that are completed throughout the day. Self-care activities are vital to your health and well-being. The following are obvious self-care activities:

- Hygiene: showering, shaving, putting on deodorant, etc.
- Brushing your teeth
- Taking medication
- Eating
- Sleeping
- Fitness

When people think about self-care these are often the areas that they think about, however, there are many other daily activities that are also considered self-care activities such as:

- Laundry
- Cleaning/tidying the house/cell
- Spiritual activities
- Relaxation
- Attending groups/therapy
- Setting and working toward goals

Self-care includes more than just taking care of our bodies. It includes taking care of our physical health, mental health and our environment. Self-care routines can take up a lot of time in the day, which is why most people end up having routines that they follow. For example, someone may shower, get dressed, brush their teeth and eat breakfast all within the first hour of being awake. Doing things in the same order and same way everyday makes it easier for us to manage the day and know what to expect. When something falls out of routine it is much more work and takes more effort. The bottom line is:

THE MORE CONSISTENT WE MAKE OUR SELF-CARE ROUTINES = THE EASIER THEY WILL BE AND THE LESS TIME THEY WILL TAKE

Hygiene

Hygiene is a very important part of good self-care. Individuals who have good hygiene routines are often more positive and feel more satisfied with their lives. Taking good care of your body will make you feel more prepared and ready for the day. It will also help prevent illness and maintain your health. Good hygiene consists of:
• Showering at least 3x/week and more in the summer or if completing physical activity. This includes washing your body and shampooing your hair.
• Shaving at least once a week or clipping/trimming your beard
• Brushing teeth twice daily- after breakfast in the morning and before bed at night
• Cutting nails regularly and keeping them clean
• Washing hands after using the washroom and before handling food
• Taking medication as prescribed
• Eating a healthy diet- follow Canada’s Food Guide
• Regular fitness-complete 30 minutes of fitness at least 3x/week
• Getting a good night sleep. Aim for 7-10 hours to feel rested and allow your body the rest it needs to function properly.

When an individual is having difficulty maintaining healthy hygiene routines it is often a sign that they are experiencing stress or other mental health problems. Self-care routines are often the first thing that an individual gives up on when they are having an increase in symptoms or are experiencing difficulties in their lives. If you notice that your hygiene routines are slipping, it may be an early warning sign that you are struggling with a bigger issue and may need to implement some coping strategies or talk to someone.

Sleep

Sleep is another very important self-care activity that is often overlooked. It is recommended that individuals get between 7-10 hours of sleep every night. This amount of sleep is essential to allow your body to rest and function optimally. Lack of sleep can result in many negative consequences such as:
• Decreased immune system
• Increase in symptoms
• Decrease in memory
• Decrease in mental function
• Fatigue and decreased physical function
• Increase in negative behaviour-short temper, frustration, irritability, etc.
• Poor decision making

Allowing your body time to rest at night allows it to repair itself and let’s your mind relax. Being in an institution, along with your own sleep habits, can make it difficult to get a good night sleep. It is important to be able to identify these factors and learn how to cope with them. Some things that may disrupt sleep include:
• Use of alcohol or drugs
• Caffeine intake
• New medication/change in medication
• Illness
• Noise level
• Temperature
• Stress
• Diet
• Exercise

There are lots of things you can do to help overcome these disruptions and allow yourself the opportunity to sleep well throughout the night. The following are some ways that you can improve your sleep hygiene:

• Go to bed at the same time every night.
• Wake up at the same time every morning.
• Establish a bedtime routine that you follow every night such as brushing your teeth, reading, drinking a warm drink, dimming the lights, etc. This will help your body and mind prepare for sleep.
• Eat healthy throughout the day. Try to avoid eating right before bed, as your body will stay awake to break the food down.
• Avoid napping and sleeping throughout the day. This will disrupt your night sleeping pattern and make falling asleep at night more difficult.
• Exercise regularly. Our bodies were meant to use up energy. Exercising throughout the day will make your body tired and help you feel satisfied when trying to fall asleep.
• Avoid stimulants such as alcohol, drugs, caffeine and nicotine, as they can be stimulants that make it difficult to sleep.

Self-care plays a very important role in our health and well-being. Good self-care routines can set us up for success in our lives!

**Living a Balanced Life**

Living a balanced life may seem like a simple concept, but it can be difficult to put into action. When areas of one’s life become unbalanced, the possibilities of relapse, hospitalization, rehabilitation, incarceration and/or illness are very real possibilities. A balanced lifestyle improves an individual’s ability to cope with stress, allowing them to become productive, positive, healthier and happier in all aspects of their life: physically, mentally and emotionally. Time use can be broken down into 4 different types of activities:

• Work: activities you have to do- you may or may not enjoy them
  o Job
  o Budgeting
  o Cooking
  o School

• Leisure: activities you do that are fun, relaxing and enriching that are healthy for you
  o Sports
  o Hobbies
  o Arts/crafts
  o TV
  o Music
  o Socializing

• Self-Care: activities that are vital to your health and well-being
  o Sleep
  o Medication
• Hygiene
• Eating
• Spirituality

• Unhealthy: activities and/or behaviours you do that are unhealthy
  • Drugs/alcohol
  • Self-pity
  • Worry/ ruminating
  • Self-harm
  • Excessive TV/video games
  • Socializing with negative people
  • Excessive sleep

Some activities may fall into more than one category based on the REASON that an individual completes it. For example, fitness or exercise may be both a self-care and leisure activity for individuals. If they participate in fitness for the health benefits then it would be self-care, but if they participate to engage with others and socialize then it may fall into the leisure category.

In order to live a balanced lifestyle, individuals need to engage in activities from the work, leisure and self-care categories every day. Too many hours spent on one category can result in poor outcomes. Engaging in unhealthy activities can also result in poor outcomes. These activities should be limited.

Example: an offender spends most of his time watching TV and playing video games in his cell. He does attend the recreation group and goes to yard to play cards with a couple of buddies. He finds it difficult to get up in the morning and get ready for the day. He is not sleeping well at night. He has found himself wondering more recently what the purpose of his life is.

In this scenario the offender is engaged in only unhealthy and leisure activities. It is affecting his mood and motivation to complete his self-care routines including his sleep. The offender would benefit from engaging in work related activities such as groups on the range, school or applying for an institutional job. He would also benefit from more exercise for self-care.

To help identify whether or not you are living a balanced life it can be helpful to write down or fill out a time use schedule for a week. The following is an example:

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Length</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>7am</td>
<td>Showered</td>
<td>15 min</td>
<td>Self-care</td>
</tr>
<tr>
<td>7:15am</td>
<td>Took meds</td>
<td>5 min</td>
<td>Self-care</td>
</tr>
<tr>
<td>7:30am</td>
<td>Ate breakfast</td>
<td>15 min</td>
<td>Self-care</td>
</tr>
<tr>
<td>7:45am</td>
<td>Watched TV</td>
<td>45 min</td>
<td>Leisure</td>
</tr>
<tr>
<td>8:30am</td>
<td>Life skills group</td>
<td>60 min</td>
<td>Work</td>
</tr>
<tr>
<td>9:30am</td>
<td>Canteen sheet</td>
<td>30 min</td>
<td>Work</td>
</tr>
<tr>
<td>10am</td>
<td>Wrote a letter</td>
<td>45 min</td>
<td>Leisure</td>
</tr>
<tr>
<td>10:45am</td>
<td>Listened to music</td>
<td>30 min</td>
<td>Leisure</td>
</tr>
<tr>
<td>11:15am</td>
<td>Ate lunch</td>
<td>20 min</td>
<td>Self-care</td>
</tr>
</tbody>
</table>
Once a time use schedule has been completed it is easy to see what areas an individual may need to cut back on and what areas need more attention. A plan for change, as discussed in the last session, can then be created for living a more balanced lifestyle. Balancing out the activities in your life will improve your satisfaction with life and make it meaningful!
For homework this week complete the following task:

Fill out the table below to track your time use over the next week. List all of the activities you participated in for each category. Beside each activity put how long you participated in it for:

**WORK:**
- Ex. School - 2hrs 5x/week = 10hrs

**LEISURE:**
- Ex. Visit - 2hrs

**SELF-CARE:**
- Ex. Shower - 15min 4x/week = 1hr

**UNHEALTHY:**
- Ex. Video games - 3hrs daily = 21hrs

Add up the amount of time you spend during the week in each category and then answer the following questions:

1. What category do you spend the most time on?
2. What category do you spend the least time on?

3. What activities could you add to your week to make your life more balanced?
Suicide Prevention
Suicide Prevention

Session Outline

• Learn about stressors, risk factors and warning signs for suicide
• Learn what to do if you or someone else is suicidal

Definitions

Suicide: is an act of voluntarily, or deliberately, taking one's own life.

Self-Injury/Self-Mutilation: are actions that may cause serious harm but the person did not hurt themselves in order to die. Examples of this are cutting, burning, or head-banging.

Suicidal Thoughts or Feelings: someone is thinking about killing him or herself. They may feel that there is no other way to solve their problems than to end their life. Or they may wish they were dead but have no intention of actually killing themselves.

Depression: is a sad or low mood that lasts for a long period of time. It can affect many areas of a person's life including physical health, emotions, and behaviours.

Depression is experienced differently by everyone. For example, some people who experience depression recover quickly and never become depressed again. Others may have periods of depression throughout their lives. Some people stay depressed for long periods of time, even years. If a person has been depressed in the past, they are more likely to experience depression again. People who have other mental or physical illnesses are at higher risk for depression (e.g., schizophrenia, HIV/AIDS, or cancer).

People who are depressed may cry a lot or experience a change in appetite or weight, lose interest in food, have sleep problems (sleep too much or too little), and have low energy. They may not be interested in others, participating in activities, taking care of themselves or making plans for their future. They may feel irritable or angry. People who are depressed may have feelings of anxiety, helplessness, and hopelessness. They may talk badly about themselves and feel very worthless and guilty for things that they have done in the past. People who are depressed may think about suicide.

Stressors that may contribute to Suicide Risk

Stressor: an activity, event, or thing that causes stress. Examples: parole hearing, upcoming release, issues on range, or a relationship break-up.

Many of us, if not all, have had a time or period in our lives where we felt like we just could not take it anymore. As stressful events and circumstances (or 'stressors') pile one on top of another, this can make us feel like we cannot go on. The way stressors affect us can be different from person to person. The type of situation, and the feelings that come with it, can develop quickly or slowly build over months or years.
Different Types of Stressors (General):

- Depression/ Loneliness
- Mental illness
- Financial problems
- Unemployment
- Frustration with life events/circumstances
- Abuse and violence
- Divorce/Separation/Breakdown of relationship
- Recent loss or death of someone close
- Family problems
- Addictions
- Serious and chronic physical illness or disability

Specific Events that can be Stressful:

- Holidays (e.g., Christmas time)
- Significant dates/anniversaries
- Legal decisions/new charges
- Denial of appeal/parole/transfer/UTAs/ETAs
- Parole suspension
- Sentencing changes and complications
- Loss or end of a relationship (e.g., relationship breakup or death)
- Upsetting visit or phone call from family
- Lack of/decreased visits or phone calls from family
- Incidents in the institution/on the unit
- Other inmate commits or attempts suicide in the institution
- Changes in medication

Stressors in the Institutional Environment:

- Strict environment/many rules
- Feeling like you have limited/no control over your life or the future
- Isolation from family, friends, and community
- Physical conditions of an institution (noisy, dirty, etc.)
- Fears of violence/Possible use of force by staff
- Conflict on range
- Guilt or shame over the conviction/offence
- Poor physical health or a terminal illness (e.g., Cancer, HIV/AIDS)
- Another inmate's suicide attempt(s)
- Loss of faith
- Boredom/lack of activities
- Isolation
- Placement in segregation
- Lengthy incarceration
- Transfer to another institution/another range
- Anxiety about upcoming release or concerns about release plan
• Threats of assault, bullying
• Outstanding debts

There is no typical person or profile of who can become suicidal. So it’s important to know the warning signs and possible stressors of suicide in order to help yourself and others.

Stressors can build up and can lead you, or someone else, to feel that you cannot go on. If you are aware of these stressors and you know how they affect you, you can do something and get help before the situation becomes critical. A good way to recognize your stressors before they become too overwhelming, is to use self-monitoring tools.

Self-monitoring is paying attention to what is happening. It involves using all of your senses: seeing, hearing, feeling, smelling, and touching. Self-monitoring is paying attention to yourself, your surroundings, and the effect you have on your surroundings.

**Signs and Symptoms of Suicide Risk**

Rarely does a suicide occur without there being signs or symptoms. If you notice these signs and symptoms in you or someone else, you need to act immediately to get help. The more signs of suicide, the greater the risk of suicide. These signs are often someone's 'invitations to help.' That is, the person may be thinking about suicide but unsure about whether or not to go through with it. They may be giving signs that they need help figuring this out. Therefore, these signs should not be ignored. Rather they are a sign that you need to take action.

The signs and symptoms of suicide can show up in different ways. For instance, someone's **thoughts, feelings, or behaviours** can all be clues to tell us that this person is in pain and may be thinking about suicide.

**Thoughts:** Someone thinking about suicide may appear to be distracted or have difficulty concentrating and/or staying focused on the conversation or what they are doing. They may talk about suicide or death directly or in a seemingly joking way. They may also say things like:

"I wish I were dead"
"All of my problems will end soon"
"I won't be needing these things anymore"
"I'm a loser"
"Everyone will be better off without me"
"I can't do anything right"
"No one can do anything to help me now"
"I just can't take it anymore"
"I just can't keep my thoughts straight anymore"
"My family would be better off without me"
"Nothing seems to work for me"
**Feelings:** For someone thinking about suicide, they may be having feelings such as:

- Sadness
- Distress
- Grief/loss
- Apathy or feeling that 'I just don't care what happens to me.'
- Low energy
- Feelings of being out of control
- Hopelessness
- Helplessness
- Worthlessness
- Feeling overwhelmed
- Anger, frustration, irritability
- Feeling trapped, terrified
- Loneliness
- Extreme mood changes (e.g., marked hostility to indifference)
- Feelings of failure, uselessness, lack of hope or loss of self-esteem
- Isolation, and despair

**Behaviour:** You may see changes in behaviour, such as:

- Increased agitation or frustration (e.g., being short with others)
- Excessive risk-taking/impulsivity
- Extreme changes in eating or sleeping habits
- Changes in appetite or weight
- Extreme or chronic fatigue
- Nightmares
- Outbursts of anger
- Using drugs or misusing prescription medication
- Withdrawal from family, friends, school, or work
- Unable to relate to others or avoiding others
- Being inactive
- Loss of interest in hobbies
- Boredom, lack of concern, indifference
- Giving away possessions
- Making final arrangements (e.g., drawing up a will)
- Self-injury (e.g., cutting, burning oneself)
- Collecting pills or other medications
- Not maintaining hygiene (e.g., not showering)

**Another key sign is a Current Suicide Plan.** This is a plan a person has for killing themselves.

*Signs to look for include:*

- Do they have very specific ways or ideas about how they are going to commit suicide?
• Is their suicide plan realistic?
• Is their suicide plan possible in the prison environment?
• Do they have a timeframe?

If you can tell that they have thought about this plan a lot and they know how they will do it, then this is a **high-risk situation** and that person needs to get help as soon as possible. None of these signs is a "for-sure" sign that someone is going to commit suicide. But when a number of these things happen at the same time, risk for suicide increases. We need to respect people's privacy and choices, but if we ask in a caring and respectful manner, we can do it without causing offence.

**What to do if You Are Suicidal**

If you are thinking about killing yourself you need to know what to do to get help. It is important that you get to know yourself and your feelings so that you can find help when you need it. It's up to you to let others know you are hurting. You will have an opportunity to complete a Safety Plan for homework to develop your own individual plan to help you get through crisis.
Who Can You Talk to if You Need Support?

<table>
<thead>
<tr>
<th>WHO IS YOUR SUPPORT CONTACT?</th>
<th>HOW CAN YOU REACH THEM</th>
<th>WHEN ARE THEY AVAILABLE?</th>
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</table>

What to do if someone else is suicidal?
If someone approaches you and says they are depressed, lonely, or possibly mentions suicide, what could you do to help?

GET HELP
Go find help!

Encourage them to reach out for help. For example, he could ask a guard to call their ‘BST’, Psychology staff or other staff. This way, you maximize the other person’s independence.

Tell him that he needs to see someone for help. Sources of help include Correctional Officers, Parole Officers, Psychology staff, Nurses, Chaplains, Elders or ALOs, Teachers, Work Supervisors, peer support team members, family, friends, or another inmate. As you can see, there are many different people who could be helpful, so if he is not comfortable speaking to one type of person, there are others.

Suicide is a difficult and challenging issue that is best dealt with through a great deal of sensitivity and the professional knowledge of qualified staff. If you are struggling with whether or not to tell someone else (e.g., a staff member) because it feels like you are breaking the "inmate code" (i.e., "ratting"), remind yourself that this person has come to you for help. They have told you about their thoughts/plans of suicide because they may want or need your help.
Even if they may have told you not to say anything, they need to know that help is needed and that you will try to get help for them. The best thing you can do for the suicidal person (including if it is you) is to not keep this information to yourself.

*What else can you do?*

- Listen non-judgmentally. Criticizing someone can lead them to turn away from the help you are offering.
- Don't rush to share your opinions or your own solutions with someone else. They might not work as well for that person.
- Let them talk about themselves. Don't change the subject to yourself or your problems.
- Be as calm as you can in your body language and speech.

*If you arrive on a scene of a suicide or self-injury, **CALL FOR HELP** immediately!*

**The Process of Helping**

1. **Suicide Prevention** includes education, information, and awareness of suicide risk, which we hope will help to protect you and others from suicide. By you being aware of stressors, and the signs and symptoms of suicide, and being able to recognize the facts and myths of suicide, you can help prevent suicide for yourself, fellow inmates, and your family and friends.

2. **Suicide Intervention** is finding help for someone who may be feeling suicidal, including yourself. By knowing who to contact, how to talk with someone who is at risk or suicidal, and what to do in a crisis situation, you are learning how to help yourself or someone else.

3. **Suicide Postvention, or "after-care,"** includes things a person can do if they have seen or been affected by the suicidal behaviour of another. It is equally important to know that it is not your fault if someone who confided in you or who you tried to help, decides to commit suicide. It may be important for you to seek support or talk to someone about your feelings about what happened. It is quite common to feel responsible and guilty after someone we know commits suicide, even if they did not reach out to us.
Homework

For homework this week complete the following:

1. Complete the Safety Plan

2. Are there any coping skills that you don’t have listed that you would like to learn?

3. Are there any supports that you don’t have listed that you would like to add to your support network? How would you do this?
**Safety Plan**

Warning Signs (e.g. thoughts, feelings, behaviours, recent events).

Coping strategies and activities that help you relax (e.g. listen to music, breathing exercises).

People that you can talk to and ask for help (e.g. your BST, friends).
Name:
Name:
Name:
Name:
Name:
Name:
Name:

What do I do if I’m in crisis?
1.
2.
3.

How can I make my cell more safe?
1.
2.
3.
Symptom Management
Symptom Management

Session Outline
• Learn about different strategies to help manage symptoms
• Explore/attempt new coping strategies for symptom management
• Create a list or toolbox of strategies for personal symptom management

Symptom Management

What are symptoms and why is symptom management important?

Individuals who have a diagnosis of a mental illness experience various symptoms that are associated with the illness and that have an impact on their lives. Usually a diagnosis is made based on the symptoms an individual is experiencing and how severely their ability to function in daily life is affected. For more information on specific mental health diagnoses and their symptoms refer back to session 2. Most individuals with mental health diagnoses implement coping strategies or symptom management techniques to help decrease the impact mental health symptoms have on their ability to function. Symptom management techniques are unique to each person and what works for one person may not work for another. Individuals often spend a lot of time determining what strategies will work best for them.

Determining the best symptom management plan can be a long process. Symptoms, the environment, and other factors in your life can change, which will require a change in the management strategies being used.

Symptom management is a key part of learning to live with a mental illness. It allows an individual to learn how to limit the effect an illness has on their lives and allows them to function as best as they can. If an individual does not implement symptom management strategies then their symptoms will continue to increase and can lead to negative consequences such as:
• Loss of important relationships with friends and family
• Inability to tell right from wrong
• Loss of employment
• Incarceration
• Hospitalization
• Injury or death

These are a few of the consequences that may be avoided if an individual is able to manage their symptoms effectively.

What can increase mental health symptoms?

When discussing symptom management, it is important to understand what can cause an increase in mental health symptoms. There are many things that can result in an increase in symptoms including:
• Life stress such as loss of a loved one, change, bad news, etc.
• Lack of sleep
• Poor diet
• Use of drugs/alcohol
• Living an unbalanced life (i.e. no leisure activities, too many unhealthy activities)
• Negative environment/relationships
• Illness such as the flu
• Time of year: season, anniversaries, birthdays, etc.

It is essential for each person to know what factors result in a rise in their symptoms so that they can be prepared and maybe even prevent the increase. This is all part of a successful symptom management plan!

*What is the difference between daily symptom management and crisis management?*

Every once in a while individuals with mental illness can experience a crisis in regards to managing their symptoms. When a person is in crisis it is very difficult for them to implement symptom management techniques and they will need help from their support network (professionals such as a psychologist, friends, family, etc.). A person in crisis will do best with support from others to help them remember the symptom management techniques that work best for them and help them to calm down. Crisis is a scary time for both the individual and those around them, but with a good crisis plan in place it can be managed successfully and limit the impact it may have on the individual’s life.

**Coping Strategies**

There are lots and lots of coping strategies that can be used to help manage mental health symptoms. Some strategies are healthy and others are unhealthy. Some UNHEALTHY coping strategies are listed below:

• Drugs and alcohol- make symptoms worse and often have negative consequences
• Self-harm- may allow for short-term relief, but does not manage the symptom. Can be very dangerous.
• Aggression- fighting, yelling, screaming at others are not positive ways of coping with symptoms
• Avoiding- pretending not to have symptoms or not admitting that we have symptoms is not a way of coping.

Unhealthy coping strategies often make symptoms worse and lead to crisis. The following are a few of the most common HEALTHY symptom management techniques:

1. Medication:
   • Proper use of medications plays a large role in successful symptom management. Medications can even out chemical imbalances in the brain and reduce symptoms.
   • Types of medications and dose should be determined in consultation with a doctor.
   • It is important to educate yourself on the medications you are taking including what it does, the side effects, what happens if you miss a dose, etc.
2. Support:
   • It is essential to have people in your life who know you well and can support you through your mental illness.
   • This could include:
     o Friends
     o Family
     o Staff: program staff, primary worker, CX, etc.
     o Professionals: psychologist, psychiatrist, doctor
   • More than one source of support is needed in case someone is busy when you need or to avoid overwhelming them.
   • Supports can help you:
     o Identify early warning signs
     o Implement coping strategies
     o Get you through crisis
     o Listen and not judge you

3. Education about mental illness:
   • Learning about your mental illness can help you identify early warning signs and symptoms and how to manage them.
   • It can also help you educate others including those in your support system.

4. Sleep:
   • As discussed in previous sessions, a lack of sleep results in poor functioning and does not give your brain the time it needs to rest and restore.
   • Good sleep hygiene (discussed in session 6) can reduce symptoms and improve daily function.

5. Groups:
   • Groups are a great way to stay busy, meet people, learn about your illness and other coping strategies and to keep busy!
   • Each group offers different opportunities, but they all provide a place to interact with others and a regular check-in with staff.
   • Groups can also contribute to a healthy life balance and good time use!

6. Therapy/counseling:
   • 1:1 counseling or therapy is specific to the individual and allows them the opportunity to work through personal issues and problems.
   • Therapy often involves goal setting, in-depth conversation, trust with your therapist/psychologist/primary worker
   • The counselor and the individual work together to make a plan for successful management of mental health symptoms.

7. Hobbies:
   • Engaging in leisure activities that are meaningful can be relaxing and allow an individual to distract themselves or find a sense of calm.
• Hobbies could include sports/fitness, writing/journaling, reading, gardening, playing cards, etc.

8. Relaxation techniques:
• Specific activities that help an individual to relax and quiet their mind.
• Relaxation can include:
  o Deep breathing
  o Progressive muscle relaxation
  o Meditation
  o Listening to music
  o Visualization
  o Yoga

9. Exercise:
• Exercise promotes the release of positive hormones such as endorphins into our body, which results in an improvement in mood.
• Contributes to a healthy life balance.
• Allows for release of stress and can be a good distraction from negative thoughts/worrying.

10. Asking for help:
• As discussed previously, there are times when it is too difficult to manage symptoms by yourself and you need help. This is where your support system is most helpful.
• There is no shame in asking for help! The difficult part is being able to identify when you need it!

11. Sensory input:
• Our environment can impact on our symptoms in a big way. Being aware of what sensory inputs (sound, vision, touch, taste, smell, movement and body awareness) help calm us and which ones help alert us can help manage symptoms.
• For example, drinking a warm drink, snuggling in a blanket, listening to soft music and rocking in a chair or hammock is calming. Listening to loud heavy metal, jumping/dancing and eating something sour or cold is more alerting.
• Being in a more familiar environment (our home) is more relaxing and calming than being in a new or unknown environment.
• Once you know what sensory inputs are calming or alerting for you, you can use them to help manage your symptoms and self-regulate.

12. Self-monitoring:
• Monitoring your mood on a regular basis using the traffic light system can help you identify early warning signs and symptoms so you can implement a strategy to help you return to an optimal level (green).
• The strategy you use to return to green will be personal to you, but the important part is recognizing that you are yellow and need to do something to return to green.
• The goal is to prevent yourself from getting to red!

13. Healthy Diet:
• Eating a healthy diet gives your body the nutrients it needs to function the best it can.
• Eating lots of sugar can disrupt your mood and ability to manage your behaviour/symptoms.
• Consuming too much caffeine can impact on your mood, sleep, energy levels, etc., which negatively effects your ability to manage your symptoms.
• Drugs and alcohol impact the way your brain functions and can have many negative effects:
  o Negatively interacts with medications
  o Decrease in decision making skills
  o Decrease in memory
  o Increase in symptoms-affects brain chemistry
  o Increase in stress and anxiety
  o Negative impact on sleep

14. Thought Stopping:
• This is a simple strategy that people use when they are having a difficult time with negative thoughts/continuous worrying
• The strategy involves saying the word “STOP” out loud and consciously changing your thinking. The act of saying “STOP” makes your brain pause for a moment and allows you the opportunity to think about something more positive.
• Some individuals also like visual reminders such as a stop sign on the wall or to visualize a stop sign in their mind.

These are just some of the numerous ways people cope with the symptoms of mental illness. The most important part of symptom management is to find strategies that work for you and clearly identify them. Know when they are the most effective and maybe even write them down. A person who has a clear, thought out symptom management plan will be more successful in living a satisfying life!
**Homework**

For homework this week complete the following:

1. Complete the following chart to identify what HEALTHY coping strategies you already use and when you tend to use them the most:

<table>
<thead>
<tr>
<th>Strategy</th>
<th>When it is used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ex: Listening to happy music</td>
<td>When I am having a hard time stopping my negative thoughts</td>
</tr>
</tbody>
</table>

2. List 3 strategies discussed in the session that you are interested in trying to help manage your symptoms. Why these ones? What will they help you with?

3. Have you ever or do you currently use any unhealthy coping strategies? What healthy strategies could you use instead?

4. Use the Progressive Muscle Relaxation and Deep Breathing Transcripts to practice relaxation
Practicing Progressive Muscle Relaxation Transcript

1. Loosen your clothing, take off your shoes and get comfortable.
2. Take a few minutes to relax, breathing in and out in slow, deep breaths.
3. When you are ready to start, shift your attention to your right foot. Take a moment to focus on the way it feels.
4. Slowly tense the muscles in your right foot, squeezing as tightly as you can. Hold for a count of 10.
5. Relax your right foot. Focus on the tension flowing away and the way your foot feels as it becomes limp and loose.
6. Stay in this relaxed state for a moment, breathing deeply and slowly.
7. When you’re ready, shift your attention to your left foot. Follow the same sequence of muscle tension and release.
8. Move slowly up through your body, contracting and relaxing the muscle groups as you go.
9. It may take some practice at first, but try not to tense muscles other than those intended.

Use these steps to go through the following sequence:

1. Right foot
2. Left foot
3. Right calf
4. Left calf
5. Right thigh
6. Left thigh
7. Hips and buttocks
8. Stomach
9. Chest
10. Back
11. Right arm and hand
12. Left arm and hand
13. Neck and shoulders
14. Face
The key to deep breathing is to breathe deeply from the abdomen, getting as much fresh air as possible in your lungs. When you take deep breaths from the abdomen, rather than shallow breaths from your upper chest, you inhale more oxygen. The more oxygen you get the less tense, short of breath, and anxious you feel.

Steps:

1. Sit comfortably with your back straight. Put one hand on your chest and the other on your stomach.
2. Breathe in through your nose. The hand on your stomach should rise. The hand on your chest should move very little.
3. Exhale through your mouth, pushing out as much air as you can while contracting your abdominal muscles. The hand on your stomach should move in as you exhale, but your other hand should move very little.
4. Continue to breathe in through your nose and out through your mouth. Try to inhale enough so that your lower abdomen rises and falls. Count slowly in your mind as your exhale.

If you are finding it difficult to breath from your abdomen while sitting up, try lying on the floor. Put a small book on your stomach, and try to breathe so that the book rises as you inhale and falls as you exhale.
Boundaries and Harassment
Boundaries and Harassment

Session Outline

- Learn the difference between Harassment, Boundaries and Norms
- Learn what behaviour is acceptable while living on IMHCU
- Discover your own personal boundaries

Harassment, Boundaries and Norms

It is important to learn and review what behaviour is appropriate when interacting with different people in the institution. There are bound to be interpersonal issues that come up when living so close to others so this session will help you to maintain good social relationships.

Harassment

The formal definition of harassment is long and complicated. These are the main points:

- Improper behaviour (action, comment or display) that is directed at or is offensive to anyone
- The person doing the behaviour knew or should have known that the behaviour was inappropriate and unwanted
- The behaviour can be made on a onetime or continuous basis
- The behaviour demeans, belittles or causes personal embarrassment to another person

Harassment is illegal and the Canadian Human Rights Act (CHRA) lists the following as areas that constitute harassment:

- Race
- National or ethnic group
- Colour
- Religion
- Age
- Sex
- Sexual orientation
- Marital status
- Family status
- Physical or mental disability
- Pardoned conviction

There are other categories that could be considered harassment, but these are the main areas identified by the CHRA.

Sexual harassment falls under the umbrella of harassment. The difference is that it is specific to behaviour, comments, gestures and contact of a sexual nature. Just like any kind of harassment the person should have known it was unacceptable and it can occur on a onetime or continuous basis.
Harassment is the same for everyone and there are specific laws regarding it. It is clear what is acceptable and unacceptable in regards to harassment.

**Boundaries**

Boundaries are less obvious than harassment. They are personal and individual to each person. Boundaries are:

- Invisible limits between people
- A set of rules or expectations for behaviour
- Exist in every relationship
- Not the same for everyone
- Can be flexible and change over time

Personal boundaries are set by each individual and define what that person is comfortable or uncomfortable with. For example:

Every person has a different amount of space they feel comfortable having other people stand in while talking to them. Some don’t mind people standing close to them when talking and others like more distance.

It can be difficult for another person to know what your personal boundaries are unless you communicate it to them such as asking them to move back a bit or telling them that you are uncomfortable. A person needs to know what your boundaries are and what the consequences may be if they are unable to behave in a way that fits with your boundaries. Having CLEAR boundaries in relationships will allow them to be healthy and successful. Boundaries protect us and others from being hurt and feeling upset. They also allow us to connect to others in a safe way. Boundaries are a part of who we are and contribute to how we see ourselves.

There are many different types of boundaries including:

- Physical- touch and proximity
- Emotional- feelings (your own and taking on other peoples’)
- Psychological- thoughts and beliefs
- Behavioural- actions/failure to act
- Sexual- behaviours that are sexual in nature

Individuals need to know their comfort level in each of these areas. What are they comfortable with? With who? When? Where? Some things may be alright in some environments and situations, but unacceptable in other situations. An individual needs to think about these things and know what they are ok with.

It is also important to think about how your boundaries may change depending on who you are talking to or interacting with. Your boundaries and behaviour would be different with each of the following:

- Interacting with another inmate
- Interacting with a CX
- Interacting with your primary worker
• Interacting with a female vs. a male
• Interacting with a doctor or nurse

Depending on who you are interacting with, you may be comfortable with certain things that you would be uncomfortable with if it was another person.

It can be difficult for individuals to set boundaries and let other people know what is acceptable and unacceptable. It is important to be clear, but also appropriate when communicating your comfort level. Following are some examples of phrases you could use to express your boundaries:

• I’d prefer not to
• I have a problem with that
• I feel uncomfortable about
• This is what I need
• I understand your point of view, but
• That’s unacceptable

These are just some examples, but there are lots of different things you can do and say to make your boundaries known. The important thing is to be clear and firm in your position and do not let others push your boundaries if you are uncomfortable.

Norms

Norms are similar to boundaries as they are always different, but they are not specific to an individual. Norms are considered to be what is acceptable or unacceptable in a certain group. While living on the IMHCU it is important to know what the norms are on the range. Every range you live on has different norms set out by the individuals living there. These are specific rules and behaviours that are ok and not ok. Norms cover every topic, but the following are some general categories:

• Privacy- is it ok to go in each other’s cells, listen to phone calls, look in cell windows?
• Touch- what kind of touch is ok? Handshakes? Hugs? Pat on the back?
• Belongings/items- is it ok to share items? For how long? What if you break it?
• Emotions and thoughts- what is it ok to share with each other? Offence history? Family? Money? Plans for illegal activity?
• Verbal- is it ok to tease each other? Tell secrets? Bully?

These are all important things to think about and to discuss as a range. If everyone is on the same page then conflict will be reduced.

Living on the MIICU

Everyone living on the MIICU is required to follow certain behavioural expectations. Some of these expectations are set by CSC and some are set by the staff on the MIICU. These rules include:

• Following the Millhaven Institutional Handbook rules of conduct
Any violation of these rules could result in either a major or a minor charge depending on the offence
- No muscling
- No entering in another inmate’s cell
- Be respectful of other inmates, CX and staff
- Do not damage or steal items from other offenders, programs or the institution
- Do not invade the privacy of other offenders
- Do not lend, borrow or trade items

Violations of these rules will not be tolerated and can lead to charges (legal or institutional), fines, time in segregation, removal from the MIICU, etc.

**Your Personal Boundaries**

As discussed above it is essential to know what your own personal boundaries are and how they change over time. A relationship with a person should start slowly and as trust develops then your boundaries with that person will likely change. As people become closer to each other it is happy and positive and feels exciting. As you get closer with someone you may feel more comfortable sharing information with them, lending them items, more intimate touch such as hugs, etc. These relationships need to be mutual and both people must feel the trust and connection. It is important to discuss things so that there are no assumptions and both people are comfortable.

When trust is broken, a relationship takes a step backwards and the personal boundaries may change again. You may no longer feel comfortable sharing information with that person or lending them items. If trust is broken it usually results in feelings of sadness and loss.

Sometimes relationships feel “off”. This is often because something happening between people does not match the relationship level that they are in. Example: someone you don’t know very well tells you something private about themselves. You feel awkward. Or it could involve abuse from someone you trust. You feel confused. Tell someone you trust when a relationship feels “off”.

Therapeutic relationships are different from other relationships, in that there is often a need and assumption that communication must be honest and freely exchanged. There is not the same mutuality and balance that must be present in other relationships, and there is not always time for the slow development of trust.

It is important to think about the people in your life and where they may fall in the circle model below. People closest to the middle you feel comfortable sharing information with and you trust while those in the furthest circle are strangers or individuals you do not know or trust. You would not feel comfortable sharing personal information with these people. As you get to know someone better and gain trust, they move closer to the middle circle and if trust is broken then an individual may move to a farther circle.
The Circle Model
The following circle shows you what relationships involve in different circles:
CONGRATULATIONS!!! You have completed the Orientation Program on the MIICU!

Please complete the following feedback survey to let us know what you liked and didn’t like about the group. We are constantly trying to make things better and need your feedback to do so.

Thank you so much for your participation and hard work!
Feedback Survey

Please answer the following questions honestly:

1. What did you enjoy most about the group sessions?

2. What did you like least about the group sessions?

3. What did you think about the homework? Did it make sense? Did it help you understand the information learned in the group? Was it too easy/hard?

4. Did you find the session handouts helpful? Were they easy to understand? Will you keep the manual to refer back to?

5. If you could change anything about the group what would you change?
Appendix I: Medication Management Manual

Medication Management 2012

Co-Developed By:
Barbara Graham, Reg. N Institutional Mental Health Nurse
&
Cassandra Murphy, Behaviour Science Technician
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Introduction

Purpose Of The Manual & Rationale

The medication management group consists of 6 sessions. Poor medication compliance is one of the greatest barriers to achieving optimal outcomes in individuals with a mental illness. The goal of this intervention is to motivate participants to improve medication compliance/adherence. Medication compliance/adherence will decrease the frequency and severity of the symptoms, decrease potential for relapse and improve activities of daily living.

Throughout this group, participants will be asked to complete an assessment of their knowledge and understanding of the medications they are prescribed. They will be provided accurate information (knowledge is a key factor in improving medication compliance) for each of the medication categories of psychiatric medication (what symptoms they are prescribed to treat, side effects, and strategies to cope with side effects). This is done with intent to help participants gain an understanding of the role medication compliance/adherence plays in their recovery and general well being. By the end of the group, participants should have a better understanding and awareness of the barriers that could interfere with following their medication regime, and develop strategies to improve compliance/adherence.
Session 1 - Introduction

Welcome to Medication Management

Comment - Throughout this group we will be discussing medication
specifically medication used for the treatment of mental health illnesses.

→ we will be talking about the benefits [advantages],
disadvantages [*side effects], medication adherence/compliance
and coping strategies [being able to get the best results from your prescribed medication].
→ there will be 6 sessions

→ each session will be 45 minutes to 1 hour long

→ there will be 1 session per week

→ sessions will be a combination of 1. teaching [providing you with accurate basic information
2. discussion [this will be an opportunity to ask questions and clarify information]
3. in group exercises
4. small homework assignments

Comment: We will begin each session with a "go-round" this will give us an indication of how you are doing generally. We do not expect a detailed explanation - just an idea. You may choose to use the "stop light" method from previous groups or you may just make a comment. If you have questions or concerns about the material covered in previous sessions now is the time to ask. We prefer this time be related to group related topics.

Go - Round - How are you doing today? [Facilitators participate also]

Handout - Group Rules remind group members that the rules from previous groups apply to this one. Briefly review

Warm - up Exercise - Questionnaire
[allow a maximum of 15 minutes to complete]
Questionnaire - Session 1

1. Which of the following is a benefit from taking medication for mental illness?
   - They reduce pain and swelling
   - They improve psychiatric symptoms and prevent relapse
   - They cure mental illness

2. Which of the following is an example of a side effect of taking psychiatric medication?
   - Drowsiness
   - Tooth decay
   - Hearing loss

3. Symptoms of mental illness will improve with time even if there is no treatment? T F

4. Without treatment symptoms are likely to stay the same or worsen over time? T F

5. It is a bad idea to ask the doctor or nurse questions about medications and how they will affect you? T F

6. Medications affect people in different ways? T F

7. To get the best results from medication, it is a good idea to....
   - Take the medication at the same time each day
   - Change the dose of the medication depending on the day
   - Take it whenever you feel the need
   - Change the dose of the medication depending on the day
   - Take it whenever you feel the need
People have different beliefs about medication, based on their culture, family background and individual experiences. Which of these quotations reflect your beliefs?

______ "My uncle is diabetic and takes insulin. He leads a normal life. I have a mental illness and take medication for it. It is the same thing to me"

______ "My medication helps me get rid of the symptoms I was having. It has made a world of difference to my peace of mind"

______ "I tried everything I could on my own - exercise, relaxation techniques, counselling. I was still miserable and depressed until I tried some medication"

______ "In my culture, we don't believe in Western medicines. I only want herbal medicine"

______ "I'm afraid of the long-term effects on my body using medication"

______ "It is a matter of will power. I shouldn't need a drug to make me feel better"
What are your personal feelings about taking medication to treat your illness?
Discuss responses to page 1. of questionnaire

Comment: People around the world take medications everyday for a variety of conditions.

Ask: What are some conditions someone might take medication for?
   [cancer, thyroid, diabetes, high blood pressure]

Can you think of any other conditions someone might take medications for?
   schizophrenia
   bipolar
   depression
   anxiety
   ADHD
   substance abuse [methadone]

Ask: Is taking medication for a mental health illness different than taking medication for a physical illness?
   No.....it still works to treat a variety of symptoms someone is experiencing.

Ask: Why do you have to take medication?
   → helps to reduce symptoms i.e. Hallucinations, delusions & paranoia
   → helps you to function on a daily basis
   → improves your mood
   → improves concentration and ability to think more clearly

Comment: Treatment for mental illness involves many factors
Ask: Do you know what they may be?
   → counselling
   → rehabilitation [acquiring new skills]
   → medication
Comment: It is important to be aware of your feelings about taking medication. Your beliefs may interfere with your decisions regarding taking medication and/or your ability to problem solve.

Ask: Do you think taking medication has had a positive effect on you? If yes, how so? [Open up a discussion]

Staff Homework - review the MARS [in healthcare] and know the medication each participant is taking.
**Group Rules**

**Attendance** - show up on time [not an option]. The only reasons not to attend are medical and lawyer appointments. If you are sick, get word to us. If there is some problems, like sleeping in, let's talk about it NOW so we can figure out how solve it and get you through the group. You must make up missed information.

**Conduct** - what are some ways that people can behave in group that will make it a good experience for everyone? [Politeness and Respect - what does that look like]? Monopolizing - how shall we deal with that? Not talking at all [you don't want me to yammer on forever]; fooling around, fidgeting, cross talk - how will we deal with that? Keep swearing to a minimum, talk one at a time, wait your turn to talk. Stay on topic.

**Participation [effort]** - I assume that everyone is here because they are hoping to get something positive out of it. You need to try new things if you want your life to be different. So, trying the exercises in group and thinking about the information are very important. You are going to get as much from this group as you are prepared to put into it. If there is some reason why it would be hard for you to try various things, let us know and we will help you figure out how to solve that problem. Ask questions, do homework.

**Feedback** - What is feedback? [talking about how we think, talk and act]. Not just criticizing - can be positive, can be a new way of thinking, can point out how something does not work well. Group members can give each other feedback - good work, I don't understand what that means - could you please explain? It is our job as a facilitator to give feedback. For everyone, it needs to be respectfully done. What would that look like? Let's say you disagree with something I said [Deep breathing is a very powerful stress management technique. How can you do that respectfully]?

**Disagreements** - we will disagree sometimes. How will we handle that? If you get upset or come to group upset, how will we deal with that? Because you still need to participate [self monitoring skill].

**Confidentiality** - we need to keep what we talk about in the room. What we talk about in the room stays in the room. It does not go back to the unit. That said, the clinical team will talk amongst ourselves and information will end up in final reports. We will not put someone else's business in your report.

**Group Leaders** - How might the rules be different for us? We will need to interrupt. We will need to keep things moving along. We will need to shut down discussions as we need keep to what is in the manual. We will use the Parking Lot and if there is time at the end of group we will address the issue. We are available to talk before or after the group. We want to help. We are open and welcome feedback also.

**Other** - washroom and coffee. Please go before group. Hot drinks are not allowed.
Session Two  - Psychiatric Medication

Go Round - How is everyone doing today?

Comment: When you participated in the Orientation group, spoke to a counsellor or saw the psychiatrist you may have been told that your mental health illness may have been caused by a variety of factors including; heredity/genes, structural abnormalities in the brain, emotional trauma, the social environment one is raised in, interpersonal problems and substance abuse...Did you ever hear the symptoms of mental illness could possibly be the result of an imbalance of chemicals in your brain? [It can also be a result of a combination of these].

Ask - What do you think that means? - [chemical imbalance]

Comment: No one knows for sure....but scientific research supports the theory that mental illness happens when brain chemicals get out of balance.

Your brain is the hardware of your soul. It determines what you think and perceive, how you feel and how you interact with others [behaviour].

Your brain’s ability to function plays an important role in all your thoughts and feelings. Your brain manufactures chemicals that convert into thoughts and feelings. Each part of your brain plays a specific role in processing and storing information.

Brain cells, which are called neurons, are lined up in order to pass messages from one cell to another. They do not touch each other, so they are unable to pass the message directly. There are chemicals in your brain that carry messages called neurotransmitters.

There are more than 100 billion neurons in your brain with 100 trillion connecting pathways between them.

Your brain produces over 100,00 chemical reactions in any given second.

Review pages 2 through 4 in the participant manual.

Comment: Medications work by changing the imbalance of chemicals in the brain. Correcting this imbalance is important....WHY?
Comment: Having a balance in your brain chemicals helps you to......
   1. **RECEIVE** - the information from your senses [what you see, hear, touch, taste and smell

   **Ask:** In what condition may you see this impaired/affected?
   [schizophrenia by symptoms of hallucinations]

   2. **RECOGNIZE** - the information, be able to process it, make sense of it and compare it to your memory banks.

   **Ask:** In what condition may you see this impaired/affected?
   >schizophrenia by symptoms of delusions
   >depression by symptoms of guilt and shame
   >bipolar by inability to recognize consequences

   3. **REACT** - and make decisions based on information you receive, recognize and process

   **Ask:** In what condition may you see this impaired/affected?
   > bipolar risky behaviour
   >schizophrenia [hallucinations, paranoid thoughts]
   >depression [low mood, hopelessness and suicidal/self harm behaviour

Comment: It is not uncommon for many people with mental health illness to be prescribed more than 1 medication to get the best relief from symptoms. Sometimes it is about finding the "right mix for the cocktail" or "ingredients for the recipe".

**ACTIVITY/HOMEWORK ASSIGNMENT**
In your participant’s manual on page 7. you will find several pages titled "My Medications".

Write down all the medication you are prescribed for mental health reasons.
Write down the dose of the medication you are prescribed.
Write down the time you take each medication.
Write down what you understand is the reason you are taking each medication.
Do not fill in side effects at this time

Allow 10 - 15 minutes in session to answer questions this will allow you to see how much knowledge they have. Have the participants complete the exercise for homework [facilitators should review MARS and/or healthcare files and have accurate information to provide participants with]
Session Three - Psychiatric Medication [cont'd]

Go Round: How is everyone doing?

Ask: Are there any questions from the previous sessions?

> How did you make out completing the homework assignment?

Note: [if you have reviewed the records in healthcare you may be able to help complete information for those who could not do so on their own. This will give you a good idea of how much participants understand what medication they are taking].

> Have each participant review their record in group.
   [allow up to 15 minutes to complete]

Comment: There are a large number of medications used to treat the symptoms of mental illnesses. A big step in managing your mental illness is managing the medication used to treat the symptoms. One way to do this is by improving your awareness [education] and understanding. Research has proven that knowledge and awareness improves motivation to take medication as prescribed.

So....Let's learn about psychiatric [psychotropic] medication

Ask: What comes to your mind when you hear the term psychiatric medication?
   → crazy
   → bug/bug juice
   → zombie
   → spaced out
   → drool
   → changed the lives of many for the better

Comment: For the purpose of this group, we will define psychiatric medication as: any medication capable of affecting the mind, emotions [mood] and behaviour.

Ask: As mentioned before, medications treat the symptoms of mental illness. What are some symptoms a person could experience who has a mental health illness?

   → hearing voices
   → sleeping too much
   → inability to concentrate
   → suspiciousness
   → low mood
   → feeling hopeless
   → excessive cleaning/hand washing
   → increased appetite
Comment: We keep repeating psychiatric medications treat the symptoms of mental health illness.

Ask: Do they cure mental illness?

No

So....What does that mean?
the medication reduces symptoms ↓
reducing symptoms improves mood, feeling better improves motivation ↓
feeling better makes someone function better ↓
functioning better helps improve thought processes ↓
improved thought processes helps someone to be more receptive to challenge ↓
challenge helps your ability to understand, comprehend and reason ↓
this makes someone more receptive to other forms of treatment

Comment: It is important to remember that medication needs to be taken daily and as prescribed. Even when the symptoms are manageable. The medication may only be prescribed for a short time or for the rest of your life. Medication works differently for everyone. The effectiveness of medication can vary...some work quickly and others take 2-4 weeks to be effective.

There are a wide number of medications used to treat mental illness. They are grouped into 5 main categories.

Ask: Any idea what these are? [Discuss one category at a time as long as you get responses].

→ Antipsychotic medication [also known as major tranquilizers]
→ Mood stabilizers
→ Antidepressants
→ Anti-anxiety and Sedatives
→ Stimulants

Teaching Information: Ask participants what they know about these medications?

Antipsychotic Medication
used to treat psychotic disorders [someone who is out of touch with reality]
→ Schizophrenia, Bipolar Illness and Psychotic Depression
are designed to reduce symptoms including:
→ false perceptions [hallucinations]
→ false beliefs [delusions]
→ confused thinking [thought disorder]
2 types of anti psychotic medications:

→ **Older Generation** - more effective at reducing symptoms such as: lack of motivation, decreased energy, decreased pleasure

  *examples* - Chlorpromazine and Haldol

→ **Newer Generation [second generation or atypical]** - more effective at reducing positive symptoms such as: hallucinations, delusions and also hostility and aggression

  *examples* - Clozaril, Resperidone, Olanzepine/Zyprexa, Quetiapine/Seroquel

**Mood Stabilizing Medication**

  most commonly used to treat bipolar disorder

  mood stabilizers suppress swings between mania [highs] and depression [lows]

  mood stabilizers are purely anti-manic agents meaning they are effective at treating mania and mood cycling and shifting, but are not effective at treating depression

  *examples* - Lithium which is the exception to the rule as it has proven effective at also treating depression also anti-convulsant [seizure] medication is used such as Valporic Acid [Divalproex] and Carbamazepine [Tegretol]

  *other* some atypical antipsychotics also have a mood stabilizing effect such as Resperidone, Olanzepine and Quetiapine

**Antidepressant Medication**

  used to treat the symptoms of depression

  most commonly used antidepressants are the Tricyclic antidepressants Elavil [Amitriptyline], Doxepin and Imipramine [Tofranil]

  as well as treating depression they also are used to treat anxiety, chronic pain and bed wetting in children [Imipramine]

  and SSRIs [selective serotonin reuptake inhibitor] SSRI's help restore brain chemicals improving certain moods

  most commonly seen are Celexa, Prozac, Paxil and Luvox
Anti-anxiety and Sedative Medication

the medication used to treat anxiety cannot change the underlying issues and situations in your life that are causing the anxiety
the medication can be very effective at relieving the symptoms of anxiety such as; rapid heart beat, sweating and dizziness

e**amples** - Xanax, Valium, Clonazepam and Ativan
tolerance to these drugs develops very quickly requiring increasing the medication often. They are highly addictive and not used in our population

Buspirone is a newer generation anti-anxiety medication with less addictive qualities and very effective for generalized anxiety

SSRI antidepressants are also effective

Stimulants/ADHD Medication

helps to improve ability to concentrate, control impulses, plan ahead and follow through with tasks
even when taking the medication you may still struggle with disorganization, distractibility and social awkwardness
relieves symptoms while being taken but once the medication is stopped the symptoms return

e**amples** - Ritalin, Adderall, Dexadrine and newer generation Vyvanse

F**un Fact**: Most psychiatric medication began to be developed around the 1950 mark. In the world of medicine they are considered babies. Since this time they have been continuously changing and evolving.

A**ctivity** - Take the list of your medications that you filled out in the previous session and indicate the category each one belongs to.

H**int** - If you already identified what the medication was prescribed for, it will be easier to determine what category it falls under

A**sk**: Does this match your understanding of what you are being treated for?
Session Four - Medication Compliance/Adherence

Go Round - How is everyone doing?

Ask- Are there any questions from the previous session?
   So...

   Everyone has completed the assignment and knows exactly what medication they are on and why!!!

Comment: Psychiatric medication is just like any other form of medication; in that there are positive and negative effects. These medications can be tough on the body, but can also offer a lot of relief. It is important for you to know if the benefits outweigh the negatives.
   ** An important reminder to yourself is that the treatment success rate with medication is quite high** [70% of antidepressants are effective on the first try].

Ask: How many people here take medication other than psychiatric medication?

*What benefits do you get from those medications?
   →pain management
   →control of high blood pressure
   →control of high cholesterol
   →manage diabetes [high blood sugar]
   →treat positive Hepatitis C
   →manage HIV symptoms

*Are there negatives to taking these medications?

* What are they?
   →nausea
   →dizziness
   →kidney/liver damage
   →changes in electrolytes [blood work]
   →increased risk of infection

Ask- Why do you continue to take them?
   [open up a discussion]
**Ask:** What are the benefits to you by taking psychiatric medication?

- no voices  
- no self harm/suicidal thoughts/actions  
- mood is stable  
- less suspiciousness  
- better concentration  
- can perform daily activities [school, work, socialize]

**Comment:** When symptoms of mental illness are the most severe and troublesome, it is called an "acute" episode or a relapse. 
Taking medication as prescribed on a daily basis helps to prevent an acute episode or a relapse of symptoms. 
Taking medication as prescribed on a daily basis is considered a "protective layer" between you and symptoms or an "insurance policy" for staying well. 
Taking medication is not a cure but it can bring quality to your life.

**Ask:** Have you ever had an experience where stopping your medication has worsened your symptoms or caused a relapse? 

**Example:** you have been prescribed antibiotics for a chest infection. You are to take them for 10 days and after 7 you stop taking them because you feel better. In 2 weeks your chest infection comes back.

**Comment/Ask:** So......if medication is prescribed in order to make you feel better, and your symptoms are worse when you are not taking it....Why do people stop taking medication?  

- allow time for comments -
- dopey  
- being muscled  
- don't need it  
- paranoid  
- not helping  
- against a religious belief  
- take too many pills  
- can't remember when to take  
- don't like the side effects  
- stigma  
- like the energy I have when not down

**Comment:** For the rest of this session we are going to discuss medication compliance/adherence, roadblocks to compliance/adherence and how you can improve managing your medication.

Medication management is a complex problem, especially for people with a chronic illness.

Health care professionals rely heavily on medications to treat illness/disease, prevent hospitalizations and to help improve quality of life. Research has shown
that medication can improve clinical outcomes and reduce illness, disability and death.

Despite these findings, we still have quite the problem with medication compliance/adherence.

**Exercise:** Handout and ask the participants to complete Medication Adherence Questionnaire
[allow 15 minutes to complete]

**Ask** each participant how they did
[allow time for comments]

**Ask:** What do you think we mean by compliance/adherence?
→skipping/missing a dose →abruptly stopping the meds
→taking more medication than prescribed [if one is good 2 or 3 is better]
→taking at the wrong time →not picking up the meds
taking someone else’s meds →taking all medication at one time
altering the medication [crushing/snorting when you feel like it]

**Ask:** Anything sound familiar?
What can you do to improve some of the above mentioned things?
  have a schedule or daily log
time taking medication with other familiar activities [meals, brushing teeth]
daily pill containers
set an alarm

Refer to pages 10 & 11 in Participants Workbook
Medication Adherence Questionnaire

A = never/rarely
B = once in a while
C = sometimes
D = usually
E = all the time

1. Do you sometimes forget to take your medication? __________

2. People sometimes miss taking their medication for reasons other than forgetting. Thinking over the past 2 weeks, were there any days when you did not take your medication? __________

3. Have you ever cut back or stopped taking your medication without telling the nurse or doctor because you felt worse when you took it? __________

4. Did you take all of your medication yesterday? __________

5. When you feel your symptoms are under control do you sometimes stop taking your medication? __________

6. Do you ever feel it is a hassle to take medication everyday? __________

7. My thoughts are clearer on medication. __________

8. Do you ever give your medication to someone else to try and/or do you ever try someone else's medication? __________

Total __________

Scoring:
A = 0
B - E = 1
Scores

Greater than 2 = low adherence

1 - 2 = medium adherence

0 = high adherence
Comment: Compliance/Adherence is defined by the World Health organization [WHO] as: "the extent to which a person's behaviour in taking medication corresponds with agreed recommendations from a health care provider"

70% of people diagnosed with depression and 50% of people diagnosed with schizophrenia do not take their medication as prescribed.

Comment: Earlier in the group we discussed some reasons that make it difficult to maintain medication compliance/adherence. What are some things that you can do to make it easier?

→ gain an understanding of the symptoms of your illness
→ understand the medication
→ increase your interest/motivation [schedule, pill organizers]
→ figure out the best time to take

Comment: One of the main reasons why people stop taking their medication is because they experience negative side effects. These can vary from person to person and depend on the medication prescribed. Our next session will focus on various side effects and what you can do to deal with them.
Session Five - Side Effects from Psychiatric Medication

Go Round - How is everyone doing today?

Ask - Are there any questions from the previous session?

So far we have discussed - What is involved with treatment
  - Your thoughts/attitudes about taking medication to treat your symptoms
  - Psychiatric medication and how it works
  - Medication compliance/adherence

Comment - We have a story to share with you
  Read the story of "Spice and her Problem"
Spice and her Problem

My cat Spice ran around our neighbourhood mousing, birding and catching and eating moths. Unfortunately my neighbour did not appreciate this very much and called animal control. They took Spice to the pound and shot her full of thorazine and admitted her.

When I found her 1 month later and went to visit her, she looked a bit washed out. She was used to being outside in the fresh air and sunshine where she could run and jump everyday. They kept her in a cage and didn't let her out to exercise. They said she became depressed and her meow was weak. She was used to good quality cat food with a side of mice and birds not no-name food with no hor d'oerves. They put her on a tricyclic antidepressant. She started to eat the poor food and because of the medication she became very fat and lazy. To bring her out of the shock of being there they gave her some Lithium to level out her moods. She became very withdrawn. They added some Cogentin to the cocktail and she began to shake. They added Tegretol to help control the shaking.

Spice was a beautiful fluffy kitty; shiny fur, alert eyes that could spot a mouse a mile away and jump 4 feet in the air to catch a bird. Now all she does is lie in the sun with her belly up and a pitiful croak for a meow. They gave her a diagnosis of paranoid psychosis with delusions. she is unaware she is a cat. I was quite shocked. I brought her home

The strange thing is now when she goes outside and she sees a bird she hides in fear. Perhaps they can give her medication for that.
**Ask:** Any Comments?

**Comment:** While it is important to be aware of how medication can be a benefit to you...Ask
Do you remember what some of the benefits you identified earlier were???

It is equally important to know what the undesirable effects are. Often the undesirable effects are why people cut back or stop taking their medication. It is very important to ask what side effects are possible prior to taking new medication. This just helps you to recognize what may be happening.

**Ask:** What are some undesirable effects you are aware of from psychiatric medications? allow 10 minutes for comments

**Comment:** Medication affects people in different ways. Some people taking the same medication have little to no side effects others have many.

**Ask:** Why is that?

reaction depends on many factors - age weight sex metabolic rate other medication they are taking

**Comment:** In most cases side effects are temporary and will improve with time. Newer generation medications tend to have fewer side effects.

Let’s talk a bit about side effects and what we can do about them. How about we start at the top of our head and work our way down.

**Skin and hair - rash**  happen with any medication, allergy?

**What can you do?**  Talk to the doctor topical cream

**Sensitivity to light**  - especially with antidepressants and antipsychotics

**What can you do?**  stay in the shade sunscreen protective clothing [hat]

**Dry Mouth**  - especially with antidepressants, antipsychotics and ADHD meds may improve as treatment continues
What can you do? sugar-free hard candy or gum
sip water or suck ice chips
lightly brush teeth

*** it is important not to drink too much. Some people actually drink too much because their brains do not tell them when to stop. This has serious consequences because it can change levels of chemicals in the body [sodium/potassium]. These chemicals are important to organs in your body [kidneys, heart, lungs]. ***

Muscle/Nervous System - muscle spasms/stiffness/tremor/feeling slowed down
- especially with antipsychotics, some antidepressants and mood stabilizers

What can you do? Tell nurse/doctor
will respond to a change in dosage
also addition of another medication used to counter-act these side effects....Cogentin

GastroIntestinal - side effect from any medication and most psychiatric medications

Constipation
What can you do? High fibre diet [fruit, veggies, bran]
drink 6-8 glasses of water
avoid rice and bananas [they are constipating]
laxative/stool softener

Nausea +/- Vomiting
usually improves with time

Trouble Urinating
let medical staff know right away

Sexual Functioning - side effect from a majority of psychiatric medications
low sex drive [loss of desire]
decrease in orgasms
difficulty achieving an erection

What can you do? - may respond to a change in medication/dosage
talk to your sexual partner [stress can make this worse]
General Side Effects:

1. Dizziness - side effect from antidepressants and antipsychotics caused by a lowering of blood pressure
   What can you do about this? - don't make sudden movements when getting up from a lying down position; sit on the side of the bed for a few minutes before standing; squat rather than bend from the waist

2. Drowsiness - side effect from antidepressants and antipsychotics usually subsides within 10 days - 2 weeks

3. Blurry vision - this is usually temporary and will improve with time

4. Feeling "slowed down"; often referred to as being a "zombie" - side effect of antipsychotics - it may go away over time or not
   What can you do about this? - may ease or decrease with a reduction of medication.

5. Restlessness - side effect from most psychiatric medication - difficult to tell sometimes if it is a side effect or a symptom of the illness [agitation] - feels like you are unable to stop moving/can't sit still
   What can you do about this? Cogentin is helpful

6. Increased appetite/weight gain - side effect from antidepressants and antipsychotics can lead to serious health risks [high blood pressure, high cholesterol, heart problems, diabetes and kidney problems]
   What can you do about this? reduce sugar and fats in your diet sugar free beverages, gum and candy increase physical activity [exercise]

Comment: We have talked about some of the more common side effects of psychiatric medications. There are more serious and potentially life threatening side effects. That is why some prescribed medications require blood work to be taken.
Remember if you have a sore throat, muscle stiffness, nausea, vomiting, diarrhea and/or confusion. Help is needed right away.

Remind participants that stopping psychiatric medication abruptly can result in withdrawal symptoms including seizures.

Questions?
allow a 5-10 minutes to answer

Homework Assignment

Complete the pages in your work book titled Make your mind up time! Pages 14-16 When you come back to group be prepared to answer the question "Do you feel taking medication is good for you? And in what way".

also

Looking at your adherence questionnaire fill out the page in your workbook [Page 17] with 3 ways you could improve your adherence and/or cope with the negative aspects of taking medication.
Session Six - Final Session and Participant Feedback

Go Round: How is everyone doing?

Ask: Are there any questions from the previous session?
    allow several minutes for discussion if necessary

Ask: How did everyone make out with the homework assignment?
    [go around the room and ask each person]
    What was your decision?
    How can you improve medication adherence/side effects?

Comment: We have spent 6 sessions educating you and discussing medication management.
    Medication is one of the key components to illness management and recovery.
    Medication gets you to the point where you can begin to participate in other
    forms of treatment.
    Medication helps prevent illness relapse. Symptoms of mental illness can vary in
    intensity over time. They can be absent, they can be mild, or they can be quite
    severe. We call this "acute'. Scientists have not been able to identify all the
    reasons that people have relapses of their symptoms

Ask the participants to take some time to fill in the feedback form for the group. Stress that
we would appreciate honest feedback.
Useful suggestions are always considered for making improvements to future sessions.
Feedback Form

We need your honest feedback about your experience in this group. It will help us decide how we run groups in the future. You do not have to give your name but you can if you want to.

Name of Group: Medication Management
Name of Facilitators: ____________________________________________

1. What has been helpful to you? Please comment on topics you learned about, or how the group was run.

2. What did you like about the topics or how the group was run?

3. What might you like to change or improve about the topics or how the group was run? Are there other topics we should cover?

4. Please circle a number on the scale to show your overall level of satisfaction with the group:

0 1 2 3 4 5 6 7 8 9 10
Not Satisfied Very Satisfied
5. Please rate how helpful you found the material in the group:

<table>
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<th>9</th>
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</table>
Not Satisfied | Very Satisfied

6. Please rate how confident you feel about using the tools and skills you learned in your real life

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<th>10</th>
</tr>
</thead>
</table>
Not Satisfied | Very Satisfied

7. Please rate your satisfaction with how the facilitators ran the group:

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<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
</table>
Not Satisfied | Very Satisfied

Do you have any suggestions for how the facilitators could improve how they run the group?

8. Would you recommend this group to others?  Yes  No

Why or why not?

9. Any other comments?
Emotion Regulation Group Manual
Session 1: Orientation

- Introductions of facilitators and group members
- Review informed consent: voluntary can withdraw, not a correctional program, access to session notes and final OMS note, certificate of completion
- Group structure: importance of homework and participation, mindfulness exercise and then session split between homework review and introduction of new skill
- Collaboratively develop group rules
- Handout and discuss DERS profiles
- Discuss outline of sessions using Handout 1 – Goals of Emotion Regulation Training
  - Provide Worksheet 1 (Personal Goals) for participants to work on in group – brainstorm examples together, focusing on operationalizing the goal
- Discuss functions of emotions
  - Ask group: Why do we have emotions anyways? What would happen if we didn’t have emotions?
  - Provide Handout 2 – What Emotions Do For You
  - Assign Worksheet 2 (Figuring Out What My Emotions Are Doing For Me)
- Provide Handout 3 (Emotion Words) and Smiley-Face Feelings Guide to aid in completing Worksheet 2
- Introduce mindfulness (Handout 4)
- Checkout
  - Homework: Worksheets 1 & 2
  - Use Handout 3 to identify an emotion felt over past week or current session (“I feel/felt _____ when __________.”)
Handout 1: Goals of Emotion Regulation Training

1) Understand your own emotions
   • Understand what emotions do for you
   • Identify (observe and describe) emotions

2) Decrease the frequency of unwanted emotions
   • Check whether your emotions fit the facts
   • Change painful emotions through opposite action
   • Change situations that set off painful emotions

3) Decrease emotional vulnerability
   • Decrease negative vulnerability
   • Increase resilience and positive emotions

4) Decrease emotional suffering
   • Manage extreme emotions so that you don’t make things worse
   • Let go of painful emotions through mindfulness
Worksheet 1: Personal Goals

What do I hope to gain from participating in this group?

1. __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

2. __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

3. __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

How will I know when I have achieved these goals? What will be different in my life? What would a friend notice about me?

1. __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

2. __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

3. __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
Handout 2: What Emotions Do For You

1) Emotions communicate to ourselves
   • Emotional reactions can give us important information about a situation. Emotions can be signals or alarms that something is happening.
   • Gut feelings can be like intuition; a response to something important about the situation. This can be helpful if our emotions get us to check out the facts.
   • Sometimes we treat emotions as if they are facts about the world: The stronger the emotion, the stronger our belief that the emotion is based on absolute fact. (Examples: “If I feel unsure, I am incompetent.” “If I get lonely when left alone, I shouldn’t be left alone.” “If I feel confident about something, it is right.” “If I’m afraid, it is threatening.” “I love her, so she must be OK.”)
   • If we assume that our emotions represent facts about the world, we may use them to validate our thoughts or actions. This can be trouble if our emotions get us to ignore the facts.

2) Emotions communicate to (and influence) others
   • Facial expressions are a hard-wired part of emotions. Facial expressions communicate faster than words.
   • Our posture, gestures, words, and voice tone can also be hard-wired. Like it or not, they also communicate our emotions to others.
   • Whether we intend it or not, the communication of emotions influences others. For example, your sad face may cause someone to ask you if you are okay and give you some support.

3) Emotions motivate (and organize) action
   • Emotions motivate our behaviour and prepare us for action. The action urge connected to specific emotions is often “hard-wired.”
   • Emotions save time in getting us to act in important situations. Emotions can be especially important when we don’t have time to think things through.
   • Strong emotions help us overcome obstacles—in our mind and in the environment.
Worksheet 2: Figuring Out What My Emotions Are Doing For Me

**Instructions:** Select a current or recent emotional reaction and fill out as much of this worksheet as you can. When picking an emotion to reflect on, you might pick the strongest emotion of the day, the longest-lasting one, or the one that was the most painful or gave you the most trouble. Next, consider which function(s) your emotion is serving.

**Emotion Name:** ____________________________  **Intensity (0 – 100):** __________

**Communication to Myself**
What does my emotion say to me? Does it tell me that something important is going on around me? Does it tell me something about my values?

Are there facts that I can check to be sure that the message my emotion is sending me is correct?

**Communication to Others**
What is my facial expression? Posture? Gestures? Words? Actions?

What message does my emotion send to others (even if I don’t intend to send the message)?

How does my emotion influence others (even if I don’t intend to influence them)? What did others do or say as a result of my emotional expression or actions?

**Motivation to Action**
What action is my emotion motivating and preparing me to do? (Is there a problem my emotion is getting me to solve, overcome, or avoid?)
Handout 3: Introduction to Mindfulness
(Adapted from http://greatergood.berkeley.edu/ and Linehan’s (1993) Skills Training Manual)

What Is Mindfulness?

Mindfulness means maintaining a moment-by-moment awareness of our thoughts, feelings, bodily sensations, and surrounding environment. Mindfulness also involves acceptance, meaning that we pay attention to our thoughts and feelings without judging them—without believing, for instance, that there’s a “right” or “wrong” way to think or feel in a given moment. When we practice mindfulness, our thoughts tune into what we’re sensing in the present moment rather than rehashing the past or imagining the future.

Why Practice Mindfulness?

Studies have shown that practicing mindfulness, even for just a few weeks, can bring a variety of physical, psychological, and social benefits. Here are some of these benefits, which extend across many different settings.

- Increase positive emotions while reducing negative emotions and stress
- Improves memory and attention
- Makes changes to brain to fosters compassion, empathy, and altruism
- Enhances relationships by making couples more satisfied, optimistic, relaxed, and accepting of each other
- Boosts the immune system’s ability to fight off illness
- Fights obesity by encouraging healthier eating habits (e.g., savor food)
- Effective treatment for a variety of mental health issues, including anxiety, depression, suicidal behaviour, substance abuse, posttraumatic stress, and psychosis
How to Practice Mindfulness?

Here are a few key components of practicing mindfulness:

- Notice—really notice—what you’re sensing in a given moment, the sights, sounds, and smells that ordinarily slip by without reaching your conscious awareness. Tune into your body’s physical sensations, from the water hitting your skin in the shower to the way your body rests in your chair. Pay close attention to your breathing, especially when you’re feeling intense emotions.

- Watch your thoughts and feelings come and go, as if they are on a conveyor belt. Don’t push them away. Just let them happen, even when they’re painful.

- Label what you observe with words (e.g., “My heart is pounding” or “I feel scared”). Describe only what you observe, without interpretations or judgements. Don’t judge your judging.

- Recognize that your thoughts and emotions are fleeting and do not define you, an insight that can free you from negative thought patterns.
- **Session 2: Emotion Myths and Describing Emotions**
  - Check-in by sharing an emotion felt over past week (“I felt _____ when _______”)
  - Review group rules. Any additions?
  - Comments about structure/content of last session? Any feedback?
  - Review Worksheet 1 (Goals)
  - Review Worksheet 2 (Functions of Emotions)
  - Mindfulness exercise: Candy Demonstration
  - Introduce Handout 5: Myths About Emotions
    - What’s a myth? (assumptions/stories about the world that can influence our behaviour)
    - Why talk about emotion myths? (Need an awareness of how they can be triggered and cause us to react in unhelpful ways)
    - Go through different categories of myths and check with group members about which ones they endorse
    - What do they notice about the categories of myths? If needed, point out that they represent extreme views of emotions (either too positive/taken as fact or too negative/easily dismissed)
  - Invite discussion about more balanced view of emotions (provide Handout 6: Healthy Perspective on Emotions)
  - Present the model for describing emotions
    - Ask group members what they notice happens when they experience an intense emotions; use their answers to plot out the model for describing emotions on the whiteboard
    - After discussing the components of the model, provide Handout 7
    - Work through examples
    - Provide Worksheet 3 for homework
Handout 4: Myths About Emotions

Myths are stories that we come to believe, simply because they have been a part of our lives or our thinking for so long. We often don’t ever question them. We just assume that they are real. Our thoughts can be like myths, “stories” that are so deep a part of how we live, that we no longer notice them. Myth thoughts may not be something that we would admit to believing if someone asked us about them, but we believe them in our emotion mind, in our hearts, anyway.

These myths of thinking may come from our families, friends, or culture. We have myths about almost everything in our lives. Most people have myths about emotions that cause them to react in ways that are not helpful sometimes. The key is to know what your own myths are, what usually “triggers” them in your mind, and how you can keep them from controlling your behaviour when that behaviour would hurt you.

Although each person’s myths are unique, the following are some fairly common myths. Check the ones that you believe in (even if you only believe it sometimes).

- **Myths reflecting a negative view of emotions:**
  - Some emotions are stupid.
  - Letting others know that I am feeling bad is a sign of weakness.
  - Painful emotions are not important and should be ignored.
  - Negative feelings are bad and destructive.
  - Being emotional means being out of control.

- **Myths reflecting a distrust or invalidation of emotional experiences:**
  - There is a right way to feel about every situation.
  - Other people are the best judge of how I am feeling.
  - All painful emotions are a result of a bad attitude.
  - Emotions can happen for no reason.
  - If others don’t approve of my feelings, I obviously shouldn’t feel the way I do.

- **Myths reflecting a positive view of extreme emotions:**
  - Extreme emotions get you a lot further than trying to regulate your emotions.
  - Creativity requires intense, often out-of-control emotions
  - Drama is cool.

- **Myths exaggerating the validity of emotions:**
  - Emotional truth is what counts, not factual truth.
  - People should do whatever they feel like doing.
  - It is inauthentic to try and change my emotions.
  - Acting on your emotions is the mark of a truly free individual.
  - My emotions are who I am.
  - My emotions are why people love me.
  - Emotions should always be trusted.
Handout 5: Healthy Perspectives on Emotions

- Emotions are neither good nor bad or right nor wrong. Feelings just ARE. They exist. It is not helpful to judge your emotions.

- Emotions are not facts. When emotions are very powerful, they feel just like “the truth.”

- There is a difference between having an emotion and doing something or acting on the emotion. When a strong emotion comes, you do not have to act on a feeling. All you need to do is recognize the emotion and feel it.

- You cannot get rid of emotions because they serve important survival functions. Be willing to radically accept your emotions as they arise.

- Emotions don’t last forever. No matter what you’re feeling, eventually, it will lift and another emotion will take its place.
Handout 6: Model for Describing Emotions

**Vulnerability Factors:**
What happened before that made me vulnerable to

**Prompting Event:**
What was it that triggered my emotion (who, what,

**After-effects:**
What effect did this emotion have on me (my state of mind,

**Interpretation:**
How did I understand or make sense of what happened? What did I

**Emotional Expression:**
What were my facial expressions,

**Emotional Experience and Urges:**
What do I feel in
Worksheet 3: Observing and Describing Emotions

Emotion Name: ____________________________  Intensity (0 – 100): __________

**Prompting Event:** What was it that triggered my emotion (who, what, when, where)? Or what thought, memory, etc.?

**Vulnerability Factors:** What happened before that made me vulnerable to the prompting event?

**Interpretation:** How did I understand or make sense of what happened? What did I tell myself about this event? Did I make any assumptions?

**Face and Body Changes and Sensing:** What do I feel in my face/body?
**Action Urges:** What did I feel like doing or saying?

**Body Language:** What were my facial expressions, gestures, and body language?

**What I SAID in the situation:** Be specific.

**What I DID in the situation:** Be specific.

**After-Effects:** What effect did this emotion have on me (my state of mind, other emotions, behaviours, thoughts, memories, body).
Session 3: Checking the Facts

• Collect any remaining questionnaires
• Check-in by sharing either (a) an emotion felt over past week (“I felt _____ when _______”) or (b) something you have learned about yourself or about emotions so far
• Any comments on last session?
• Take up homework (Worksheet 3 – Observing and Describing Emotions)
  o Give the caveat that we’ll be discussing some emotional experiences right now without attempting to change the emotional response, so this homework review might not be very rewarding. We will be getting in the skills-training starting later this session though.
  o Go over a few examples using flipchart to clarify the model of emotions (refer back to Handout 7)
  o Provide Handout 8 – Ways to Describe Emotions
  o As needed, assign another Worksheet 3 for coming week
• Mindfulness exercise: Body Scan
• Introduce the first strategy to change emotional responses by challenging interpretations of events:
  o Discuss difference between facts and opinions (Handout 9) and invite examples of how thoughts or opinions about something have influenced their emotions
  o Discuss potential threats that may be present when emotions do fit the facts (Handout 10)
  o Discuss common cognitive distortions (Handout 11)
  o Introduce steps to go through to check whether your reactions fit the facts of the situation (Handout 12 – Checking the Facts) by working through examples (Worksheet 4)
• Next week: What to do when the emotions don’t check the facts?
• Check-out
Handout 7a: Ways to Describe Anger

**Global Information Given by Anger:** Perception of violation or thwarting of freedom, standards, goals, person, or property

**Global Need Identified by Anger:** Respect, dignity, rights

**Anger Words**

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<tr>
<td>annoyance</td>
<td>frustration</td>
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**Prompting Events for Feeling Anger**

- Having an important goal blocked or prevented
- Having an important or pleasurable activity interrupted, postponed, or stopped
- You or someone you care about being attacked or hurt physically or emotionally by others
- You or someone you care about being threatened with physical or emotional pain by someone or something
- You or someone you care about being insulted
- Losing power
- Losing status
- Losing respect
- Not having things turn out the way you expected
- Experiencing physical pain
- Experiencing emotional pain
- Not obtaining something you want (that another person has)
Interpretations of Events that Prompt Feelings of Anger

- Believing that you have been treated unfairly
- Believing that important goals are being blocked or that pleasurable activities are being interrupted, postponed, or stopped
- Believing that others are attacking or trying to hurt you or someone that you care about
- Blaming
- Believing someone is insulting, disrespecting, or trying to control you
- Believing that things “should” be different than they are
- Rigidly thinking “I’m right”
- Judging that the situation is illegitimate, wrong, or unfair
- Ruminating about the event that set off the anger in the past

Biological Changes and Action Urges of Anger

- Muscles tightening
- Teeth clamping together, mouth tightening
- Hands clenching
- Feeling your face flush or get hot
- Feeling rigidity in your body
- Feeling like you are going to explode
- Feeling incoherent
- Feeling out of control
- Being unable to stop tears
- Feeling extremely emotional
- Feeling nervous tension, anxiety, or discomfort
- Wanting to hit, bang the wall, throw something, blow up
- Wanting to hurt someone

Expressions and Actions of Anger

- Physically attacking the cause of your anger
- Verbally attacking the cause of your anger
- Making aggressive or threatening gestures
- Pounding, throwing thing, breaking things
- Walking heavily, stomping, slamming doors
- Walking out
- Using a loud voice, yelling, or screaming
- Acting quarrelsome or sarcastic
- Using obscenities or swearing
- Criticizing or complaining
- Talking about how lousy things are
- Clenching your hands or fists
- Frowning or not smiling
- Having a mean or unpleasant facial expression
- Brooding or withdrawing from others
- Gritting or showing your teeth in an unfriendly manner
- Sarcastic or caustic voice tone
- Crying
- A red or flushed face

**After-Effects of Anger**

- Narrowing of attention
- Attending only to the situation making you angry
- Ruminating about the situation making you angry and not being able to think of anything else
- Remembering and ruminating about situations that have made you angry in the past
- Imagining future situations that will make you angry
- Depersonalization, dissociative experience, numbness
Handout 7b: Ways to Describe Sadness

**Global Information Given by Sadness:** Something important is being or has been lost

**Global Need Identified by Sadness:** For attachment and to maintain experiences that bring us joy or happiness or that are important to us

### Sadness Words

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<th>neglected</th>
<th>rejection</th>
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### Promting Events for Feeling Sadness

- Losing something or someone that is irretrievable
- Things are not the way you expected or wanted and hoped for
- The death of someone you love or thinking about deaths of people you love
- Losing a relationship or thinking about losses
- Being separated from someone you care for or value; thinking about how much you miss someone
- Being rejected or excluded
- Being disapproved of or disliked; not being valued by people you care about
- Things turning out badly
- Getting what you don’t want
- Things being worse than you expected
- Not getting what you have worked for
- Not getting what you want and believe you need in life; thinking about that you have not gotten that you wanted or needed
• Discovering that you are powerless or helpless
• Being with someone else who is sad, hurt, or in pain
• Reading or hearing of other people’s problems or troubled in the world
• Being alone or isolated or an outsider

Interpretations of Events that Prompt Feelings of Sadness

• Believing that a separation from someone will last for a long time or will never end
• Seeing things or your life as hopeless
• Believing that you will not get what you want or need in your life
• Believing that you are worthless or not valuable

Biological Changes and Action Urges of Sadness

• Feeling tired, run-down, or low in energy
• Feeling lethargic, listless; wanting to stay in bed all day
• Feeling as if nothing is pleasurable anymore
• Feeling in pain or hollowness in your chest or gut
• Feeling empty
• Feeling as if you can’t stop crying or that if you ever start crying you will never stop
• Difficulty swallowing
• Breathlessness
• Dizziness

Expressions and Actions of Sadness

• Avoiding things
• Acting helpless
• Moping, brooding, or acting moody
• Making slow, shuffling movements
• Withdrawing from social contact
• Avoiding activities that used to bring pleasure
• Sitting or lying around, being inactive
• Staying in bed all day
• Giving up and no longer trying to improve
• Saying sad things
• Talking to someone about sadness
• Talking little or not at all
• Using a quiet, slow, or monotonous voice
• Eyes drooping
• Frowning, not smiling
• Posture slumping
• Sobbing, crying, whimpering
After-Effects of Sadness

- Not being able to remember happy things
- Feeling irritable, touchy, or grouchy
- Yearning and searching for the thing lost
- Having a negative outlook; thinking only about the negative side of things
- Blaming or criticizing yourself
- Remembering or imagining other times you were sad and other losses
- Hopeless attitude
- Fainting spells
- Nightmares
- Insomnia
- Appetite disturbance, indigestion
- Depersonalization, dissociative experiences, numbness, or shock
Handout 7c: Ways to Describe Fear

**Global Information Given by Fear:** Perception of danger

**Global Need Identified by Fear:** Safety/security

### Fear Words

- fear
- edginess
- jumpiness
- panic
- terror
- anxiety
- fright
- nervousness
- shock
- uneasiness
- apprehension
- horror
- overwhelmed
- tenseness
- worry
- dread
- hysteria

### Prompting Events for Feeling Fear

- Having your life, your health, or your well-being threatened
- Being in a similar or the same situation where you have been threatened or gotten hurt in the past, or where painful things have happened
- Flashbacks
- Silence
- Being in situations where you have seen others threatened or be hurt
- Being in a new or unfamiliar situation
- Being alone (e.g., walking alone, being home alone, living alone)
- Being in the dark
- Being in crowds
- Leaving your home
- Having to perform in front of others (e.g., school, work)
- Pursuing your dreams

### Interpretations of Events that Prompt Feelings of Fear

- Believing that you might die or that you are going die
- Believing that you might be hurt or harmed, or that you might lose something valuable
• Believing that someone might reject, criticize, dislike, or disapprove of you
• Believing you will embarrass yourself
• Believing that failure is possible; expecting to fail
• Believing that you will not get help you want or believe you need
• Believing that you might lose help and assistance you already have
• Believing that you might lose someone or something you want
• Losing a sense of control; believing that you are helpless
• Losing a sense of mastery or competence

### Biological Changes and Action Urges of Fear

• Breathlessness
• Fast heartbeat
• Choking sensation, lump in throat
• Muscles tensing, cramping
• Clenching teeth
• Feeling nauseous
• Getting cold

• Feeling clammy
• Feeling your hairs standing on end
• Feeling of heaviness or fluttering (“butterflies”) in stomach
• Feeling nervous, jittery, or jumpy
• Wanting to run away or avoid things
• Wanting to scream or call out

### Expressions and Actions of Fear

• Fleeing, running away
• Running or walking hurriedly
• Hiding from or avoiding what you fear
• Engaging in nervous, fearful talk
• Pleading or crying for help
• Talking less or becoming speechless
• Screaming or yelling
• Darting eyes or quickly looking around
• Frozen stare

• Talking yourself out of doing what you fear
• Freezing or trying not to move
• Crying or whimpering
• Shaking, quivering, or trembling
• A shaky or trembling voice
• Sweating or perspiring
• Breathing fast
• Diarrhea, vomiting
• Hair standing on end
After-Effects of Fear

- Narrowing of attention
- Being hypervigilant to threat
- Losing your ability to focus on becoming disoriented being dazed losing control
- Imagining the possibility of more loss or failure
- Isolation
- Remembering and ruminating about other threatening times or other times when things did not go well
- Depersonalization, dissociative experiences
- Numbness or shock
Handout 7d: Ways to Describe Happiness

Global Information Given by Happiness: This is good for my well-being

Global Need Identified by Happiness: To thrive

**Happiness Words**

<table>
<thead>
<tr>
<th>happiness</th>
<th>satisfied</th>
<th>jovial</th>
<th>exhilaration</th>
<th>ecstasy</th>
</tr>
</thead>
<tbody>
<tr>
<td>joy</td>
<td>blissful</td>
<td>triumphant</td>
<td>optimism</td>
<td>gladness</td>
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<td>enjoyment</td>
<td>enthusiasm</td>
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<td>zest</td>
<td>pride</td>
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<td>jolliness</td>
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</tr>
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<td>thrilled</td>
<td>jubilation</td>
<td>gaiety</td>
<td>glee</td>
</tr>
<tr>
<td>enthralled</td>
<td>cheerful</td>
<td>zaniness</td>
<td>pleasure</td>
<td>rapture</td>
</tr>
<tr>
<td>hopeful</td>
<td>euphoria</td>
<td>delight</td>
<td>zeal</td>
<td></td>
</tr>
</tbody>
</table>

**Prompting Events for Feeling Happiness**

- Receiving a wonderful surprise
- Reality exceeding your expectations
- Getting what you want
- Getting something you have worked hard for or worried about
- Things turning out better than you thought they would
- Being successful at a task
- Achieving a desirable outcome
- Receiving esteem, respect, or praise
- Receiving love, like, or affection
- Being accepted by others
- Belonging somewhere or with someone or a group
- Being with or in contact with people who love or like you
- Having very pleasurable sensations
- Doing things that create or bring to mind pleasurable sensations
Interpretations of Events that Prompt Feelings of Happiness

- Interpreting joyful events just as they are, without adding or subtracting
- This is good
- This is what I wanted
- This is helping me to my goals
- I’m making progress
- I’m getting there
- I got more than I expected
- I belong
- I’m loved
- I’m doing okay
- This feels good

Biological Changes and Action Urges of Happiness

- Feeling excited
- Feeling physically energetic, active
- Feeling like giggling or laughing
- Feeling your face flush
- Feeling at peace
- Feeling open or expansive
- Feeling calm all the way through

Expressions and Actions of Happiness

- Smiling
- Having a bright, glowing face
- Being bouncy or bubbly
- Communicating your good feelings
- Sharing the feeling
- Silliness
- Hugging people
- Jumping up and down
- Saying positive things
- Using an enthusiastic or excited voice
- Being talkative or talking a lot

After-Effects of Happiness

- Being courteous or friendly to others
- Doing nice things for other people
- Having a positive outlook; seeking the bright side
- Having a high threshold for worry or annoyance
- Remembering and imagining other times you have felt joyful
- Expecting to feel joyful in the future
Handout 7e: Ways to Describe Love

Global Information Given by Love: This person is important to and contributes to my well-being; this person is valuable

Global Need Identified by Love: To have attachments and companionship

Love Words

<table>
<thead>
<tr>
<th>love</th>
<th>caring</th>
<th>enchanted</th>
<th>liking</th>
<th>sentimental</th>
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<tbody>
<tr>
<td>adoration</td>
<td>charmed</td>
<td>fondness</td>
<td>longing</td>
<td>sympathy</td>
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<tr>
<td>affection</td>
<td>compassion</td>
<td>infatuation</td>
<td>lust</td>
<td>tenderness</td>
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<td>desire</td>
<td>kindness</td>
<td>passion</td>
<td>warmth</td>
</tr>
<tr>
<td>attraction</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Prompting Events for Feeling Love

- A person offers or gives you something you want, need, or desire
- A person does things you want or need the person to do
- A person does things you particularly value or admire
- Feeling physically attracted to someone
- You spend a lot of time with a person
- You share a special experience together with a person
- You have exceptionally good communication with a person
- Being with someone you have fun with

Interpretations of Events that Prompt Feelings of Love

- Believing that a person loves, needs, or appreciates you
- Thinking a person is physically attractive
- Judging a person’s personality as wonderful, pleasing, or attractive
- Believing that a person can be counted on, or will always be there for you
Biological Changes and Action Urges of Love

(When you are with or thinking about someone)

• Feeling excited and full of energy
• Fast heartbeat
• Feeling self-confident
• Feeling invulnerable
• Feeling happy, joyful, or exuberant
• Feeling warm, trusting, and secure
• Feeling relaxed and calm

• Wanting the best for a person
• Wanting to give things to a person
• Wanting to see and spend time or your life with a person
• Wanting physical closeness or sex
• Wanting emotional closeness

Expressions and Actions of Love

• Saying “I love you”
• Expressing positive feelings to a person
• Eye contact, mutual gaze
• Touching, hugging, holding, cuddling

• Sexual activity
• Smiling
• Sharing time and experiences with someone
• Doing things that the other person wants or needs

After-Effects of Love

• Only being able to see a person’s positive side
• Feeling forgetful or distracted; daydreaming
• Feeling openness and trust
• Feeling alive, capable

• Remembering other times and people you have loved
• Remembering other people who have loved you
• Remembering and imagining other positive events
• Believing in yourself, believing you are wonderful, capable, competent
Handout 7f: Ways to Describe Shame

Global Information Given by Shame: I have done something that threatens my value and worth in the eyes of others/myself.

Global Need Identified by Shame: To belong, to have value and standing in the group, and to feel self-worth.

Shame Words:

shame disgrace embarrassed mortified shy
contrite discomposed humiliated self-conscious

Prompting Events for Feeling Shame:

- Being rejected by people you care about
- Having others find out that you have done something wrong
- Doing, feeling, or thinking something that other people you admire believe is wrong or immoral
- Comparing some aspect of yourself or your behaviour to a standard and feeling like you do not live up to that standard
- Being betrayed by a person you love
- Being laughed at or made fun of
- Being criticized in front of others; remembering public criticism
- Other attacking your integrity
- Being reminded of something wrong, immoral, or shameful you did in the past
- Being rejected or criticized for something you expected praise for
- Having emotions/experiences that have been invalidated
- Exposure of a very private aspect of yourself or your life
- Exposure of a physical characteristic you dislike
- Failing at something you feel you are (or should be) competent to do
Interpretations of Events that Prompt Feelings of Shame

- Believing that others will reject you (or have rejected you)
- Judging yourself to be inferior, not “good enough,” or not as good as others; self-invalidation
- Comparing yourself to others and thinking that you are a loser
- Believing yourself unlovable
- Thinking that you are bad, immoral, or wrong
- Thinking that you are defective
- Thinking that you are a bad person or a failure
- Believing your body (or body part) is too big, too small, or too ugly
- Thinking that you have not lived up to other’s expectations of you
- Thinking that your behaviour, thoughts, or feelings are silly or stupid

Biological Changes and Action Urges of Shame

- Pain in the pit of the stomach
- Sense of dread
- Wanting to shrink down and/or disappear
- Wanting to hide or cover your face and body

Expressions and Actions of Shame

- Hiding behaviour or characteristics from others
- Avoiding the person you have harmed
- Avoiding persons who have criticized you
- Avoiding yourself (distracting, ignoring)
- Withdrawing, covering the face
- Bowing your head, groveling
- Appeasing, saying you are sorry over and over
- Looking down and away from others
- Sinking back, slumped and rigid posture
- Halted speech, lowered volume while talking
### After-Effects of Shame

- Avoiding thinking about your transgression, shutting down, blocking all emotions
- Engaging in distracting, impulsive behaviours to divert your mind or attention
- High amount of self-focus or preoccupation with self
- Depersonalization, dissociative experiences, numbness, or shock
- Attacking or blaming others
- Conflicts with other people, isolation, feeling alienated
- Impairment in ability to problem-solve
Handout 7g: Ways to Describe Guilt

**Global Information Given by Guilt:** I have been the cause of harm to or deprivation of another

**Global Need Identified by Guilt:** To feel trustworthy, moral, honest, and deserving of what you have

**Guilt Words**

- guilt
- regret
- wrong
- haunted
- sullied
- apologetic
- remorse
- responsible
- undeserving
- dishonest
- culpable
- sorry
- burdened

**Prompting Events for Feeling Guilt**

- Doing or thinking something you believe is wrong
- Doing or thinking something that violates your personal values
- Not doing something that you said that you would do
- Committing a transgression against another person or thing you value
- Causing harm/damage to another person, object, or yourself
- Being reminded of something wrong you did in the past

**Interpretations of Events that Prompt Feelings of Guilt**

- Thinking your actions are to blame for something
- Thinking you behaved badly
- Thinking “if only” you had done something differently
Biological Changes and Action Urges of Guilt

• Hot, red face
• Jitteriness, nervousness
• Suffocating

Expressions and Actions of Guilt

• Trying to repair the harm, make amends for the wrongdoing, fix the damage, or change the outcome
• Asking for forgiveness, apologizing, confessing
• Giving gifts, making sacrifices, trying to make up for the transgression
• Bowing your head, kneeling before the person

After-Effects of Guilt

• Making resolutions to change
• Making changes in behaviour
• Joining self-help programs
Handout 7h: Ways to Describe Envy

Global Information Given by Envy: Unequal distribution of limited resources

Global Need Identified by Envy: Sufficient resources for survival and reproduction

Envy Words

- envy
- craving
- displeased
- greed
- pettiness
- bitterness
- discontented
- dissatisfied
- green-eyed
- resentment
- covetous
- disgruntled
- down-hearted
- longing
- wishful

Prompting Events for Feeling Envy

- Someone has something that you really want or need but don’t or can’t have
- Someone gets positive recognition for something and you don’t
- Being around people who have more than you have
- Someone you are competing with is more successful than you in an area important to you
- Others get something you really want and you don’t get it
- Being reminded that you don’t have things you want when others do
- You are not part of the “in” crowd
- Someone appears to have everything
- You are alone while others are having fun
- Someone else gets credit for what you’ve done

Interpretations of Events that Prompt Feelings of Envy

- Thinking you deserve what others have
- Thinking others have more than you
- Thinking about how unfair it is that you have such a bad lot in life compared to others
- Thinking you are inferior, a failure, or mediocre in comparison to others who you want to be like
- Thinking you are unlucky
- Comparing yourself to others who have more than you
• Comparing yourself to people who have characteristics that you wish you had
• Thinking you are unappreciated

**Biological Changes and Action Urges of Envy**

• Muscles tightening
• Teeth clamping together, mouth tightening
• Feeling your face flush or get hot
• Feeling rigidity in your body
• Pain in the pit of the stomach
• Jitteriness, nervousness
• Feeling nervous tension, anxiety, or discomfort
• Hating the other person
• Wanting the person or people you envy to lose what they have, to have bad luck, or be hurt
• Feeling pleasure when others experience failure or lose what they have
• Feeling unhappy if the other person experiences some good luck
• Wanting to hurt the person or people you envy
• Having an urge to get even
• Feeling motivated to improve yourself

**Expressions and Actions of Envy**

• Doing everything you can to get what the other person has
• Working a lot harder than you were to get what you want
• Trying to improve yourself and your situation
• Taking away or ruining what the other person has
• Attacking or criticizing the other person
• Doing something to get even
• Doing something to make the other person fail or lose what he or she has
• Saying mean things about the other people or making people look bad to others
• Trying to show the other person up, to look better than the other person
• Avoiding persons who have what you want

**After-Effects of Envy**

• Narrowing your attention
• Attending only to what others have that you don’t
• Remembering and ruminating about all the other times that others have had more than you
• Ruminating about what you don’t have and not being able to think of anything else
• Making resolutions to change
• Discounting what you do have; not appreciating things you have or that others do for you
Handout 7i: Ways to Describe Jealousy

Global Information Given by Jealousy: Perceived threat to valued relationship

Global Need Identified by Jealousy: To belong to social groups or relationships

Jealousy Words

jealous    cautious    clinging    clutching    possessive    suspicious    wary

defensive    rivalrous    self-protective    watchful

P Prompting Events for Feeling Jealousy

• Someone is threatening to take away important things in your life
• A desired relationship is threatened or in danger of being lost
• You find your lover is having an affair
• Someone goes out with the person you like
• Someone ignores you while talking to a friend of yours
• A potential competitor pays attention to someone you love
• Someone is more attractive, outgoing, or self-confident than you
• A person you are romantically involved with looks at someone else
• Apparently flirtatious behaviour of your partner towards someone else
• Your boyfriend or girlfriend tells you that s/he desires more time alone
• Not being treated with priority

Interpretations of Events that Prompt Feelings of Jealousy

• My partner does not care for me anymore
• I am nothing to him/her
• He/she is going to leave me
• He/she is behaving inappropriately
• I don’t measure up to my peers
• I deserve more than what I am receiving
• I was cheated
• No one cares about me
• My rival is possessive and competitive
• My rival is insecure
• My rival is envious

**Biological Changes and Action Urges of Jealousy**

• Breathlessness  
• Fast heartbeat  
• Choking sensation, lump in throat  
• Muscles tensing  
• Clenching teeth  
• Feeling suspicious and mistrustful of others  
• Having injured pride  
• Feelings of rejection, need to be in control  
• Becoming mistrustful  
• Feeling helpless  
• Wanting to grasp or keep hold of what you want to have  
• Wanting to push away or eliminate your rival

**Expressions and Actions of Jealousy**

• Violent behaviour towards the person threatening you  
• Threatening violence towards the person threatening you  
• Attempting to control the freedom of the person you are afraid of losing  
• Verbal accusations of disloyalty or unfaithfulness  
• Spying on the person  
• Interrogating the person, demanding accounting of time or activities  
• Collecting evidence of wrong doings  
• Clinging, enhanced dependency  
• Increased or excessive demonstrations of love  
• Increased demands of sexual activity

**After-Effects of Jealousy**

• Narrowing of attention  
• Being hypervigilant to threats to your relationships  
• Becoming isolated or withdrawn  
• Changing the interpretation of previous events to suggest the jealousy is reasonable  
• Seeing the worst in others
Handout 7j: Ways to Describe Disgust

Global Information Given by Disgust: Perceived threat to biological or moral integrity

Global Need Identified by Disgust: To preserve well-being

Disgust Words

disgust  condescension  disdain  repugnance  scorn
abhorrence  contempt  distaste  repulsion  sickened
antipathy  dislike  hate  resentment  spite
aversion  derision  loathing  revolted  vile

Prompting Events for Feeling Disgust

• Seeing or smelling waste products of a human or animal body
• Having a person or an animal that is dirty or unclean come close to you
• Tasting something or swallowing something you really don’t want
• Being near, seeing, or touching something you really don’t want or that reviles you (e.g., insects)
• Seeing or being near a dead body
• Touching items worn or owned by a stranger or disliked or dead person
• Seeing blood or getting an injection or blood drawn
• Observing or hearing about a person who behaves without dignity or who takes the dignity of another
• Observing or hearing about a person acting with extreme hypocrisy
• Observing or hearing about betrayal, child abuse, racism, or other types of cruelty
• Being forced to watch something that deeply violates your own values
• Being confronted with someone who is deeply violating your own values
• Being forced to engage in or watch unwanted sexual contact

Interpretations of Events that Prompt Feelings of Disgust

• Believing that you are swallowing something toxic
• Believing your skin is contaminated
• Believing your own or someone else’s body is ugly
• Believing that an object has negative sensory characteristics (e.g., smell, feel, taste)
• Disapproving of or feeling morally superior to someone
• Extreme disapproval of self or one’s feelings, thoughts, or behaviours

• Believing that a person is disrespecting authority or group norms or being disloyal
• Judging that a person is deeply immoral or has sinned or violated the natural order of things
• Believing that you will become contaminated by being around the “poisonous ideas” of others
• Believing others are evil or the “scum” of the earth

**Biological Changes and Action Urges of Disgust**

• Feelings of nausea
• Sick feeling
• Urge to vomit, vomiting
• Gagging, choking
• Having a lump in your throat
• Aversion to drinking or eating
• Urge to take a shower

• Intense urge to get rid of something
• Wanting to destroy something
• Urge to run away or push away
• Feeling contaminated, dirty, unclean
• Feeling mentally polluted
• Fainting

**Expressions and Actions of Disgust**

• Vomiting, spitting out
• Closing your eyes, looking away
• Washing, scrubbing, taking a bath
• Cleaning your body surface
• Changing your clothes
• Cleaning your apartment
• Avoiding eating or drinking
• Pushing or kicking away, running away
• Treating with disdain or disrespect, disregarding

• Going first, stepping over, crowding another person out
• Physically attacking the cause of your disgust
• Using obscenities or cursing
• Clenching your hands or fists
• Frowning or not smiling
• Mean or unpleasant facial expression
• Speaking with a sarcastic voice tone
• Nose and top lip tighten up
• Lip curled up on one side, smirking
After-Effects of Disgust

- Narrowing of attention
- Closing down senses
- Feeling ugly
- Feeling dirty
- Becoming hypersensitive to dirt

- Ruminating about the situation making you feel disgusted and not being able to think of anything else
- Depersonalization, dissociate experience, numbness
Handout 8: Fact or Opinion?

**FACT**
- Evidence to support its truth
- Undisputable
- Driven by rational thought
- Head

**OPINION**
- Based upon a belief or personal view
- Arguable
- Driven by and reinforced by emotion
- Heart

At stressful times, we tend to be driven by our emotions and opinions, which create a vicious cycle by fuelling each other. Our emotions strengthen our opinions, which in turn, intensify our emotions. This leads to impulsive acts and unhelpful longer term consequences, which help to maintain the overall problem. Realising that many thoughts are opinion rather than fact makes it less likely that we’ll be distressed by them, and more able to make wise and calm decisions about the best action to take.

It is helpful to ask ourselves whether our thoughts are FACT or OPINION.

- If OPINION, then we can look at the facts – what we do know about the situation?
- If FACT, then we can make choices about the best thing to do.

**Example: What words might we use to describe this picture?**

Fact (Evidence-based)
- Clown
- Painted face

Opinion
- Colourful
- Circus performer
- Smiling
Opinion (Varies, personal view)

- Funny
- Weird hair
- Scary
- Happy
- Ugly

In the same way, individuals can have many varied opinions about the same event or situation. If someone we know walked past us without saying hello, we might think, “they deliberately ignored me”, “she’s being snooty and rude”, “they didn’t want to talk to me because they don’t like me” and so on. This might lead us to feel upset, and react in ways that are unhelpful. The only fact is that the person walked past, anything else is opinion – our own personal interpretation of the event. The reality is that they just didn’t see us. Realising that many thoughts are opinion rather than fact makes it less likely that we’ll be distressed by them, and more able to make wise and calm decisions about what the best action to take.
### Handout 9: Examples of Emotions that Fit the Facts

<table>
<thead>
<tr>
<th>Emotion</th>
<th>Fact</th>
</tr>
</thead>
</table>
| **Fear** | • There is a threat to your life, health, or well-being  
• There is a threat to the life, health, or well-being of someone you care about  
• Other: ________________________________________________ |
| **Anger** | • An important goal is blocked or a desired activity is interrupted or prevented  
• You or someone you care about is attacked or hurt by others  
• You or someone you care about is insulted or threatened by others  
• Other: ________________________________________________ |
| **Disgust** | • Something you are in contact with could poison or contaminate you  
• Somebody whom you deeply dislike is touching you or someone you care about  
• You are around a person or group whose behaviour or thinking could seriously damage or harmfully influence you or the group you are part of  
• Other: ________________________________________________ |
| **Envy** | • Another person or group gets or has things you don't have or that you want or need  
• Other: ________________________________________________ |
| **Jealousy** | A relationship or thing in your life is very important and desired by you AND:  
• It is in danger of being damaged or lost OR  
• Someone is threatening to take it away from you  
• Other: ________________________________________________ |
| **Love** | Who or what is loved does things or has qualities that you admire AND:  
• Loving the person, animal, or object enhances the quality of your life or of those you care about OR  
• Loving the person, animal, or object increases your chances of attaining your own personal goals  
• Other: ________________________________________________ |
| **Sadness** | • You have lost something or someone irretrievably  
• Things are not the way you wanted or expected and hoped them to be  
• Other: ________________________________________________ |
| **Shame** | • You will be rejected by a person or group you care about if characteristics of yourself or your behavior are made public  
• Other: ________________________________________________ |
| **Guilt** | • Your own behaviour violates your own values or moral code  
• Other: ________________________________________________ |
Handout 10: Unhelpful Thinking Habits

Over the years, we tend to get into unhelpful thinking habits such as those described below. We might favour some over others, and there might be some that seem far too familiar. Once you can identify your unhelpful thinking styles, you can start to notice them – they very often occur just before and during distressing situations. Once you can notice them, you can start to challenge or distance yourself from those thoughts and begin to see the situation in a different and more helpful way.
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Source: psychologytools.org
Handout 11: Checking the Facts

This first strategy for changing emotional responses is used to check out whether your reactions fit the facts of the situation. By changing your beliefs and assumptions to better fit the facts, you can change your emotional reactions to situations.

FACT: Many emotions and actions are set off by our thoughts and interpretations of events, not by the events themselves.

EVENT \rightarrow THOUGHTS \rightarrow EMOTION

Our emotions can also have a big effect on our thoughts about events:

Questions to Ask to Help Check the Facts

1. What is the emotion I want to change? (*Refer to Handouts 3 and 8*)

2. What is the event prompting my emotional reaction?
   - Describe the facts that you observed through your senses
   - Leave out any opinions about the facts (*Refer to Handout 9*)

3. What are my interpretations, thoughts, and assumptions about the event? (*Refer to Handout 11*)
   - Challenge judgments, extremes, and absolute black-and-white descriptions
   - Think of other possible interpretations, sides of the situation, and points of view

4. Am I assuming a threat? (*Refer to Handout 10*)
   - Label the threat
   - Assess the probability that the threatening event will really occur
   - Think of as many other possible outcomes as you can
5. What is the catastrophe?
   • Imagine the catastrophe really occurring
   • Imagine saying “so what?” and coping well with a catastrophe

6. Do my emotion and the intensity of my emotions fit the actual facts?
   • How likely is it that the expected outcomes will occur?
   • How great and/or important are the outcomes?
   • How effective is the emotion in your life?
Worksheet 4: Check the Facts

It’s hard to problem-solve emotional situations if you don’t have your facts straight. It is important to know what the problem is before you can solve it. This worksheet is to help you figure out whether it is the event that occurred that is causing your emotion, your interpretation of the event, or both. Before you can figure out what to change, you have to figure out what really happened.

Step 1: What is the emotion that you want to change? __________________________

How intense (0-100) is this emotion? Before checking the facts: ______

After checking the facts: ______

Step 2: Describe the prompting event. Who did what to whom? What led up to what? What is it about this event that is a problem for me? Be very specific in your answers. Leave out any opinions you may have about the facts.

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Step 3: What are my interpretations, thoughts, and assumptions about the event? What thoughts of mine am I adding to the description?

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
CHECK THE FACTS:

Identify and challenge any unhelpful thinking habits that may be creeping into your interpretations. Rewrite the facts, if necessary to be more correct.

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

List as many other possible interpretations of the facts as you can.

1. ________________________________________________________________
2. ________________________________________________________________
3. ________________________________________________________________
4. ________________________________________________________________

Step 4: Next ask, what is the threat? What about this event or situation is threatening to me?

What worrisome consequences or outcomes of this event am I expecting? What’s the probability that the threatening event will really occur?

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
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CHECK THE FACTS:

List as many other possible outcomes as you can, given the facts.

1. _________________________________________________________________
2. _________________________________________________________________
3. _________________________________________________________________
4. _________________________________________________________________

Step 5: What’s the catastrophe if the outcome I am worrying about does occur? Describe in detail the worst outcome you can reasonably expect. Describe ways to cope if the worst happens.

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Step 6: Does my emotion and the intensity of this emotion FIT THE FACTS? Consider how likely it is that the expected outcome will occur, how important the outcome is, and how effective the emotion is in your life.

Rate how sure you are that your emotion fits the facts using a scale from 0 (not at all sure) to 5 (I am certain): _____
If you are unsure whether your emotions or your emotional intensity fit the facts (for example, you give a score of 2, 3, or 4), keep checking the facts. Be as creative as you can be. For example, ask others for their opinions or do an experiment to see if your predictions or interpretations are correct. Describe what you did to check the facts.
Session 4: Opposite Action

- Check-in by sharing either (a) an emotion felt over past week (“I felt _____ when _______”) or (b) something you have learned about yourself or about emotions so far
- Take up homework (Worksheet 4 – Checking the Facts)
  - Clarify that the catastrophe step of the process. Imagine the catastrophe before you make it worse.
  - General impressions of checking the facts
  - Handout 10: Have you noticed any unhelpful thinking habits popping up?
  - Handout 11: Did anyone come up with other facts that fit any of the emotions?
  - Did anyone notice any change to their emotion by checking the facts?
  - Any stuck points?
  - Work through examples. Ask specifically whether group members who didn’t have an example worked through last week have an example they’d like to work through.
  - Given that the next strategy builds on being able to check the facts, ask whether there are any remaining questions about this strategy
- Introduce the second strategy to change emotional responses: Handout 12 – Opposite Action
  - Involves recognizing your emotional urges and doing the opposite
  - Stress that it is different than suppressing your emotions because it involves using the emotional information to do something that is helpful rather than destructive
  - Stress that this strategy is only used when the emotion is not justified or effective
  - Brainstorm possible opposite actions with group before providing Handout 13
  - Discuss basic research findings that smiling can improve your mood, make you more attractive, is contagious, relieves stress, boosts your immune system, relieves natural pain relievers (endorphins and serotonin), and lowers your blood pressure
    - Strack et al., 1998: whether participants held pencil between their teeth (forcing them to smile) or between their lips (forcing them to frown) affected their ratings of how funny cartoons were
    - Has to be Duchenne smiles (genuine smiles that engage the muscles in the mouth, cheeks, and eyes)
  - Point out the added decision-point when doing opposite action for shame and guilt
  - Assign Worksheet 5 for homework
- Check-out
Handout 12: Opposite Action

Emotions come with specific action urges or tendencies that push us to act in certain ways. One way of changing your current emotion is by **ACTING OPPOSITE** to your emotional urge. The idea behind this technique is that it can help to deal with distressing emotions by setting into motion an action that is helpful, not harmful. Doing this counteracts the suffering you might otherwise feel because of the distressing emotion.

For example, if we are angry, there are many actions that we might take to express our angry feelings. But if the action that we take is one that is opposite to the emotion we feel, like walking away from a situation when we are angry, or distracting ourselves with something nice, then we have put our energy into something that is eventually going to make us feel better. In this way, we not only reversed our action (walked away instead of yelling at someone), but we also began to make a change in our angry feelings. We didn't escalate or heighten our feelings, but we did something that made the feelings decrease by putting something positive in their place.

It's important to know that this skill is not about trying to suppress our emotions. **Don’t suppress the emotion:** when we suppress emotions, they just get bigger. Emotions are not the problem – urges and/or intensity are the problems. Opposite action is different than emotional suppression because we are acknowledging our emotions and urges and using that information to be able to take a different action. The result of this will be a gradual change in our emotions.
When to use Opposite Action

1. When knowing the facts does not change your emotions.
2. When the emotion or its intensity or its duration is not justified by the facts (i.e., the emotion does not fit the facts of the situations)
3. When the emotion or its intensity or its duration is not effective for your goals in the situation.
4. When you can commit to doing the opposite action all the way.

Opposite Action Step-By-Step

1. Identify the emotion you want to change (see Handout 3)
2. Check the facts and check to see if:
   a. Your emotion fits the facts (see Handouts 9, 10, 11 and 12)
   b. Your emotion is effective for your goals
   If your emotion does not fit the facts or if acting on your emotion is not effective, go to Step 3.
3. Ask yourself: Do I want to change the emotion? If yes, go to Step 4.
4. Identify your action urges (see Handout 8)
5. Figure out the OPPOSITE ACTION to your urge (see Handout 14)
6. Fully commit and carry out the OPPOSITE ACTION
7. Repeat acting opposite to your urges until your emotional sensitivity to the prompting event goes down and you experience or act on your urge less often
Handout 13: Figuring Out Opposite Actions

When **FEAR** (or its intensity or duration) is not justified or not effective:

- Do what you are afraid of doing...OVER AND OVER.
- Approach events, places, tasks, activities, and people you are afraid of.
- Do things to give yourself a sense of CONTROL and MASTERY over your fears.
- Keep your EYES AND EARS OPEN and focused on the feared event. Look around slowly, explore the information from the situation, and notice that you are safe.
- Change your BODY LANGUAGE AND CHEMISTRY. Keep your head and eyes up, shoulders back but relaxed, assertive body posture, and pace your breath by breathing in deeply and breathing out slowly.

When **ANGER** (or its intensity or duration) is not justified or not effective:

- GENTLY AVOID the person you are angry with (rather than attacking).
- TAKE A TIME-OUT and breath in and out deeply and slowly.
- BE KIND (rather than mean or insulting).
- BUILD UNDERSTANDING and empathy for the other person. Step into their shoes and try to see the situation from their point of view. Imagine good reasons for what has happened.
- Change your BODY LANGUAGE AND CHEMISTRY. Unclench your hands and teeth; relax your chest, stomach, and face muscles; and half-smile. Pace your breath by breathing in deeply and breathing out slowly, or run or engage in other energetic (non-violent) activity.

When **SADNESS** (or its intensity or duration) is not justified or not effective:

- GET ACTIVE; approach.
- AVOID AVOIDING. Start doing what is needed to build the life you want now.
- BUILD MASTERY. Do things that make you feel competent and self-confident.
- Pay attention to the PRESENT MOMENT. Be mindful of your environment, each detail as it unfolds. Experience new or positive activities you are engaging in.
- Change your BODY LANGUAGE AND CHEMISTRY. Head up, eyes open, shoulders back, upbeat voice; increase physical movement (e.g., run, jog, walk, other exercise).

When **JEALOUSY** (or its intensity or duration) is not justified or not effective:

- LET GO of controlling others’ actions.
- SHARE what and who you have in your life.
- STOP SPYING or snooping. Suppress probing questions, such as “Where were you? Who were you with?”
• STOP AVOIDING: Listen to all the details, focus on sensations; keep your eyes open and look around to take in all the information about the situation.
• Change your BODY LANGUAGE AND CHEMISTRY. Unclench your hands and teeth; relax your chest, stomach, and face muscles; half-smile; and pace your breath by breathing in deeply and breathing out slowly.

When ENVY (or its intensity or duration) is not justified or not effective:

• INHIBIT DESTROYING what the other person has.
• COUNT YOUR BLESSINGS. Make a list of the things you are thankful for. Avoid discounting some blessings or exaggerating your deprivations.
• Stop EXAGGERATING others’ net worth or value. Check the facts.
• Change your BODY LANGUAGE AND CHEMISTRY. Unclench your hands and teeth; relax your chest, stomach, and face muscles; half-smile; and pace your breath by breathing in deeply and breathing out slowly.

When SHAME (or its intensity or duration) is not justified or not effective…

A. … and your behaviour DOES NOT violate your own moral values
   • MAKE PUBLIC your personal characteristics or your behaviour (with people who won’t reject you).
   • REPEAT the behaviour that sets off shame over and over (without hiding the behaviour from those who won’t reject you).
   • NO APOLOGIZING or trying to make up for a perceived transgression
   • TAKE IN all the information from the situation
   • Change your BODY LANGUAGE. Look innocent and proud. Head up, “puff up” your chest, maintain eye contact, steady and clear voice.
B. … and your behaviour DOES violate your own moral values
   • APOLOGIZE publically.
   • REPAIR the transgressions or work to prevent or repair similar harm for others.
   • COMMIT to avoiding that mistake in the future.
   • ACCEPT the consequences gracefully.
   • FORGIVE yourself. Acknowledge the causes of your behaviour.
   • LET IT GO.

When GUILT (or its intensity or duration) is not justified or not effective…

A. … and you WILL NOT be rejected by a person or a group you care about if found out
   • MAKE PUBLIC your personal characteristics or your behaviour (with people who won’t reject you).
   • REPEAT the behaviour that sets off guilt over and over (without hiding the behaviour from those who won’t reject you).
   • NO APOLOGIZING or trying to make up for a perceived transgression
• TAKE IN all the information from the situation
• Change your BODY LANGUAGE. Look innocent and proud. Head up, “puff up” your chest, maintain eye contact, steady and clear voice.

B. … and you WILL be rejected by a person or a group you care about if found out
• HIDE your behaviour (if you want to stay in the group).
• USE YOUR INTERPERSONAL SKILLS (if you want to stay in the group)
• WORK TO CHANGE the person’s or group’s values.
• JOIN A NEW GROUP that fits your values and will not reject you.
• REPEAT the behaviour that sets off guilt over and over with your new group.
• VALIDATE yourself.

When LOVE (or its intensity or duration) is not justified or not effective:

• AVOID the person, animal, or object you love.
• DISTRACT from thoughts of the person, animal, or object.
• REMIND yourself why love is not justified when loving thoughts do arise (rehearse the “cons” of loving).
• AVOID CONTACT with everything that reminds you of the person: pictures, letters, messages, emails, belongings, mementos, places you were together, places you planned to go or wanted to go, places the person has been or will be at; no following, waiting, or looking for the person.
• STOP EXPRESSING LOVE for the person, even to friends; “unfriend” the person on Facebook, Twitter, etc.
• Change your BODY LANGUAGE. No leaning toward, no getting close enough to touch, no sighing or gazing at the person.
Worksheet 5: Opposite Action to Change Emotions

Select a current or recent emotional reaction that you find painful or want to change. Figure out if the emotion is justified by the situation. If it is not, then notice your action urges, figure out what would be opposite actions, and then do the opposite actions. Remember to practice opposite action all the way. Describe what happened.

EMOTION NAME: ___________________  INTENSITY (0-100) Before: _____  After: _____

PROMPTING EVENT for my emotions (who, what, when, where):

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Is my emotion JUSTIFIED? Is it EFFECTIVE? List the facts that justify the emotion or that make it effective and those facts that do not. Check the answer that is most correct. (If needed, refer back to Worksheet 4.)

<table>
<thead>
<tr>
<th>Justified/Effective</th>
<th>Not Justified/Effective</th>
</tr>
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<tbody>
<tr>
<td>___________________</td>
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☐ Justified & Effective: Go to Problem-Solving  ☐ Not Justified or Effective: Continue
ACTION URGES: What do I feel like doing or saying?

__________________________________________________________________________

__________________________________________________________________________

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__________________________________________________________________________

__________________________________________________________________________

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OPPOSITE ACTION: What are the actions opposite to my urges? What am I not doing because of my emotions? Describe both what and how to act opposite ALL THE WAY in the situation.

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WHAT I did and HOW I did it: Describe in detail, including body language, facial expressions, posture, gestures, and thoughts.

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What AFTER EFFECT did the opposite action have on me (my state of mind, other emotions, behaviour, thoughts, memory, body, etc.)?

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Session 5: Problem-Solving

- Check-in by sharing either (a) an emotion felt over past week (“I felt _____ when _______”) or (b) an assessment on your progress on one of your goals (Worksheet 1)
- Take up homework (Worksheet 5 – Opposite Action to Change Emotions)
- Review: When do you use opposite action? (when emotion or intensity is not justified/effective, when knowing the facts doesn’t change the emotion, when you can commit and do it all the way, when you want to change your emotion)
- General impressions of opposite action? Any changes to emotional intensity?
- Any stuck points?
- Work through examples. Ask specifically whether group members who didn’t have an example worked through last week have an example they’d like to work through.
- Review decision-point for opposite action for shame and guilt (see Handout 14)
- Mindfulness Exercise: Fusion vs. Defusion
- Introduce the third strategy to change emotions: Handout 15 – Problem-Solving
- What is problem-solving? (A systematic/organized/cyclical process of identifying and resolving/reducing obstacles/barriers/etc.)
- Why talk about problem-solving? (Emotions tell us information about our environments; they’re a signal that something in the environment is going on)
- What alternatives are there to problem-solving when there’s a problem?
  - Avoid → problem could get worse → emotions escalate
  - Act impulsively on the emotional urge → problem could get worse → emotions escalate
- Discuss difference between problem-solving and worry
  - Worry: hypothetical problems (not current problems), related to anxiety (which restricts attention and interferes with problem-solving), focused on the problem rather than the solution, vague vs. specific, aimless vs. directed
- Compare when to do problem-solving vs. opposite action
- Go through steps
- Assign Worksheet 6 for homework
- Check-out: impressions from session, goals for week
Handout 14: Problem-Solving

Emotions tell us important information about our environments. For example, emotions can act as an alarm or a signal that there is a problem for us to solve. If emotions are thought of as signals, then one way of changing your current emotion is to engage in effective problem-solving. Problem-solving is a practical and helpful process, which focuses on problems in the here-and-now and generates a clear plan of action. If you lack confidence in your problem-solving skills, you might try avoiding the problem or respond impulsively with your emotional urges. Unfortunately, both of these strategies can make the problem worse and further fuel your negative emotions. In contrast, by learning how to address the source of your negative emotions directly, in a step-by-step way, you can better manage your emotions and achieve your goals.
When to use Problem-Solving:

1. When your emotion is justified by the facts and is effective for your goals in the situation.
2. If you have a real problem, that exists in the here-and-now, and that you have some influence over. If the problem is hypothetical (some unlikely future event) or something that you have little influence over, it does not require a solution.
3. When you can set aside enough time. Problem-solving takes energy and concentration, and isn’t something that can be done on the run. You will need to give it the time and attention it deserves to gain the most benefit.
4. When you’re not in extreme emotional distress.

Problem-Solving Step-By-Step

1. OBSERVE and DESCRIBE the problem situation. Work through one problem at a time. Be objective and specific about the behaviour, situation, timing, and circumstances that make it a problem. Describe the problem in terms of what you can observe rather than with your opinions.
2. CHECK THE FACTS. Check ALL the facts to make sure that you have the correct problem. If your facts are correct and the situation is the problem, continue with problem-solving. If your facts are not correct, return to Step 1.
3. Identify your GOAL in solving the problem: Identify what needs to happen or change for you to feel okay. Keep it simple and something you can really achieve.
4. BRAINSTORM lots of solutions. Think of as many solutions as you can. Ask for suggestions from people you trust. Be creative and forget about the quality of the solutions. If you allow yourself to be creative, you may come up with some options that you would not otherwise have thought of/
5. EVALUATE the possible solutions. Choose at least two solutions that look best from Step 4 and identify the pros and cons to compare the solutions. Think of the pros and cons for both the short-term and the long-term.
6. CHOOSE the solution that looks best. Specify the steps involved and when they will take place.
7. Put the solution into ACTION. Take the first step, then the second, and so on.
8. EVALUATE the outcome. If it didn’t work, try a new solution. If it created a new problem, restart the process.
Worksheet 6: Problem-Solving to Change Emotions

Select a prompting event that triggers a painful emotion. Select an event that can be changed.

Turn the event into a problem to be solved by following the steps below.

EMOTION NAME: _____________________  INTENSITY (0-100) Before: ________  

After: ________

1. What is the problem? Be objective and specific about the behaviour, situation, timing, and circumstances that make it a problem.

______________________________________________________________________________
______________________________________________________________________________
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2. Check the facts. Describe what you did to be sure of your facts.

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3. What is a realistic short-term goal of your problem-solving? What has to happen for you to think you’ve made progress?

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4. Brainstorm solutions: List as many solutions and coping strategies as you can think of without evaluating them.

  • ____________________________________________  • ____________________________________________
  • ____________________________________________  • ____________________________________________
  • ____________________________________________  • ____________________________________________
  • ____________________________________________  • ____________________________________________
  • ____________________________________________  • ____________________________________________
5. Which two ideas look best? Which ones will most likely meet your goal and seem possible to do? Think of both the short- and long-term consequences.

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<th>Solution A: __________________</th>
<th>Solution B: __________________</th>
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6. Choose the solution to try. List the steps involved and when they will take place. Check off the steps when you’ve completed them, and record how well they work.

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<th>Action Step</th>
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<th>Done?</th>
<th>What Happened?</th>
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7. Did you reach your goal? Describe. If not, what can you do next? Is there a new problem to be solved? If yes, describe and problem solve again.

______________________________________________________________________________
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Session 6: Reducing Vulnerability and Accumulating Positive Emotions

- **Check-in:** Introduce yourself to the guest facilitator by sharing (a) something you’ve learned so far, (b) an assessment on your progress on one of your goals (Worksheet 1), or (c) something you’re still hoping to learn.

- **Take up homework (Worksheet 6 – Problem Solving to Change Emotions)**
  - Review: When do you use problem-solving? [When your emotions fit the facts, you have a real/current problem that you have some influence over, you have the time to work through it, you’re not emotionally over-aroused]
  - Overall level of success with problem-solving? Any changes to emotional intensity?
  - Any stuck points?
  - Work through examples. Ask specifically whether group members who didn’t have an example worked through last week have an example they’d like to work through.

- **Review topics covered to date (refer back to Handout 1 if necessary)**
  - Use Handout 6 to point out where in the model the different emotion regulation strategies exert their effects:
    - Check the Facts → Interpretation
    - Opposite Action → Emotional Experience/Emotional Expression
    - Problem-Solving → Prompting Event

- **Introduce today’s topic of reducing vulnerability through self-care and building positives**
  - Introduce PLEASE skills (Handout 15)
    - Put acronym on the board and encourage participation to identify the five areas of self-care
    - Facilitate discussion on what group members are doing to take care of these areas, as well as any examples of how ignoring these areas can worsen mood
    - Provide Handout 15
  - Introduce methods of building positive emotional experiences in the short-term
    - Increase frequency of pleasant activities. Plan them, and do them spontaneously. Do things you’ve never done before. Get group to brainstorm activities.
    - Build mastery/sense of accomplishment. Key is to do challenging, but possible activities, and to gradually increase the difficulty.
    - Provide Handout 16
  - Assign Worksheet 7 for homework

- **Check-out:** What one emotion regulation skill would you like to practise (in addition to Worksheet 7) for homework? (Observe/Describe, Check the Facts, Opposite Action, Problem-Solving)
Handout 15: Reduce Vulnerability PLEASE

If you are feeling sick, hungry, tired, or under the influence of drugs, or if you aren’t getting much exercise, you will be more vulnerable to negative emotions and less able to use your emotion regulation skills. Therefore, one way of reducing your vulnerability to having negative emotions is by taking care of your general physical and mental well-being. As you read through these different ways of taking care of your basic health, you may find that you are already doing some of these things, or you might find that you need to work on one or two of these in particular.

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<th>P</th>
<th>Treat Physical Illness</th>
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Do you have a physical illness that needs to be tended to? Do you have medication or treatments prescribed for you that you aren’t taking or doing? What things keep you from treating your physical illness? Take some time to think about this, and see what it would take for you to take care of your physical needs.

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<th>E</th>
<th>Balance Eating</th>
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How well do you eat? Do you eat too little? Too much? What kinds of food do you eat? (Eating too little means that your body doesn’t get the nourishment it needs. Also, if you eat too little over a period of time, your body goes into starvation mode and burns the food more slowly, trying to protect itself from starving.) What foods make you feel good? Calm? Energized? What foods make you feel bad? How does eating a lot of sugar make you feel? Caffeine? The key here is to eat foods that are healthy and that make you feel good.

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<tr>
<th>A</th>
<th>Avoid Mood-Altering Drugs</th>
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Alcohol and drugs can lower resistance to certain negative emotions. For example, when you drink alcohol, you might feel more depressed and sometimes more frightened. If you use drugs or alcohol, notice how they make you feel. How can you get some help for problematic use?

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<tr>
<th>S</th>
<th>Balance Sleep</th>
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How much sleep makes you feel good? Some people do fine on 5-6 hours, others need 9-10 hours. Some people need to nap during the day. Learn to plan your schedule so that you get the sleep you need. Do you have trouble sleeping? It is common for people who do not get enough sleep on a regular basis to feel irritable and short-tempered and to find that their judgment is less good.

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<thead>
<tr>
<th>E</th>
<th>Get Exercise</th>
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Regular exercise, besides being good for your heart, lungs, muscles and bones, stimulates chemicals in your brain called endorphins, which are natural antidepressants. We are talking about aerobic exercise, the kind that makes you out of breath. Do you get regular exercise? What kind? If not, is there something you can do for exercise, starting out with just a little?
Handout 16: Building Positives in the Short-Term

Another way of dealing with difficult emotions is to practise increasing your positive emotions. We need some positive emotions to put in the place of the negative emotions, or to share their space. If we are very used to dealing with negative emotions a lot, it may take a while to make some space for positive emotions and pleasant experiences. This is not an effort to invalidate the negative emotions that we feel. Rather, it’s a way of expanding our experiences and of providing some alternatives to some of our difficult times.

There are two ways to start building positive emotional experiences NOW:

1. **INCREASE PLEASANT ACTIVITIES** *(see back of handout for examples)*

   Pleasant activities could be something like going for a walk, watching a favorite TV show, or talking on the phone to a friend. You probably already do something like this in your life, but we’re asking you to INCREASE doing pleasant things that give you positive emotions. Doing more of this makes you feel good, which you deserve, and it gets you in the habit of having positive feelings. It's helpful if you plan what you are going to do early in the day, but you could also do something spontaneously. I would challenge you to do at least one thing on the list that you have never tried before, maybe something you have been wanting to do. Enjoy yourself.

2. **BUILD MASTERY**

   To defend against a sense of helplessness or hopelessness, do things that make you feel competent, effective, and accomplished each day. Plan for success, not failure. In other words, do something difficult, but possible. Gradually increase the difficulty over time. If the first task is too difficult, do something a little easier the next time.
1. **BE MINDFUL OF POSITIVE EXPERIENCES:** Focus your attention on the positive moments when they are happening. Refocus your attention when your mind wanders to the negative. Participate and engage fully in the experience.

2. **BE UNMINDFUL OF WORRIES:** Distract yourself from thinking about when the positive experience will end, whether you really deserve this positive experience, or what might be expected of you now that you've had this experience.

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<table>
<thead>
<tr>
<th>Pleasant Activities</th>
<th>Pleasant Activities</th>
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<tbody>
<tr>
<td>Listening to the radio/music</td>
<td>Sightseeing</td>
</tr>
<tr>
<td>Watching TV</td>
<td>Gardening</td>
</tr>
<tr>
<td>Recalling favourite memories</td>
<td>Early morning coffee and newspaper</td>
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<tr>
<td>Lying in the sun</td>
<td>Watching my children play</td>
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<tr>
<td>Laughing</td>
<td>Going to plays and concerts</td>
</tr>
<tr>
<td>Listening to others</td>
<td>Making lists of tasks</td>
</tr>
<tr>
<td>Hobbies (stamp collecting, model building)</td>
<td>Going bike riding</td>
</tr>
<tr>
<td>Planning a day's activities</td>
<td>Enjoying nature</td>
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<tr>
<td>Meeting new people</td>
<td>Completing a task</td>
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<tr>
<td>Saving money</td>
<td>Teaching</td>
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<tr>
<td>Going home from work</td>
<td>Photography</td>
</tr>
<tr>
<td>Eating tasty food</td>
<td>Going fishing</td>
</tr>
<tr>
<td>Working on my car (bicycle)</td>
<td>Thinking about pleasant events</td>
</tr>
<tr>
<td>Having quiet evenings</td>
<td>Playing with animals</td>
</tr>
<tr>
<td>Exercising</td>
<td>Reading</td>
</tr>
<tr>
<td>Playing sports</td>
<td>Acting</td>
</tr>
<tr>
<td>Visiting with family or friends</td>
<td>Being alone</td>
</tr>
<tr>
<td>Planning my career</td>
<td>Writing diary entries or letters</td>
</tr>
<tr>
<td>Thinking how it will be when I finish school</td>
<td>Dancing</td>
</tr>
<tr>
<td>Relaxing</td>
<td>Going on a picnic</td>
</tr>
<tr>
<td>Jogging, walking</td>
<td>Thinking &quot;I did that pretty well&quot;</td>
</tr>
<tr>
<td>Thinking I have done a full day's work</td>
<td>Meditating</td>
</tr>
<tr>
<td>Going camping</td>
<td>Having lunch with a friend</td>
</tr>
<tr>
<td>Singing</td>
<td>Going to the mountains</td>
</tr>
<tr>
<td>Practicing religion</td>
<td>Thinking about having a family</td>
</tr>
<tr>
<td>Going to the beach</td>
<td>Playing cards</td>
</tr>
<tr>
<td>Thinking I'm an OK person</td>
<td>Solving riddles mentally</td>
</tr>
<tr>
<td>A day with nothing to do</td>
<td>Having a political discussion</td>
</tr>
<tr>
<td>Traveling</td>
<td>Seeing and/or showing photos</td>
</tr>
<tr>
<td>Painting, drawing, doodling</td>
<td>Knitting</td>
</tr>
<tr>
<td>Doing something spontaneously</td>
<td>Doing puzzles (crossword, jigsaw)</td>
</tr>
<tr>
<td>Going for a drive</td>
<td>Shooting pool</td>
</tr>
<tr>
<td>Going hunting</td>
<td>Dressing up and looking nice</td>
</tr>
<tr>
<td>Playing musical instruments</td>
<td>Reflecting on how I've improved</td>
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<tr>
<td>Doing arts and crafts</td>
<td>Talking on the phone</td>
</tr>
<tr>
<td>Making a gift for someone</td>
<td>Going to museums</td>
</tr>
<tr>
<td>Watching sports</td>
<td>Thinking religious thoughts</td>
</tr>
<tr>
<td>Cooking</td>
<td>Saying &quot;I love you&quot;</td>
</tr>
<tr>
<td>Going hiking</td>
<td>Thinking about my good qualities</td>
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<tr>
<td>Writing (poems, stories)</td>
<td>Doing woodworking</td>
</tr>
<tr>
<td>Sewing</td>
<td>Debating</td>
</tr>
<tr>
<td>Going out to dinner</td>
<td>Doing something new</td>
</tr>
<tr>
<td>Discussing books</td>
<td>Thinking I'm a person who can cope</td>
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</table>
Worksheet 7: Reducing Vulnerability and Building Positives

This form is for tracking your planned PLEASE skills, pleasant activities, and efforts to build mastery. At night or first thing in the morning, write down what you plan to do that day, and at the end of the day, add a checkmark if you actually did it. Over time, you will find that you can do more and more of what you plan, and as that happens, you will find your vulnerability to negative emotions going down. At the bottom of the page, check whether planning these activities was helpful during the week. (Hint: To achieve more positive outcomes, challenge yourself to plan activities that you aren’t already doing.)

<table>
<thead>
<tr>
<th>Day</th>
<th>PLEASE Skill</th>
<th>Done?</th>
<th>Pleasant Activity</th>
<th>Done?</th>
<th>Effort to Build Mastery</th>
<th>Done?</th>
</tr>
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<tbody>
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Helpful?  

$\square$ Yes  $\square$ Yes  $\square$ Yes

$\square$ No  $\square$ No  $\square$ No
Session 7: Accumulating Positive Emotions in the Long-Term

• Check-in: share an emotion from the past week or share any emotion regulation challenges over the past week that they would like the group’s feedback on
• Review homework (Worksheet 7: Reducing Vulnerability and Building Positives)
  o PLEASE skills: what did you work on and was it helpful?
  o Pleasant activities: did you try anything new and was it helpful?
  o Effort to build mastery: what did you accomplish this week and was it helpful?
• Refer back to Handout 1 to review what we’ve covered and to remind them of where we’re going during the final few sessions
• Mindfulness exercise – Alternate Nostril Breathing
• Introduce Handout 18 – Building Positives in the Long-Term
  o What are values?
    ▪ How would you define them?
    ▪ Why are they important?
    ▪ Brainstorm examples
  o What are goals?
    ▪ How are they different from values? (They can be achieved)
    ▪ Why distinguish between goals and values? (You can live a life that is consistent with your values by working to any number of goals, which may vary depending on present circumstances/barriers)
    ▪ Can work towards goals even when you don’t “feel” like it (plaid socks example)
    ▪ Characteristics of SMART goals
• Introduce Worksheet 8 – Identifying Your Values
  o Begin working through different boxes to help group members articulate their values in each of these areas. Refer them to the words in the box on Handout 17 to help give them examples of qualities they may wish to include.
  o Point out that the discrepancy between the perceived importance of the value, their level of action towards the value, and their current satisfaction in this area can help them set priorities for setting value-guided goals
  o Assign rest of worksheet for homework
• Introduce Worksheet 9 – Getting from Values to Specific Action Steps
  o Discuss “avoid avoiding” as the first step. This can also involve brainstorming of barriers that may arise during future steps of the process.
  o Assign for homework
• Check-out: can you make a commitment to take a step towards one of your values this week?
Another way for you to regulate your emotions involves making changes in your life so that positive events are more likely to occur in the future. To build positives in the long-term, you will need to:

1. Identify your values and
2. Set and work towards goals that are consistent with those values

**What are your values?**

Values are what we find meaningful in life. They are what you care about and consider to be important. Values are different for everybody, and they can change over time. Deep down inside, what is important to you? What do you want your life to stand for? What sort of qualities do you want to develop as a person? How do you want to be in your relationships with others? Values are our heart's deepest desires for the way we want to interact with and relate to the world, other people, and ourselves. They are leading principles that can guide us and motivate us as we move through life.
<table>
<thead>
<tr>
<th>Faith</th>
<th>Entertainment</th>
<th>Assertiveness</th>
<th>Generosity</th>
<th>Honesty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acceptance</td>
<td>Fitness</td>
<td>Diversity</td>
<td>Gratitude</td>
<td>Independence</td>
</tr>
<tr>
<td>Caring</td>
<td>Wisdom</td>
<td>Dependability</td>
<td>Cooperation</td>
<td>Skillfulness</td>
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<tr>
<td>Kindness</td>
<td>Accomplishment</td>
<td></td>
<td>Courage</td>
<td>Wealth</td>
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<tr>
<td>Love</td>
<td>Adventure</td>
<td></td>
<td>Curiosity</td>
<td>Creativity</td>
</tr>
<tr>
<td>Respect</td>
<td>Connection</td>
<td></td>
<td>Trust</td>
<td>Authenticity</td>
</tr>
<tr>
<td>Responsibility</td>
<td>Fun</td>
<td>Supportiveness</td>
<td></td>
<td>Excitement</td>
</tr>
<tr>
<td>Security</td>
<td>Integrity</td>
<td></td>
<td>Teamwork</td>
<td>Fairness</td>
</tr>
<tr>
<td>Contribution</td>
<td>Compassion</td>
<td></td>
<td>Altruism</td>
<td>Hardworking</td>
</tr>
<tr>
<td>Freedom</td>
<td>Loyalty</td>
<td>Beauty</td>
<td>Safety</td>
<td>Family</td>
</tr>
<tr>
<td>Health</td>
<td>Pleasure</td>
<td>Intimacy</td>
<td>Cleanliness</td>
<td>Accuracy</td>
</tr>
<tr>
<td>Individuality</td>
<td>Imagination</td>
<td>Intelligence</td>
<td>Maturity</td>
<td>Discretion</td>
</tr>
</tbody>
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*(continued on back)*
Values are not the same as goals.

Values are directions we keep moving in, whereas goals are what we want to achieve along the way. A value is like heading North; a goal is like the river or mountain or valley we aim to cross whilst traveling in that direction. Goals can be achieved or “crossed off,” whereas values are an ongoing process. For example, if you want to be a loving, caring, supportive partner, that is a value – an ongoing process. If you stop being loving, caring and supportive, then you are no longer a loving, caring, supportive partner; you are no longer living by that value. In contrast, if you want to get married, that’s a goal – it can be ‘crossed off” or achieved. Once you’re married, you’re married – even if you start treating your partner very badly. If you want a better job, that’s a goal. Once you have it – goal achieved. But if you want to fully apply yourself at work, that’s a value – an ongoing process.

When it comes to setting goals, make sure you set a SMART goal:

**S** pecific
Specify the actions you will take, when and where you will do so, and who or what is involved. Examples of vague goals are “I will spend more times with my kids” or “I will be more loving towards my wife.” Examples of specific goals are “I will take the kids to the park on Saturday to play basketball” or “I will call my wife at lunchtime to tell her that I love her.”

**M** easurable
There should be clear criteria for measure whether the goal has been achieved. If a goal is not measurable, it is not possible to know whether you are making progress towards successful completion.

**A** chievable
The goal should be realistically achievable. Take into account your health, competing demands on your time, financial status, and whether you have the skills and resources to achieve it.

**R** elevant
The goal should be relevant to your values. If the goal is not meaningful to you, what’s the point?

**T** ime-bound
To increase the specificity of your goal, set a day, date, and time for it. If this is not possible, set as accurate of a time limit as you can.
Worksheet 8: Identifying Your Values

The following are areas of life that are valued by some people. Not everyone has the same values, and this is not a test to see whether you have the "correct" values. Think about each area in terms of general life directions, rather than in terms of specific goals. There may be certain areas that you don’t value much; you may skip them if you wish. It is also important that you write down what you would value if there were nothing in your way. What’s important? What do you care about? What personal qualities do you want to show?

After describing your values in each of these areas, rate how **IMPORTANT** each value is to you (0 = not at all, 10 = very important), your level of **ACTION** towards this value in the past month (0 = have not been active at all towards this value, 10 = very active towards this value), and how **SATISFIED** you are with your level of action (0 = not at all satisfied, 10 = completely satisfied).

<table>
<thead>
<tr>
<th>Value</th>
<th>I</th>
<th>A</th>
<th>S</th>
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<tbody>
<tr>
<td><strong>Family relations.</strong> What sort of husband/boyfriend, father, uncle, brother, and/or son do you want to be? What personal qualities would you like to bring to those relationships? What sort of relationships would you like to build? How would you interact with others if you were the ideal you in these relationships?</td>
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<tr>
<td><strong>Friendships/social life.</strong> What sort of qualities would you like to bring to your friendships? If you could be the best friend possible, how would you behave towards your friends? What sort of friendships do you want to build?</td>
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<tr>
<td><strong>Career/employment.</strong> What do you value in your work? What would make it more meaningful? What kind of worker would you like to be? If you were living up to your own ideal standards, what personal qualities would you like to bring to your work? What sort of work relations would you like to build? What do you want your work to be about or stand for?</td>
<td></td>
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</tr>
<tr>
<td>Value</td>
<td></td>
<td>I</td>
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<tr>
<td><strong>Education/personal growth and development.</strong> What do you value about learning, education, training, or personal growth? What new skills or knowledge would you like to learn? What sort of student would you like to be? What personal qualities would you like to apply?</td>
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<tr>
<td><strong>Recreation/fun/leisure.</strong> What sorts of hobbies, sports, or leisure activities do you enjoy? How do you relax and unwind? How do you have fun? What sorts of activities would you like to do? Why do you enjoy these things?</td>
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<tr>
<td><strong>Spirituality.</strong> Whatever spirituality means to you is fine. It may be as simple as communing with nature, or as formal as participation in an organised religious group. What is important to you in this area of life?</td>
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<tr>
<td><strong>Citizenship/environment/community life.</strong> How would you like to contribute to your community or environment, e.g. through volunteering, or recycling, or supporting a group/charity/political party? What sort of environments would you like to create at home, and at work? What environments would you like to spend more time in?</td>
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<tr>
<td><strong>Health/physical well-being.</strong> What are your values related to maintaining your physical and mental well-being? How do you want to look after your health, with regard to sleep, diet, exercise, smoking, alcohol, etc? Why is this important?</td>
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Worksheet 9: Getting From Values to Specific Action Steps

STEP 1: AVOID AVOIDING. Rate the degree that you have been avoiding working on building a life worth living: In the past _____ Now _____ (0 = no avoidance, 100 = avoided completely even thinking about it).

Check reasons for avoiding: □ hopelessness □ giving up
□ too hard □ other ______________________

Cope ahead by writing out a plan for getting yourself to avoid avoiding:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

STEP 2: PICK A VALUE TO WORK ON NOW. If possible, pick a value that you have identified as being of high importance to you and as low current satisfaction.

Value: __________________________________________________________

STEP 3: IDENTIFY SOME GOALS RELATED TO THIS VALUE. Make sure your goals are SMART (specific, measurable, achievable, relevant, and time-framed).

Goal #1: _________________________________________________________
Goal #2: ________________________________________________________________

Goal #3: ________________________________________________________________

**STEP 4: CHOOSE ONE GOAL TO WORK ON NOW.** Pick the one that is most important to work on now. If necessary, do a pros and cons chart to pick the goal to work on now.

Goal to work on: __________________________________________________________

**STEP 5: IDENTIFY SMALL ACTION STEPS TOWARD YOUR GOAL.** Break your goal into lots of small steps that you can do. If you start to feel overwhelmed because a step looks too big, break it down into smaller steps that you think you can actually do.

Action Step #1: ____________________________________________________________

Action Step #2: ____________________________________________________________

Action Step #3: ____________________________________________________________

Action Step #4: ____________________________________________________________

Action Step #5: ____________________________________________________________

**STEP 6: TAKE THE FIRST ACTION STEP.** Describe what you did:

________________________________________________________________________

________________________________________________________________________

Describe what happened next:

________________________________________________________________________

________________________________________________________________________
Session 8: Distress Tolerance

- Check-in: share an emotion from the past week
- Invite someone to summarize last session for group members who were absent
- Review homework:
  - Identification of values:
    - Any surprises?
    - Where were the discrepancies between importance and satisfaction?
    - Any difficulties putting values into words?
    - Are the values you identified yours or someone else’s?
  - Goal-setting:
    - Invite examples of value-based goals that were set?
    - Any barriers to carrying out goals?
- Mindfulness exercise
- Introduce distress tolerance skills (Handout 18)
  - Discuss situations where emotions are so high that you can’t use any skills
  - Goal of distress tolerance skills is to just get through the moment without making things worse
  - Emphasize that they’re only to be used when you can’t solve the problem
  - Two categories of skills: distraction techniques and strategies to improve the moment
  - Go through each skill in Handouts 19 & 20 and brainstorm examples of each
  - Provide Worksheets 10 and 11 for homework
Handout 18: Distress Tolerance Skills

Sometimes emotional arousal is so high that you can’t use any skills, particularly if the skills are complicated or take any thought on your part. At these times, distress tolerance skills can be used to simply survive a crisis without making it worse. There are many different strategies that you can use to help you get through difficult feelings and situations, and these strategies involve tolerating (dealing with, getting through, sitting with, accepting) the things that you can’t immediately change. The key is to find some of these skills and techniques that work for you. If you practice them when you are not overly distressed and make them a part of your everyday life, you’ll be able to call them up whenever you need them. All of the distress tolerance skills are meant to give you a break from dealing with your pain. They don’t resolve the painful situation, but they put it away for awhile so that you get a break and a chance to live some part of your life without it.

Two rules of crisis survival:

1. If you’re in a crisis and you can solve the problem now, solve it.
2. If you can’t solve the problem, survive it.

When do you need crisis survival skills?

- When you’re in crisis. A crisis is a short-term stressful event or traumatic moment that you want resolved NOW.
- When the crisis can’t be resolved NOW
- When you can’t afford to make it worse
How do you tolerate distress?

1. Distract yourself with:

   (see Handout 19)

   • Activities
   • Contribute
   • Comparison
   • Emotions
   • Pushing Away
   • Thoughts
   • Sensations

2. Improve the moment with:

   (see Handout 20)

   • Imagery
   • Create Meaning
   • Prayer
   • Relaxation
   • One Thing in the Moment
   • Vacation
   • Encourage Yourself
Handout 19: Distress Tolerance Through Distraction

A wise mind in distress ACCEPTS that that the crisis can’t be resolved now and uses distraction techniques to survive the moment.

Activities

Distract yourself by throwing yourself into activities, such as reading, exercising, getting organized, doing hobbies, going to an event, or getting together with friends. Make sure you pick an activity that requires your full attention and that really gets your mind involved. Don’t pick one that’s too easy and that you do mindlessly.

Contribute

Distract yourself from your distress by focusing your energy on someone or something else that you can contribute to. The idea is to distract yourself in a way that will actually make the world a little bit better. You could do some volunteer work or do something nice for someone else. It’s important to remember that your contributions don’t have to be big. Small things you could do include calling someone you haven’t spoken to in a while, holding the door open for someone, giving someone a compliment, sending a thank you note, helping someone with a task, and the list goes on...

Comparison

Compare your current situation or crisis to one that’s worse. You could compare to people who have less than you or to people who have the same thing as you but who have a harder time coping. You can also take a look at your own life and compare your current situation to the times when things have been a lot harder or when you didn’t have as many resources as you do now. The idea is to generate a sense of gratitude by sort of telling yourself, “it could be worse.”

Emotions

Distract yourself from your current emotions by creating another emotion. Listening to music can be a really effective way of doing this, but make sure you pick music that goes against your current emotion. For example, if you’re sad, pick energetic music, and if you’re anxious, pick calming music. You can also try reading an emotional book or watching an emotional movie or television show. For example, read some comics or watch a scary movie.

(Continued on back)
Pushing Away

Make a list of the main problems that are on your mind right now. For each one, ask yourself if there’s anything you can do about it and if now is a good time to do it. If the answer’s yes, go ahead and solve the problem. If the answer’s no though, imagine yourself picking up the problem, putting it in a locked box, and putting that box on a shelf, in a closet. Do this imaginary exercise for each problem separately. Each time the problem comes to mind, tell it to go away. Refuse to think about it. Imagine yourself pushing it away with all your strength.

Focus your mind on distracting thoughts. One way to do this is by counting. You could count the tiles on the floor, the stars in the sky, or the blades of grass, or you could try counting backwards from 1000 by 7s (1000, 993, 987, ...). You could also start naming things, like the articles of clothing someone’s wearing, the names of different colours/sports/shapes/animals, or words starting with a certain letter. Try to memorize something. Think of anything that keeps your mind busy so that you can’t ruminate about your crisis.

Distract yourself with other sensations that do not cause you harm. Hold an ice cube in your hand and let it melt, or hold a frozen bag of peas to the back of your neck. Squeeze a rubber ball very hard, take a hot or cold shower, listen to loud music, snap a rubber band on your wrist, suck on a lemon, or engage in intense exercise. Any strong physical stimulus like this can kind of shake you out of your distressing feelings.
Handout 20: Distress Tolerance by Improving the Moment

If you're in a crisis, but can’t solve the problem, you could try to IMPROVE the moment in your mind.

**Imagery**

Using imagery, you can create a situation or a scene that is different from the one that you are now in. In a way, you can leave the situation. It will help if you do this in a quiet room or a quiet spot outdoors. Try to relax, and close your eyes if you feel safe. Envision in your mind a place that you would like to be – somewhere safe, relaxing, or beautiful. Focus on this place. It usually helps to notice details of the imaginary place that you are in. Relax. Breathe slowly and gently as you do this, and let yourself feel that you are in this place. Let your hurtful feelings drain or wash out of you, relieving you and making you more comfortable.

One image that you might try is floating on an inner tube in the ocean. Try to feel the waves gently bouncing you around and the sun shining on your face as you are doing this.

Imagine things going well for you. Imagine that you know how to take care of the situation you are in. When you have a conflict with someone, tell yourself that you can handle it, that you can do a good job, keep your cool, and deal with the situation in a good way. Keep telling yourself this and imagine yourself doing it. This strategy helps to handle the situation effectively.

**Create Meaning**

The way we think about our situation and ourselves has a lot to do with how we feel, so it can be very helpful and comforting to find or create meaning in a difficult situation. Finding meaning is like making lemonade out of lemons. Try focusing on the positive aspects of your suffering. For example, are you seeing something more clearly? Are you learning something? Has this brought you closer to friends or family members? Are you preparing for a change in your life? Has your distress energized or inspired creative artwork? This concept of making something good out of something not so good can be hard to accept, but we are not denying that things are bad or trying to say that distressing things are not distressing. The idea is just to improve the moment by finding something that make ourselves more comfortable.

**Prayer**

Relief from distress can come through prayer, whether it’s prayer to a supreme being, God, Buddha, a higher power, or your own wise mind. This is not begging to have your suffering taken away or asking “why me?” Prayer is more effective for tolerating distress when it is used to open yourself up to what is true in the present moment without trying to fight it. Ask for the strength to bear your current pain, without giving in to the idea that it will last forever.
Relaxation
Using relaxation and stress reduction exercises is an excellent way to help ourselves feel better in the moment. Many of us become more tense when we are in distress, and relaxing changes that response. The goal is to accept reality with the body, not to fight against it or try to push it away. The body and the mind are closely linked. Relaxing the body also relaxes the mind.

- **Deep Breathing:** This exercise can be practiced in a variety of positions. However, it is most effective if you can do it lying down with your knees bent and your spine straight. Place one hand on your abdomen and one hand on your chest. Inhale slowly and deeply through your nose into your abdomen to push up your hand as much as feels comfortable. Your chest should only move a little in response to the movement in your abdomen. When you feel at ease with your breathing, inhale through your nose and exhale through your mouth, making a relaxing whooshing sound as you gently blow out. This will relax your mouth, tongue and jaw. Continue taking long, slow deep breaths which raise and lower your abdomen. As you become more and more relaxed, focus on the sound and feeling of your breathing. Continue this deep breathing for five or ten minutes at a time, once or twice a day. At the end of each session, scan your body for tension. As you become used to this exercise, you can practice it wherever you happen to be, in a standing, sitting or lying position. Use it whenever you feel tense.

- **Progressive Muscle Relaxation:** Sitting comfortably in a chair or lying down, practice tensing and relaxing each of your major muscle groups (feet, calves, quads, buttocks, abdomen, hands/forearms, biceps, shoulders/chest/back, neck, face). As you tense each muscle group, hold the tension for 4 to 8 seconds. Bring your full awareness to the sensation of relaxation.

- **Self-Soothe Through Your Senses:**
  - Vision: Bring your awareness to things you see, like beautiful artwork, photos of people you love, a candle flame, animals, scenes of nature, patterns, architecture, and vibrant colours; look at birds in flight, watch a sunset, look up at night to see the stars, sit in a garden, or watch the snowflakes decorate the trees during a snowfall.
  - Sound: Listen to the sounds of nature, like birds singing, leaves rustling, or running water. Play calming music. Listen to a baby gurgling, children playing, the sound of laughter, or the voice of someone you love.
  - Smell: Notice all the different smells around you. Walk in a garden or in the woods, maybe just after a rain, and breathe in the smells of nature. Light a scented candle or incense. Bake some bread or a cake, and take in all the smells.
  - Taste: Have a special treat, and eat it slowly, savoring each bite. Cook a favorite meal. Drink something soothing like herbal tea or hot chocolate. Let the taste run over your tongue and slowly down your throat. Chew a piece of gum. Go to a potluck, and eat a little bit of each dish, mindfully tasting each new thing.
- Touch: Wear silky, soft fabrics, snuggle under the covers of your bed, brush your hair, rub lotion on your hands, run your fingernail across your lip. Pet your dog or cat, take a bubble bath, or float in a pool.

One Thing in the Moment

One thing in the moment involves developing your mindfulness skills. Focus your entire attention on just what you are doing right now, in the present moment. Often our suffering is made more intense by remembering past suffering and worrying about future suffering. If we can stay in the moment and focus on what is happening in the here and now, our suffering will be greatly reduced. Focus your entire attention on physical sensations that accompany nonjudgmental tasks, such as walking, washing, doing dishes, or cleaning. Be aware of how your body moves during each task. Open up your senses and notice your surroundings.

- **Breathing Awareness:** Lie down on the floor with your legs flat or bent at the knees, your arms at your sides, palms up, and your eyes closed. Put one hand on your abdomen, right at the waistline, and put your other hand on the center of your chest. Without trying to change your breathing, notice how you are breathing. Which hand rises most as you inhale, the hand on your chest or the hand on your belly? Notice the sensation of the air going in and out of your nostrils or through your lips. Is your inhale or exhale longer? Is there a pause after the inhale or exhale? Don’t try to change anything, just notice it.

- **Tangerine/Orange Meditation:** Sit at a table with a tangerine or an orange in front of you. Look at the tangerine. Look at the color and the shape. Notice any markings. See the dimple at the center. Is it exactly round? Hold the tangerine in your hands. Feel the skin. Smell the skin. Imagine the grove where the tangerine grew, and see it hanging on the tree. See the other trees in the grove. Now begin to peel the tangerine. Feel the oiliness of the skin. Notice the inside of the peel. Notice the color and shape of the section. See the white strings on the section of tangerine. Hold it to your nose and smell its fragrance. Bite into the tangerine. Feel its texture. Notice its taste. Are there seeds? Is it juicy? Does the juice run down your chin or get on your fingers? Continue to eat the pieces of tangerine – how many slices are there? Notice how you feel after eating the tangerine. How was the experience of really taking notice of how it looked, smelled, tasted? This is mindful eating. Try eating some other foods in this way, really paying attention to the food and the experience of eating it.

Vacation

Give yourself a brief vacation from your troubles. Get into bed and pull the covers up over your head for 20 minutes. You could buy some chips, get yourself something cold to drink, turn on some good television, and enjoy life. Be sure to pick the right time, keep them brief, and don’t take too many.
Encourage Yourself

Encouraging yourself involves being your own cheerleader. Say to yourself, “I can do it” or whatever else you might say to encourage someone else. Remember, cheerleaders don’t yell things like “you might do it” or “you’ll probably lose, but it won’t hurt to try.” Here are some good affirmations to read to yourself when discouraged:

1. This situation won’t last forever.
2. I’ve already been through many other painful experiences, and I’ve survived.
3. My feelings make me uncomfortable right now, but I can accept them and cope.
4. I’m strong enough to handle what’s happening to me right now.
5. This is an opportunity for me to learn how to cope with my fears.
6. My anxiety/fear/sadness won’t kill me; it just doesn’t feel good right now.
7. My thoughts and feelings don’t control my life. I do.
8. I’m doing the best I can.
9. I am a valuable and important person, and I’m worthy of the respect of others.
10. I’ve gotten this far against all odds, and I am not willing to give up the good fight.
11. I do many things deserving of compliments even though it is hard to hear them.
12. It is not what happens to me, but how I handle it, that determines my well-being.
Worksheet 10: Distress Tolerance Through Distraction

Check off two distraction skills to practice during the week when you feel upset.

☐ Activities       ☐ Comparisons       ☐ Pushing Away       ☐ Sensations
☐ Contribute       ☐ Emotions       ☐ Thoughts

Briefly describe the stressful situations you were in when you practised these skills:

Skill # 1:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Skill # 2:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Did using these skills help you to (1) cope with uncomfortable feelings and urges, (2) avoid conflict of any kind, and/or (3) feel soothed, calm, or nurtured?

Skill # 1:    YES/ NO    Skill # 2:    YES/ NO
If yes, please describe how it helped:

Skill # 1:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Skill # 2:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

If no, please describe why you believe it did not help:

Skill # 1:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Skill # 2:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
Worksheet 11: Distress Tolerance by Improving the Moment

Check off two skills to practice during the week to improve the moment when you feel upset.

- Imagery
- Create Meaning
- Prayer
- Relaxation
- One Thing in the Moment
- Encourage Yourself
Briefly describe the stressful situations you were in when you practised these skills:

Skill # 1:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Skill # 2:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Did using these skills help you to (1) cope with uncomfortable feelings and urges, (2) avoid conflict of any kind, and/or (3) feel soothed, calm, or nurtured?

Skill # 1: YES/ NO          Skill # 2: YES/ NO

If yes, please describe how it helped:

Skill # 1:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
Skill # 2:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

If no, please describe why you believe it did not help:

Skill # 1:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Skill # 2:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
Session 9: Acceptance

- Check-in: share an emotion from the past week
- Where we’re going:
  - Today: homework review + acceptance
  - Next week: review acceptance homework, put it all together, post-measures, feedback on group, goals moving forward
  - 1 month follow-up: problem-solving around barriers to using strategies
- Review homework:
  - What new distress tolerance skills did you try?
  - What was helpful or unhelpful?
  - Any problems applying specific skills that you’d like clarification on?
  - Did anyone use their distress tolerance skills too much over the past week?
  - How would you know if you were using them too much?
- Mindfulness
- Introduce acceptance
  - Can you remember a time in life without pain? (No, pain is a part of life)
  - If pain is inevitable, what can you do when it happens? 1) solve the problem, 2) change how you feel about the problem, 3) accept the problem, or 4) be miserable
  - Brainstorm what comes to mind when talking about acceptance, differentiating between what acceptance is and what it is not (refer to Handout 21)
  - Use examples to clarify bullet points on Handout 21 (e.g., uninvited party guest, house fire, child’s bike accident)
  - Costs of not accepting reality: waste energy, prevent change, increase suffering, make problem worse
  - Assign Worksheet 12
- Check-out
Handout 21: Acceptance

Many of our emotion regulation skills focus on changing your behaviour in order to help you get through life. If you can change something that’s causing you distress, then by all means, change it. If it’s something that you can’t change or that will take a while to change though, then accepting it can go a long way towards making it better. The reality is that life feels bad for everyone at times. However, although pain is inevitable, suffering is optional. Suffering is what happens when you refuse to accept the pain. This is because until you accept what is, you can’t change things. Meaning, until you accept the present moment, you’re stuck in the past thinking of all the “should haves” and “could haves,” which wastes a lot of energy that could otherwise be spent on building a life that’s consistent with your values. By adopting a stance of acceptance, you can find that life can be worthwhile, even when there is pain.

### Acceptance is:
- Seeing reality for what it is, even if you don’t like it
- Willingness to allow different thoughts, emotions, memories, and other experiences to occur without trying to control them and without judging them as good or bad, pleasant or unpleasant, or desirable or undesirable
- Believing that everything has a cause, even if we don’t know what it is. It should be this way because it is this way. If it shouldn’t be this way, it wouldn’t be.
- The opposite of resistance or denial
- A decision to stop wishing it were different
- A way to conserve energy by stopping the struggle with the current situation
- A choice to turn your mind towards the “acceptance road” and away from the “rejecting reality road.” You may have to make this choice and turn your mind over and over again.
- Respecting what is true in the moment and working with it
- A way to turn suffering that you can’t cope with into pain you can cope with
- A prerequisite for change: You have to accept that things are the way they are before you can figure out what needs changing and how to do it
- Recognizing that pain is a part of life and can’t always be avoided

### Acceptance is NOT:
- Admission of defeat
- Indifference or not caring
- Resignation, which includes judgment (e.g., “okay, I’ll live with it the way it is, but I don’t like it”)
- Toleration, which is a form of acceptance, but with strings attached (i.e., only willing to accept distress up to a certain level and no more)
- Ignoring the problem
- Giving up
- Wanting it to be the way it is
- Giving approval
- Agreeing to continue suffering or a life of pain
- Accepting that things will never change
- Letting go of your desire to change or grow
- A sign of weakness
- Taking a passive approach
- Wallowing in negative emotions
Worksheet 12: Practising Acceptance

1. Identify a problem, situation, memory, or emotion that you are struggling with accepting. You might think of a story that you heard in the news, an upsetting event that happened in your life many years ago, an ongoing stressor, or anything else that strikes you as unacceptable in the moment.

2. What emotion are you experiencing as you reflect on this situation?
   Emotion: ____________________
   Intensity (0-100): __________

3. Rate your level of acceptance on a scale from 0 (can’t take it, no ability to accept it) to 100 (can take it, total acceptance of this painful reality): __________

4. Describe the part of that problem, situation, or emotion that is unacceptable.

5. Describe the reality in the moment.

6. What are some of the causes that lead up to this reality?

7. What role did you play in creating this situation?

8. What roles did other people play in creating this situation?

9. What do you have control of in this situation?

10. What don’t you have control of in this situation?

11. What has your response to this situation been so far?
12. How has your response so far affected your own thoughts and feelings?

13. How has your response so far affected the thoughts and feelings of other people?

14. Practice accepting with the whole self, with your mind, body, and spirit. Breathe deeply, put your body into an open, accepting posture, and notice and let go of thoughts and feelings that fight the reality. Allow your emotions to wash over you like a wave, pay attention to any physical sensations, and notice how long it takes the emotion to go away without trying to change it. Focus on a statement of acceptance, such as “it is what it is” or “everything is as it should be.” Describe what you did:

15. Re-rate your level of acceptance on a scale from 0 (can’t take it, no ability to accept it) to 100 (can take it, total acceptance of this painful reality): __________

16. What emotion are you experiencing now?
   Emotion: ____________________
   Intensity (0-100): __________

17. How could the situation have occurred differently if you had decided to accept the situation sooner?
Session 10: Wrap-Up

- Pass out post-testing questionnaires/feedback form as participants arrive
- Check-in
- Review Worksheet 12
  - Were you able to identify some causes of your struggle?
  - Were you able to separate what you did and did not have control over in the situation?
  - What did you do/say to yourself to practise acceptance?
  - What happened to the intensity of your emotion?
  - Did your level of acceptance go up?
  - Did you have to keep “turning your mind” towards acceptance?
- Mindfulness exercise: Sensory awareness
- Review skills:
  - Draw Model for Describing Emotions (Handout 7) on whiteboard
  - Write list of skills learned on the whiteboard
    - Understand why we have emotions (Handout 2, Worksheet 2)
    - Observe and describe emotions (Handouts 3, 6 & 7a-j, Worksheet 3)
    - Mindfulness (Handout 4)
    - Challenge emotion myths (Handouts 5 & 6)
    - Check the facts (Handouts 9, 10, 11, & 12 Worksheet 4)
    - Opposite action (Handouts 13 & 14, Worksheet 5)
    - Problem-solve (Handout 15, Worksheet 6)
    - Reduce physical vulnerability and accumulate positive experiences (Handouts 16 & 17, Worksheet 7)
    - Identify values and set SMART goals (Handout 18, Worksheets 8 & 9)
    - Distress tolerance (Handouts 19, 20, & 21, Worksheets 10 & 11)
    - Acceptance (Handout 22, Worksheet 12)
  - Have group members write the different skills learned throughout the group on the board at the place in the model where that skill can be used to regulate their emotions
  - Provide Handout 23
  - Invite any remaining questions about skills covered
- Wrap-up
  - Refer back to Handout 1 – Did we achieve what we set out to achieve?
  - Refer back to Worksheet 1 – Did you achieve what you set out to achieve?
  - What would you like us to check-in with you about at the booster in 4 weeks?
  - Complete post-testing and feedback form
  - Check-out
Handout 22: Review of Skills for Emotion Regulation

**SKILLS:** Understand why we have emotions (Handout 2, Worksheet 2), observe and describe emotions (Handouts 3, 7 & 8a-j, Worksheet 3), mindfulness (Handout 4), and acceptance (Handout 22, Worksheet 12)

**SKILLS:** Reduce physical vulnerability and accumulate positive experiences (Handouts 16 & 17, Worksheet 7),

Vulnerability factors (previous events that increase...

**SKILLS:** Distress tolerance (Handouts 19, 20, & 21, Worksheets),

Prompting event (internal (Handout 15, Worksheet 6)

**SKILLS:** Challenge emotion myths (Handouts 5 & 6), check the facts

**SKILLS:** Opposite action (Handouts 13 & 14, Worksheet 5)

**SKILLS:** Understand why we have emotions (Handout 2, Worksheet 2), observe and describe emotions (Handouts 3, 7 & 8a-j, Worksheet 3), mindfulness (Handout 4), and acceptance (Handout 22, Worksheet 12)
1. First pay attention to the candy using touch. Notice the weight of the candy in your hand. Is it heavy? Light? Feel the texture of the wrapper. What do you notice?
2. Observe the shape of the candy within its wrapper. What colour is it?
3. Slowly unwrap the candy. Notice the sound the foil makes. Silently describe this sound to yourself.
5. Using your sense of smell, notice the candy. What scent does it remind you of? Does it evoke any sort of feeling for you?
6. Now put the candy in your mouth. Using taste, acknowledge the candy. Is it sweet? Sour? Salty? Spicy? How rich is it? What kind of texture does it have? Does the size or shape change as you experience it?
7. Now using your sense of hearing, pay attention to the candy. Does it click against your teeth?
8. Pay attention to the way it moves and how you respond.
9. Do your sensations change? Take a moment to finish the candy.
Mindfulness Exercise #2: Guided Body Scan

To begin, I’d like you to take a few moments to settle into your chair. Sit in an upright, comfortable position, with both feet flat on the floor, and closing your eyes if that feel ok. This guided body scan mindfulness exercise is intended to help you increase your moment-by-moment awareness of your bodily sensations. It is best if you can manage to stay awake throughout the entire exercise. It’s important to remember to not try to relax. This will just create tension. What you’ll be doing instead is becoming aware of each passing moment and just accepting what is happening within you, seeing it as it is. Let go of the tendency of wanting things to be different from how they are now and allow things to be exactly as you find them. Just watch the activity of your mind, letting go of judgmental and critical thoughts when they arise, and just doing what the exercise guides you to do as best you can.

Begin by slowly bringing your attention to the fact that you are breathing. Not trying to control your breath in any way but simply experiencing it as the air moves in and out of your body and noticing your abdomen and feeling the sensations there as your breath comes into your body and your abdomen gently expands. Then noticing your belly deflate as the breath comes out of your body. And following the rhythmic movement of each breath…the rising of your belly on the in-breath and on each out-breath just letting go, letting your body become heavy as it sinks a little bit deeper into relaxation. Just bringing full attention to each breath in each moment.

Now bringing your attention to your feet, becoming aware of whatever sensations are there. Bring a gentle curiosity to investigate the quality of the sensations you find, perhaps noticing the sense of contact between the toes, a sense of tingling, warmth, or no particular sensation. If you are registering a blank as you tune in, then just experiencing nothing. As you breathe in, imagine your breath moving all the way down to your feet and then when you reach your feet, begin your out-breath and let it move all the way up your body and out your nose. So that you’re breathing in from your nose and breathing out from your feet. And when you are ready, letting your feet dissolve in your mind’s eye.

Now become aware of the shins and calf muscles and the sensations in the lower legs, not just on the surface but right down into the bones, experiencing and accepting what you feel here and breathing into it, then breathing out from it. Then letting go of your lower legs as you relax into your chair.

Moving now into the thighs, and from one hip to the other, noticing whatever sensations or lack of sensations you are experiencing. Notice your buttocks in contact with the chair and the sensations of contact and of weight. If there’s any tension there, just notice that. Breathing into and out from the thighs. Then letting your thighs dissolve and relax.
Be totally present in each moment. Content to just be right here as you are right now. Direct your attention now to your lower back. And just experiencing your back as it is. Letting your breath penetrate and move into every part of your lower back on the in-breath. And on the out-breath, just letting any tension, any tightness, any holding on just flow out as much as it will. And then letting go of your lower back. And moving up into your upper back now. Just feeling the sensations in your upper back. You may even feel your ribcage, in back as well as in front, expand on the in-breath. And any tightness, fatigue or discomfort in this part of your body, just letting them dissolve and move out with the out-breath as you let go and sink even deeper into stillness and relaxation.

And now shifting your attention to your belly again and experiencing the rising and falling of your belly as you breathe. Feeling the movements of your diaphragm, that umbrella-like muscle that separates your belly from your chest. And experiencing the chest as it expands on the in-breath and deflates on the out-breath. And if you can, tune into the rhythmic beating of your heart within your chest. Feeling it if you can. As well as the lungs expanding on either side of your heart. Just experiencing your chest, your belly, as you lie here...the muscles on the chest wall, the breasts, the entirety of the front of your body. And now just letting this region dissolve into relaxation as well.

Moving your attention now to your fingertips and to both hands together, just becoming aware of the sensations now in the tips of your fingers and thumbs where you may feel some pulsations from the blood flow, a dampness or a warmth or whatever you feel. Just feeling your fingers. And expand your awareness to include the palms of your hands and the backs of your hands and your wrists. And here again perhaps picking up the pulsations of the arteries in your wrists as the blood flows to and from your hands. And becoming aware as well of the forearms. And the elbows. Any and all sensations regardless of what they are. Allowing the field of your awareness to include now the upper arms. Right up to your shoulders. Just experiencing your shoulders and if there are any tensions, breathing into your shoulders and arms. And letting that tension dissolve as you breathe out. Letting go of the tension and letting go of your arms. All the way from your fingertips, right through to your shoulders. As you sink even deeper into a state of relaxed awareness. Just being present in each moment. Letting go of whatever thoughts come up or whatever impulses to move and just experiencing yourself in this moment.

And now focus your attention on your neck and throat and feel this part of your body, experiencing what it feels like perhaps when you swallow and when you breathe. And then letting it go. Letting it relax and dissolve in your mind’s eye. Becoming aware of your face now. Focusing on the jaw and the chin, just experiencing them as they are.

Becoming aware of your lips and your mouth. And becoming aware of your cheeks now...and your nose, feeling the breath as it moves in and out at the nostrils. And be aware of your eyes.
And the entire region around your eyes and eyelids. And if there’s any tension, letting it leave as the breath leaves. And now the forehead, letting it soften to let go of stored emotions. And the temples. And if you sense any emotion associated with the tension or feelings in your face, just being aware of that. Breathing in and letting the face dissolve into relaxation and stillness. And now become aware of your ears, and back and top of your head. Now letting your whole face and head relax. For now, just letting it be as it is. Letting it be still and neutral. Relaxed and at peace.

Now letting your breath move through your entire body in whatever way feels natural for you. Through the entire length of your body. All of your muscles in a deep state of relaxation. And your mind simply aware of this energy, of this flow of breath. Experiencing your entire body breathing. Sinking deeper and deeper into a state of stillness and deep relaxation. Allow yourself to feel whole. In touch with your essential self in a realm of silence, of stillness, of peace. And seeing that this stillness is in itself healing. And allowing the world to be as it is beyond your personal fears and concerns. Beyond the tendencies of your mind to want everything to be a certain way. Seeing yourself as complete right now as you are. As totally awake right now.

As the exercise ends, bring your awareness back to your body again, feeling the whole of it. You may want to wiggle your toes and fingers. Allow this calmness and this centeredness to remain with you when you move. Congratulate yourself on having taken the time to nourish yourself in this way. And remember that this state of relaxation and clarity is accessible to you by simply paying attention to your breath in any moment, no matter what’s happening in your day. Let your breath be a source of constant strength and energy for you.
The Three Minute Breathing Space

The three minute breathing space is a brief practice and can be used when we find our thoughts or mood spiralling in a negative direction. The first thing we do with this practice because we want to come into the present moment quickly is to take a very definite posture. The back is erect, but not stiff, letting the body express a sense of being present and awake.

Now, closing your eyes, if this feels comfortable, take the first step of becoming aware of what is going on with you right now. Becoming conscious of what is going through your mind: what thoughts are around? Here again, as best you can, just noting thoughts as mental events...so we note them, and then we note the feelings that are around at the moment...in particular, turning toward any sense of discomfort or unpleasant feelings. So, rather than try to push them away or shut them out, just notice them, perhaps saying, “Ah there you are; that’s how it is right now.” Similarly, with sensations in the body... are there sensations of tensions, of holding, of letting go? And again, becoming aware of them, simply noting whatever is arising in this moment.

Silence (15 seconds)

So, you have a sense of what is going on right now, having stepped out of automatic pilot. The second step is to collect your awareness by focusing on a single act—the movement of the breath. So now really gather yourself, focusing your attention down in the movements of the abdomen, the rise and fall of the belly as the breath moves in and out...spending a minute or so to focus on the motion of the abdominal wall, moment by moment, breath by breath, as best you can right here, right now. Noticing when the breath is moving in, and when the breath is moving out, being with the breath as it moves into your body and out, binding your awareness to this process, to be present right now.

Silence (25)

And now, the third step, is allowing your awareness to expand to the entire body, bringing a more spacious awareness to your experience, letting the breath be present but in the background. Bringing attention to the entire length of the body from head to toe, including any tightness or sensations related to holding or bracing. In this moment holding your awareness in this spaciousness place, breathing in and breathing out. (Silence) And when you are ready, opening your eyes, letting go of this brief practice.

Silence (20)
Mindfulness Exercise #4: Fusion vs. Defusion

An exercise to demonstrate a) fusion vs defusion and b) how positive thoughts attract negative ones (and vice-versa)

In this exercise, explain to the client: *I am going to say a few sentences. As I say them out aloud, I want you to close your eyes and do two things:*

- *a) notice the words I say*
- *b) notice your automatic reaction to those words – the thoughts and feelings that immediately pop into your head as I say them.*

Then read each sentence below out aloud slowly & calmly:

- *I am a human being.*
- *I am a worthwhile human being.*
- *I am a worthwhile, lovable human being.*
- *I am a worthwhile, lovable, valuable human being.*
- *I am a worthwhile, lovable, valuable, wonderful human being.*
- *I am complete, whole, and perfect.*
- *I am a useless piece of human garbage.*

Then debrief the client; what was their reaction to each statement? As the words grew ever more positive, what negative reactions showed up? When the final negative statement was read out, what positive thoughts showed up?

Then remind them that the instruction was to notice the words; not to analyse them, agree, disagree, change them, assess them as true or false etc.

Then repeat the exercise, but ask the client this time to simply notice the words; the sound, volume, speed, pitch, timbr etc.

After that, debrief; how was their reaction different when they just noticed the words?
Appendix K: Grief and Loss Group

Grief-Focused Group Psychotherapy Program
Session 1 Outline

1. Introductions and housekeeping - what will be put in the file, certificates, group rules, etc.

2. Ask clients to share something they would like to gain from the group:

“On this next go-around, I would like you to share something you would like to get out of the group or something you would like to change in your life as a result of being in the group.”

3. Ask clients to share their story about why they joined the group:

“I would now like to ask each of you to share your story of loss or losses. We’ll do this by sharing a few details about our lives and the way our losses have changed our lives. Briefly tell us where you were born and grew up, and then describe the loss you have come here to work on and when it occurred.”*no need to mention anything about your crime

4. Ask clients to discuss how they have been coping with their loss:

“Thank you for sharing your experiences. You have all shown a lot of courage – we know that they are not easy to talk about. There will be plenty of time in our future sessions to talk about your experience in depth and give each person’s story the attention it deserves. Everyone has lived through some very difficult experiences which have changed us in ways we are not always fully aware of. I guess I am wondering how you all have been holding it together. That said, I would like to open the discussion and speak together about the ways you have been coping with your loss. As we talk I will write the coping skills you have been using on the board.”

5. Discuss organization and structure of the group:

“At the end and beginning of each week we will do a check-in about thoughts and feelings that came up and how we are feeling after the group. Each week we will talk about a new topic related to loss, such as healthy ways of coping, reminders of the loss, symptoms of grief, identifying feelings and planning for difficult days. We will look at handouts, discuss thoughts and feelings, and participate in exercises depending on the topic of the day. The last group will be dedicated to saying good-bye in a healthy way.”

Address what I hope they can gain from the group:

“I would also like to add what I hope you gain from the group which is...

- **First,** I hope it will provide you with an opportunity to help and support each other. There is a special kind of support that only you can give each other, because you really know what it's like to go through these things. Your experiences have prepared you to
really understand each other, encourage each other, and to share ideas and advice about how to deal with the problems you face.

• **Second**, I hope the group will be a safe and supportive place in which you can **deal with painful memories and feelings connected to your loss** in ways that will help to make them less upsetting and less likely to interfere with doing things that are important to you.

• The **third** thing I hope this group does for you is to help you to **deal with your feelings of grief over the loss of someone or something dear to you**. We will spend time learning about grief symptoms and reminders of our losses so that they become more understandable and predictable. We will also work on making our memories of loved ones we have lost a source of comfort and reassurance to us, instead of something that is so painful that we may not enjoy—or may even avoid—talking or thinking about them.

• The **fourth** thing I hope this group does for you is to help you learn to **deal with the many adversities** created by these losses. As we have learned from listening to each other’s stories, these experiences have deeply changed our lives: (Cite several examples from the members’ descriptions, such as):
  
  • When we have to return to places that remind us of them...
  • When we miss friends and family who are no longer with us...
    ...then it is easy to understand why we may be feeling discouraged, alone, angry, or sad. In this group we will learn how to deal with these problems in ways that will keep them from seeming so overwhelming. Some of the tools we’ll learn include:
    • Learning how to think about our problems in ways that are more optimistic, so that we’ll be less likely to feel discouraged, hopeless, or depressed.
    • Learning how to ask for support when we want it, so that we don’t have to rely only on ourselves when facing a difficult situation. This group will provide some of that support, especially at first.
    • Learning to talk to people about what happened in ways that let them know how deeply these experiences have influenced our lives on the one hand, but which won’t really upset us OR them on the other hand.

  “Any questions about the organization of the group?”

6. Create group rules together and provide clients with handout

7. Discuss grief quote and grief reactions – refer to handouts

8. Check-out:

  “How are you feeling now? What did you learn about yourself today?”
Death leaves a heartache no one can heal, love leaves a memory no one can steal.

~From a headstone in Ireland
Grief Reactions

- Feeling sad whenever you are reminded that they are gone and not in your life anymore.
- Feel angry at the way they died.
- Sometimes you may lose faith in the people who are supposed to keep you safe.
- Feel regret about things you did or didn't do.
- Feel depressed and hopeless.
- Wonder why you are alive and not them.
- Find it difficult to think about the person you lost because thoughts or images of how he/she died come into your mind.
Grief-Focused Group Psychotherapy Program
Session 2 Outline

1. Check-in:

“How is everyone feeling today? Did any of you have any thoughts or feelings that came up between sessions? Is there anything you want to discuss with group?”

2. Summarize previous group:

“Last week we introduced you to the topic of grief and the range of experiences you have struggled with. This week we will be discussing reactions related to grief and loss.”

3. Types of grief:

• Complicated grief can manifest in several different forms, all of which demonstrate an inability to accept the loss over time through the 'work' of grieving. Avoidance of grief might be signaled by not tending to the deceased's belongings, by maintaining a fixation on the magnitude of the loss, or by holding on to guilt or anger rather than finding forgiveness over time. In chronic or prolonged grief the bereaved does not find feelings of pain and loss lessening over time, and feels intense grief responses years after the loss has occurred. Complicated grief may also trigger other psychiatric disorders, such as clinical depression or anxiety. Any of the complicated grief responses above should be brought to the attention of a medical or mental health professional.

• Delayed grief is characterized by an exaggerated reaction to a current loss, indicating unresolved grief from a previous loss.

• Inhibited or masked grief includes self-destructive behaviors such as neglecting health, alcohol or drug abuse, extended preoccupation with suicidal thoughts, acting out impulsively, or developing prolonged psychosomatic symptoms or complaints.

• Traumatic, unexpected, or sudden losses can be more difficult for individuals to process and normal reactions to death tend to be intensified or take longer due to the suddenness of it. With traumatic or unexpected loss individuals may had difficulty comprehending what actually happened, an individual’s ability to cope is reduced shock one experiences, a sense of safety and security is diminished, and there is no chance to say final “goodbyes.” Other secondary losses may occur with sudden loss, such as stability, finances, or home. The grief process is further complicated in cases when the individual has no closure, for example, when someone is missing and no body is found.

4. Reactions to Grief:

• Emotional reactions – sad, anxious, angry, lonely, regretful
• Cognitive reactions – preoccupied with thoughts of them
• Perceptual reactions – sensing their presence nearby, “seeing” or “hearing” them
• Behavioral responses – crying or weeping, searching for them, avoiding loss reminders, acting absent-minded or distracted
• Social responses – decreased interest and motivation for relationships, boredom, being angry, critical, or irritated, withdrawing from others
• Physical responses – feeling fatigued, lethargic, physical agitation, jumpiness, restlessness, hyperactivity, get sick more easily
• Spiritual/philosophical reactions

5. Personal reactions and normal responses to grief handout.

6. Check-out:

“How are you feeling now? What did you learn about yourself today?”
A few possible emotional responses to grief include:

- The loss does not feel real to you.
- You have a sense of the loved one's presence, expecting them to walk in the door at the usual time, hearing their voice or seeing their face.
- You may assume traits or mannerisms of the loved one.
- You may feel guilty or angry over things that did or did not happen in the relationship.
- You may feel intensely angry at the loved one for leaving you.
- Mood changes or unexpected crying over seemingly small things are common.
- You may feel out of place with people, and withdraw from friends and activities.
- You may have a need to tell and retell things about the loved one and the experience of death, or, conversely, you may feel unable to talk about the loved one.
- You may experience difficulty with concentration, forgetfulness, and sleeplessness.

Some common physical responses to grief:

- Tightness in the throat or heaviness in the chest.
- An empty feeling in the stomach or loss of appetite.
- Shortness of breath.
- Dry mouth.
- Intestinal problems.
- Oversensitivity to noise.
- Muscle weakness, fatigue, or listlessness.
- 'Heartache' or aching arms.
- Physical symptoms experienced by the deceased before death (which can be understood as a way to feel closer to the person you have lost).
Personal Impact of Grief
Week Two Handout

Physical Reactions:
As part of the individual’s way of handling the stress and anxiety of his/her loss experience, the following are possible physical reactions:

Changes in appetite:
- Overeating; binge eating
- Under-eating; loss of appetite

Sleep disturbances:
- Oversleeping; difficulty falling asleep and awakening; inability to get started/motivated for another day
- Under-sleeping; nightmares, loss-centered dreaming; interrupted sleep

Exaggeration of other physical situations:
- Blood pressure, diabetes, allergies, digestive and stomach problems, headaches/migraines

Note: All are often triggered by poor eating and sleeping habits, thereby affecting the immune system and the body’s ability to maintain a healthy balance.

Behavioural Reactions:
The loss event changes the individual and their behaviours, whether while alone or in social settings. Behavioural reactions also reflect the change the individual is experiencing.

- Aggressive behaviors: volume/tone in speaking; irritability; tension
- Withdrawn/passive behaviors: very quiet and introverted; short answers; limited conversation; feels unworthy of happiness
- Self-doubt increases: needs much reassurance; decisions are difficult, indifference/apathy may follow; meaninglessness; not wanting to initiate activities or leave home.
- Reckless or self-destructive behaviors:
  - Alcohol use/abuse: often to numb feelings
  - Drug use/abuse: to numb and escape the emotional reactions
  - Sexual promiscuity: to seek comfort; or to “dare” something to happen to me
  - Reckless driving or other behaviors to challenge fate/the world.
- Hyperactivity: excessive energy to act out the stress/anxiety
  - Cleaning
  - Attention-getting
  - Working
  - Shopping/Spending
  - Talking
  - Home fix-it projects
  - Shopping
  - Excessive organizing
Cognitive Reactions:

- Reduced attention span: inability to follow a conversation, to read and to stay focused; this affects many on the job regarding performance; forgetfulness.
- Loss-centered thinking: focus of much of the individual’s thought process to the point of obsessiveness.
- Impaired self esteem.
- Idealization of the past, of the future and of the individual and the relationship lost.
- Exaggerations in magical thinking (I made it happen).

Emotional Reactions:

- Self blame and guilt: “I could have...,” “I shouldn’t have...,” “If only...,” “Why didn’t I...”
- Fears: of getting through each day; of being alone; of being a single parent; “What will I do now?”; “Will God punish me too?”; of the dark; of new places and of old favorite places; of social settings; of making the right decision(s).
- Helplessness and hopelessness.
- Anger: at life’s situation, at God, at unfairness, at the one who died, at others for being happy.
- Yearning or desiring the lost loved one and the world that was.
- Withdrawn; not sharing feelings with others because they don’t understand or “get it,” not able to give emotionally to others—even family members.
- Anxiety: all of the above create an accumulation of general anxiety for many grieving individuals. Trying to handle life in a new fashion means creating a new “normal.” This is all transition and for many that means anxiety until it becomes the “new” acceptable way of life.

Spiritual/Philosophical/Religious Reactions:

- Whatever one’s belief system, there may be challenges to that system. What was believed often comes into question and is examined in light of the loss and goes through its own change—strengthened or weakened—but changed. This is part of the process of grief and adaptation to the loss.
- Those with a belief in God may question: why God didn’t intervene, why did God let this happen, where is God in their paining/adjusting experience.
- Various questioning about God and one’s anger towards him often creates guilt for the individual to work through.
Grief-Focused Group Psychotherapy Program
Session 3 Outline

1. Check-in:

“How is everyone feeling today? Did any of you have any thoughts or feelings that came up between sessions? Is there anything you want to discuss with group?”

2. Summarize previous group:

“Last week were talking about reactions to grief. This week we will look at emotions and how differences in gender can influence our grief reactions and how we talk about them.”

Emotions:

*It may be helpful to think of grief-related emotional reactions like waves in the sea. Waves come and go, they can be strong, medium, or weak in their intensity, and they have peaks and valleys. One day you may be “riding” a wave of anger, and then after a while it begins to weaken, and you are next picked up by a wave of guilt-related feelings, or sadness, or perhaps a bittersweet emotion like being grateful that you had such a special person in your life.*

*Prompting questions: “What do you do when you find yourself feeling sad, angry or feeling guilty?”*

3. Guilt

- When we feel guilty in situations beyond our control. For example, not being able to protect the loved one who died.
- We cannot predict the future, we cannot control other people’s actions, and we cannot always be with our loved one’s to keep them safe.
- Guilt about what I did, said, or even just thought about (the deceased) that I feel guilty about.
- Guilty about the things I should have done or said and not being able to make it up to him/her.
- Blaming yourself.
- Guilt over being a survivor (“survivor guilt”).

4. Sadness

- Sadness is a transient feeling that passes as a person comes to term with his/her troubles.
- Some sadness may be related to the guilty thoughts we have.
- Sometimes we do not experience sadness at all. Sometimes the anger covers up sadness.

5. Anger

- About the Way They Died
- At The People Responsible
• At the World
• At God/Creator/Higher Power
• At The People Around Me
• At the Person Who Died
• At Yourself

6. Gender Differences:

• Men are socialized to adopt a code of male gender roles which provide protection against being experienced or perceived as feminine.
• Four dimensions of the masculine gender role: need for success, power, competition; restrictive emotionality; restrictive affectionate behavior between men; and conflicts between work and family relations.
• Be in control, in charge, self-reliant, independent, important, successful, dominant, aggressive, and not appearing feminine in any way.
• The focus on action and doing, achievement, success, problem-solving, and other masculine traits serve to ward of pain and vulnerability of loss and separation.

7. How do we cope with grief? Discuss how people have been coping – bother healthy and unhealthy ways.

8. Coping and Anger handout.

9. Check-out:

“How are you feeling now? What did you learn about yourself today?”
Experiencing Anger
Week Three Handout

1. About the Way They Died
   - It’s not right
   - He/she deserved better

2. At The People Responsible
   - They should be punished

3. At the World
   - I need him/her
   - It’s not fair
   - He/she was too young
   - We didn’t deserve this
   - All my hopes, plans, and wishes involving him/her must be altered or abandoned

4. At God/Creator/Higher Power
   - For letting it happen
   - For not protecting us

5. At The People Around Me
   - For the way people treat me since the death
   - Because others go unscathed while we struggle and suffer

6. At the Person Who Died
   - For leaving us when we really need you
   - For the hardships your death has created for us
   - For unkind things you did while you were alive
   - For not keeping your promises that we’ll have a future together

7. At Yourself
   - For not being there to help
   - For not preventing the death/injury
   - For things you have said or done (or not said and done)
   - For feeling angry with them
Facts About Angry Feelings

1. Everyone who loses someone close feels angry at times.

2. It's OK to feel angry.

3. Being angry doesn't mean you need to hurt yourself or others. How you respond is your choice.

4. “Hard” feelings of anger, irritability, and frustration often cover “softer” feelings of sadness, pain, and longing.

5. If you give up being angry about the death, it doesn't mean you have forgotten him or her.
Coping with Loss  
Week Three Handout

Unhealthy Ways of Coping

- Avoiding all people and places that make you feel bad.
- Withdrawing from friends and family.
- Withdrawing from activities or important obligations.
- Not asking for help (when you need or want it).
- Drinking alcohol/taking drugs.
- Over-eating.
- Excessive TV or computer games.
- Doing risky or dangerous things.
- Acting angry and aggressive/getting into fights.
- Blaming others.
- Not taking care of yourself (sleep, diet, exercise, grooming, etc.)/getting sick.

The Basics of Healthy Coping

Following a sudden loss, death or tragic event, it is important for the grieving person to remember to take care of him/herself. Focusing on the basis survival needs for the body is especially needed during time of stress and uncertainty:

- Take it one hour at a time, one day at a time.
- Maintain a normal routine. Try to keep doing regular activities. Adding structure into a daily routing will help the grieving person regain a sense of control.
- Get enough sleep or at least enough rest.
- Try and get some regular exercise. This can also help relieve stress and tension.
- Keep a balanced diet. Watch out for junk food or high calorie comfort food binges.
- Drink plenty of water.
- Do what comforts, sustains and recharges you.
- Remember other past losses and the coping strategies used to survive them. Draw on these inner strengths again.

Ways of Coping

- Give yourself permission to grieve.
- Talk to someone/tell your story (even if it is a pet or stuffed animal).
- Listen to each others stories.
- For news making losses, keep up with news reports, as new information becomes available. However, take breaks away from the intense news coverage for periods of time or avoid media coverage altogether.
- Reflect on what is important and brings special meaning to life. Losses can be viewed as a "Wake-up" call, chance to re-evaluate life and life’s priorities.
- Draw strength from your spiritual or religious beliefs and traditions.
- Attend (or organize) memorial or funeral services.
• Avoid making any major life-changing decisions. Instead use the time to evaluate priorities—which may have changed following the loss, death or life-changing event.
• Spend time with family and/or loved ones.
• If your feelings remain as strong or last longer than four to six weeks, or thoughts are out of control, causing inactivating depression or anxiety, you may want to seek professional help to help you sort through feelings.
• Many begin healing by giving. By thinking of and helping others the grieving person can begin their own healing process.

Additional Ways of Coping

• Express emotions down on paper via creative writing, journaling, poetry, and even list making.
• Take slow deep breaths, especially when feeling tense (relaxation, mediation, deep breathing).
• Soak in a warm bath or warm bubble bath.
• Walk, run, hike, dance, play tennis, swim, ride a bike, climb a rock – just get moving.
• Attend religious services.
• Plant a "memory garden."
• Send your condolences.
• Walk or run for charity.
• Design a Website.
• Organize or attend a memorial service.
• Sing, listen to soothing music.
• Pray or meditate.
• Hug a loved one.
• Get a massage.
• Create a memorial – quilt, mural, sculpture etc.
• Help someone else less fortunate.
• Volunteer.
• Pound a pillow, your mattress with fists or a tennis racket (Please stay away from walls).
• Scream in a pillow, in the shower, in your car, or in the woods.
• Have a temper tantrum on your bed, mattress or couch (carefully).
• Howl, wail, yell, scream, laugh, cry, sing, etc. Whatever noise or expression seems to express how you feel.
• Laugh at least once a day. Laughter is good for the soul.
• Paint, draw, doodle, scribble, or create something.
• Dance, skip, saunter, gallop, hop, etc. Move in whatever way seems to work.
• Stop suffering. Suffering is an avoidance mechanism, a way of not dealing with feelings and working through the emotions.
• Do the necessary grief work, in whatever form seems to work best with you.
• Join a support group, with meetings, or on-line.
• Look for resources on grief, do not underestimate the helpfulness of books.
Grief-Focused Group Psychotherapy Program
Session 4 Outline

1. Check-in:

“How is everyone feeling today? Did any of you have any thoughts or feelings that came up between sessions? Is there anything you want to discuss with group?”

2. Summarize previous group:

“Last week we discussed some of the more common emotional experiences individuals who have experienced loss face. We also spoke about gender differences and began to look at coping. This week loss reminders, planning for difficult days and getting support.”

3. Loss reminders and changes associated with loss:

Losses create many changes in our lives—in our moods, our relationships, our day-to-day activities, and in our physical surroundings. Adapting to these changes is an important part of grief work. Put simply, grieving is making the changes, both inside of ourselves and outside of ourselves, that help us to accommodate to the ongoing absence of our loved one from our lives. The more central our relationship was to our loved one, the more changes we need to make in our daily lives as we learn to live without their physical presence.

Relationships with families and friends often change after someone close dies. Sometimes families draw closer, and sometimes they grow more distant, depending on member’s unique reactions to the loss. Family members can become more emotionally expressive and accessible to each other, or they can become more argumentative and emotionally cut off. Likewise, friends can have a wide range of reactions: some feel uncomfortable and avoid you; some may act awkwardly because they don’t know what to say, and others may go out of their way to spend time with you. Overall, these changes can bring about losses or gains in the amounts and kinds of support that young people receive.

Prompts for processing changing since the loss:
- How have your relationships changed since the death?
- Would you describe your family as closer or more distant since the loss?
- Do members of your family grieve in similar ways or in different ways?
- What can you say about the amount of support you have now, compared to what you need?
- Who have you gone to for emotional support, such as someone you can openly talk to and with whom you can share your feelings—before and after the death?

When someone dies, the lives of all the people who had a relationship with that person also change in some way. Other changes can be found in the way the family celebrates the holidays and other special days, like graduations, catechisms, and bar-mitzvahs. These times, once very joyous, can become stressful and sad reminders of the lost loved one, because their absence is deeply felt. For this reason, families sometimes stop doing their rituals, or they change them to
allow them to remember and honor their loved one while also doing something new and enjoyable.

Prompts for talking about changes:

- What are some ways in which you can change your life to make living with the loss easier to deal with?
- Are there any negative changes in your life brought about by the loss that you can work on to improve the quality of your life?
- Is there a positive change brought about by the loss that you can enhance, or use to improve the lives of your family or friends?

4. Planning for difficult days:

“Difficult days” are expected.

Two categories of difficult days:

- The first includes “special days” (i.e. birthdays, holidays, anniversaries, graduations, reunions, etc.) that may generate or contain painful trauma or loss reminders and stressful interactions. Rando (1993) characterizes these reminders as “cyclical” meaning that they are linked to cycles of days, weeks, months, seasons, and years, and are thus comparatively predictable.
- The second category of difficult days consists of stressful daily occurrences and interactions with which the group members routinely contend. Rando (1993) characterizes these reminders as “linear”, indicating that they occur with comparative randomness along survivor’s personal timelines.

5. Planning for the holidays

How to handle the holidays:

Usually a lot of pressure to “feel good”
- If you need some quiet time, take it
- Ask others to respect your boundaries
- Allow yourself time to feel sad or have a good cry

A lot of reminders of the person lost
- Go somewhere different
- Engage in different activities

Very draining
- Save energy for most important things
- Be around few people

Sharing memories
- Around the table – plan to do it with those you trust
• Look at old photos
• Observe a moment of silence or prayer

6. Discuss how individuals may seek support using the handout as a guide.

7. Handouts - Loss Reminders and Getting Support

8. Review Coping Strategies

9. Check-out

“How are you feeling now? What did you learn about yourself today?”
Five Steps to Getting Support
Week Four Handout

1) What Do I Want?
The first part of good communication is taking the time to figure out what you really want. There are two parts to this:

A. Look outside yourself: What kinds of demands are my physical circumstances placing on me? Do I want?
   • Advice?
   • Practical assistance in solving a problem?
   • Material support?

B. Look inside yourself: What am I thinking and feeling that I could use support in dealing with?
   • Do I want someone to just listen and try to understand?
   • Do I want a hug?
   • Do I want companionship?
   • Do I want encouragement that I can handle a difficult situation?
   • Do I want reassurance that people will be there for me in case I need them?

2) Who Should I Ask?
The second step is to think about your relationships with the people you know. Who has been, or could be, a good source of support for what you want? Our parents or guardians are usually very important sources of many types of support, but there are usually others as well, such as siblings, relatives, close friends our age, or an adult mentor.

3) Find the Right Time.
Because you'll be talking to the person about something that matters to you, you want them to take the time to listen. Thus, you need to pick an occasion in which they will have enough time and energy to be a good listener.

4) Request With an "I"-Message.
Once we have decided what we want, who to ask, and found a good time to talk, we talk to them. A good way to do this is with an "I" message. In an "I" message we communicate three things:
   • We tell them how we're feeling.
   • We tell them about our situation, which led us to feel the way we do.
   • We tell them specifically what we want them to do.

5) Express Sincere Appreciation.
Finally, end the conversation by sincerely thanking them for listening.
A loss reminder is something that reminds us of the ongoing absence of someone or something dear to us and what it means to us to be without them. Loss reminders elicit grief symptoms, such as sadness and longing to be with the person or thing that we love.

Loss reminders generally fall within two categories:

**Missing reminders**, such as:

- Empty situations: Situations in which they used to be present, such as their bedroom, favorite chair, clothes, or place at the table.
- Shared activities: Activities that we used to do together, such as playing games, going for walks, doing homework together, and eating meals together.
- Rituals: Activities such as graduations, birthdays, holidays, or other family celebrations, award ceremonies, and weddings.
- Favorite activities: Objects or activities connected to them that remind us of their absence, such as their hobbies, favorite food or music, or favorite sayings.

**Adversities and changes related to the loss**, such as:

- Moving to a new house or town
- Separation from loved ones
- Difficulty adjusting to a new environment
- Difficulty making new friends
Grief-Focused Group Psychotherapy Program
Session 5 Outline

1. Check-in:

“How is everyone feeling today? Did any of you have any thoughts or feelings that came up between sessions? Is there anything you want to discuss with group?”

2. Summarize previous group:

“Last week we discussed loss reminders, planning for difficult days and seeking support. This week we will look at ways to remember the loved one who died.”

3. Staying connected to a deceased loved one:

Normalize group members’ experiences with thinking, dreaming about, talking to, and even sensing the presence of, the deceased. This is accomplished by reframing these behaviors as natural—and perfectly normal—desires to maintain a psychological connection to the deceased.

The first way in which mourners frequently try to stay connected to a deceased loved one is to fantasize about physically reuniting with them—that is, imagine that they return to us alive, as if they had never died

- Does anyone remember feeling the urge to search for your loved one—to go to places they used to frequent, or the last place you saw them, to see if they were still there?
- Does anyone remember actually catching yourself searching for your loved one?
- (If yes) Do you remember how you felt when you saw for yourself that they weren’t there?

The second way in which mourners frequently try to stay connected to a loved one usually occurs as they come to fully realize that a physical reunion will never take place. As this realization occurs, mourners often seek to connect with their loved ones in symbolic ways—that is, to reunite with them in their minds and hearts.

What do we mean by symbolic? Well, although death has ended the mortal life of the person we care about – making it impossible to physically reunite with them – death hasn’t ended our mental and emotional relationship with them if we choose otherwise. This relationship can continue symbolically in our thoughts, imaginations, dreams, feelings, conversations, and other behaviours. We are relating to our loved ones in a symbolic way whenever we:

- Dream about them
- Participate in grief rituals (such as lighting candles)
- Keep mementos
- Reminisce about them by talking about them, thinking about them, visualizing them (as they used to be), visualizing times we spent together, learning more about them and their lives, and strive to follow their good teachings and example.
Those of us who have lost a loved one know that they don’t need to be alive and physically present in order to be an important part of our lives in these and other ways.

One of the most important ways in which we maintain this connection with our deceased loved one is through **reminiscing**. As we discussed, we reminisce whenever we:

- Talk about our loved one
- Think about them
- Visualize them (as they used to be)
- Visualize times we spent together
- Learn more about them and their lives

4. **Barriers to reminiscing**

**Familial Barriers**
Different families react very differently to a loss, and even different people within a family can react in different ways. One way in which families differ is in how open or closed they are to talking and expressing emotions about the deceased.

**Cultural Barriers**
One of the most difficult barriers to reminiscing is being told by others that maintaining a connection to a dead person (or cherished object) is unnatural, weird, unhealthy, weak, immature, or a sign that we cannot deal with reality. For example, has anyone ever told you things like: “Hanging on to the past is unhealthy.”

**Personal (Attitudinal) Barriers**
A third potential barrier to healthy reminiscing is our own beliefs about thinking about, talking about, and having feelings about someone or something dear we have lost. These things can be fear over our own reactions, or reluctance to deal with unpleasant feelings.

5. **Rituals** – Handout on Rituals (process and explore)

6. **Keeping mementos**

A **memento** is an object or item that serves to remind us of a person, past event, etc.; a keepsake; a souvenir.

Share examples of mementos they have.

7. **Check-out:**

“How are you feeling now? What did you learn about yourself today?”
Rituals to Commemorate
Week Five Handout

Rituals are effective and meaningful when they have significance to the deceased and to the survivor. The following are merely suggestions and might be altered and enhanced to appropriately accommodate the relationship involved.

- Prepare a favorite meal of the loved one and enjoy it as he/she did.
- Prepare a favorite dessert – share with family or friends.
- Watch a movie(s) enjoyed by your loved one.
- Plant flowers, a tree or a flowering bush in memory of your loved one.
- Light a candle and recall the comfort or guiding light he/she was for you.
- Read book(s) or article(s) on a favorite topic(s) he/she enjoyed.
- Play music appreciated by your loved one and see if you can enjoy it now.
- Attend a concert/performance that would be pleasurable to you both.
- Look through photo albums and focus on shared times and memories.
- Wear a piece of jewelry that was a favorite of the person.
- Wear an item of clothing given to you by him/her.
- Have a tattoo created in their honor.
- Visit the burial place – bring a balloon or symbolic item to leave.
- Journal some favorite stories.
- Travel to a place he/she enjoyed or always desired to visit.
- Review how your life is better because he/she was a part of it.
- Focus on the gift he/she was to you.
- Purchase flowers on the anniversary. Bring for display at church or home gathering. When people leave, have them take a flower.
- Send flowers or a card to a close family member on the anniversary.
- Read a favorite poem(s) or book enjoyed by your loved one.
- Watch home videos and remember.
- Volunteer for an organization in memory of your loved one.
- Become an activist in the cause of death issue – by participating in a walk-a-thon, phone-a-thon, etc.
- If you kept greeting cards given to you by your loved one, take time to read them again.
- Enjoy a leisurely walk taking time to recall shared events in life together.
Grief-Focused Group Psychotherapy Program
Session 6 Outline

1. Check-in:

“As you know, today is our last official session together, so a lot of our work today is going to focus on saying a “good goodbye” to each other. But before we begin, it is very important that we point out the big difference between how we are parting and the way you have parted from other people in the past. We are separating voluntarily because we have done the work that we formed our group to do. Nevertheless, saying goodbye today may still remind us of other times when we never had the chance to say goodbye—of relationships in which we never wanted to have to say goodbye.”

2. Processing the group

- Let’s first reflect on what we’ve accomplished during this time we have been meeting together, both as individuals and as a group.
- Now I’d like you to disclose what working with the group has been like for you. Keep your disclosures brief but sincere.
- Now I invite each of you to share one or two of the most valuable things that you have learned or gained from the group. What will you take with you that you consider most helpful or valuable.
- Now I’d like to give each of you some time to talk about how you think and feel about the group ending.

3. Poem – A Reason, A Season (if desired)

4. Say goodbyes

5. Offer Certificates of Completion and provide reminders about paperwork, etc.
A Reason, a Season, or a Lifetime

People come into your life for a reason, a season, or a lifetime. When you figure out which one it is, you will know what to do for each person.

When someone is in your life for a REASON . . . It is usually to meet a need you have expressed. They have come to assist you through a difficulty, to provide you with guidance and support, to aid you physically, emotionally, or spiritually. They may seem like a godsend, and they are! They are there for the reason you need them to be.

Then, without any wrong doing on your part, or at an inconvenient time, this person will say or do something to bring the relationship to an end.

Sometimes they die.
Sometimes they walk away.
Sometimes they act up and force you to take a stand.

What we must realise is that our need has been met, our desire fulfilled, their work is done. The prayer you sent up has been answered. And now it is time to move on.

When people come into your life for a SEASON . . . Because your turn has come to share, grow, or learn. They bring you an experience of peace, or make you laugh. They may teach you something you have never done. They usually give you an unbelievable amount of joy. Believe it! It is real! But, only for a season.

LIFETIME relationships teach you lifetime lessons; things you must build upon in order to have a solid emotional foundation. Your job is to accept the lesson, love the person, and put what you have learned to use in all other relationships and areas of your life. It is said that love is blind but friendship is clairvoyant.