Developing a Program Evaluation Model for an Inpatient Forensic Mental Health Unit

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I would like to dedicate my thesis to my family. I am here because of you and thank you endlessly for everything.
Abstract

Individuals in the forensic mental health system often have complex needs and difficulty integrating into public mental health programs, and as such, it is essential to provide them with meaningful services. The purpose of this thesis was to develop an evaluation framework with which to assess whether the model of group intervention Providence Care’s Forensic Mental Health Services offers is meeting the needs of their clients. Currently, there are no formal evaluation procedures for assessing the group interventions. The thesis consisted of two main components. Firstly, a thorough literature review that highlights current evidence based practices in the forensic mental health population was completed to empirically support the existing group interventions and to identify any potential service gaps. Secondly, a program evaluation plan was created, encompassing a program logic model (PLM), a stakeholder map and analysis, an evaluation framework, suggested assessment measures, along with recommendations on how to implement the plan. The PLM provides an operationalized view of the program’s current services and desired outcomes. Along with the literature review, the PLM served as the basis for the evaluation plan presented as a manual for the staff to incorporate into their routine practices. The evaluation framework proposes a pre-post research design to assess the impacts of each group, based on a utilization-focused evaluation approach. The chosen approach contains both summative and formative evaluation aspects and aims to elicit information about what and how clients benefit from engaging in the group interventions. Implementation of the proposed evaluation plan should provide clinical staff at Providence Care with an easy-to-use tool that can identify program strengths, client outcomes, and areas for improvement.
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Chapter I: Introduction

Only recently has the diagnosis and treatment of mental illness gained prominence and become standard within Canadian healthcare. Mental health concerns often affect those involved with the criminal justice system. However, these individuals are seldom properly accommodated within public mental health services. Therefore, in order to foster pro-social functioning, community reintegration, and optimal mental health, offering alternative treatment services is crucial.

Forensic Mental Health

Individuals in the forensic mental health system usually have a complex mental illness such as schizophrenia, schizoaffective disorder, bipolar disorder, and/or personality disorder (Bettridge & Barbaree, 2008). Often, individuals who have mental illness and have committed a crime will be assessed for criminal responsibility and/or fitness to stand trial. When people are found Not Criminally Responsible (NCR) or Unfit to Stand Trial, they may be offered psychiatric treatment through a hospital rather than being mandated to serve time at a correctional institution (Bettridge & Barbaree, 2008). To acquire such status, a forensic assessment is conducted to determine whether the individual’s mental illness contributed to the crime and resulted in an impaired understanding of its nature and consequences (Bettridge & Barbaree, 2008). More specifically, to be found NCR under the Criminal Code of Canada, individuals must be unable to appreciate the nature of their actions or fail to understand that their actions were wrong at the time of the offence, due to their mental disorder (Bettridge & Barbaree, 2008). Likewise, under the Criminal Code of Canada, to be Unfit to Stand Trial requires that an individual be unable to comprehend the nature, object, or consequences of court proceedings, or be unable to communicate with and instruct their lawyer (Bettridge & Barbaree, 2008).

When clients are found Unfit or NCR, they are placed under custody of the Ontario Review Board (ORB) who grant one of three dispositions: detention, conditional discharge, or absolute discharge (Salem et al., 2015). The disposition outlines the following:

1) their living situation, i.e. whether they should reside in a hospital or in the community;
2) the level of security required;
3) the maximum privileges allowed;
4) any conditions to follow for the year, i.e. random drug testing.

An individual’s disposition is reviewed annually by the ORB (Bettridge & Barbaree, 2008). NCR and Unfit individuals generally remain under the ORB’s custody indefinitely and may spend more time in the hospital than they would have served in jail (Bettridge & Barbaree, 2008). Ideally, these individuals will thrive given an opportunity to participate in appropriate treatment.

Providence Care Hospital is one of 10 hospitals in Ontario offering forensic mental health services (Ontario Ministry of Health and Long-term Care, 2013). Their forensic mental health program seeks to provide mental health treatment to clients who have been deemed Unfit or NCR. (Providence Care, 2017). Forensic Mental Health Services at Providence Care Hospital manages numerous clinical and recreational therapy groups that address various needs of their inpatient clients, with the ultimate goals of managing risk, reducing recidivism, and supporting clients on their recovery journey (Providence Care, 2017). While some groups have a basis in
Cognitive Behavioural Therapy (CBT) or Dialectical Behavioural Therapy (DBT), other groups use recreational or occupational therapy techniques (Providence Care, 2017).

The Need for Program Evaluation

A vital component of effective treatment implementation is ensuring that programs being offered are meeting the needs of the clients. To do this, an internal program evaluation plan should be developed with its data being updated and reviewed regularly. A necessary step in program evaluation includes designing a program logic model, which examines the appropriateness of existing clinical groups and activities in meeting the clients’ needs (W.K. Kellogg Foundation, 2004). The logic model links the short-and-long term outcomes of the programs to the theories supporting them. A program logic model displays the intended chain of cause-effect links between inputs, activities, outputs, and outcomes (Alkin, 2011). It provides an overview of current thinking and helps produce evaluation questions which further mold the program evaluation (W.K. Kellogg Foundation, 2004). The program logic model can be modified when changes in policies occur or when an evaluation has been done (Alkin, 2011).

Accordingly, the purpose of this research project is to develop an internal program evaluation framework for the overall model of intervention at Providence Care Forensic Mental Health Services. Firstly, a thorough literature review highlights evidence-based clinical practices and evaluation methods that are most appropriate for the forensic population. Then, a program logic model is presented which outlines the current procedures and resources within Forensic Mental Health Services. Subsequently, the logic model and literature review will be used to guide changes to the clinical curriculum, the selection of optimal formative and summative measures, and enable the staff to conduct future internal program evaluations. As there are few formal evaluation procedures currently in place at Providence Care, this thesis helps determine changes to existing groups as needed, potential new therapy groups to be included, and novel assessment measures to evaluate the outcomes of the comprehensive services being delivered. Consequently, this will close any service gaps for the clients receiving this unique spectrum of forensic mental health services.

Thesis Overview

The chapters in this thesis include an introduction, an extensive literature review, methodology, results, and the discussion. The introduction presents an overview of the forensic population, program evaluation, and purpose of this project. The literature review highlights and critically analyzes existing evidence-based interventions and assessment measures for forensic mental health. Furthermore, it discusses program evaluation and its use to ensure effective treatment implementation and ultimately act as a basis for the evaluation plan. The method section outlines the participants, the evaluation plan, and selected measures. Next, the results chapter summarizes the findings of any collected data. Lastly, the discussion analyzes the results in relation to the research questions and identifies strengths and limitations. This section also examines the contribution this thesis has made to the field of behavioural psychology and the implications for future research.
Chapter II: Literature Review

Individuals in the forensic system often have complex needs and pose a threat to public safety. As such, it is difficult to integrate them into treatment with the general mental health population (Rowaert, Vandevelde, Lemmens & Audenaert, 2017). However, providing services that target both mental health needs and criminal behaviour is imperative for improved functioning in these individuals (Rowaert et al., 2017). As noted, those who act against the law on account of a mental health disorder are often mandated to an inpatient forensic hospital, specifically designed to serve individuals with severe mental illness. This ensures both public safety and opportunity for treatment (Rowaert et al., 2017). There are various rehabilitative interventions outlined in the literature that have been, or could be used for forensic populations.

The literature review will provide an overview of evidence-based treatments for the forensic population. Moreover, it will have a focus on the recovery model of care and empirically supported interventions that fall under this model. The forensic population overlaps with both the general mental health and offender populations. Thus, the treatments outlined may have demonstrated efficacy with the three populations.

The literature review was conducted by searching the PsychInfo and PubMed databases. Initially, a broad search of mental health treatment was done. Then, a search for mental health treatment for offenders was conducted. The focus was subsequently narrowed, and mental health treatment for forensic populations was reviewed. Upon reviewing these articles, empirical studies for specific treatments were searched for. Inclusion criteria for the search were peer-reviewed articles outlining treatment options for general, offender, or forensic mental health populations. Additionally, meta-analyses, books, and websites were also reviewed. Exclusion criteria included studies with individuals under 18.

Recovery Oriented Care in Mental Health

Mental health treatment paradigms have previously emphasized clinical definitions of recovery, but the focus of recovery has shifted in recent years (Burgess, Pirkis, Coombs, & Rosen, 2011). Clinical recovery falls under the medical model and is usually measured by decreased symptoms and functional impairment (Burgess et al., 2011). Although this is of high importance, it is equally as important to emphasize client-based definitions of recovery that encompass a sense of purpose, hope, empowerment, and connection (Burgess et al., 2011; Simpson & Penney, 2011). The mental health consumer movement in the 1960s and 1970s led to the recovery model of care (Simpson & Penney, 2011). Pouncey and Lukens (as cited in Simpson & Penney, 2011) describe recovery-oriented care as a way to encourage patient choice, accountability and autonomy. Therefore, eliminating the illness and its symptoms is not the only focus. The premise of recovery-oriented care is using clients’ strengths while addressing their challenges to establish integrity, meaning, mastery, and hope back into their lives (Burgess et al., 2011).

Recovery Oriented Care in Forensic Mental Health

Clients residing in a forensic psychiatric facility have unique treatment needs. As expected, forensic clients often also need the same services as anyone living with mental illness, regardless of criminal involvement, such as psycho-education, symptom management, effective medication, vocational assistance, and positive support systems (Burgess et al., 2011). Furthermore, establishing a sense of purpose, hope, and empowerment is particularly important.
for this population (Simpson & Penney, 2011). Thus, best practices of recovery-oriented care should inform treatment services in the forensic institutions (Simpson & Penney, 2011). Although many aspects of the recovery model of care can be used in a forensic inpatient hospital, certain challenges arise. For example, living in a secure facility causes community isolation and limits autonomy (Simpson & Penney, 2011). Moreover, when forensic clients are stable enough to attend community events, engage in job opportunities, or transition into the community living, they are often stigmatized and as such, face difficulty integrating (Simpson & Penney, 2011). Despite the challenges of stigmatization, offering client-centered approaches is a holistic way to improve treatment outcomes in forensic settings by promoting goal setting and achievement.

Various therapeutic group interventions with a recovery focus should take place in conjunction with medication to yield significant improvements.

**Evidence-Based Mental Health Treatment in Forensic Mental Health**

Aligned with the recovery model, Drake, O’Neal, and Wallach (2001) assert that treatment for people with mental illness needs to encompass their own goals. As with anyone with a chronic illness, individuals with mental health disorders generally want to optimally function in society (Drake, O’Neal, and Wallach, 2001). The emphasis on treatment outcomes such as increased independence, vocational success, beneficial relationships, and overall improved quality of life stems from the recovery model of care and should be implemented in forensic institutions though evidence-based practice (Drake et al., 2001). Individuals with mental illness have the right to participate in treatment that has been implemented consistent with evidence-based practices (Drake et al., 2001). Offering interventions with less empirical support can also be of value when used in conjunction with evidence based interventions (Drake et al., 2001). However, problems arise when interventions with minimal or no evidence are offered solely instead of empirically supported treatment (Drake et al., 2001).

Notably, there is vast evidence supporting interventions that adhere to the Risk-Need-Responsivity (RNR) principles when treating offenders with mental illness (Morgan et al., 2012). These principles are grounded in matching the risk level of the client to the level of service intensity, targeting criminogenic needs, and providing individualized Cognitive Behavioural Therapy (CBT) techniques (Morgan et al., 2012). Livingston, Chu, Milne, and Brink (2015) discuss a theoretical model developed by Prins and Draper that applies the RNR principles and suggest that both criminogenic needs and degree of functional impairment must guide treatment. These two factors should dictate the intensity mental health treatment and its synchronization with the criminal justice system (Livingston, Chu, Milne, & Brink, 2015).

Morgan and Winterowd (2002) discuss evidence suggesting that open admission groups (i.e., groups that allow members to join at any time) produce more favorable outcomes than those with closed admission policies (i.e., members can only join at the very start) in forensic units. Open admission is also consistently recommended for group therapy offered in the general mental health system (Kanas, as cited in Morgan et al., 2012). Morgan and Winterowd attributed this to the continuous learning offered by new clients who join the group and share their experiences. This is something to consider when implementing group therapies.

Bonta and Andrews (2017) highlight interventions that do not have sufficient empirical evidence for use within correctional or forensic settings, such as highly punitive treatments like boot camps, solely psychodynamic approaches, and programs that do not target criminogenic needs. However, as the recovery model of care is increasingly used to inform services, there has been less emphasis on RNR principles, especially in forensic psychiatric facilities (Simpson &
There is increasing evidence supporting interventions that do not target criminogenic needs as therapeutically beneficial for forensic clients by decreasing stigma and criminalization of forensic clients (Simpson & Penney, 2011).

**Psycho-educational groups.** Psycho-education is a key component of providing treatment to those with mental illness across various settings. This involves teaching clients about their illness and the associated symptoms, as well as discussing barriers, challenges, and coping strategies (Vallentine, Tapp, Dudley, Wilson, & Moore, 2010). Psycho-education can address self and peer stigmatization through cognitive restructuring (Yanos, Roe, West, Smith, & Lysaker, 2012). Vallentine et al., proposed that when clients have increased insight into their illness, they are more likely to adhere to their treatment plan. Furthermore, psycho-education allows clients to attribute an explanation to their experiences, reducing distress (Yanos et al., 2012). However, it is noted that improved insight can sometimes cause an increased sense of hopelessness and lowered self-esteem because of the (Hasson-Ohayon, Kravetz, Roe, David, & Weiser, 2006).

Despite its importance, there are some barriers to implementing psycho-educational groups in high-secure facilities, including treatment resistance, illness severity, and risk management (Yanos et al., 2012). Involving family members into psycho-educational groups is common and often aids in the success of such a group, but doing so is not always feasible in forensic settings due to ethical reasons, such as confidentiality or because offences may have been against family members (Vallentine et al., 2010). Vallentine, Tapp, Dudley, Wilson, and Moore (2010) analyzed the effectiveness of a psycho-educational group in a forensic hospital, predicting improved over-all wellbeing and mental state. They used two pre-post measures, the Clinical Outcomes in Routine Evaluation (CORE-OM) and The Self-Concept Questionnaire (SCQ) to examine three modules that focused on schizophrenia, depression, and anxiety (Vallentine et al., 2010). The results of the pre-post tests indicated that clinically and statistically significant and reliable changes occurred in terms of life-functioning. The authors found that more than 50% of participants indicated a positive change in scores on the CORE-OM, while a small percentage reported no change. The results of the SCQ suggested that 50% of participants indicated improved self-esteem, while the rest reported either no change or a decrease in self-esteem (Vallentine et al., 2010). Beneficially, psycho-education groups can be offered to all clients despite their different needs (Aho-Mustonen et al., 2011). A study completed by Aho-Mustonen (2011) demonstrated results consistent with the Vallentine et al study. Immediately following, and three months post-treatment, participants demonstrated improved knowledge and insight about their symptoms after participation in a psycho-educational group implemented for forensic clients with schizophrenia (Aho-Mustonen, 2011).

**Cognitive behavioural therapy.** For years, Cognitive Behavioural Therapy (CBT) has improved the mental health of numerous populations (Lovell & Richards, 2000). Considered an evidence-based treatment consisting of techniques such as problem solving, cognitive restructuring, behavioural activation, and relapse prevention, CBT has demonstrated success in cultivating positive changes in mental health (Wenzel, 2017).

CBT is often used with offender and forensic populations because of its adherence to the RNR model (Bonta & Andrews, 2017). Bonta and Andrews (2017) identified antisocial personality traits as being one of the Big Four criminogenic needs, and these needs are commonly addressed in cognitive behavioural interventions. Targeted traits include impulsivity, problem-solving, emotional regulation, and negative automatic thoughts (Bonta & Andrews, 2017). The length and intensity of a CBT program should be dependent on the needs of the client.
One way to determine the intensity of services required by clients is to use the Level of Service Inventory—Ontario Revision which indicated their needs (LSI-OR; Bonta & Andrews, 2007). Using this scale would allow different CBT groups to be implemented that target a wider range of risk levels.

Williams, Ferrito, and Tapp (2014) completed a study that used CBT in a secure forensic hospital for individuals with schizophrenia. They used standardized measures to assess positive and negative symptoms as well as interpersonal functioning. CBT group participants showed improvement on negative symptoms and interpersonal functioning as compared to treatment as usual (TAU) participants.

Travers, Mann, and Hollin (2014) implemented a cognitive skills training program called Enhanced Thinking Skills (ETS) with adult offenders. They assessed whether or not ETS demonstrated comparable levels of effectiveness across individuals who had committed different types of offences. For example, does ETS elicit the same results for those who were convicted for theft as it does for violent offenders? This program is commonly offered to offenders in England and Wales. It targets impulse control, thought patterns, values, moral reasoning, critical thinking, and interpersonal problem-solving (Travers, Mann, & Hollin, 2014). The focus is on clients’ reasoning rather than on the actual content of their thoughts (Travers et al., 2014). The sessions use role-playing, discussion, and homework exercises to interactively teach the material to offenders with mental illness (Travers et al., 2014). In Travers et al.’s study, 21,373 adult male offenders who had participated in the ETS program while in custody were followed for a minimum of two years post-release. They used a manual developed by Clark in 2000, which outlines the skills the program is designed to build upon (Travers et al., 2014). To differentiate the risk of recidivism between the participants, the Offender Group Reconviction Scale (OGRS) was used (Travers et al., 2014). This measures the static variables of an offender while also looking at demographic variables to predict risk of recidivism. Static variables are characteristics that predict recidivism but are not changeable with intervention, such as prior criminal offences (Bonta & Andrews, 2017). Dynamic risk factors also predict the risk of recidivism, but are changeable with intervention, such as substance use (Andrews & Bonta, 2017). The participants were grouped by offense type and risk level (Travers et al., 2014). The study found that that rates of recidivism for ETS participants were significantly lower than predicted across all offense types, excluding those in high-level drug dealing, and robbery. However, since there was no control group in the study, it is hard to definitively attribute the decrease to ETS, although the authors point out their findings were consistent with previous studies, suggesting that cognitive skills training is a highly evidence-based treatment to decrease reoffending. Travers et al., also point out the importance of adhering to the responsivity principle of the RNR model in that this intervention seemed to be more valuable to violent offenders than serious acquisitive offenders. Since the ETS program has had documented success with offenders, it has potential to be a worthwhile CBT program to implement in forensic mental health settings.

Timmerman and Emmelkamp (2005) discuss several studies that support CBT in forensic settings, but assert that treatment success varies vastly across studies. In forensic psychiatry, the definition of successful treatment for mental illness is highly variable (Timmerman & Emmelkamp, 2005). Structured treatment, such as CBT, is significantly more effective across different diagnoses compared to unstructured treatment (Timmerman & Emmelkamp, 2005). Timmerman and Emmelkamp measured coping skills, social awareness, self-esteem, anger, anxiety, and psychological distress in forensic inpatients. Thirty-nine clients participated in a CBT-based intervention. The focus was on behavioural modification techniques such as
reinforcement and shaping, along with cognitive restructuring skill building (Timmerman & Emmelkamp, 2005). These were incorporated into the multidisciplinary treatments the clients were already involved in, as well as through specific cognitive skills training sessions (Timmerman & Emmelkamp, 2005). Several pre-post measures were used to assess changes in cognition and behaviour, such as the Symptom Checklist, The Dissociation Questionnaire, and the Utrecht Coping List. Overall, the results confirmed that using CBT techniques contributed to increased coping skills, interpersonal functioning, and general well-being (Timmerman & Emmelkamp, 2005).

Rees-Jones, Gudjonsson, and Young (2012) implemented a cognitive skill building program called Reasoning & Rehabilitation (R&R). R&R was among the first manualized programs designed to be used for the treatment of antisocial behaviours in offenders (Rees-Jones, Gudjonsson, & Young, 2012). It was designed to encourage prosocial behaviour through making gains in cognitive and social skills, as well as highlighting values (Rees-Jones et al., 2012). Sixty-seven forensic inpatients participated in a modified version of R&R that was designed to adhere to the responsivity principle (Rees-Jones et al., 2012). The Reasoning & Rehabilitation Mental Health Program (R&R MHP) works to promote client engagement in the program by including individual mentoring between group sessions to reinforce learned content (Bonta & Andrews, 2017). Rees-Jones et al., compared measures for R&R MHP participants and a control group of clients receiving TAU. The authors discussed the low drop-out rate for R&R MHP, linking it to mentoring between sessions and the fewer number of sessions, which also encouraged higher levels of retention. When compared to the TAU group, the findings of this study implicate R&R as a beneficial cognitive skill building group for forensic clients that led to significant and durable improvements in prosocial behaviours and thoughts.

Anger management. Henwood, Chou, and Browne (2015) conducted a meta-analysis of 14 studies to determine the effectiveness of CBT groups to reduce anger in offender populations. Their analysis confirmed the effectiveness of CBT in reducing anger, hostility, violent reactions, and general recidivism. CBT groups are commonly used to regulate anger by teaching how to think in a manner incompatible with anger to challenge negative cognitions (Henwood, Chou, & Browne, 2015). As well, providing alternative, more realistic, rationalizations for precipitating events helps individuals act in a less hostile or violent way (Howells, 1998). Furthermore, CBT groups teach ways to reduce physiological states of anger through breathing and visualization strategies (Novaco, 2011).

Wilson et al., (2013) evaluated a group-based CBT anger management intervention in a forensic mental health setting. Eighty-six inpatients participated in 20 sessions and were assessed using self-report measures to capture changes in anger, as well as documented aggressive incidents (Wilson et al., 2013). Scores on both the RAMAS Anger Assessment Profile and State-Trait Anger Expression Inventory-2 indicated significant improvements in coping skills and emotional control for CBT anger management participants compared to the control group (Wilson et al., 2013). The post-test indicated the forensic clients identified decreases in anger and felt that they were better equipped to cope with anger (Wilson et al., 2013). Moreover, there were fewer reports of aggressive incidences after group participation (Wilson et al., 2013). Therefore, implementing a CBT-based anger management program is beneficial to hospitalized forensic clients.

Psychosis. Hornsveld and Nijman (2005) compared 16 chronically psychotic forensic inpatients who participated in a CBT group to 16 inpatients who engaged in TAU. Those receiving CBT showed significant improvements across several subscales of the MI Observation
scales, especially in social skills and coping skills (Hornsveld & Nijman, 2005). The Positive and Negative Syndrome Scale (PANSS) was also used, but there were no clinically or statistically significant differences between the CBT and control groups. Moreover, a meta-analysis conducted by Zimmermann, Favrod, Trieu, and Pomini (2005) explored the efficacy of CBT for psychiatric patients experiencing positive symptoms of schizophrenia. Their analysis, which included 14 studies with a total of 1484 psychiatric patients, supported CBT as an adjunct to medication to improve positive symptoms. The results showed consistent large decreases in symptoms for CBT participants. However, it should be noted that this reduction in symptoms was greater for those with acute rather than chronic symptoms of psychosis (Zimmermann, Favrod, Trieu, & Pomini, 2005). As such, implementing a CBT group for forensic clients with psychosis is likely to improve symptoms.

Relapse prevention. CBT also acts to prevent criminogenic relapse for forensic clients. Skeem, Steadman, and Manchak (2015) argue that simply targeting the symptoms of mental illness will not have an effect on criminal behaviour, and as such, group interventions should target criminogenic risk factors. Implementing a CBT group conceptualized around the RNR principles is a positive approach that works with forensic clients’ strengths and goals (Mitchell, Wormith & Tafrate. 2016). CBT guided by the RNR principles teaches new skills, cognitions and thinking patterns, as well as routines that work against risk factors, thus reducing overall risk (Andrews, Bonta, & Wormith, 2011). Dynamic risk factors can be addressed through CBT in a positive fashion, such as by encouraging prosocial behaviours (Mitchell, Wormith & Tafrate, 2016). Andrews et al., (1990) conducted a meta-analysis of 80 studies where CBT based on the RNR principles was delivered to forensic patients. The recidivism rates of those who participated in RNR guided treatment decreased by approximately 50%, while the rates of recidivism did not change for those who engaged in non-CBT interventions or CBT interventions that did not target criminogenic needs (Andrews et al., 1990). Such interventions have also demonstrated success for individuals who have sexually offended or were convicted of domestic violence (Lösel & Schmucker, 2005; Babcock, Green, & Robie, 2004). Therefore, when CBT is delivered in adherence with the RNR principles, it may lead to reduced recidivism.

Sexual offending. Oftentimes, adjudicated sexual offenders in Canada will return to live in the community at some point, so it is important that treatment is delivered while they are in custody (Jeglic, Hanson, & Calkins, 2016). If they are in a forensic psychiatric hospital, treatment opportunity is heightened (Jeglic et al., 2016). Interventions that focus on triggers are often successful in reducing recidivism (Jeglic et al., 2016). Frequently, in forensic settings sexual offenders are given a DSM diagnosis, for example paraphilia, and are subsequently treated with medication to reduce their sex drive, along with counselling (Jeglic et al., 2016). Again, the importance of applying RNR principles is highlighted by the authors. Treatment of sexual offending is strongly rooted in behavioural therapy (Andrews et al., 1990). Much of the treatment for sexual offending uses general CBT techniques (Jeglic et al., 2016). Jeglic et al., suggest that CBT can also target certain criminogenic factors related to sexual offences. A meta-analysis of 46 studies conducted by Helmust, Hanson, Babchishin, and Mann (2013) examined attitudes and cognitions that predicted recidivism. For example, believing children are provocative or women encourage rape by dressing a certain way are common myths that can be addressed in CBT (Jeglic et al., 2016). The therapist will lead group participants to recognize, label, and challenge cognitions and subsequently think of a more appropriate response (Jeglic et al., 2016). Furthermore, Mann, Hanson, and Thornton (2010) argue that problem-solving skill deficits are often identified in sexual offenders; this skill can be developed in a CBT group.
Jeglic et al., state that the opportunity to discuss potential solutions to problem behaviours or thoughts with other group members is particularly beneficial, indicating that a group format is desirable.

Overall, CBT proves to be an effective group intervention in forensic psychiatric hospitals for a variety of concerns. CBT has a large evidence base for the treatment of offenders and individuals with mental illness. It can address various needs for clients across different risk levels.

**Dialectical behaviour therapy.** Bonta and Andrews (2007) underline that certain risk factors associated with antisocial behaviour, such as substance use, antisocial thought patterns, and antisocial peers, have a more significant relationship with recidivism than any symptoms of mental illness do, indicating the need to target both risk factors and symptoms. Dialectical Behaviour Therapy (DBT) is increasingly incorporated into psychiatric treatment due to its ability to increase pro-social behaviour while minimizing antisocial behaviour (Evershed et al., 2003). DBT was initially developed by Marsha Linehan to treat those with borderline personality disorder to decrease emotional dysregulation and suicidal ideation (Tomlinson & Hoaken, 2017). DBT uses mindfulness and group skills training that aim to reduce emotional dysregulation, negative emotions, and self-injurious behaviour, while also working to improve distress tolerance and interpersonal relationships (Tomlinson & Hoaken, 2017). Often, DBT includes an individual psychotherapy component. However, Tomlinson and Hoaken’s (2017) examined the effectiveness of only implementing a skill-building DBT group in a forensic unit. They followed Linehan’s manual closely. The participants were split into two groups, TAU or DBT (Tomlinson & Hoaken, 2017). One group participated in DBT for the first six months while the other group participated in TAU; once the first DBT group ended, the TAU participants started DBT training (Tomlinson & Hoaken, 2017). There were no notable behavioural changes between the DBT and TAU group on various pre-post measures during the first six months (Tomlinson & Hoaken, 2017). Both groups of participants showed comparable decreases in hostility. However, it was noted that the TAU clients varied significantly in their scores, with some deteriorating in the first six months, whereas all DBT participants remained stable or improved across all measures (Tomlinson & Hoaken, 2017). The authors noted that the greatest improvements were seen in the first six months following the DBT sessions. Likewise, Evershed et al., (2003) reported that forensic inpatients in their DBT group made more positive and lasting changes regarding violent behaviour and in self-reported anger and hostility.

Berzins and Trestman (2004) discuss various ways of implementing DBT for forensic populations; many implement slightly modified versions of it, simplifying language or modifying the content to be more applicable. Correctional Services Canada (CSC) offers DBT to their offender populations (Berzins & Trestman, 2004). Suitable clients receive one to two hours of skills training each week, but cannot progress through the material until behavioural changes are recorded (Berzins & Trestman, 2004). CSC also incorporates a session that teaches clients about the crime cycle through behavioural chains (Berzins & Trestman, 2004).

Recently, self-regulation has become a focus in the treatment of sex offenders in mental health settings (Reid, Beauregard, Fedina, & Frith, 2014). Emotional dysregulation has been connected to recidivism among sexual offenders (Reid et al., 2014). Although additional research is needed, DBT addresses self-regulation within three of its modules, thus potentially being an effective therapy for sexual offenders (Reid et al., 2014).

McCann, Ball, and Ivanoff (2000) outline various reasons why using DBT-based therapies is valuable in forensic settings. These include: the prevalence of clients with
personality disorder is generally high; the clearly structured cognitive behavioural therapy basis has demonstrated efficacy in many populations, including general mental health, offenders, and forensic mental health; and the potential for alleviating violent behaviours, which is beneficial to the overall well-being of all on a forensic unit. DBT has many possible benefits for the whole forensic population, but may be particularly useful for those with personality disorders.

**Occupational therapy.** The forensic population faces barriers to some rehabilitation opportunities because of the restrictive settings they live in. For example, despite occupation being highly important and empowering to people, forensic clients often cannot participate in such activities due to risk management limitations (Farnworth, Nikitin, & Fossey, 2004). Farnworth, Nikitin, and Fossey (2004) explored how forensic inpatients spent their time through examining eight participants’ time diaries, clinical notes, and interviews over five weeks. Many of the clients reported that they were dissatisfied with how they spent their time and that the system prevented them from partaking in worthwhile activities (Farnworth, et al., 2004). Clients reported higher quality of life when involved in a meaningful activity, partly due to increased community connection (Farnworth, et al., 2004). The authors found that using the clients’ past employment experiences, skill sets, and interests to offer opportunities that cultivate resourcefulness and purpose can be beneficial within forensic mental health (Farnworth, et al., 2004). Providing clients with valuable activities and improving their ability to perform independent living skills can greatly increase their quality of life. CAMH (n.d.) recommends life skills programs for forensic clients, which is often something that occupational therapists (OTs) can work on in a group setting. OTs also use sensory-based approaches for some clients who may benefit from them. (Champagne, 2005).

**WRAP.** OTs embody person-centered and holistic interventions (American Occupational Therapy Association, 2008). An intervention well suited for OTs to implement is the Wellness Recovery Action Plan (WRAP; Gardner, Dong- Olson, Castronovo, Hess, & Lawless, 2012). WRAP is a group intervention that encourages participation in activities and occupations that foster clients’ recovery (Gardner et al., 2012). WRAP allows members to discuss and monitor unwanted feelings and behaviours, while building a plan to eliminate them (Copeland, 2015). A main goal of WRAP is to encourage self-management. Facilitated by trained staff, group members work to build an action plan that incorporates six sections: daily maintenance plan; triggers; early warning signs; escalation/crisis signs; crisis planning; post crisis plan (Copeland, 2001, 2015). It is feasible to implement in various settings as only a few inexpensive materials are needed.

The impacts of WRAP can be measured using the pre-post assessment designed by Copeland (Gardner et al., 2012). Cook et al., (2010) completed a study to assess WRAP as a peer-led group. They looked at factors such as symptom reduction and management, as well as quality of life post-intervention and at a 6-month follow-up (Cook et al., 2010). Five-hundred and ninety individuals diagnosed with complex mental illnesses participated and were assigned randomly to an 8-week implementation of WRAP or a waitlist control group (Cook et al., 2010). Immediately following treatment and at six-month follow-up, the WRAP clients: displayed significant decreases on the Brief Symptom Inventory, Global Symptom Severity, and Positive Symptom Total, reported fewer feelings of hopelessness, improved insight, increased coping strategies, and expressed better overall quality of life as assessed by the World Health Organization Quality of Life-BREF environment subscale (Cook et al., 2012). These results indicate that peer-led WRAP training helps in mental health recovery and should be considered when offering people-centered care (Cook et al., 2012). Additionally, another study conducted
by Cook et al., (2012) measured clients’ anxiety and depression before and after WRAP. WRAP participants reported had significantly greater reductions on the anxiety and depression subscales of the Brief Symptom Inventory compared to those in the control group (Cook et al., 2012). Moreover, WRAP participants’ scores also showed significant improvement on the confidence and goal setting subscales, indicating that participation in WRAP reduced clients’ anxiety and depression while improving their outlook on recovery (Cook et al., 2012). Fukui et al.’s (2011) findings were consistent with the previously mentioned studies, indicating reduction in depressive symptoms and increased feelings of hope. Likewise, Buffington (2003) followed up 234 WRAP participants. Post-intervention results indicated regular use of the individualized WRAP plans (Buffington, 2003). At three-month follow-up, 140 of the 234 participants agreed to complete a survey (Buffington, 2003). All 140 participants reported feelings of increased hope regarding their treatment than they had prior to participating in WRAP (Buffington, 2003). Furthermore, O’Keeffe, Hickey, Lane, and Clark (2015) discuss the improvement WRAP fostered in addictive behaviour and identity and self-esteem. They measured quality of life, anxiety, and depression using the Mental Health Recovery Star, Beck Depression Inventory-II, Hospital Anxiety and Depression Scale, as well as the World Health Organization Quality of Life-BREF (O’Keeffe, Hickey, Lane, & Clark, 2015). These tests were administered pre and post intervention as well as at six-month follow-up (O’Keeffe et al., 2015). The results suggested WRAP did not have a large impact on personal recovery, quality of life, or psychiatric symptoms, but did have a positive effect on substance use behaviours and improved self-esteem (O’Keeffe et al., 2015). However, it is likely that if decreased substance use and increased self-esteem occur, then the chances of recovery and quality of life will improve.

O’Keeffe et al., did not find significant changes in quality of life or symptoms. They recommend further research to measure the success of WRAP across various domains. Despite this, there are many reported benefits and personal gains seen in many studies that have used WRAP.

**Vocational training.** Employment is a vital component of life, with known benefits of reduced recidivism and increased sense of meaning (Davis & Rinaldi, 2004). Employment provides structure, reinforces pro-social behaviour, and broadens one’s network (Davis & Rinaldi, 2004). Davis and Rinaldi (2004) underline that although 90% of individuals with mental illness report a desire to work, only 24% succeed in maintaining employment. Implementing vocational training groups can greatly improve post-release employment outcomes for individuals with mental illness and is often provided by occupational therapists (Davis & Rinaldi, 2004). In this study, OTs used a multilevel approach in which they worked with clients who were receiving mental health treatment to simultaneously promote short-term vocational interventions (Davis & Rinaldi, 2004). The OTs created vocational profiles that evaluated motivation and beliefs that prevented clients from working, as well as their current routines, commitments, education, employment history, and mental status to help clients find and maintain appropriate employment (Davis & Rinaldi, 2004). Blankertz and Robinson (1996) randomly assigned 122 clients to a vocational group or to a control group. The vocational group taught necessary skills for employment and interpersonal effectiveness (Blankertz & Robinson, 1996). At nine months post-group, 34 of 61 clients were employed and all participants showed higher levels of skill acquisition and reported positive shifts in attitudes regarding vocation (Blankertz & Robinson, 1996). For forensic inpatients with privileges, vocational training functions as a positive tool to cultivate meaningful activity back into their lives, as well as restoring an important life skill.
**Schema-focused therapy.** Schema focused therapy (SFT) combines cognitive behavioural, psychodynamic, and humanist approaches and was originally devised to offer treatment alternatives to clients with personality disorders (Young et al., 2003). SFT focuses on Early Maladaptive Schemas (EMS), which are persistent maladaptive thoughts and behaviours that result from negative childhood experiences (Bernstein, Antz, & Vos, 2007). These schemas tend to greatly influence behaviour and can instigate powerful emotions as they progress through life (Bernstein, et al., 2007). GiesenBloos et al., (2006) noted considerable improvements in symptoms and overall functioning in clients with Borderline Personality Disorder (BPD) across a three-year SFT intervention, and at follow-up one-year post treatment. Forensic clients with personality disorders face increased risk of recidivism once released from a secure psychiatric hospital compared to those with another diagnosis (Jamieson & Taylor, 2004). Thus, offering interventions for clients with personality disorders is highly important. SFT was not developed for forensic populations, but it can be adapted to meet the unique needs of these clients, which is what Bernstein, Arntz, and Vos (2007) aimed to do in their study. In SFT developed by Young, there are 18 identified schemas, but Bernstein et al., suggested the inclusion of an additional four modes that more appropriately encompass the needs for forensic clients. These include the Angry Protector Mode, Predator Mode, Conning and Manipulative Mode, and Over-controller Mode (Bernstein et al., 2007). Bernstein et al., note that SFT can be more effective than cognitive behavioural techniques for clients with personality disorders because of its focus on changing maladaptive schemas commonly found in those with personality disorders. The goal of SFT in forensic settings is to optimistically foster personality change that results in decreased antisocial behaviour (Bernstein et al., 2007). Although these findings are encouraging, they should be considered preliminary and the authors suggest further examination of SFT in forensic settings. A recent study assessed whether implementing an intervention that combined principles from SFT and DBT was effective in treating Borderline Personality Disorder (Leppänen, Kärki, Saariaho, Lindeman, & Hakko, 2015). The study found a statistically significant decrease in eight of 18 schemas for the clients receiving the combined therapy for a year, compared to those receiving TAU. TAU clients showed no change across any schemas, suggesting the effectiveness of SFT and DBT used together for those with BPD (Leppänen et al., 2015). Similarly, Farrell, Shaw, and Webber (2009) assessed how 30 sessions of group SFT compared to TAU for clients with BPD. The clients participating in the SFT group noted significant reductions in severity of BPD and overall psychiatric symptoms, which coincided with improved functioning overall (Farrell, Shaw, & Webber, 2009). Farrell et al., (2009) claimed that 94% of SFT group participants no longer met the criteria for BPD, compared to only 16% of those participating in TAU, again indicating the possible benefits of using an SFT group for forensic clients with personality disorders.

SFT is a worthwhile intervention in forensic facilities, especially when offered to clients diagnosed with BPD.

**Family interventions.** Despite the recognized value of incorporating clients’ families into treatment when it would be therapeutically beneficial, it is difficult to implement in secure forensic units (Davies, Mallows, Easton, Morrey, & Wood, 2014). Family therapy was originally designed for adults with schizophrenia, as it was hypothesized that mental illness symptoms would subside with strengthened familial relationships (Bertrand, 2006). The implementation of family therapy in medium secure forensic units was examined through semi-structured interviews with clients, therapists, family members, and staff (Davies et al., 2014). The interviews suggested that family therapy is valuable to the clients and family, especially in
regard to discharge planning and providing social support (Davies et al., 2014). The staff also identified barriers to implementing family therapy, such as not being trained to do so. Systemic family therapy is beneficial as it does not follow a predetermined approach or focus solely on one diagnosis; rather, it tends to be flexible and allows the family to dictate the topics discussed (Davies et al., 2014). However, other approaches, such as behavioural family therapy, have also been successful in identifying relapse triggers and prevention strategies, decreasing distress, increasing insight and knowledge regarding mental health, and increasing problem-solving skills (Davies et al., 2014). Such topics are often discussed in therapy groups, but the family is seldom included (Davies et al., 2014). Involving the family can enrich the interdisciplinary team by adding new perspectives to improve discharge planning, and increasing clients’ support networks through improving their family dynamics (Davies et al., 2014). However, with the unique needs of the forensic population, implementing family therapy has its challenges. Staff training in family therapy is often minimal, families may hinder client’s progress, or a family member may have been the victim of the client’s offence (Davies et al., 2014). For these reasons, it is important to ensure that staff are competent to implement family therapy and only recommend it for clients and their families who would benefit therapeutically from it (Davies et al., 2014).

Furthermore, psycho-educational groups for families can help in relieving the burden felt by family members (McDonnell, Short, Berry, & Dyck, 2003). These burdens include stigma, emotional distress, and uncertainty about how to interact with their ill family member (McDonnell et al., 2003). Family psycho-education interventions are considered to be best-practice in the treatment of schizophrenia, and have also consistently decreased relapse and improved symptoms (McDonnell et al., 2014; Lehman & Steinwachs, 1998). Multiple Group Family Therapy (MGFT) involves psycho-education and behavioural therapy in a format consisting of multiple families (McFarlane, 2002). Equipping families with both the knowledge and resources needed to cope with the challenges their family member’s illness imposes, will likely lead to improved relationships between family members. (McDonnell, Short, Berry, and Dyck, 2003). A psycho-educational group designed for family members of forensic clients can be beneficial in numerous ways and promotes peer support for them.

Cognitive remediation. Cognitive remediation therapy is designed to improve cognition in clients with schizophrenia (Wykes et al., 2007). By improving cognition, it is hypothesized that overall functioning will increase (Wykes et al., 2007). Wykes et al., (2007) followed the cognitive mediation manual developed by Delahunty et al., which includes 40 sessions of skill-building practice (Wykes et al., 2007). They randomly assigned 43 clients with schizophrenia to cognitive remediation, and 42 clients to a control group. The findings suggest lasting cognitive advancement, as measured six months post-treatment (Wykes et al., 2007). Along with this, there was a significant increase in cognitive flexibility which continued to improve after treatment (Wykes et al., 2007). The authors suspect that this is due to the group positively reinforcing the use of the cognitive system (Wykes et al., 2007). Reinforcement was derived from tasks given in groups and the increased self-esteem and self-efficacy (Wykes et al., 2007). There is growing evidence suggesting that cognitive remediation may serve as a useful group for forensic inpatients, particularly those with schizophrenia.

Substance use. Those with mental illness are three times more likely to have problematic substance use or a substance use disorder than the general population, likely due to self-medicating to reduce positive symptoms (Regier et al., 1990). Treatment for substance use is therefore vital in the mental health population. When implementing substance abuse interventions, it is important to consider the biopsychosocial perspective (Herie & Skinner,
2014). Although not an approach, this perspective can help guide the treatment programs so that they encompass three domains-- biological, psychological, and sociological - and aim to treat substance use problems through targeting all three of these aspects (Herie & Skinner, 2014). Treatment for concurrent disorders is often most successful when both concerns are addressed simultaneously, but in some cases, it is best to treat the substance use first (CAMH, n.d.).

**Motivational interviewing.** Originally created to treat substance abuse, motivational interviewing has demonstrated effectiveness in increasing motivation for behavioural change (Heather, Rollnick, & Bell, 1993). Motivational interviewing encourages ambivalent clients to commit to change (Heather et al., 1993). It has been utilized with offender populations and has proven efficacy to foster increased motivation to change (Heather et al., 1993). Research does not demonstrate effectiveness when implemented on its own. However, it is helpful as a component of treatment (Merlo et al., 2010).

**Group counselling.** Drake, O’Neal, and Wallach (2008) conducted a systematic review of psychosocial interventions for people with concurrent disorders. Although the group interventions varied across studies, there were some common factors; they were often implemented for at least six months in length, used CBT strategies, and were aligned with the stages of change model (Drake, O’Neal, & Wallach, 2008). The review included eight studies which provided education, peer support, and coping strategies (Drake et al., 2008). All studies demonstrated significant positive changes in substance use and associated beliefs, attitudes, and behaviours (Drake et al., 2008). Notably, significant changes arose from interventions using CBT techniques, social skills training, and contingency management, especially for clients with both schizophrenia and a substance use disorder (Bellack, Bennett, Gearon, Brown, & Yang, 2006). CBT interventions have also been effective in the treatment of substance use in clients with bipolar disorder (Weiss et al., 2007).

Given the efficacy of group CBT in treating various populations and concerns, it might be well-suited to treat substance use in a forensic setting (Bonta & Andrews, 2017). In group intervention for substance use, it is important that clients recognize stages of change, their personal triggers, and the physical and mental effects drugs and/or alcohol have (Herie & Skinner, 2014). Consequently, the group participants can expand upon their coping and relapse prevention strategies through peer support that other group members offer (Herie & Skinner, 2014). Overall, group intervention for substance use can be beneficial for forensic clients.

**Relaxation and mindfulness.** Sistig, Friedman, McKenna, and Consedine (2015) discuss mindfulness as a practice used to diminish overwhelming emotions by shifting attention to the present through redirecting the mind to a specific thought, image, or behaviour. Mindfulness interventions have a strong root in Eastern spiritual practices and have gained popularity in forensic settings in the last decade (Howells, Tennant, Day, Elmer, 2010). Howells, Tennant, Day, and Elmer (2010) completed a meta-analysis examining mindfulness as a therapeutic technique in forensic and correctional facilities. They asserted that the psychological states targeted in mindfulness are often seen in forensic populations, such as emotional dysregulation, low mood, impulsivity, and borderline personality features. Howells et al. concluded that mindfulness contributes to increased use of positive coping skills and decreased risk, making it a beneficial supplementary treatment option.

Despite the efficacy of mindfulness, Sistig et al., identified the need to offer mindfulness in various ways to maximize its potential to be beneficial for forensic clients. Their study assessed supplementing usual treatment with an eight-week yoga program for forensic patients. Yoga incorporates both mental and physical relaxation while teaching body postures, breathing
techniques, relaxation, and meditation (Sistig, Friedman, McKenna, & Consedine, 2015). The benefits of yoga are vast, as different body systems are in use simultaneously (Sistig et al., 2015). In addition to measuring the efficacy of implementing a mindful yoga intervention, Sistig et al., measured the effects that yoga had on anxiety and/or depression symptoms, stress levels, risk to self or others, as well as on overall well-being. There were three groups of 10-15 men and women participants across three forensic facilities (Sistig et al., 2015). The authors implemented an intervention based on the Mindfulness-Based Stress Reduction yoga component, trauma-sensitive guidelines by Hopper et al., and Hatha yoga. Four pre-posttest assessments were used and completed by participants that measured mindfulness, stress, anxiety, and depression (Sistig et al., 2015). Qualitative self-reports were also completed post-treatment and at a two-month follow-up. The results of these assessments indicated clinically significant improvements in psychiatric symptoms over time, particularly for anxiety and stress (Sistig et al., 2015). Although the measures did not show statistically significant changes, self-reports indicated subjective positive changes and higher levels of body awareness and increased relaxation (Sistig et al., 2015).

Francesco, Mauro, Gianluca, and Enrico (2010) suggested that relaxation techniques such as progressive muscle relaxation and deep breathing are effective at reducing anxiety in various populations. They state that regardless of individual differences, various studies support that anxiety and distress reduction is common when relaxation techniques are used. Moreover, for those with Generalized Anxiety Disorder (GAD), relaxation training has been proven to have strong efficacy for managing symptoms (Francesco, et al., 2010).

Although multiple studies indicate emerging evidence for the effectiveness of relaxation techniques, there are gaps to be clarified. Standardized pre-posttests do not indicate high levels of change, but participants report various benefits on subjective self-reports.

**Music therapy.** Music is generally composed, listened to, and played for emotional expression (Hakvoort, Bogaerts, Thaut, & Spreen, 2013). Music acts to help people recognize and better cope with the emotions and cognitions that regularly affect them (Hakvoort et al., 2013). Therefore, when music therapy is implemented in a therapeutic and systematic manner, it holds promise as a therapy technique (Hakvoort et al., 2013). For example, CBT music therapy has been used in forensic psychiatry. When based on the RNR principle outlined by Bonta and Andrews (2007), music therapy works to improve problem-solving, self-management, anger management, and coping skills. Additionally, in CBT music therapy, the music is often used as a reinforcer and motivator to facilitate skills training (Hakvoort et al., 2013).

Hakvoort, Bogaerts, Thaut, and Spreen (2013) examined how music therapy influences coping skills and anger management in forensic psychiatric patients across four facilities using five music therapists to deliver the treatment. The Social Dysfunction and Aggression Scales were given to participants to measure coping skills and feelings of anger prior to participants being randomly assigned to either the experimental or control group (Hakvoort et al., 2013). Those in the experimental group participated in 20 hours of music therapy and treatment as usual (TAU; Hakvoort et al., 2013). Those in the control group continued TAU and were not invited to partake in music therapy until after they completed their post-test. The experimental group followed a standardized music therapy anger management program that has a basis in CBT (Hakvoort et al., 2013). At the pre-test, both groups showed similar mean levels of coping skills, but at the post-test, the music therapy group showed a significantly larger reduction in avoidance coping skills (Hakvoort et al., 2013). There were no differences between the groups in coping skills (Hakvoort et al., 2013). The two scales used presented no significant changes between pre-
post measures for either group (Hakvoort et al., 2013). Both groups showed increased self-management of assaultive behaviour skills on the post-test (Hakvoort et al., 2013). There was also a noted increase in symptom self-management in the music therapy participants post-test but the authors state this is should not be considered a significant result as it is likely due to a general increase in cognitive functioning resulting from participation in other therapies.

Chen, Leith, Aaro, Manger, and Gold (2016) completed a meta-analysis of five studies that used music therapy to improve mental health in offender populations. Music therapy has been used for many years and in both individual and group settings (Chen, Leith, Aaro, Manger, & Gold, 2016). The authors assert that music therapy helps with both internalizing and externalizing problems. However, music therapy tends to target internalizing problems more than externalizing problems (Chen et al., 2016). Although there was some evidence of changes in externalizing factors such as aggressive behaviours, internalizing problems were more impacted (Chen et al., 2016). Chen et al., examined self-esteem, behaviour management, anxiety, depression, and social functioning scores on pre-post measures. The scores on the post-tests demonstrated improved self-esteem and social functioning.

Art groups. Despite the lack of adherence to the RNR model and difficulties in establishing an evidence-based approach, art interventions can be therapeutically beneficial for individuals with mental illness as they promote positive social behaviour, an emotional outlet, rapport building and increased confidence and optimism (Bonta & Andrews. 2016; Howells & Zelnik, 2009; Kelaher et al., 2013). Furthermore, Howells & Zelnik (2009) suggest that art interventions can decrease stress and anxiety. Kelaher et al., (2013) evaluated three community-based art programs in which a total of 103 individuals with mental illness participated. They used several qualitative and quantitative measures before and after the art interventions, including the Basic Psychological Needs Scales (BPNS) which measures relatedness, autonomy and competence. Additionally, the Arts Climate Scale adapted from the Learning Climate Scale was also used to measure autonomy (Kelaher et al., 2013). Lastly, participants completed surveys that captured personal reflection and changes in social support. Post-intervention, there were significant improvements in overall psychological well-being, autonomy, and social support (Kelaher et al., 2013). Additionally, Van Lith (2014) found that art often has a spiritual aspect to it, with participants often reporting feelings such as meaning, hope, commitment, and a deepened sense of self.

Based on the aforementioned studies, it can be assumed that an art group would be a worthwhile and meaningful activity to implement in conjunction with other therapeutic interventions to increase quality of life and promote positive prosocial activities on the unit.

Physical activity. Due to the increasing adherence to the recovery model of care, physical activity programs and opportunities have been encouraged for forensic mental health patients. Physical activity has demonstrated benefits to the overall well-being of individuals with schizophrenia (Holley, Crone, Tyson, & Lovell, 2011). Typically, those with schizophrenia or
other mental illnesses struggle to maintain optimal physical health due to various reasons, including medication side effects and negative symptoms (Holley et al., 2011). Chapman, Fraser, Brown, and Burton (2016) explored inpatients’ attitudes regarding physical activity. The clients in the study expressed interest in physical activity to lose or manage weight, improve overall health, and improve stress levels and emotional well-being (Chapman, Fraser, Brown, & Burton, 2016). However, their study indicated that social interaction was the least important aspect of physical activity. Chapman et al. speculate that social interaction is an additional benefit of physical activity, but not a motivator for participation. Consistent with previous research, walking was the preferred activity (Chapman et al., 2015). Implementing a physical activity group is a physically and mentally beneficial adjunct to therapy treatment.

Program Evaluation

Two evaluation approaches commonly used are formative and summative. Formative evaluation approaches generally occur near the beginning of interventions to produce information that can be used to generate program improvement (Alkin, 2011). This usually includes examining whether the program activities are being implemented effectively and in a manner to potentially reach the desired outcomes (Alkin, 2011). Summative evaluations typically are used to guide decision-making (Alkin, 2011). These decisions often include whether a program is effective and if it should continue to be implemented or not (Alkin, 2011).

According to the W.K Kellogg Foundation (2004), program evaluation is not only about obtaining data; it allows agencies to gather and use information that increases their awareness of how they can improve the services that they offer. A program logic model (PLM) can support successful program planning, implementation, evaluation, and outcomes (W.K. Kellogg Foundation, 2004). This allows for improvement when documenting outcomes, serves as a powerful learning tool, and demonstrates which programs are meeting their objectives and how this is being done (W.K. Kellogg Foundation, 2004).

Tremblay, Coulombe, and Briand (2017) described the various ways that using a logic model can benefit a mental health organization. They stated that logic models can help shape an understanding of the expectations for running programs, such as the resources, clientele, and outcomes. Additionally, PLMs can be used to share ideas, highlight assumptions, provide team building opportunities, and improve communication (Tremblay, Coulombe & Briand, 2017). PLMs also help to emphasize the critical evaluation of program components to highlight those that are vital to achieving the program’s goals and identify those that are inconsistent with the program’s desired outcomes (Tremblay et al., 2017).

Moreover, Morgan et al., (2012) suggested that many clinicians providing services to offenders with mental illness do not have enough data supporting the effectiveness of their groups and are often left wondering if treatment is having a worthy impact. Thus, program evaluation is a key activity that is needed when offering clinical services.

Given the need for effective treatment in a forensic mental health setting proposed in the literature, program evaluation guided by a PLM will assist in identifying needed curriculum changes to existing groups to better meet the needs of their clients and close any service gaps that are present. This may also help towards reducing staff burnout from providing therapy if the services provided are based on actual needs and the outcomes are tracked.
Relevance of Literature Review

Livingston et al. (2015) asserted that forensic mental health services rarely follow empirically supported principles. As the present system used at many forensic mental health hospitals is based on a traditional framework of care that focuses solely on reducing symptoms, it restricts the potential for significant improvements in the target population (Livingston et al., 2015). Routine program evaluations allow organizations to objectively determine if the services they are offering are being implemented the way they are desired to be. This literature review highlights evidence-based practices implemented in forensic hospitals, as well as interventions being used for populations with overlapping needs, such as the general and offender mental health systems. The focus is on evidence-based group interventions for a population with diverse needs while ensuring a holistic treatment approach. It can contribute to the process of identifying potential gaps in treatment offerings at Providence Care Forensic Mental Health Services and support the implementation of current treatment groups.
Chapter III: Method

Consent to Use Company Name and Logo (Appendix A)

Dr. Rebecca Douglas gave consent to use the agency name and logo in the thesis on November 24th, 2017.

Participants

Staff personnel. Since the program evaluation will be conducted by staff in the future, staff members were involved in the development through both informal and formal discussion. They provided valuable input regarding the PLM and evaluation questions.

Target population. Forensic Mental Health at Providence Care is an inpatient hospital serving clients who are referred by the courts to be assessed for Fitness to Stand Trial and/or for criminal responsibility. Clients are also on the unit to receive treatment if they are found Unfit or NCR. The forensic unit treats both men and women who are at least 18 years of age with a wide range of diagnoses. However, the average individual in the forensic mental health system in Canada is male, approximately 30 years of age, and has a primary diagnosis of a psychotic disorder (Crocker et al., 2015). The program evaluation is intended to examine the implementation and effectiveness of the overall model of group intervention that the clients participate in to ensure it is meeting their needs and making positive changes.

Informed Consent

Since there are no client data being presented in this thesis, informed consent was not collected. All of the data presented is operational in nature.

Procedures

The staff at Providence Care will use the proposed evaluation framework to determine the effectiveness of their group interventions. Information from the recommended pre- and post-tests should be collected and summarized on a regular basis at the Recovery Process Action Team (RPAT) meetings. The procedures are outlined in further details within the components of the Program Evaluation described below.

Program Evaluation

Purpose of evaluation. Currently, there are numerous group interventions offered on the unit that are expected to address the clients’ individual needs. This is done through the development of treatment plans and by offering invitations to closed groups for clients who would benefit from participating. Open groups allow all clients on the unit to participate and are also available. The unit/ward uses a variety of standardized measures to guide treatment. However, pre-post group measures are not completed for all groups offered, and as such, the actual impact of the groups are unknown. Most of the outcome assessments are anecdotal in nature and made by staff. As there are no formal procedures currently set in place for determining the effectiveness of the group interventions, the program evaluation will provide information on service gaps, strengths and weaknesses of the group intervention model, and insights regarding the impacts the groups have. Furthermore, empirically supported group interventions pertaining to forensic mental health have been identified throughout the literature review, thus providing an opportunity to recommend curriculum changes based on best practices and suggestions for summative and formative measures. By routinely incorporating program
evaluation into their clinical work, the team at Providence Care will be better able to ensure they are providing the most appropriate treatment for their clients.

**Evaluation approach.** A utilization-focused evaluation (UFE) approach is proposed for the evaluation plan. This approach was developed by Michael Quinn Patton and suggests that programs should be evaluated on the benefits it provides to its intended users (Patton, 2008). The UFE produces findings that can be used to enhance the program through improving processes and informing decisions (Patton, 2008). There are two important aspects of the UFE approach; the primary intended users need to be identified and engaged early on in the evaluation process and they must be involved in making decisions that guide the evaluation process (Patton, 2008). Moreover, one of the main goals of this evaluation approach is to facilitate discussion and decision making between those who will be using the results of the evaluation (Patton, 2008). Therefore, the evaluator is not making decisions regarding the implementation of programs but rather providing the intended users of the evaluation with the necessary information to take ownership of the evaluation process and results (Patton & Horton, 2009). The UFE approach is often used for both formative and summative evaluation designs, as well as many others (Patton, 2008).

Elements of impact evaluation were also included in the framework. The impact evaluation approach focuses on the outcomes, whether expected or unexpected, that an intervention has (Peersman, 2015). This approach must outline what caused the measurable changes (Peersman, 2015). Impact evaluations are carried out to make improvements or changes to an intervention for formative purposes, or to guide decisions about continuing, discarding, or scaling up interventions for summative purposes (Peersman, 2015).

For this evaluation plan, a pre-post design was selected. Eventually, it is recommended that the design be extended to include follow-up data to provide information regarding maintenance of treatment gains. Furthermore, it would be beneficial to conduct staff and client interviews to elicit qualitative information on the treatment programs.

**Program logic model.** A program logic model (PLM; Appendix B) was drafted to present a snapshot of the model of group intervention in its current state. The first draft of the model was reviewed by Dr. Rebecca Douglas and Dr. Jan Looman. Some revisions were made, and the PLM was presented at a meeting of the Recovery Process Action Team (RPAT) meeting to elicit team discussion and feedback. The discussion surrounded the programs overall desired impacts and areas of strength and improvement. The PLM was also sent as an email attachment to capture additional staff feedback. Since the program evaluation will be used by staff, it was important to ensure that everyone was in agreement regarding the current operations of the unit. Feedback regarding content and structure was noted and integrated into the PLM. The questions that emerged from the discussions surrounding the development of the PLM became the evaluation questions, which serve as the basis of the evaluation framework. The sections of the PLM are:

**Purpose.** This is the overall purpose statement of Forensic Mental Health Services that encompasses their desired outcomes for the program.

**Inputs.** For their model of group intervention, Forensic Mental Health Services invests funding, time, and training in order to run the groups. The interdisciplinary team is comprised of professionals with varying expertise and who work collaboratively to facilitate group interventions in order to provide a holistic model of care.
**Components.** These are the main groups of related activities in the model of intervention at Providence Care. This includes assessment, group intervention and care planning, rehabilitation, treatment, risk mitigation, wellness, and enrichment.

**Participants.** The population consists of adult individuals with a major mental illness and have been found Not Criminally Responsible by reason of Mental Disorder (NCR), Unfit to Stand Trial, or who are on assessment orders to determine criminal responsibility and/or fitness. The NCR clients are typically the ones participating in the group interventions, but assessment clients also have opportunities to engage in select groups.

**Activities.** There are various group interventions that are currently being implemented, have been implemented, or are going to be implemented on the unit. These groups are either open (i.e. both assessment and NCR clients are invited to join) or closed (i.e. only NCR clients can participate, or it is by invitation only) depending on their content. There are few pre-post measures currently in place to evaluate the effectiveness on both the program and patient level, thus the indicated need of identifying measures to use. Moreover, treatment planning is a large part of the activities on the unit. Offering various groups and inviting clients to engage in groups that allow them to work towards their recovery goals is an important aspect of group intervention.

**Outputs.** These are the concrete results produced by the program, such as number of groups, number of participants, group attendance, group protocols, and group documentation. There are typically 20 NCR clients on the unit and 10 assessment clients. As previously discussed, there are opportunities for both client groups to engage in treatment. Attendance is ideally captured for each session and included in the clients’ charting data.

**Short-term outcomes.** The short-term outcomes listed in the PLM derive from the group protocols for the various interventions. The group protocols all list the outcomes they aim to achieve. Furthermore, group attendance and engagement are included.

**Intermediate outcomes.** The intermediate outcomes identified are the desired results of participating in groups and achieving the short-term outcomes. Ontario Review Board (ORB) recommendations rely heavily on treatment engagement and progress. These recommendations allow the ORB to set dispositions which outline maximum privileges. The treatment team is then responsible to appropriately distribute privileges to the clients based on the progress and mental status. The intermediate outcomes also encompass improved mental status and functioning.

**Long-term outcomes.** The overall outcome that Forensic Mental Health Services works towards is successful discharge. This means an individual is functioning well enough to be reintegrated into the community with reduced risk of recidivism and risks to self or public safety.

**Evaluation questions.** The evaluation approach, PLM, and discussion with staff produced evaluation questions that fell under three domains: inputs, activities, and impacts. These are outlined in an evaluation framework (Appendix C).

**Evaluation Plan Package**

An Evaluation Plan Package (Appendix D) was composed and is intended to be used by the Forensic Mental Health Services team at Providence Care to guide future evaluations. It is comprised of six different sections that cover the current program description and operations, the proposed evaluation methodology, the aforementioned literature review, the existing group protocols and suggested measures, and finally, recommendations regarding the curricula of group interventions.
**Section 1: Program description.** This section covers the purpose of Forensic Mental Health Services, the target population, their current staffing ratios and resources, and a brief description of current activities. As well, the stakeholder map and program logic model are included.

**Stakeholder analysis and map.** The Stakeholder Analysis identifies all the primary, secondary, and key stakeholders and highlights their relationship and interest to the evaluation. Team members who are a part of the RPAT committee expressed interest in the overall success of the group intervention model. Both formal and informal stakeholder engagement was conducted. This was done through formal meetings and discussions, emails, and informal discussion.

**Section 2: Evaluation methodology.** The second section of the evaluation plan defines the purpose of the evaluation, the evaluability assessment checklist, and the evaluation approach. Subsequently, it outlines the evaluation questions identified by the program logic model. The evaluation questions were integrated into the evaluation framework (Appendix E), which was included in this section.

**Evaluation framework.** The evaluation framework identified these three domains of questions: inputs, process, and impact. Within the three domains, one to five questions were identified. Indicators, which suggest where one might find the answers, such as ePR or client feedback were included. Finally, suggestions for data collection were identified, such as attendance rates and pre-post scores.

**Section 3: Literature review.** Section three contains the literature that discusses evidence based approaches to forensic mental health treatment.

**Section 4: Current group protocols.** Section four of the evaluation plan contains all of the current group protocols provided by Providence Care Hospital Forensic Mental Health Services.

**Sections 5: Recommendations.** The final section of the evaluation plan includes recommendations on potential changes to the current group curricula. This includes suggestions about new group interventions to implement or modifications to make to the current ones. As well, there is a recommendation of the group delivery schedule for the calendar year. Importantly, this section outlines suggested pre-post measures to determine the impacts of group intervention at both the client and organizational level. There are also general recommendations based on discussions with the staff and suggestions on how to best select staff to implement the groups.

**Section 6: Group intervention measures.** The psychological assessment measures outlined are identified to measure the intended outcomes of the group interventions. They are outlined below and a copy of the test or its Mental Measurements Yearbook description are included in the evaluation plan package as appendices. Appendix F contains a table that displays what measures should be used for the group interventions currently being implemented. There is an additional chart with recommended group interventions and their corresponding suggested measures (Appendix G).

**Drug Taking Confidence Questionnaire (DTCQ; Annis, Sklar, & Tuner, 1997).** The DTCQ is a self-report treatment outcomes measure that used to measure for substance use programs that examines an individual’s likelihood of coping with high risk situations related to drugs and alcohol (Sklar, Annis, & Turner, 1997). There are 50 questions measured using a Likert scale ranging from 0 (not at all confident) and 100 (very confident; Sklar et al., 1997). A total of eight scores is obtained across the following subscales: unpleasant emotions, physical
discomfort, pleasant emotions, testing personal control, urges and temptations to use, conflict with others, social pressure to use, and pleasant times with others (Sklar et al., 1997). Studies have shown the DTCQ to have good internal consistency (Sklar et al., 1997). Sklar et al. (1997) measured the validity of using the DTCQ to assess self-efficacy by correlating subscales that including questions regarding consumption, social context, and information about use (e.g., motivation to quit). They also examined the DTCQ with various psychometric tests including the Stages of Change and Readiness Treatment Eagerness Scale and the Beck Depression Inventory (Sklar et al., 1997). These studies provide evidence of convergent and discriminant validity, but there is not much evidence of predictive validity regarding treatment prognosis (Sklar et al., 1997). The authors discuss previous studies that demonstrate high self-efficacy and treatment success (Sklar et al., 1997).

**Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES; Miller & Tonigan, 1996).** The SOCRATES is a 19-item scale that encompasses three subscales including taking steps, recognition, and ambivalence. The participants answer questions regarding alcohol and drug use using a Likert scale from 1 (No! Strongly disagree) to 5 (Yes! Strongly agree; Miller & Tonigan, 1996). Miller and Tonigan (1996) assert that the scale demonstrates excellent psychometric properties. The Cronbach’s alpha coefficient ranges from 0.88 to 0.96 across the three scales indicating strong internal consistency, while test-retest reliability is also excellent, ranging from 0.83-0.99 (Miller & Tonigan, 1996). Rollnick and Bell (1993) describe SOCRATES as having strong predictive validity. The mean levels of consumption between intake and follow-up were compared to behaviours associated with the stages of change (Rollnick & Bell, 1993). It was found that substance usage was predicted by the stages of change model (Rollnick & Bell, 1993).

**Positive and Negative Symptom Scale (PANSS; Kay, Opler, & Fiszbein, 1992).** This is an assessment tool for those already diagnosed with schizophrenia (Kay et al., 1992). It contains 30 items that examine the positive and negative symptom clusters of schizophrenia (Kay et al., 1992). In a structured interview format, it assesses 9 clinical dimensions to The PANSS has an alpha reliability coefficient of .70 demonstrating satisfactory reliability (Kay et al., 1992). Criterion-related validity indicates that the positive and negative items on the assessment are negatively correlated (Kay et al., 1992).

**Reactions to Provocations (RP; Novaco, 1994).** The RP consists of two parts (CSC, 2009). The first part contains 12 subscales with a total of 48 questions that measure thinking patterns and feelings (CSC, 2009). The subscales in Part A include attentional focus; rumination; hostile attitude; suspicion; intensity; duration; somatic activation/tension; irritability; impulsive reaction; verbal aggression; physical confrontation; and indirect expression (CSC, 2009). Part B contains 25 questions regarding the individuals level of anger if certain situations were to occur (CSC, 2009). It contains five subscales: disrespectful treatment; unfairness/injustice; frustration/interruption; annoying traits; and irritations. Mills, Kroner, and Forth (1998) argue that this measure is reliable, with a Cronbach’s coefficient greater than 0.80. Furthermore, the RP demonstrates strong construct and concurrent validity (CSC, 2009). Moeller, Novaco, Heinola-Nielen, and Hougaard (2016) examined the psychometric properties by comparing results of different anger assessments and those of the RP and found that it had high concurrent and discriminant validity when used with adult offender samples.

**The Clinical Outcomes in Routine Evaluation - Outcome Measure (CORE – OM; Evans et al., 2000).** The CORE - OM is used to measure changes in four subscales: problems; risk to self and to others; life functioning; subjective well-being, across 34-items (Evans et al.,
2000). In forensic populations, all scales except for well-being demonstrate excellent reliability, with coefficients of 0.80 to 0.95 and all scales had good internal consistency, with Cronbach’s alpha coefficients of 0.80 to 0.95 (Evans et al., 2000). McCloskey (2001) examined the usage of the CORE – OM in forensic settings and found that when compared to the norms of the non-clinical population, convergent validity was high. Moreover, Evans et al., (2005) discuss similar findings, suggesting the test has strong convergent validity when compared to similar measures, such as the Beck Depression Inventory.

**Barratt Impulsivity Scale (BIS; Barratt, 1994).** The BIS contains 30-items that measure impulsivity (CSC, 2009). It measures impulsivity in three domains: motor, attentional, and non-planning (CSC, 2009). It demonstrates good internal consistency, reliability, and validity (CSC, 2009). Using norms for the non-clinical population, concurrent validity was determined to be strong (Stanford et al., 2009).

**Personality Belief Questionnaire (PBQ; Beck & Beck, 1991).** The PBQ is designed to assess maladaptive, dysfunctional, and unrealistic thinking in those with personality disorders (Beck & Beck, 1991). It contains nine subscales with a total of 126 self-report questions (Beck & Beck, 1991). It has been determined to have high internal consistency with a Cronbach’s alpha coefficients of 0.77 to 0.93 (Butler, Beck, & Cohen, 2006). Furthermore, the reliability is good, with coefficients ranging from 0.78 to 0.91 (Butler et al., 2006). Butler, Beck, and Cohen (2006) found that the PBQ has good criterion validity, indicating that the beliefs on the test link to the disorders it is measuring.

**Aggression Questionnaire (AQ; Buss & Perry, 1992).** The AQ examines four subcategories of aggression including physical, verbal, anger, and hostility (Bus & Perry, 1992). These subcategories are reflected throughout 29 questions and are answered on a Likert scale ranging from 1 (extremely uncharacteristic) to 5 (extremely characteristic; Buss & Perry, 1992). The scales demonstrate good internal consistency, and reliability (Buss & Perry, 1992). Bus and Perry’s (1992) study consisted of comparing peer nominations to self-reports of aggression to measure construct validity. They found that the AQ had strong construct validity.

**Reduced Emotional Intensity Scale (REIS; Geuens & DePelsmacker, 2002).** The REISS measures emotion intensity through two domains, positive emotional intensity and negative emotional intensity (CSC, 2009). Geuens and DePelsmacker (2002) assert the REIS has good test-retest reliability. Geuens and DePelsmacker examined the full-length version of the test and the REIS, the short-form, and concluded that the REIS has good construct validity.

**Difficulty in Emotion Regulation Scale-Short Form (DERS-SF; Kaufmen et al., 2015).** This test measures emotional dysregulation using a Likert scale ranging from 1 (almost never) to 5 (almost always). Kaufmen et al. 2015 suggest that the full-length DERS (Appendix P) has demonstrated high reliability with a Chronbach’s alpha coefficient ranging from .78 to .91 for the total scale. The Chronbach’s coefficients ranged from .79 to .91 for the short form of the DERS, called the DERS-SF, which also displayed high reliability (Kaufmen et al., 2015). Kaufman et al., explained that the reliability of DERS-SF highly correlated with that of the total scale. Furthermore, they compared the concurrent validity of the two scales, and noted that the DERS-SF also had good concurrent validity.

**Emotional Regulation Questionnaire (ERQ; Gross & John, 2003).** The ERQ is used to measure differences in emotional regulation through cognitive reappraisal and expressive suppression across 10-items (Gross & John, 2003). Butler et al. (2003) suggest that the ERQ demonstrated high levels of reliability. Interobserver agreement was used to calculate the reliability on 25 out of 36 tapes in Butler et al.’s study. Positive expression had a reliability score
of .90, negative expression had a score of .92, and responsiveness had a score of .87. Gross and John (2003) have measured the validity of the ERQ and found that it has sound convergent and discriminant validity. Furthermore, Ioannidis and Siegling (2015) determined the criterion validity to be good.

**Social Problem-Solving Inventory – Revised Short-Form (SPSI-R; D’Zurilla, Nezu & Maydeu-Olivares, 1999).** The SPSI-R contains 25 items to measure problem-solving skills across five subscales including: positive problem orientation; negative problem orientation; rational problem solving; impulsive/careless style; or avoidant style (CSC, 2009). This measure demonstrates adequate concurrent and predictive validity (D’Zurilla et al., 1999).

**Work and Social Adjustment Scale (WSAS; Mundt, Marks, Shear, & Greist, 2002).** The WSAS is a self-report Likert scale that measures daily living activities. It consists of five questions where answers range from 1 (not at all) to 5 (very severely; Mundt et al., 2002). Mundt, Marks, Shear, and Greist (2002) analyzed validity data from two studies that used the WSAS with over 500 patients. They found that although a short test, the WSAS had strong convergent and criterion validity.

**Five Facet Mindfulness Questionnaire (FFMQ; Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006).** The FFMQ measures five subscales of mindfulness (Baer et al., 2006). The subscales capture these five facets: observing, describing, acting with awareness, non-judging of inner experience, and non-reactivity to inner experience (Baer et al., 2006). There are 39 questions answered with a Likert scale from 1 (never or very rarely true) to 5 (very often or always true). Baer et al., (2006) measured construct validity of the FFMQ between two sample populations; one sample consisted of individuals who have practiced mediation and one consisted of those who did not. They concluded the FFMQ showed construct validity, but that the results varied with meditation experience.

**The Perceived Stress Scale (PSS; Cohen, Karmarck, & Mermelstein, 1983).** The PSS contains 10 questions pertaining to ordinary life occurrences in which individuals answer if they have perceived them as being overwhelming, unpredictable, or uncontrollable (Cohen et al., 1983) is well validated and has good internal reliability, with a Cronbach’s alpha coefficient of 0.78 (Cohen & Williamson, 1988). There is evidence of strong predictive validity as higher scores on the PSS were correlated with lower scores of making positive gains (Cohen & Williamson, 1988).

**Quality of Life Enjoyment and Satisfaction Questionnaire (QLESQ; Endicott, 1990).** The QLESQ is a self-report scale that encompasses 96 questions across six subscales including physical health, subjective feelings, leisure time activities, social relationships, general activities, overall life enjoyment and satisfaction (Endicott, 1990). As well, it includes three optional scales if clients are involved in such, including work, household duties, school/coursework, (Endicott, 1990). The QLESQ has demonstrated sound internal consistency, reliability, and validity (Endicott, 1990). Endicott (1990) asserts a more sophisticated scoring system be developed to improve these. It is a good tool to assess quality of life issues for the purpose of insightful discussion (Endicott, 1990). Ritsner, Kurs, Gibel, Ratner, and Endicott (2005) measured construct validity by testing the QLES ability to differentiated between schizophrenic and non-mentally ill individuals. The QLES displays good construct validity (Ritsner, Kurs, Gibel, Ratner, & Endicott, 2005). Moreover, Ritsner et al., determined that the QLESQ has good concurrent validity by using the DSM-IV diagnostic criteria for schizophrenia and comparing this to scores obtained on the QLESQ.
**Shortened COPE Inventory (Carver, Scheier, & Weintraub, 1989).** The Shortened COPE Inventory consists of 28-trait-like coping skills to assess the client’s range of coping strategies (Carver et al., 1989). The client rates how often they used the specific strategy on a scale of 1 (not at all) to 4 (often). Relatively stable data has been proven through test-retest reliability (Carver et al., 1989). Carver, Scheier, and Weintraub (1989) found evidence of convergent and discriminant validity. They also suggested that the COPE inventory has good discriminant validity.

**Self-Compassion Scale (Neff, 2003).** This is a 26-item self-report measure that addresses compassion to one’s self during difficult times. Using a Likert scale from 1 (never) to 5 (almost always) it examines how often individuals engage in the statement given, Neff (2003) says the Self-Compassion Scale demonstrates strong internal reliability with an alpha coefficient of 0.86. The Self-Compassion Scale demonstrates good convergent validity (Cuhna, Xavier, & Castilho, 2016).

**Generic Program Performance Measure (GPPM; Stewart, 2005).** The GPPM is a pre-post measure developed by Correctional Service Canada (CSC) in order to assess treatment gain. The test measures clients’ progress and efforts towards meeting the goals of the intervention (Usher & Stewart, 2011). The group facilitator rates the participants on three scales: performance, responsivity, and effort using a Likert scale ranging from -2 (absence) to +2 (excellent; Stewart, Usher & Vandermey, 2015). The GPPM has excellent internal consistency, interrater reliability, and validity. The Cronbach’s alpha coefficient was .93 for pre-test score and .92 for post-test scores. Several studies by CSC have indicated good construct and criterion validity (Usher & Stewart, 2011).

**The Psychological Inventory of Criminal Thinking Styles (PICTS; Walters, 1995).** The PICTS measures thought patterns associated with criminal behaviour (Walters, 1995). Four meta-analyses conducted by Walters (1995) describes the PICTS as having strong test-retest reliability. Walters (2012) discusses that the PICTS scores correlate with past criminal behaviour and is also useful in predicting future criminality. Thus, there is evidence of predictive validity.

**Interpersonal Reactivity Index (IRI; Davis, 1983).** The IRI measures levels of empathy that an individual feels (Davis, 1983). There are four subscales: Perspective Talking, Fantasy, Empathetic Concern, Personal Distress (Davis, 1983). There are 28 questions in total that are rated on a Likert scale from 1 (does not describe me well) to 5 (describes me very well). It has good psychometric properties including concurrent and construct validity, internal consistency, and reliability (Davis, 1983).

**Understanding of Medication Questionnaire (UMQ; MacPherson, Jerrom, & Hughes, 1996).** The UMQ measures patient knowledge regarding antipsychotic medications (MacPherson et al., 1996). The test contains questions regarding the medication’s role, side effects, cautions, risk and benefits, as well as effects of stopping usage (Zhao, Sampson, Xia, & Jayaram, 2015). The lowest score individuals can get is 0 (no understanding) while the highest score is 35 (full understanding; MacPherson et al., 1996).

**The Short Form International Physical Questionnaire (IPAQ; 1998).** The IPAQ measures physical activity levels and has been used across many populations including psychiatric patients (Craig et al, 2003). Despite having weak to moderate psychometric properties, it would serve as a good comparison of physical activities before and after participating in a group (Craig et al, 2003).

**Group Satisfaction Survey.** This survey was developed by Mackennisie Pritchard to capture client satisfaction with the groups they attended collectively. The intended use is for it to
be completed by clients upon discharge to collect program feedback. This can also help gather data for clients who might be discharged prior to completing some groups.
Chapter IV: Results

The intent of this thesis was to provide Providence Care Hospital Forensic Mental Health Services with an internal program evaluation framework that would allow them to assess the effectiveness and improve implementation of their group intervention.

The program evaluation plan is attached as an appendix. There are six sections, including; program description, evaluation methodology, literature review, current group protocols, recommendations, and assessment measures. To guide the development of this plan, a program logic model was created in collaboration with program staff to provide an operationalized overview of current services. Upon its creation, both reflection and discussion regarding program components and goals were elicited. The program logic model and discussion prompted the formulation of evaluation questions that are the basis of the evaluation framework. The framework also includes indicators, such as the pre-post measures and electronic patient record (ePR) system, that identify how to measure and collect data that produces answers to these questions. This utilization-focused evaluation approach relies on a pre-post design that is outlined in the evaluation plan package. It is hoped that the staff can use this framework to ensure their model of group intervention is aligned with the program’s desired goals. However, the evaluation plan was created with the intention of staff to implement it in the future, so it was not conducted. Until the framework is used and data is collected, its efficacy cannot be confirmed.
Chapter V: Discussion

The development of a program evaluation framework of this thesis fills a gap in terms of program service delivery. The services offered at Providence Care are helpful and meaningful to many clients, yet there are little data to reflect this currently. Program staff identified the need to measure the outcomes of their model of group intervention to determine whether the desired changes are occurring. The evaluation framework contained key evaluation questions pertaining to the desired outcomes of the group interventions. The UFE approach assesses the benefits the intended program users receive (Patton, 2008). This approach is typically used to improve program processes and to inform program decisions (Patton, 2008). Furthermore, some elements of impact evaluation were incorporated to elicit specific data on both intended and unintended outcomes of the program (Peersman, 2015). These two approaches combine both formative and summative evaluation practices.

The first component of the thesis consisted of a literature review highlighting current evidence-based practices in forensic mental health populations. Identifying these interventions confirmed that many of the group interventions Forensic Mental Health Services provides are well supported by research. Moreover, the literature review also provided suggestions of new group interventions to implement or modifications to current groups. Additionally, the literature search also identified assessment measures that will attempt to answer the evaluation questions.

Strengths

This thesis is directly beneficial to Forensic Mental Health Services at Providence Care. Program staff were involved in the development of the evaluation framework, which ensures it meets their needs. By incorporating an evaluation as part of their routine operations, staff can identify service gaps, modifications needed to current group curricula, and client outcomes. It is valuable to know if the group interventions they are offering are meeting the needs of their clients, and this is the intention of the program evaluation.

Furthermore, as mentioned, the evaluation plan was created with the staff in mind. Since the current plan was for them to conduct it themselves, a simple pre-post design was selected to minimize effort and ensure that it was feasible.

The development of the program logic model allowed the staff to critically reflect on the current operation and desired outcomes of their group intervention. There was also discussion on new directions to take to make sure the clients success was maximized.

Limitations

The main limitation of the thesis was that the evaluation framework could not be immediately implemented, so no data have yet been collected. Until data are available, it is hard to say with certainty that it will generate the data the staff ideally want. Moreover, as mentioned there were presentations and discussions pertaining to the program logic model, but there was no formal documentation of staff feedback.

Multilevel Challenges to Program Evaluation

Client level. Clients in the forensic mental health system can be hard to engage in group intervention. Therefore, it might be difficult to obtain the pre-and-post assessments outlined in
the evaluation plan. Similarly, clients might be tempted to give what they assume are desired answers.

**Program level.** The group interventions all have protocols to dictate how the group is to be implemented and what desired outcomes are. However, if different staff implement it at different times, it is likely to affect how clients respond to treatment. Moreover, although clients are strongly encouraged to attend groups, they cannot be forced to.

**Organizational level.** Completing a program evaluation is a large task requiring resources such as staff time. The staff is already busy with their caseloads, so finding time to thoroughly complete the program evaluation might be difficult.

**Societal level.** By routinely completing a program evaluation, staff can make improvements to their services to optimize client success. As clients in the forensic system have difficulty integrating into society, it is important to know how and to what extent the group interventions are helping them reintegrate into the community successfully and safely.

**Recommendations**

Although this program evaluation framework will provide staff with the desired information they identified and is a practical tool to obtain information on program effectiveness, it is recommended that this plan be integrated into program and unit operational plans. If feasible, the evaluation approach to be shifted slightly to formally include staff interviews about group interventions and follow-up interviews with clients to provide data for maintenance of treatment gains. This would be much more time-consuming and hard to complete internally, so hiring an external program evaluator might be considered.

It is imperative to identify and secure resources for the evaluation. Often, the availability of resources such as time and funding influence the approach and scope of an evaluation (BetterEvaluation, n.d.). Some resources to consider for this evaluation plan include designated staff time to conduct the evaluation, necessary funding, and if student involvement could be incorporated (BetterEvaluation, n.d.). Doing so will ensure that the evaluation framework will produce the results needed to contribute to program implementation and improvement (BetterEvaluation, n.d.).

Moreover, information management needs to be considered. This might involve developing a new electronic data repository or database for program evaluation data and/or having additional administrative support for data entry (BetterEvaluation, n.d.). The proposed level of methodological rigor is needed to ensure scientifically-defensible findings.
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Appendix A
Consent to Use Agency Name and Logo

St. Lawrence College
www.stlaw.ca

Date: 24 Nov 2017

Consent for Use of Agency Name

I, Dr. Rebecca Douglas, consent to the use of the name of Providence Care Hospital in Mackenzie Pritchard's applied thesis for the Honours Bachelor of Behavioural Psychology program at St. Lawrence College.

Agency Staff Signature

Student Signature

Printed Name

Printed Name
CONSENT FOR USE OF AGENCY LOGO

I, Rebecca Douglas, consent to the use of the logo of Providence Care Hospital in Mackenzie Pritchard's applied thesis and thesis poster for the Honours Bachelor of Behavioural Psychology program at St. Lawrence College.

Agency Staff Signature
Rebecca Douglas, PSYCH.

Student Signature
Mackenzie Pritchard

Printed Name
Mackenzie Pritchard

Printed Name
Providence Care
### Appendix B

**Program Logic Model**

#### Inputs

<table>
<thead>
<tr>
<th>Component</th>
<th>Activities</th>
<th>Outputs</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment Approach</td>
<td>Assessments</td>
<td>Approximately 20 groups</td>
<td>Rehabilitation/Treatment/Risk Mitigation:</td>
</tr>
<tr>
<td>Person-centered Care</td>
<td>Internal pre-post tests for some groups</td>
<td>20-25 NCR/Rehab Clients</td>
<td>• Skills and knowledge to reduce or stop using substances in assisting with recovery goals</td>
</tr>
<tr>
<td>Evidence Based</td>
<td></td>
<td>5-10 Assessment Clients</td>
<td>• Knowledge and skills to manage their symptoms of psychosis</td>
</tr>
<tr>
<td>Good Stewardship</td>
<td></td>
<td></td>
<td>• Maintains wellness through optimal use of a client's medication regime</td>
</tr>
<tr>
<td>Recovery Model</td>
<td></td>
<td></td>
<td>• Understanding of a variety of topics related to psychosocial education and wellness</td>
</tr>
</tbody>
</table>

#### Team

- Admin Support (1)
- Behavioral Clinic (1)
- Clinical Director (1)
- Occupational Therapists (1.5)
- Operational Director (1)
- Peer Support Worker (0.1)
- Pharmacist (0.5)
- Psychiatrist (2)
- Psychologists (2)
- Recreational Therapist (0.5)
- Registered & Practical Nurses (31)
- Review Board Coordinator (1)
- Social Workers (7)
- Spiritual Health Worker (0.2)
- Transitional Case Manager (1)
- Transitional Care Manager (1)
- Staff, Volunteers, Residents

#### Group Intervention and Care Planning

- Development of Treatment Plans
- Person-centered Care
- Meets client's rights and requirements of ORS
- Menu of therapy groups

#### Rehabilitation/Treatment/Risk Mitigation

- Addictions
- Health Services
- Medication Group
- Meds & Mood
- Mental Health
- Medication Group
- Mood Management
- Peer Support

#### Treatment

- Addictions
- CBT for Psychosis
- IMR
- Living Well
- Life Skills

#### Risk Mitigation

- Addictions
- CBT for Psychosis
- IMR
- Living Well
- Life Skills

#### Resources

- Providence Care Hospital Heritage 0 Unit
- Large Activity Room
- Classroom/Visting Room
- Kitchen/Dining Room
- Conference Group Room
- Secure Courtyard
- Secure Gymnasium

#### Wellness

- Art Group
- Branch Out
- Sleep Group
- Social Skills
- Social Skills Training
- WRAIP

#### Enrichment

- Breakfast & Lunch Skills
- Community Integration
- Leisure Drop-in
- Open Gym

#### Evaluation

- Identified Recovery Goals
- Privilege Requests
- ORS Recommendations
- Community Integration
- Improvement in Functioning and Menthe Stabiliz

#### Intermediate

- Increased functioning and stability
- Improved quality of life
- Decreased utilization of healthcare services

#### Long-term

- In conjunction with psychosocial rehabilitation and other individual therapy, group intervention will:
  - Decrease rates of recidivism
  - Decrease readmission rates at FMS and general mental health services
  - Increase employment engagement
  - Increase housing stability to allow for successful reintegration and community safety upon discharge
1.1. Are the appropriate resources being utilized to support the implementation of group interventions?
2.1. What are the group intervention attendance and engagement rates?
2.2. Are the clients satisfied with various aspects of the group programming?
2.3. Are the clients being referred to appropriate group interventions?
2.4. Is group intervention based on evidence-based practices?
3.1. What role does group intervention have in fostering positive individual change?
3.2. Does the group programming decrease likelihood of readmission?
3.3. Do clients meet their treatment goals?
3.4. To what extent is improved quality of life/functional improvement a result of the group interventions?
3.5 Did the intervention produce the intended results in the short, medium and long term? If so, for whom, to what extent and in what circumstances?
Appendix D
Evaluation Plan Package
PROVIDENCE CARE HOSPITAL

EVALUATION PLAN & FRAMEWORK
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 SECTION 1: PROGRAM DESCRIPTION

FORENSIC MENTAL HEALTH SERVICES

The inpatient Forensic Mental Health (FMH) program at Providence Care is one of ten in Ontario. The program aims to provide effective, evidence based services and risk management while promoting mental health treatment engagement. The services contribute to optimal functioning, reduced risk, and successful community reintegration. Clients are encouraged and referred to participate in group interventions and individual psychotherapy. As well, they are encouraged to find the best medication regimen for themselves. The focus of this evaluation plan is group intervention.

CLIENTELE:

Adults 18+
- Referred by the courts or the Ontario Review Board
- Diagnosed with a major mental illness, such as schizophrenia or bipolar disorder
- Found Unfit to Stand Trial or Not Criminally Responsible (NCR) and here for rehabilitation purposes
- Assessment clients who are here for 30-60 days to be assessed for fitness or criminal responsibility

PURPOSE:

Providence Care Forensic Services will provide innovative and quality client services based on available best practices and the Recovery Model of Care. Creativity will be used in order to maximize available resources for research to enhance services available to clients in an efficient manner. By networking with our community partners, we will manage risk, reduce recidivism and support our clients with their complex needs on their journey to recovery.
STAFFING AND RESOURCES
The interdisciplinary team at FMH encompasses a holistic model of care. As of November 2017, the team consists of:

- Admin Support
- Behavioural Clinician (1)
- Clinical Director (1)*
- Occupational Therapists (1.5)
- Operational Director (1)
- Peer Support Worker
- Pharmacist (0.5)
- Psychiatrists (2) *
- Psychologists (2)
- Recreational Therapist (0.5)
- Registered & Practical Nurses (31)
- Review Board Coordinator (1)
- Social Workers (1)
- Spiritual Health Worker (1)
- Transitional Case Manager (1)
- Transitional Case Manager (AMHS; 1)
- Students, Volunteers, Residents

*One psychiatrist also acts as clinical director

LOCATIONS AND MATERIALS
FMH is located on Heritage 0 of Providence Care Hospital. The current space consists of numerous offices for the interdisciplinary team members, nursing station, and various rooms where groups are offered.

In order to maximize both successful participation and engagement in groups, resources that can be used are outlined below.

<table>
<thead>
<tr>
<th>GROUP INTERVENTION AVAILABLE LOCATIONS</th>
<th>GROUP INTERVENTION AVAILABLE MATERIALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Classroom/Visiting Room</td>
<td>Art supplies</td>
</tr>
<tr>
<td>Conference Group Room</td>
<td>Board Games/Cards</td>
</tr>
<tr>
<td>Kitchen/Dining Room</td>
<td>Computers</td>
</tr>
<tr>
<td>Large Activity Room</td>
<td>iPad</td>
</tr>
<tr>
<td>Secure Courtyard</td>
<td>Kitchen Supplies &amp; Ingredients</td>
</tr>
<tr>
<td>Secure Gymnasium</td>
<td>Musical Instruments</td>
</tr>
</tbody>
</table>

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Televisions</td>
</tr>
<tr>
<td></td>
<td>Yoga Mats</td>
</tr>
</tbody>
</table>
ACTIVITIES
Currently, there are numerous group interventions offered on the unit that are expected to address the clients’ individual needs. This is done through the development of treatment plans. More information regarding the group interventions can be found in section 4 of this evaluation plan.

Assessment Measures: The program uses a variety of standardized measures to guide treatment. However, pre-post group measures are not completed for all groups offered, and as such, the actual impact the groups are having is not certain. Most of the outcome assessments are made anecdotally by staff.

STAKEHOLDER ANALYSIS AND MAP
Team members who are a part of the RPAT committee expressed interest in the overall success of the group intervention model. They are identified in Figure 1. Both formal and informal stakeholder engagement was conducted. This was done through formal meetings and discussions, emails, and informal discussion. Stakeholders who were not involved with the meetings were also identified. The stakeholder map can be found following the analysis.
Table 1: Stakeholder Analysis

<table>
<thead>
<tr>
<th>Stakeholders</th>
<th>Relationship to Program</th>
<th>Interest in Program</th>
<th>Role in Evaluation</th>
</tr>
</thead>
</table>
| Clients/Patients                          | Participant/Recipient of Services | • Access to service  
• Needs being met  
• Impacts of services                  | High Importance  
High Influence  
Primary Stakeholder                        |
| Operational & Clinical Director           | Oversees clinical activities  | • Efficiency  
• Long-term outcomes  
• Coordinated care  
• Use results for planning, to make changes, new implementation, future strategies | High Importance  
High Influence  
Key Stakeholder  
Can provide information and make decisions about evaluation |
| Program Staff                             | Direct Service                | • Service delivery  
• Competency in delivering services  
• Meeting needs of clients  
• Positive impacts/outcomes  
• Use results for planning, to make changes, new implementation, future strategies | High Importance  
High Influence  
Key Stakeholder  
Can provide information and make decisions about evaluation |
| Providence Care Administration/Senior Leadership | Service Accountability | Performance indicators                                                             | Medium Importance  
Keep informed  
Secondary Stakeholder                       |
| Ministry of Health Volunteer Fund         | Funding                       | Budgeting                                                                           | Medium Importance  
Low influence  
Keep informed  
Secondary Stakeholder                       |
| Courts/ORB                                | Referral Source Disposition   | Disposition Privileges                                                               | Medium Importance  
Keep informed  
Tertiary Stakeholder                        |
| Detention Centers                         | Transfers Client information/files |                                                                                | Low Importance  
Tertiary Stakeholder                        |
| Community                                 | Safety                         |                                                                                     | Low Importance  
Tertiary Stakeholder                        |

**Primary Stakeholder**: those who can be positively or negatively directly affected by the services an agency provides.

**Secondary Stakeholder**: those who are positively or negatively indirectly affected by the services an agency provides.

**Tertiary Stakeholder**: their interest stems from indirect benefits from or losses caused by a business.

**Key Stakeholder**: those who could be a primary or secondary stakeholder but they also have a positive or negative effect on the services, or those who are important within an agency.
A program logic model (PLM) was drafted to present the model of group intervention in its current state. The first draft of the model was reviewed by Dr. Rebecca Douglas and Dr. Jan Looman. Some revisions were made, and the PLM was presented at the RPAT meeting to elicit team discussion and feedback. The discussion surrounded the program’s overall desired impacts and areas of strength and improvement. The PLM was also sent as an email attachment to capture additional staff feedback. Feedback regarding content and structure was noted and integrated into the PLM. The questions that emerged from the PLM became the evaluation questions, which serve as the basis of the evaluation framework. See Figure 3 below.
Figure 2. Program Logic Model (PLM)

Forensic Mental Health Services Group Intervention Program Logic Model

Mission: To provide specialized multidisciplinary forensic mental health services for adults with mental illness who have come into contact with the criminal justice system, and to increase the capacity to provide these services through research, teaching, and work with community partners.

INPUTS
- Treatment Approach
  - Person-centered Care
  - Evidence Based
  - Good Stewardship
  - Recovery Model

TEAM
- Admin Support (1)
- Behavioural Clinician (1)
- Clinical Director (1)
- Occupational Therapists (1.5)
- Operational Director (1)
- Peer Support Worker (0.1)
- Pharmacist (0.6)
- Psychologists (2)
- Psychologists (2)
- Recreational Therapist (0.5)
- Registered & Practical Nurses (31)
- Review Board Coordinator (1)
- Social Workers (1)
- Spiritual Health Worker (0.6)
- Transitional Case Manager (1)
- Transitional Case Manager (AMHS: 1)
- Students, Volunteers, Residents

COMPONENTS
- Assessment
  - Development of Treatment Plans
  - Person-centered Care
  - Meets clients' rights and requirements of DRB
  - Mano of therapy groups

ACTIVITIES
- Informal pre-post tests for some groups
- Development of Treatment Plans
- Person-centered Care
- Meets clients’ rights and requirements of DRB
- Mano of therapy groups

OUTPUTS
- Short-term
  - Approximately 20 groups
  - 20-25 NCR/Rehab Clients
  - 5-10 Assessment Clients
  - Assessment measures (i.e. pre-post tests/questionnaires)
  - Attendance rate
  - Participation
  - Engagement rates
  - Documentation (i.e. Progress Notes)

- Intermediate
  - Rehabilitation/Treatment/Risk Mitigation
    - Skills and knowledge to reduce or stop using substances in assisting with recovery goals
    - Knowledge and skills to manage their symptoms of psychosis
    - Maintain wellness through optimal use of a client’s medication regime
    - Understanding of a variety of topics related to psychosocialization and wellness
    - Interpersonal effectiveness, emotion regulation and stress tolerance
    - Improve negative symptoms of Schizophrenia and other psychotic illnesses as well as depression
    - Healthy living, eating, budgeting skills
    - A “self-designed prevention and wellness process that anyone can use to get well and stay well” (Cooleland, 2015)

- Long-term
  - Improved mental and physical wellbeing
  - Intentional Peer Support and discussion
  - Transcend the daily challenges of living on the unit
  - Instilled sense of hope for recovery and the process of change
  - A welcoming and friendly space for clients to enjoy, share and play music
  - Emotional expression through art
  - Learn and utilize relaxation skills

RESOURCES
- Funding
  - Ministry of Health Volunteer Fund
- Materials
  - iPad, computers, kitchen supplies & ingredients, art supplies
  - Board games/cards, yoga mats, musical instruments, TVs
- Space
  - Providence Care Hospital Heritage 0 Unit
  - Large Activity Room
  - Classroom/Visiting Room
  - Kitchen/Dining Room
  - Conference Group Room
  - Secure Courtyard
  - Secure Gymnasium

ENRICHMENT
- Breakfast & Lunch Skills
- Community Integration
- Leisure Drop-in
- Open Gym

WELLNESS
- Art Group
- Branch Out
- Cook Out
- Peer Support
- Relaxation
- Spiritual Recovery
- Uplift Music Night
- Walking Group
- Yoga Group

ENRICHMENT
- Community Integration
- Grocery shopping and budgeting skills
- Cooking skills
- Independent activities, socialization, goal setting, team work, and engagement in treatment
- Physical activity

OTHER
- Group attendance
- Sustained engagement during group
- Symptom management/improvement

In conjunction with psychopharmacotherapy and other individual therapy, group intervention will
- Decrease rates of recidivism
- Decrease re-admission rates at FVHS and general mental health services
- Increase employment engagement
- Increase housing stability to allow for successful reintegration and community safety upon discharge
SECTION 2: EVALUATION METHODOLOGY

PURPOSE OF EVALUATION

Currently, there are numerous group interventions offered on the unit that are expected to address the clients’ individual needs. This is done through the development of treatment plans and by offering invites to closed groups for clients who would benefit from participating. Open groups are also available and allow all clients on the unit to participate. The program uses a variety of standardized measures to guide treatment; however, pre-post group measures are not completed for all groups offered, and as such, the actual impact of the groups are unknown. Most of the outcome measures are anecdotal in nature and given by staff.

As there are no formal procedures currently set in place for determining the effectiveness of the group interventions, the program evaluation will provide information on service gaps, strengths and weaknesses of the group intervention model, and insights regarding the impacts the groups have.

• Furthermore, empirically supported group interventions pertaining to forensic mental health have been identified throughout the literature review, thus providing opportunity to recommend curriculum changes based on best practices and suggestions for summative and formative measures.

By routinely incorporating a program evaluation into their clinical work, the team at Providence Care will be better able to ensure they are providing the appropriate treatment for their clients.
A utilization-focused evaluation (UFE) approach is proposed for the evaluation plan. This approach was developed by Michael Quinn Patton and suggests that programs should be evaluated on the benefits they provide to their intended users (Patton, 2008). The UFE produces findings that can be used to enhance the program through improving processes and informing decisions (Patton, 2008). There are two important aspects of the UFE approach: (a) the primary intended users need to be identified and engaged early on in the evaluation process, and (b) they must be involved in making decisions that guide the evaluation process (Patton, 2008). Moreover, one of the main goals of this evaluation approach is to facilitate discussion and decision making by those who will be using the results of the evaluation (Patton, 2008). Therefore, the evaluator is not making decisions regarding the implementation of programs, but rather providing the intended users of the evaluation with the necessary information to take ownership of the evaluation process and results (Patton & Horton, 2009).

The UFE approach is often used for both formative and summative evaluation designs, as well as many others (Patton, 2008).

Elements of impact evaluation were also included in the framework. The impact evaluation approach focuses on the outcomes, whether expected or unexpected, that an intervention has (Peersman, 2015). This approach must outline what caused the measurable changes (Peersman, 2015). Impact evaluations are carried out to make improvements or changes to an intervention for formative purposes, or to guide decisions about continuing, discarding, or scaling up interventions for summative purposes (Peersman, 2015).

For this evaluation plan, a pre-post design was selected. Eventually, it is recommended that the design be extended to include follow-up data to provide information regarding maintenance of treatment gains. Furthermore, it would be beneficial to conduct staff and client interviews to elicit qualitative information on the treatment program.
EVALUATION QUESTIONS

Based on the discussions with the staff and the program logic model, 11 questions were identified to be answered through the proposed evaluation. They fall under three domains: inputs, process, and impacts.

**INPUTS**
・Are the appropriate resources being utilized to support the implementation of group interventions?

**PROCESS**
・What are the group intervention attendance and engagement rates?
・How do clients perceive various aspects of group programming?
・Are clients being referred to appropriate group interventions?
・Is group intervention based on evidence-based practices?

**IMPACTS**
・What role does group intervention have in fostering positive individual change?
・Does group programming decrease likelihood of readmission?
・Do clients meet their treatment goals?
・To what extent is improved quality of life/functional improvement a result of the group interventions?
・Did the intervention produce the intended results in the short, medium and long term? If so, for whom, to what extent and in what circumstances?
EVALUATION FRAMEWORK

This outlines the evaluation questions, where to find the answers, and how to collect the data.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Evaluation Questions</th>
<th>Indicators</th>
<th>Data Sources/Collection Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. INPUTS Is the FMH program maximizing resources?</td>
<td>1.1. Are the appropriate resources being utilized to support the implementation of group interventions?</td>
<td>Staff utilization&lt;br&gt;Group Cycle Calendar</td>
<td>Staff surveys&lt;br&gt;Staff competency evaluation</td>
</tr>
<tr>
<td></td>
<td>2.1. What are the group intervention attendance and engagement rates?</td>
<td>Participation by group members in closed groups&lt;br&gt;Participation by clients in open groups&lt;br&gt;Group completion rate&lt;br&gt;Client engagement</td>
<td>ePR data&lt;br&gt;Client progress report&lt;br&gt;Attendance&lt;br&gt;Staff interviews</td>
</tr>
<tr>
<td></td>
<td>2.2. How do clients perceive various aspects of the group programming?</td>
<td>Feedback regarding:&lt;br&gt;• Group Menu&lt;br&gt;• Time the groups are offered&lt;br&gt;• Accessibility&lt;br&gt;• Group content&lt;br&gt;• Applicability/usefulness of the group&lt;br&gt;• Strengths/areas of improvement</td>
<td>Client surveys&lt;br&gt;Feedback forms</td>
</tr>
<tr>
<td></td>
<td>2.3. Are clients being referred to appropriate group interventions?</td>
<td>Client treatment plans&lt;br&gt;Assessment of cognitive ability</td>
<td>Individualized treatment/care plans that include suggestions for group treatment&lt;br&gt;Cognitive assessments to ensure</td>
</tr>
<tr>
<td></td>
<td>2.4. Is group intervention based on evidence-based practices?</td>
<td>Literature review&lt;br&gt;Other forensic institutions</td>
<td>Literature review&lt;br&gt;Research</td>
</tr>
</tbody>
</table>
3. IMPACT
Is the group intervention resulting in positive change and supporting their recovery goals (i.e. independent community living?)

<table>
<thead>
<tr>
<th>3.1. What role does group intervention have in fostering positive individual change?</th>
<th>Positive behaviour changes</th>
<th>Client interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Symptom management/reduction</td>
<td>Pre-post measures</td>
</tr>
<tr>
<td></td>
<td>Increased privileges</td>
<td>Staff reports</td>
</tr>
<tr>
<td></td>
<td>Increased independence</td>
<td>ePR</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3.2. Does the group programming decrease likelihood of readmission?</th>
<th>Participation in groups</th>
<th>Chart review</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Readmission rates</td>
<td>ePR</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Admission</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3.3. Do clients meet their treatment goals?</th>
<th>Scores on pre-post measures</th>
<th>Pre-post measures</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Client feedback</td>
<td>Client feedback forms</td>
</tr>
<tr>
<td></td>
<td>Staff observations</td>
<td>Clinical and progress notes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3.4. To what extent is improved quality of life/functional improvement a result of the group interventions?</th>
<th>Scores on pre-post measures</th>
<th>Group participation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Privilege progression</td>
<td>Pre-post measures</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ORB</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Risk assessments</td>
</tr>
</tbody>
</table>

| 3.5 Did the intervention produce the intended results in the short, medium and long term? If so, for whom, to what extent and in what circumstances? |
|----------------------------------------------------------------------------------------------------------------------------------|---------------------------|
|                                                                                                                                  |                           |
|                                                                                                                                  |                           |
SECTION 3: LITERATURE REVIEW

Individuals in the forensic system often have complex needs and pose a threat to public safety. As such, it is difficult to integrate them into treatment with the general mental health population (Rowaert, Vandevenelde, Lemmens & Audenaert, 2017). However, providing services that target both mental health needs and criminal behaviour is imperative for improved functioning in these individuals (Rowaert et al., 2017). As noted, those who act against the law on account of a mental health disorder are often mandated to an inpatient forensic hospital, specifically designed to serve individuals with severe mental illness. This ensures both public safety and opportunity for treatment (Rowaert et al., 2017). There are various rehabilitative interventions outlined in the literature that have been, or could be used for forensic populations. The literature review will provide an overview of evidence-based treatments for the forensic population. Moreover, it will have a focus on the recovery model of care and empirically supported interventions that fall under this model. The forensic population overlaps with both the general mental health and offender populations. Thus, the treatments outlined may have demonstrated efficacy with the three populations.

The literature review was conducted by searching the PsychInfo and PubMed databases. Initially, a broad search of mental health treatment was done. Then, a search for mental health treatment for offenders was conducted. The focus was subsequently narrowed, and mental health treatment for forensic populations was reviewed. Upon reviewing these articles, empirical studies for specific treatments were searched for. Inclusion criteria for the search were peer-reviewed articles outlining treatment options for general, offender, or forensic mental health populations. Additionally, meta-analyses, books, and websites were also reviewed. Exclusion criteria included studies with individuals under 18.

Recovery Oriented Care in Mental Health

Mental health treatment paradigms have previously emphasized clinical definitions of recovery, but the focus of recovery has shifted in recent years (Burgess, Pirkis, Coombs, & Rosen, 2011). Clinical recovery falls under the medical model and is usually measured by decreased symptoms and functional impairment (Burgess et al., 2011). Although this is of high importance, it is equally as important to emphasize client-based definitions of recovery that encompass a sense of purpose, hope, empowerment, and connection (Burgess et al., 2011; Simpson & Penney, 2011). The mental health consumer movement in the 1960s and 1970s led to the recovery model of care (Simpson & Penney, 2011). Pouncey and Lukens (as cited in Simpson & Penney, 2011) describe recovery-oriented care as a way to encourage patient choice, accountability and autonomy. Therefore, eliminating the illness and its symptoms is not the only focus. The premise of recovery-oriented care is using clients’ strengths while addressing their challenges to establish integrity, meaning, mastery, and hope back into their lives (Burgess et al., 2011).

Recovery Oriented Care in Forensic Mental Health

Clients residing in a forensic psychiatric facility have unique treatment needs. As expected, forensic clients often also need the same services as anyone living with mental illness, regardless of criminal involvement, such as psycho-education, symptom management, effective medication, vocational assistance, and positive support systems (Burgess et al., 2011). Furthermore, establishing a sense of purpose, hope, and empowerment is particularly important
for this population (Simpson & Penney, 2011). Thus, best practices of recovery-oriented care should inform treatment services in the forensic institutions (Simpson & Penney, 2011). Although many aspects of the recovery model of care can be used in a forensic inpatient hospital, certain challenges arise. For example, living in a secure facility causes community isolation and limits autonomy (Simpson & Penney, 2011). Moreover, when forensic clients are stable enough to attend community events, engage in job opportunities, or transition into the community living, they are often stigmatized and as such, face difficulty integrating (Simpson & Penney, 2011). Despite the challenges of stigmatization, offering client-centered approaches is a holistic way to improve treatment outcomes in forensic settings by promoting goal setting and achievement. Various therapeutic group interventions with a recovery focus should take place in conjunction with medication to yield significant improvements.

Evidence-Based Mental Health Treatment in Forensic Mental Health

Aligned with the recovery model, Drake, O’Neal, and Wallach (2001) assert that treatment for people with mental illness needs to encompass their own goals. As with anyone with a chronic illness, individuals with mental health disorders generally want to optimally function in society (Drake, O’Neal, and Wallach, 2001). The emphasis on treatment outcomes such as increased independence, vocational success, beneficial relationships, and overall improved quality of life stems from the recovery model of care and should be implemented in forensic institutions though evidence-based practice (Drake et al., 2001). Individuals with mental illness have the right to participate in treatment that has been implemented consistent with evidence-based practices (Drake et al., 2001). Offering interventions with less empirical support can also be of value when used in conjunction with evidence-based interventions (Drake et al., 2001). However, problems arise when interventions with minimal or no evidence are offered solely instead of empirically supported treatment (Drake et al., 2001).

Notably, there is vast evidence supporting interventions that adhere to the Risk-Need-Responsivity (RNR) principles when treating offenders with mental illness (Morgan et al., 2012). These principles are grounded in matching the risk level of the client to the level of service intensity, targeting criminogenic needs, and providing individualized Cognitive Behavioural Therapy (CBT) techniques (Morgan et al., 2012). Livingston, Chu, Milne, and Brink (2015) discuss a theoretical model developed by Prins and Draper that applies the RNR principles and suggest that both criminogenic needs and degree of functional impairment must guide treatment. These two factors should dictate the intensity mental health treatment and its synchronization with the criminal justice system (Livingston, Chu, Milne, & Brink, 2015).

Morgan and Winterowd (2002) discuss evidence suggesting that open admission groups (i.e., groups that allow members to join at any time) produce more favorable outcomes than those with closed admission policies (i.e., members can only join at the very start) in forensic units. Open admission is also consistently recommended for group therapy offered in the general mental health system (Kanas, as cited in Morgan et al., 2012). Morgan and Winterowd attributed this to the continuous learning offered by new clients who join the group and share their experiences. This is something to consider when implementing group therapies.

Bonta and Andrews (2017) highlight interventions that do not have sufficient empirical evidence for use within correctional or forensic settings, such as highly punitive treatments like boot camps, solely psychodynamic approaches, and programs that do not target criminogenic needs. However, as the recovery model of care is increasingly used to inform services, there has been less emphasis on RNR principles, especially in forensic psychiatric facilities (Simpson &
Penney, 2011). There is increasing evidence supporting interventions that do not target criminogenic needs as therapeutically beneficial for forensic clients by decreasing stigma and criminalization of forensic clients (Simpson & Penney, 2011).

**Psycho-educational groups.** Psycho-education is a key component of providing treatment to those with mental illness across various settings. This involves teaching clients about their illness and the associated symptoms, as well as discussing barriers, challenges, and coping strategies (Vallentine, Tapp, Dudley, Wilson, & Moore, 2010). Psycho-education can address self and peer stigmatization through cognitive restructuring (Yanos, Roe, West, Smith, & Lysaker, 2012). Vallentine et al., proposed that when clients have increased insight into their illness, they are more likely to adhere to their treatment plan. Furthermore, psycho-education allows clients to attribute an explanation to their experiences, reducing distress (Yanos et al., 2012). However, it is noted that improved insight can sometimes cause an increased sense of hopelessness and lowered self-esteem because of the (Hasson-Ohayon, Kravetz, Roe, David, & Weiser, 2006).

Despite its importance, there are some barriers to implementing psycho-educational groups in high-secure facilities, including treatment resistance, illness severity, and risk management (Yanos et al., 2012). Involving family members into psycho-educational groups is common and often aids in the success of such a group, but doing so is not always feasible in forensic settings due to ethical reasons, such as confidentiality or because offences may have been against family members (Vallentine et al., 2010). Vallentine, Tapp, Dudley, Wilson, and Moore (2010) analyzed the effectiveness of a psycho-educational group in a forensic hospital, predicting improved over-all wellbeing and mental state. They used two pre-post measures, the Clinical Outcomes in Routine Evaluation (CORE-OM) and The Self-Concept Questionnaire (SCQ) to examine three modules that focused on schizophrenia, depression, and anxiety (Vallentine et al., 2010). The results of the pre-post tests indicated that clinically and statistically significant and reliable changes occurred in terms of life-functioning. The authors found that more than 50% of participants indicated a positive change in scores on the CORE-OM, while a small percentage reported no change. The results of the SCQ suggested that 50% of participants indicated improved self-esteem, while the rest reported either no change or a decrease in self-esteem (Vallentine et al., 2010). Beneficially, psycho-education groups can be offered to all clients despite their different needs (Aho-Mustonen et al., 2011). A study completed by Aho-Mustonen (2011) demonstrated results consistent with the Vallentine et al study. Immediately following, and three months post-treatment, participants demonstrated improved knowledge and insight about their symptoms after participation in a psycho-educational group implemented for forensic clients with schizophrenia (Aho-Mustonen, 2011).

**Cognitive behavioural therapy.** For years, Cognitive Behavioural Therapy (CBT) has improved the mental health of numerous populations (Lovell & Richards, 2000). Considered an evidence-based treatment consisting of techniques such as problem solving, cognitive restructuring, behavioural activation, and relapse prevention, CBT has demonstrated success in cultivating positive changes in mental health (Wenzel, 2017).

CBT is often used with offender and forensic populations because of its adherence to the RNR model (Bonta & Andrews, 2017). Bonta and Andrews (2017) identified antisocial personality traits as being one of the Big Four criminogenic needs, and these needs are commonly addressed in cognitive behavioural interventions. Targeted traits include impulsivity, problem-solving, emotional regulation, and negative automatic thoughts (Bonta & Andrews, 2017). The length and intensity of a CBT program should be dependent on the needs of the client.
One way to determine the intensity of services required by clients is to use the Level of Service Inventory—Ontario Revision which indicated their needs (LSI-OR; Bonta & Andrews, 2007). Using this scale would allow different CBT groups to be implemented that target a wider range of risk levels.

Williams, Ferrito, and Tapp (2014) completed a study that used CBT in a secure forensic hospital for individuals with schizophrenia. They used standardized measures to assess positive and negative symptoms as well as interpersonal functioning. CBT group participants showed improvement on negative symptoms and interpersonal functioning as compared to treatment as usual (TAU) participants.

Travers, Mann, and Hollin (2014) implemented a cognitive skills training program called Enhanced Thinking Skills (ETS) with adult offenders. They assessed whether or not ETS demonstrated comparable levels of effectiveness across individuals who had committed different types of offences. For example, does ETS elicit the same results for those who were convicted for theft as it does for violent offenders? This program is commonly offered to offenders in England and Wales. It targets impulse control, thought patterns, values, moral reasoning, critical thinking, and interpersonal problem-solving (Travers, Mann, & Hollin, 2014). The focus is on clients’ reasoning rather than on the actual content of their thoughts (Travers et al., 2014). The sessions use role-playing, discussion, and homework exercises to interactively teach the material to offenders with mental illness (Travers et al., 2014). In Travers et al.’s study, 21,373 adult male offenders who had participated in the ETS program while in custody were followed for a minimum of two years post-release. They used a manual developed by Clark in 2000, which outlines the skills the program is designed to build upon (Travers et al., 2014). To differentiate the risk of recidivism between the participants, the Offender Group Reconviction Scale (OGRS) was used (Travers et al., 2014). This measures the static variables of an offender while also looking at demographic variables to predict risk of recidivism. Static variables are characteristics that predict recidivism but are not changeable with intervention, such as prior criminal offences (Bonta & Andrews, 2017). Dynamic risk factors also predict the risk of recidivism, but are changeable with intervention, such as substance use (Andrews & Bonta, 2017). The participants were grouped by offense type and risk level (Travers et al., 2014). The study found that that rates of recidivism for ETS participants were significantly lower than predicted across all offense types, excluding those in high-level drug dealing, and robbery. However, since there was no control group in the study, it is hard to definitively attribute the decrease to ETS, although the authors point out their findings were consistent with previous studies, suggesting that cognitive skills training is a highly evidence-based treatment to decrease reoffending. Travers et al., also point out the importance of adhering to the responsivity principle of the RNR model in that this intervention seemed to be more valuable to violent offenders than serious acquisitive offenders. Since the ETS program has had documented success with offenders, it has potential to be a worthwhile CBT program to implement in forensic mental health settings.

Timmerman and Emmelkamp (2005) discuss several studies that support CBT in forensic settings, but assert that treatment success varies vastly across studies. In forensic psychiatry, the definition of successful treatment for mental illness is highly variable (Timmerman & Emmelkamp, 2005). Structured treatment, such as CBT, is significantly more effective across different diagnoses compared to unstructured treatment (Timmerman & Emmelkamp, 2005). Timmerman and Emmelkamp measured coping skills, social awareness, self-esteem, anger, anxiety, and psychological distress in forensic inpatients. Thirty-nine clients participated in a CBT-based intervention. The focus was on behavioural modification techniques such as
reinforcement and shaping, along with cognitive restructuring skill building (Timmerman & Emmelkamp, 2005). These were incorporated into the multidisciplinary treatments the clients were already involved in, as well as through specific cognitive skills training sessions (Timmerman & Emmelkamp, 2005). Several pre-post measures were used to assess changes in cognition and behaviour, such as the Symptom Checklist, The Dissociation Questionnaire, and the Utrecht Coping List. Overall, the results confirmed that using CBT techniques contributed to increased coping skills, interpersonal functioning, and general well-being (Timmerman & Emmelkamp, 2005).

Rees-Jones, Gudjonsson, and Young (2012) implemented a cognitive skill building program called Reasoning & Rehabilitation (R&R). R&R was among the first manualized programs designed to be used for the treatment of antisocial behaviours in offenders (Rees-Jones, Gudjonsson, & Young, 2012). It was designed to encourage prosocial behaviour through making gains in cognitive and social skills, as well as highlighting values (Rees-Jones et al., 2012). Sixty-seven forensic inpatients participated in a modified version of R&R that was designed to adhere to the responsivity principle (Rees-Jones et al., 2012). The Reasoning & Rehabilitation Mental Health Program (R&R MHP) works to promote client engagement in the program by including individual mentoring between group sessions to reinforce learned content (Bonta & Andrews, 2017). Rees-Jones et al., compared measures for R&R MHP participants and a control group of clients receiving TAU. The authors discussed the low drop-out rate for R&R MHP, linking it to mentoring between sessions and the fewer number of sessions, which also encouraged higher levels of retention. When compared to the TAU group, the findings of this study implicate R&R as a beneficial cognitive skill building group for forensic clients that led to significant and durable improvements in prosocial behaviours and thoughts.

Anger management. Henwood, Chou, and Browne (2015) conducted a meta-analysis of 14 studies to determine the effectiveness of CBT groups to reduce anger in offender populations. Their analysis confirmed the effectiveness of CBT in reducing anger, hostility, violent reactions, and general recidivism. CBT groups are commonly used to regulate anger by teaching how to think in a manner incompatible with anger to challenge negative cognitions (Henwood, Chou, & Browne, 2015). As well, providing alternative, more realistic, rationalizations for precipitating events helps individuals act in a less hostile or violent way (Howells, 1998). Furthermore, CBT groups teach ways to reduce physiological states of anger through breathing and visualization strategies (Novaco, 2011).

Wilson et al., (2013) evaluated a group-based CBT anger management intervention in a forensic mental health setting. Eighty-six inpatients participated in 20 sessions and were assessed using self-report measures to capture changes in anger, as well as documented aggressive incidents (Wilson et al., 2013). Scores on both the RAMAS Anger Assessment Profile and State-Trait Anger Expression Inventory-2 indicated significant improvements in coping skills and emotional control for CBT anger management participants compared to the control group (Wilson et al., 2013). The post-test indicated the forensic clients identified decreases in anger and felt that they were better equipped to cope with anger (Wilson et al., 2013). Moreover, there were fewer reports of aggressive incidence after group participation (Wilson et al., 2013). Therefore, implementing a CBT-based anger management program is beneficial to hospitalized forensic clients.

Psychosis. Hornsveld and Nijman (2005) compared 16 chronically psychotic forensic inpatients who participated in a CBT group to 16 inpatients who engaged in TAU. Those receiving CBT showed significant improvements across several subscales of the MI Observation...
scales, especially in social skills and coping skills (Hornsveld & Nijman, 2005). The Positive and Negative Syndrome Scale (PANSS) was also used, but there were no clinically or statistically significant differences between the CBT and control groups. Moreover, a meta-analysis conducted by Zimmermann, Favrod, Trieu, and Pomini (2005) explored the efficacy of CBT for psychiatric patients experiencing positive symptoms of schizophrenia. Their analysis, which included 14 studies with a total of 1484 psychiatric patients, supported CBT as an adjunct to medication to improve positive symptoms. The results showed consistent large decreases in symptoms for CBT participants. However, it should be noted that this reduction in symptoms was greater for those with acute rather than chronic symptoms of psychosis (Zimmermann, Favrod, Trieu, & Pomini, 2005). As such, implementing a CBT group for forensic clients with psychosis is likely to improve symptoms.

**Relapse prevention.** CBT also acts to prevent criminogenic relapse for forensic clients. Skeem, Steadman, and Manchak (2015) argue that simply targeting the symptoms of mental illness will not have an effect on criminal behaviour, and as such, group interventions should target criminogenic risk factors. Implementing a CBT group conceptualized around the RNR principles is a positive approach that works with forensic clients’ strengths and goals (Mitchell, Wormith & Tafrate, 2016). CBT guided by the RNR principles teaches new skills, cognitions and thinking patterns, as well as routines that work against risk factors, thus reducing overall risk (Andrews, Bonta, & Wormith, 2011). Dynamic risk factors can be addressed through CBT in a positive fashion, such as by encouraging prosocial behaviours (Mitchell, Wormith & Tafrate, 2016). Andrews et al., (1990) conducted a meta-analysis of 80 studies where CBT based on the RNR principles was delivered to forensic patients. The recidivism rates of those who participated in RNR guided treatment decreased by approximately 50%, while the rates of recidivism did not change for those who engaged in non-CBT interventions or CBT interventions that did not target criminogenic needs (Andrews et al., 1990). Such interventions have also demonstrated success for individuals who have sexually offended or were convicted of domestic violence (Lösel & Schmucker, 2005; Babcock, Green, & Robie, 2004). Therefore, when CBT is delivered in adherence with the RNR principles, it may lead to reduced recidivism.

**Sexual offending.** Oftentimes, adjudicated sexual offenders in Canada will return to live in the community at some point, so it is important that treatment is delivered while they are in custody (Jeglic, Hanson, & Calkins, 2016). If they are in a forensic psychiatric hospital, treatment opportunity is heightened (Jeglic et al., 2016). Interventions that focus on triggers are often successful in reducing recidivism (Jeglic et al., 2016). Frequently, in forensic settings sexual offenders are given a DSM diagnosis, for example paraphilia, and are subsequently treated with medication to reduce their sex drive, along with counselling (Jeglic et al., 2016). Again, the importance of applying RNR principles is highlighted by the authors. Treatment of sexual offending is strongly rooted in behavioural therapy (Andrews et al., 1990). Much of the treatment for sexual offending uses general CBT techniques (Jeglic et al., 2016). Jeglic et al., suggest that CBT can also target certain criminogenic factors related to sexual offences. A meta-analysis of 46 studies conducted by Helmust, Hanson, Babchishin, and Mann (2013) examined attitudes and cognitions that predicted recidivism. For example, believing children are provocative or women encourage rape by dressing a certain way are common myths that can be addressed in CBT (Jeglic et al., 2016). The therapist will lead group participants to recognize, label, and challenge cognitions and subsequently think of a more appropriate response (Jeglic et al., 2016). Furthermore, Mann, Hanson, and Thornton (2010) argue that problem-solving skill deficits are often identified in sexual offenders; this skill can be developed in a CBT group.
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(Jeglic et al., 2016). Jeglic et al., state that the opportunity to discuss potential solutions to problem behaviours or thoughts with other group members is particularly beneficial, indicating that a group format is desirable. Overall, CBT proves to be an effective group intervention in forensic psychiatric hospitals for a variety of concerns. CBT has one of the largest evidence basis when treating offenders and individuals with mental illness. It can address various needs for clients across different risk levels.

**Dialectical behavioural therapy.** Bonta and Andrews (2007) underline that certain risk factors associated with antisocial behaviour, such as substance use, antisocial thought patterns, and antisocial peers, have a more significant relationship with recidivism than any symptoms of mental illness do, indicating the need to target both risk factors and symptoms. Dialectical Behaviour Therapy (DBT) is increasingly incorporated into psychiatric treatment due to its ability to increase pro-social behaviour while minimizing antisocial behaviour (Evershed et al., 2003). DBT was initially developed by Marsha Linehan to treat those with borderline personality disorder to decrease emotional dysregulation and suicidal ideation (Tomlinson & Hoaken, 2017). DBT uses mindfulness and group skills training that aim to reduce emotional dysregulation, negative emotions, and self-injurious behaviour, while also working to improve distress tolerance and interpersonal relationships (Tomlinson & Hoaken, 2017). Often, DBT includes an individual psychotherapy component. However, Tomlinson and Hoaken’s (2017) examined the effectiveness of only implementing a skill-building DBT group in a forensic unit. They followed Linehan’s manual closely. The participants were split into two groups, TAU or DBT (Tomlinson & Hoaken, 2017). One group participated in DBT for the first six months while the other group participated in TAU; once the first DBT group ended, the TAU participants started DBT training (Tomlinson & Hoaken, 2017). There were no notable behavioural changes between the DBT and TAU group on various pre-post measures during the first six months (Tomlinson & Hoaken, 2017). Both groups of participants showed comparable decreases in hostility. However, it was noted that the TAU clients varied significantly in their scores, with some deteriorating in the first six months, whereas all DBT participants remained stable or improved across all measures (Tomlinson & Hoaken, 2017). The authors noted that the greatest improvements were seen in first the six months following the DBT sessions. Likewise, Evershed et al., (2003) reported that forensic inpatients in their DBT group made more positive and lasting changes regarding violent behaviour and in self-reported anger and hostility.

Berzins and Trestman (2004) discuss various ways of implementing DBT for forensic populations; many implement slightly modified versions of it, simplifying language or modifying the content to be more applicable. Correctional Services Canada (CSC) offers DBT to their offender populations (Berzins & Trestman, 2004). Suitable clients receive one to two hours of skills training each week, but cannot progress through the material until behavioural changes are recorded (Berzins & Trestman, 2004). CSC also incorporates a session that teaches clients about the crime cycle through behavioural chains (Berzins & Trestman, 2004).

Recently, self-regulation has become a focus in the treatment of sex offenders in mental health settings (Reid, Beauregard, Fedina, & Frith, 2014). Emotional dysregulation has been connected to recidivism among sexual offenders (Reid et al., 2014). Although additional research is needed, DBT addresses self-regulation within three of its modules, thus potentially being an effective therapy for sexual offenders (Reid et al., 2014).

McCann, Ball, and Ivanoff (2000) outline various reasons why using DBT-based therapies is valuable in forensic settings. These include: the prevalence of clients with personality disorder is
generally high; the clearly structured cognitive behavioural therapy basis has demonstrated efficacy in many populations, including general mental health, offenders, and forensic mental health; and the potential for alleviating violent behaviours, which is beneficial to the overall well-being of all on a forensic unit. DBT has many possible benefits for the whole forensic population, but may be particularly useful for those with personality disorders.

**Occupational therapy.** The forensic population faces barriers to some rehabilitation opportunities because of the restrictive settings they live in. For example, despite occupation being highly important and empowering to people, forensic clients often cannot participate in such activities due to risk management limitations (Farnworth, Nikitin, & Fossey, 2004). Farnworth, Nikitin, and Fossey (2004) explored how forensic inpatients spent their time through examining eight participants’ time diaries, clinical notes, and interviews over five weeks. Many of the clients reported that they were dissatisfied with how they spent their time and that the system prevented them from partaking in worthwhile activities (Farnworth, et al., 2004). Clients reported higher quality of life when involved in a meaningful activity, partly due to increased community connection (Farnworth, et al., 2004). The authors found that using the clients’ past employment experiences, skill sets, and interests to offer opportunities that cultivate resourcefulness and purpose can be beneficial within forensic mental health (Farnworth, et al., 2004). Providing clients with valuable activities and improving their ability to perform independent living skills can greatly increase their quality of life. CAMH (n.d.) recommends life skills programs for forensic clients, which is often something that occupational therapists (OTs) can work on in a group setting. OTs also use sensory-based approaches for some clients who may benefit from them. (Champagne, 2005).

**WRAP.** OTs embody person-centered and holistic interventions (American Occupational Therapy Association, 2008). An intervention well suited for OTs to implement is the Wellness Recovery Action Plan (WRAP; Gardner, Dong-Olson, Castronovo, Hess, & Lawless, 2012). WRAP is a group intervention that encourages participation in activities and occupations that foster clients’ recovery (Gardner et al., 2012). WRAP allows members to discuss and monitor unwanted feelings and behaviours, while building a plan to eliminate them (Copeland, 2015). A main goal of WRAP is to encourage self-management. Facilitated by trained staff, group members work to build an action plan that incorporates six sections: daily maintenance plan; triggers; early warning signs; escalation/crisis signs; crisis planning; post crisis plan (Copeland, 2001, 2015). It is feasible to implement in various settings as only a few inexpensive materials are needed.

The impacts of WRAP can be measured using the pre-post assessment designed by Copeland (Gardner et al., 2012). Cook et al., (2010) completed a study to assess WRAP as a peer-led group. They looked at factors such as symptom reduction and management, as well as quality of life post-intervention and at a 6-month follow-up (Cook et al., 2010). Five-hundred and ninety individuals diagnosed with complex mental illnesses participated and were assigned randomly to an 8-week implementation of WRAP or a waitlist control group (Cook et al., 2010). Immediately following treatment and at six-month follow-up, the WRAP clients: displayed significant decreases on the Brief Symptom Inventory, Global Symptom Severity, and Positive Symptom Total, reported fewer feelings of hopelessness, improved insight, increased coping strategies, and expressed better overall quality of life as assessed by the World Health Organization Quality of Life-BREF environment subscale (Cook et al., 2012). These results indicate that peer-led WRAP training helps in mental health recovery and should be considered when offering people-centered care (Cook et al., 2012). Additionally, another study conducted
by Cook et al., (2012) measured clients’ anxiety and depression before and after WRAP. WRAP participants reported had significantly greater reductions on the anxiety and depression subscales of the Brief Symptom Inventory compared to those in the control group (Cook et al., 2012). Moreover, WRAP participants’ scores also showed significant improvement on the confidence and goal setting subscales, indicating that participation in WRAP reduced clients’ anxiety and depression while improving their outlook on recovery (Cook et al., 2012). Fukui et al’s (2011) findings were consistent with the previously mentioned studies, indicating reduction in depressive symptoms and increased feelings of hope. Likewise, Buffington (2003) followed up 234 WRAP participants. Post-intervention results indicated regular use of the individualized WRAP plans (Buffington, 2003). At three-month follow-up, 140 of the 234 participants agreed to complete a survey (Buffington, 2003). All 140 participants reported feelings of increased hope regarding their treatment than they had prior to participating in WRAP (Buffington, 2003). Furthermore, O’Keeffe, Hickey, Lane, and Clark (2015) discuss the improvement WRAP fostered in addictive behaviour and identity and self-esteem. They measured quality of life, anxiety, and depression using the Mental Health Recovery Star, Beck Depression Inventory- II, Hospital Anxiety and Depression Scale, as well as the World Health Organization Quality of Life-BREF (O’Keeffe, Hickey, Lane, & Clark, 2015). These tests were administered pre and post intervention as well as at six-month follow-up (O’Keeffe et al., 2015). The results suggested WRAP did not have a large impact on personal recovery, quality of life, or psychiatric symptoms, but did have a positive effect on substance use behaviours and improved self-esteem (O’Keeffe et al, 2015). However, it is likely that if decreased substance use and increased self-esteem occur, than the chances of recovery and quality of life will improve. O’Keeffe et al., did not find significant changes in quality of life or symptoms. They recommend further research to measure the success of WRAP across various domains. Despite this, there are many reported benefits and personal gains seen in many studies that have used WRAP.

**Vocational training.** Employment is a vital component of life, with known benefits of reduced recidivism and increased sense of meaning (Davis & Rinaldi, 2004). Employment provides structure, reinforces pro-social behaviour, and broadens one’s network (Davis & Rinaldi, 2004). Davis and Rinaldi (2004) underline that although 90% of individuals with mental illness report a desire to work, only 24% succeed in maintaining employment. Implementing vocational training groups can greatly improve post-release employment outcomes for individuals with mental illness and is often provided by occupational therapists (Davis & Rinaldi, 2004). In this study, OTs used a multilevel approach in which they worked with clients who were receiving mental health treatment to simultaneously promote short-term vocational interventions (Davis & Rinaldi, 2004). The OTs created vocational profiles that evaluated motivation and beliefs that prevented clients from working, as well as their current routines, commitments, education, employment history, and mental status to help clients find and maintain appropriate employment (Davis & Rinaldi, 2004). Blankertz and Robinson (1996) randomly assigned 122 clients to a vocational group or to a control group. The vocational group taught necessary skills for employment and interpersonal effectiveness (Blankertz & Robinson, 1996). At nine months post-group, 34 of 61 clients were employed and all participants showed higher levels of skill acquisition and reported positive shifts in attitudes regarding vocation (Blankertz & Robinson, 1996). For forensic inpatients with privileges, vocational training functions as a positive tool to cultivate meaningful activity back into their lives, as well as restoring an important life skill.
Schema-focused therapy. Schema focused therapy (SFT) combines cognitive behavioural, psychodynamic, and humanist approaches and was originally devised to offer treatment alternatives to clients with personality disorders (Young et al., 2003). SFT focuses on Early Maladaptive Schemas (EMS), which are persistent maladaptive thoughts and behaviours that result from negative childhood experiences (Bernstein, Antz, & Vos, 2007). These schemas tend to greatly influence behaviour and can instigate powerful emotions as they progress through life (Bernstein, et al., 2007). GiesenBloo et al., (2006) noted considerable improvements in symptoms and overall functioning in clients with Borderline Personality Disorder (BPD) across a three-year SFT intervention, and at follow-up one-year post treatment. Forensic clients with personality disorders face increased risk of recidivism once released from a secure psychiatric hospital compared to those with another diagnosis (Jamieson & Taylor, 2004). Thus, offering interventions for clients with personality disorders is highly important. SFT was not developed for forensic populations, but it can be adapted to meet the unique needs of these clients, which is what Bernstein, Arntz, and Vos (2007) aimed to do in their study. In SFT developed by Young, there are 18 identified schemas, but Bernstein et al., suggested the inclusion of an additional four modes that more appropriately encompass the needs for forensic clients. These include the Angry Protector Mode, Predator Mode, Conning and Manipulative Mode, and Over-controller Mode (Bernstein et al., 2007). Bernstein et al., note that SFT can be more effective than cognitive behavioural techniques for clients with personality disorders because of its focus on changing maladaptive schemas commonly found in those with personality disorders. The goal of SFT in forensic settings is to optimistically foster personality change that results in decreased antisocial behaviour (Bernstein et al., 2007). Although these findings are encouraging, they should be considered preliminary and the authors suggest further examination of SFT in forensic settings. A recent study assessed whether implementing an intervention that combined principles from SFT and DBT was effective in treating Borderline Personality Disorder (Leppänen, Kärki, Saariaho, Lindeman, & Hakko, 2015). The study found a statistically significant decrease in eight of 18 schemas for the clients receiving the combined therapy for a year, compared to those receiving TAU. TAU clients showed no change across any schemas, suggesting the effectiveness of SFT and DBT used together for those with BPD (Leppänen et al., 2015). Similarly, Farrell, Shaw, and Webber (2009) assessed how 30 sessions of group SFT compared to TAU for clients with BPD. The clients participating in the SFT group noted significant reductions in severity of BPD and overall psychiatric symptoms, which coincided with improved functioning overall (Farrell, Shaw, & Webber, 2009). Farrell et al., (2009) claimed that 94% of SFT group participants no longer met the criteria for BPD, compared to only 16% of those participating in TAU, again indicating the possible benefits of using an SFT group for forensic clients with personality disorders. SFT is a worthwhile intervention in forensic facilities, especially when offered to clients diagnosed with BPD.

Family interventions. Despite the recognized value of incorporating clients’ families into treatment when it would be therapeutically beneficial, it is difficult to implement in secure forensic units (Davies, Mallows, Easton, Morrey, & Wood, 2014). Family therapy was originally designed for adults with schizophrenia, as it was hypothesized that mental illness symptoms would subside with strengthened familial relationships (Bertrand, 2006). The implementation of family therapy in medium secure forensic units was examined through semi-structured interviews with clients, therapists, family members, and staff (Davies et al., 2014). The interviews suggested that family therapy is valuable to the clients and family, especially in
regard to discharge planning and providing social support (Davies et al., 2014). The staff also identified barriers to implementing family therapy, such as not being trained to do so. Systemic family therapy is beneficial as it does not follow a predetermined approach or focus solely on one diagnosis; rather, it tends to be flexible and allows the family to dictate the topics discussed (Davies et al., 2014). However, other approaches, such as behavioural family therapy, have also been successful in identifying relapse triggers and prevention strategies, decreasing distress, increasing insight and knowledge regarding mental health, and increasing problem-solving skills (Davies et al., 2014). Such topics are often discussed in therapy groups, but the family is seldom included (Davies et al., 2014). Involving the family can enrich the interdisciplinary team by adding new perspectives to improve discharge planning, and increasing clients’ support networks through improving their family dynamics (Davies et al., 2014). However, with the unique needs of the forensic population, implementing family therapy has its challenges. Staff training in family therapy is often minimal, families may hinder client’s progress, or a family member may have been the victim of the client’s offence (Davies et al., 2014). For these reasons, it is important to ensure that staff are competent to implement family therapy and only recommend it for clients and their families who would benefit therapeutically from it (Davies et al., 2014).

Furthermore, psycho-educational groups for families can help in relieving the burden felt by family members (McDonnell, Short, Berry, & Dyck, 2003). These burdens include stigma, emotional distress, and uncertainty about how to interact with their ill family member (McDonell et al., 2003). Family psycho-education interventions are considered to be best-practice in the treatment of schizophrenia, and have also consistently decreased relapse and improved symptoms (McDonnell et al., 2014; Lehman & Steinwachs, 1998). Multiple Group Family Therapy (MGFT) involves psycho-education and behavioural therapy in a format consisting of multiple families (McFarlane, 2002). Equipping families with both the knowledge and resources needed to cope with the challenges their family member’s illness imposes, will likely lead to improved relationships between family members. (McDonell, Short, Berry, and Dyck, 2003). A psycho-educational group designed for family members of forensic clients can be beneficial in numerous ways and promotes peer support for them.

**Cognitive remediation.** Cognitive remediation therapy is designed to improve cognition in clients with schizophrenia (Wykes et al., 2007). By improving cognition, it is hypothesized that overall functioning will increase (Wykes et al., 2007). Wykes et al., (2007) followed the cognitive mediation manual developed by Delahunty et al., which includes 40 sessions of skill-building practice (Wykes et al., 2007). They randomly assigned 43 clients with schizophrenia to cognitive remediation, and 42 clients to a control group. The findings suggest lasting cognitive advancement, as measured six months post-treatment (Wykes et al., 2007). Along with this, there was a significant increase in cognitive flexibility which continued to improve after treatment (Wykes et al., 2007). The authors suspect that this is due to the group positively reinforcing the use of the cognitive system (Wykes et al., 2007). Reinforcement was derived from tasks given in groups and the increased self-esteem and self-efficacy (Wykes et al., 2007). There is growing evidence suggesting that cognitive remediation may serve as a useful group for forensic inpatients, particularly those with schizophrenia.

**Substance use.** Those with mental illness are three times more likely to have problematic substance use or a substance use disorder than the general population, likely due to self-medicating to reduce positive symptoms (Regier et al., 1990). Treatment for substance use is therefore vital in the mental health population. When implementing substance abuse interventions, it is important to consider the biopsychosocial perspective (Herie & Skinner,
Although not an approach, this perspective can help guide the treatment programs so that they encompass three domains-- biological, psychological, and sociological - and aim to treat substance use problems through targeting all three of these aspects (Herie & Skinner, 2014). Treatment for concurrent disorders is often most successful when both concerns are addressed simultaneously, but in some cases, it is best to treat the substance use first (CAMH, n.d.).

**Motivational interviewing.** Originally created to treat substance abuse, motivational interviewing has demonstrated effectiveness in increasing motivation for behavioural change (Heather, Rollnick, & Bell, 1993). Motivational interviewing encourages ambivalent clients to commit to change (Heather et al., 1993). It has been utilized with offender populations and has proven efficacy to foster increased motivation to change (Heather et al., 1993). Research does not demonstrate effectiveness when implemented on its own. However, it is helpful as a component of treatment (Merlo et al., 2010).

**Group counselling.** Drake, O’Neal, and Wallach (2008) conducted a systematic review of psychosocial interventions for people with concurrent disorders. Although the group interventions varied across studies, there were some common factors; they were often implemented for at least six months in length, used CBT strategies, and were aligned with the stages of change model (Drake, O’Neal, & Wallach, 2008). The review included eight studies which provided education, peer support, and coping strategies (Drake et al., 2008). All studies demonstrated significant positive changes in substance use and associated beliefs, attitudes, and behaviours (Drake et al., 2008). Notably, significant changes arose from interventions using CBT techniques, social skills training, and contingency management, especially for clients with both schizophrenia and a substance use disorder (Bellack, Bennett, Gearon, Brown, & Yang, 2006). CBT interventions have also been effective in the treatment of substance use in clients with bipolar disorder (Weiss et al., 2007).

Given the efficacy of group CBT in treating various populations and concerns, it might be well-suited to treat substance use in a forensic setting (Bonta & Andrews, 2017). In group intervention for substance use, it is important that clients recognize stages of change, their personal triggers, and the physical and mental effects drugs and/or alcohol have (Herie & Skinner, 2014). Consequently, the group participants can expand upon their coping and relapse prevention strategies through peer support that other group members offer (Herie & Skinner, 2014). Overall, group intervention for substance use can be beneficial for forensic clients in terms of the added benefits of group members sharing experiences and providing peer support.

**Relaxation and mindfulness.** Sistig, Friedman, McKenna, and Consedine (2015) discuss mindfulness as a practice used to diminish overwhelming emotions by shifting attention to the present through redirecting the mind to a specific thought, image, or behaviour. Mindfulness interventions have a strong root in Eastern spiritual practices and have gained popularity in forensic settings in the last decade (Howells, Tennant, Day, Elmer, 2010). Howells, Tennant, Day, and Elmer (2010) completed a meta-analysis examining mindfulness as a therapeutic technique in forensic and correctional facilities. They asserted that the psychological states targeted in mindfulness are often seen in forensic populations, such as emotional dysregulation, low mood, impulsivity, and borderline personality features. Howells et al. concluded that mindfulness contributes to increased use of positive coping skills and decreased risk, making it a beneficial supplementary treatment option.

Despite the efficacy of mindfulness, Sistig et al., identified the need to offer mindfulness in various ways to maximize its potential to be beneficial for forensic clients. Their study assessed supplementing usual treatment with an eight-week yoga program for forensic patients.
Yoga incorporates both mental and physical relaxation while teaching body postures, breathing techniques, relaxation, and meditation (Sistig, Friedman, McKenna, & Consedine, 2015). The benefits of yoga are vast, as different body systems are in use simultaneously (Sistig et al., 2015). In addition to measuring the efficacy of implementing a mindful yoga intervention, Sistig et al., measured the effects that yoga had on anxiety and/or depression symptoms, stress levels, risk to self or others, as well as on overall well-being. There were three groups of 10-15 men and women participants across three forensic facilities (Sistig et al., 2015). The authors implemented an intervention based on the Mindfulness-Based Stress Reduction yoga component, trauma-sensitive guidelines by Hopper et al., and Hatha yoga. Four pre-posttest assessments were used and completed by participants that measured mindfulness, stress, anxiety, and depression (Sistig et al., 2015). Qualitative self-reports were also completed post-treatment and at a two-month follow-up. The results of these assessments indicated clinically significant improvements in psychiatric symptoms over time, particularly for anxiety and stress (Sistig et al., 2015). Although the measures did not show statistically significant changes, self-reports indicated subjective positive changes and higher levels of body awareness and increased relaxation (Sistig et al., 2015).

Francesco, Mauro, Gianluca, and Enrico (2010) suggested that relaxation techniques such as progressive muscle relaxation and deep breathing are effective at reducing anxiety in various populations. They state that regardless of individual differences, various studies support that anxiety and distress reduction is common when relaxation techniques are used. Moreover, for those with Generalized Anxiety Disorder (GAD), relaxation training has been proven to have strong efficacy for managing symptoms (Francesco, et al., 2010).

Although multiple studies indicate emerging evidence for the effectiveness of relaxation techniques, there are gaps to be clarified. Standardized pre-posttests do not indicate high levels of change, but participants report various benefits on subjective self-reports.

**Music therapy.** Music is generally composed, listened to, and played for emotional expression (Hakvoort, Bogaerts, Thaut, & Spreen, 2013). Music acts to help people recognize and better cope with the emotions and cognitions that regularly affect them (Hakvoort et al., 2013). Therefore, when music therapy is implemented in a therapeutic and systematic manner, it holds promise as a therapy technique (Hakvoort et al., 2013). For example, CBT music therapy has been used in forensic psychiatry. When based on the RNR principle outlined by Bonta and Andrews (2007), music therapy works to improve problem-solving, self-management, anger management, and coping skills. Additionally, in CBT music therapy, the music is often used as a reinforcer and motivator to facilitate skills training (Hakvoort et al., 2013).

Hakvoort, Bogaerts, Thaut, and Spreen (2013) examined how music therapy influences coping skills and anger management in forensic psychiatric patients across four facilities using five music therapists to deliver the treatment. The Social Dysfunction and Aggression Scales were given to participants to measure coping skills and feelings of anger prior to participants being randomly assigned to either the experimental or control group (Hakvoort et al., 2013). Those in the experimental group participated in 20 hours of music therapy and treatment as usual (TAU; Hakvoort et al., 2013). Those in the control group continued TAU and were not invited to partake in music therapy until after they completed their post-test. The experimental group followed a standardized music therapy anger management program that has a basis in CBT (Hakvoort et al., 2013). At the pre-test, both groups showed similar mean levels of coping skills, but at the post-test, the music therapy group showed a significantly larger reduction in avoidance coping skills (Hakvoort et al., 2013). There were no differences between the groups in coping
skills (Hakvoort et al., 2013). The two scales used presented no significant changes between pre-post measures for either group (Hakvoort et al., 2013). Both groups showed increased self-management of assaultive behaviour skills on the post-test (Hakvoort et al., 2013). There was also a noted increase in symptom self-management in the music therapy participants post-test but the authors state this is should not be considered a significant result as it is likely due to a general increase in cognitive functioning resulting from participation in other therapies.

Chen, Leith, Aaro, Manger, and Gold (2016) completed a meta-analysis of five studies that used music therapy to improve mental health in offender populations. Music therapy has been used for many years and in both individual and group settings (Chen, Leith, Aaro, Manger, & Gold, 2016). The authors assert that music therapy helps with both internalizing and externalizing problems. However, music therapy tends to target internalizing problems more than externalizing problems (Chen et al., 2016). Although there was some evidence of changes in externalizing factors such as aggressive behaviours, internalizing problems were more impacted (Chen et al., 2016). Chen et al., examined self-esteem, behaviour management, anxiety, depression, and social functioning scores on pre-post measures. The scores on the post-tests demonstrated improved self-esteem and social functioning. Since offenders are living in very restricted environments, whether in a correctional or psychiatric setting, using music therapy encouraged positive interactions and engagement in prosocial behaviour (Chen et al., 2016). It was noted that there was a higher rate of improved symptoms when the duration of therapy was twenty sessions or more (Chen et al., 2016). No significant improvements were observed for behaviour management. Moreover, none of the studies analyzed included follow-up measures, so the durability of the effects of music therapy remains unknown (Chen et al., 2016). At the very least, music acts as a catalyst to engage clients in a meaningful activity that promotes positive behaviours.

**Art groups.** Despite the lack of adherence to the RNR model and difficulties in establishing an evidence-based approach, art interventions can be therapeutically beneficial for individuals with mental illness as they promote positive social behaviour, an emotional outlet, rapport building and increased confidence and optimism (Bonta & Andrews, 2016; Howells & Zelnik, 2009; Kelaher et al., 2013). Furthermore, Howells & Zelnik (2009) suggest that art interventions can decrease stress and anxiety. Kelaher et al., (2013) evaluated three community-based art programs in which a total of 103 individuals with mental illness participated. They used several qualitative and quantitative measures before and after the art interventions, including the Basic Psychological Needs Scales (BPNS) which measures relatedness, autonomy and competence. Additionally, the Arts Climate Scale adapted from the Learning Climate Scale was also used to measure autonomy (Kelaher et al., 2013). Lastly, participants completed surveys that captured personal reflection and changes in social support. Post-intervention, there were significant improvements in overall psychological well-being, autonomy, and social support (Kelaher et al., 2013). Additionally, Van Lith (2014) found that art often has a spiritual aspect to it, with participants often reporting feelings such as meaning, hope, commitment, and a deepened sense of self.

Based on the aforementioned studies, it can be assumed that an art group would be a worthwhile and meaningful activity to implement in conjunction with other therapeutic interventions to increase quality of life and promote positive prosocial activities on the unit.

**Physical activity.** Due to the increasing adherence to the recovery model of care, physical activity programs and opportunities have been encouraged for forensic mental health patients. Physical activity has demonstrated benefits to the overall well-being of individuals with
Typically, those with schizophrenia or other mental illnesses struggle to maintain optimal physical health due to various reasons, including medication side effects and negative symptoms (Holley et al., 2011). Chapman, Fraser, Brown, and Burton (2016) explored inpatients’ attitudes regarding physical activity. The clients in the study expressed interest in physical activity to lose or manage weight, improve overall health, and improve stress levels and emotional well-being (Chapman, Fraser, Brown, & Burton, 2016). However, their study indicated that social interaction was the least important aspect of physical activity. Chapman et al. speculate that social interaction is an additional benefit of physical activity, but not a motivator for participation. Consistent with previous research, walking was the preferred activity (Chapman et al., 2015). Implementing a physical activity group is a physically and mentally beneficial adjunct to therapy treatment.

Program Evaluation

Two evaluation approaches commonly used are formative and summative. Formative evaluation approaches generally occur near the beginning of interventions to produce information that can be used to generate program improvement (Alkin, 2011). This usually includes examining whether the program activities are being implemented effectively and in a manner to potentially reach the desired outcomes (Alkin, 2011). Summative evaluations typically are used to guide decision-making (Alkin, 2011). These decisions often include whether a program is effective and if it should continue to be implemented or not (Alkin, 2011). According to the W.K Kellogg Foundation (2004), program evaluation is not only about obtaining data; it allows agencies to gather and use information that increases their awareness of how they can improve the services that they offer. A program logic model (PLM) can support successful program planning, implementation, evaluation, and outcomes (W.K. Kellogg Foundation, 2004). This allows for improvement when documenting outcomes, serves as a powerful learning tool, and demonstrates which programs are meeting their objectives and how this is being done (W.K. Kellogg Foundation, 2004).

Tremblay, Coulombe, and Briand (2017) described the various ways that using a logic model can benefit a mental health organization. They stated that logic models can help shape an understanding of the expectations for running programs, such as the resources, clientele, and outcomes. Additionally, PLMs can be used to share ideas, highlight assumptions, provide team building opportunities, and improve communication (Tremblay, Coulombe & Briand, 2017). PLMs also help to emphasize the critical evaluation of program components to highlight those that are vital to achieving the program’s goals and identify those that are inconsistent with the program’s desired outcomes (Tremblay et al., 2017).

Moreover, Morgan et al., (2012) suggested that many clinicians providing services to offenders with mental illness do not have enough data supporting the effectiveness of their groups and are often left wondering if treatment is having a worthy impact. Thus, program evaluation is a key activity that is needed when offering clinical services.

Given the need for effective treatment in a forensic mental health setting proposed in the literature, program evaluation guided by a PLM will assist in identifying needed curriculum changes to existing groups to better meet the needs of their clients and close any service gaps that are present. This may also help towards burnout during therapy if the services provided are based on actual needs and the outcomes are tracked.
Relevance of Literature Review

Livingston et al. (2015) asserted that forensic mental health services rarely follow empirically supported principles. As the present system used at many forensic mental health hospitals is based on a traditional framework of care that focuses solely on reducing symptoms, it restricts the potential for significant improvements in the target population (Livingston et al., 2015). Routine program evaluations allow organizations to objectively determine if the services they are offering are being implemented the way they are desired to be. This literature review highlights evidence-based practices implemented in forensic hospitals, as well as interventions being used for populations with overlapping needs, such as the general and offender mental health systems. The focus is on evidence-based group interventions for a population with diverse needs while ensuring a holistic treatment approach. It can contribute to the process of identifying potential gaps in treatment offerings at Providence Care Forensic Mental Health Services and support the implementation of current treatment groups.
## SECTION 4: CURRENT GROUP PROTOCOLS

**GROUP PROTOCOL: Addictions/Substance Use**

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group name</td>
<td>Addictions/Substance Use</td>
</tr>
<tr>
<td>Overall purpose or goal of group</td>
<td>Purpose is to provide clients with skills and knowledge to reduce or stop using substances in assisting with recovery goals</td>
</tr>
<tr>
<td>Objectives of group – patient goals addressed by this group</td>
<td>In this group, clients will be supported in their goals with:</td>
</tr>
<tr>
<td></td>
<td>• Identifying and setting goals regarding substance use/abuse</td>
</tr>
<tr>
<td></td>
<td>• Accurate information about interactions between substance/drugs/alcohol and mental illness</td>
</tr>
<tr>
<td></td>
<td>• Provide opportunity to discuss openly about experiences with substances, including both positive and negative experiences</td>
</tr>
<tr>
<td></td>
<td>• Weigh advantages and disadvantages of substance use</td>
</tr>
<tr>
<td></td>
<td>• Develop a plan for achieving recovery goals</td>
</tr>
<tr>
<td></td>
<td>• Identify high risk situations and triggers</td>
</tr>
<tr>
<td></td>
<td>• Making a plan on how to deal with high risk situations</td>
</tr>
<tr>
<td></td>
<td>• Develop strategies to get needs met</td>
</tr>
<tr>
<td>Group facilitator(s)</td>
<td>Nurse</td>
</tr>
<tr>
<td></td>
<td>Social Worker</td>
</tr>
<tr>
<td>Group size</td>
<td>Projected size is 6-8 participants</td>
</tr>
<tr>
<td>Referral process</td>
<td>Discussion re: clients who will be offered attendance at the group will occur among FMHS staff including IP team, Charge Nurse and nurses, Director &amp; Manager.</td>
</tr>
<tr>
<td>Inclusion/exclusion criteria</td>
<td>All clients eligible who possess cognitive abilities to fully participate in group processes. Priority to greatest benefit for particular clients as identified by the clinical team. Closed group to emphasize group cohesion and development.</td>
</tr>
<tr>
<td></td>
<td>Group limited to NCR clients as per mandate</td>
</tr>
</tbody>
</table>
| Group structure and sessions. | One-hour group 1x per week  
General group format includes:  
Check-in and establish group rules, round table  
Session content as follows:  
Session 1: Introduction to Addictions/Substance Group  
Thoughts regarding outcome, expectations, goal setting, group norms, managing triggers. Intro re Stages of Change  
Myths and Misconceptions around addictions  
Session 2: Effects of Drugs and Alcohol on the body  
Session 3: Substance Abuse and your Brain Reward Center, Motivation, Memory, Learning, Inhibition  
People, Places and Things (re triggers)  
Session 4: Personal Values and Expectations, My Relationships  
Session 5: Pros and Cons (tipping the balance of change)  
Reflect upon positive influences of others  
Session 6: Living Well, Temptations and Confidence (self- control)  
Session 7: Problem solving, strategies and goal setting  
Session 8. Review and Celebrate completion of this group |
| Location | Group Room |
| Documentation (What, when and where will information be documented?) | Documentation in Progress notes in EPR. Group interactions/attendance is documented on the monthly/yearly nursing reports. Group attendance will be discussed in IP conferences and nursing shift change report if relevant. |
| Evidence or best-practice related to this group | Principles of Drug Addiction Treatment - National Institute on Drug abuse. 2012  
Concurrent Mental Health and Substance Use Disorders 2014, Health Canada |
| Outcome measures/Evaluation at Intake & Discharge | - Clients will attend each session.  
- Each session assessed for comprehension and perceived relevance.  
- URICA stage of change pre/post  
- DAST & MAST pre/post |
Exit Criteria (how to measure successful completion of group) | Moving to Action or Maintenance stage of change.
---|---

**GROUP PROTOCOL: Art Group**

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group name</td>
<td>Expressions of Recovery Art Group</td>
</tr>
<tr>
<td>Overall purpose or goal of group</td>
<td>The focus is to create a safe space for clients to express themselves in a way that is beyond words. Above all, it's a chance to try something new in a stress-free, welcoming environment. Each week, clients are invited to spend an hour directing their energy into creating something with their hands.</td>
</tr>
<tr>
<td>Group facilitator(s)</td>
<td>OT Reg. (Ont.)</td>
</tr>
<tr>
<td></td>
<td>1 nursing staff</td>
</tr>
<tr>
<td></td>
<td>1 volunteer</td>
</tr>
<tr>
<td>Group size</td>
<td>Capacity is 25</td>
</tr>
<tr>
<td>Referral process</td>
<td>Open group – clients may come weekly to work on a project over several groups OR clients are welcome to attend on a drop-in basis</td>
</tr>
<tr>
<td>Inclusion/exclusion criteria</td>
<td>Open to all clients</td>
</tr>
<tr>
<td>Group structure and sessions.</td>
<td>Supplies can be brought out of the cupboard on an as-needed basis</td>
</tr>
<tr>
<td></td>
<td>Some clients feel more at ease if projects are recommended to them (i.e. weekly themes, introduction to different styles of art, encouraging painting of emotions, painting what they hear in the music)</td>
</tr>
<tr>
<td></td>
<td>Supplies must be returned to the art cupboard and accounted for upon clients leaving</td>
</tr>
<tr>
<td>Location</td>
<td>Large activity room</td>
</tr>
<tr>
<td>Documentation (What, when and where will information be documented?)</td>
<td>Progress notes will be written immediately following the group for all clients who participate</td>
</tr>
<tr>
<td>Evidence or best-practice related to this group</td>
<td>• Incorporating art-based activities into treatment results in increased self-expression, occupational participation, and the establishment of daily routines¹</td>
</tr>
<tr>
<td></td>
<td>• Art consistently referred to as a means to develop therapeutic relationships, promote communication, and self expression²</td>
</tr>
<tr>
<td></td>
<td>• When given options, clients painted significantly more than when not given choices³ – providing clients with opportunities for choices within a secure setting is important to maintaining or increasing perceived autonomy</td>
</tr>
<tr>
<td>Outcome measures/Evaluation at Intake &amp; Discharge</td>
<td>Outcome measures: tracking weekly participation numbers &amp; brief description of the group that day (i.e. was there a theme?) – this is to help identify the preferences of clients and any trends noticed</td>
</tr>
<tr>
<td>Exit Criteria</td>
<td>Ongoing group</td>
</tr>
</tbody>
</table>

**GROUP PROTOCOL: Branch Out - a pilot project**

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group name</td>
<td>Branch Out</td>
</tr>
<tr>
<td>Overall purpose or goal of group</td>
<td>To improve mental and physical wellbeing by hiking and walking in nature.</td>
</tr>
</tbody>
</table>
| Objectives of group – patient goals addressed by this group | A pilot project to determine if objectives of the group are met and to inform the development of module based ecotherapy group for Pod 2 and 3 clients.  
Objectives: 1. Lessen the feelings of being “cooped up” and indoors for long periods of time. 2. Foster an appreciation for spending time in the outdoors to nourish spiritual health. 3. Increase motivation to be outside |
| Group facilitator(s) | Leisure Life Skills Instructor  
Spiritual Health Practitioner  
Behaviour Therapist |
| Group size | 3-5 |
| Referral process | Available for Rehab clients with a 20-km community privilege. Screening Interview to explain group and goals for each participant |
| Inclusion/exclusion criteria | Clients may be excluded if privileges or behaviours present a risk to self or others. |
| Group structure and sessions | Group meets once a week for 4 weeks in outdoor spaces for hiking and walking in the outdoors and reflection on the experience. |
| Location | TBD by facilitators. |
| Documentation (What, when and where will information be documented?) | ePR documentation by SHP.  
Pre-and-post surveys will be saved in the shared drive. |
| Evidence or best-practice related to this group | http://www.mind.org.uk/news-campaigns/news/go-green-to-beat-the-blues/#.WIZXyf4zVHc  
Ecotherapy: Healing with Nature in Mind, Edited by Linda Buzzel and Craig Chalquist  
See articles in the Shared Drive (Groups- Branch Out) |
| Outcome measures | A questionnaire will be filled out at the end of each activity to determine if the activities lessened feelings of being “cooped up”.  
At the beginning and end of the four sessions a survey will be filled out to note changes in participants’ behaviours (choosing to be outdoors for personal, leisure or exercise time), their relationship to the outdoors, their sense of well-being and if the participation in the group increased their level of physical activity. |
<table>
<thead>
<tr>
<th>Parameter</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group name</td>
<td>CBT Group</td>
</tr>
<tr>
<td>Overall purpose or goal of group</td>
<td>Purpose is to provide clients with knowledge and skills to manage their symptoms of psychosis</td>
</tr>
</tbody>
</table>
| Objectives of group – patient goals addressed by this group | In this group, clients will learn:  
  - To recognize symptoms of psychosis – distressing thoughts/delusions, hallucinations etc.  
  - To develop and implement cognitive strategies to manage symptoms |
| Group facilitator(s) | Psychologist + available nursing staff or OT |
| Group size | Projected size is 6 participants |
| Referral process | Discussion re: clients who will be offered attendance at the group will occur among FMHS staff including IP team, Charge Nurse and nurses, Director & Manager.  
Participants can repeat the group at intervals of their choosing to deepen and further develop their understandings. |
| Inclusion/exclusion criteria | All clients eligible who possess cognitive abilities to fully participate in group processes and also are experiencing troubling symptoms of psychosis – delusions, hallucinations. Priority to greatest benefit for particular clients as identified by the clinical team. Closed group to emphasize group cohesion and development. |
| Group structure and sessions. | One-hour group 2X per week (Tues. & Thurs. 1:30-2:30) x 10 weeks.  
General group format includes:  
  - “Check-in” (how was your week, how are things going generally, what are your thoughts about this group?).  
  - Review the previous session.  
  - Reflective session discussion related to topic  
  - Skills practice/role plays.  
  - Closing.  
Session content as follows: |
|                                           |                                                                                     |
|                                           | **Session 1: Introduction to the Cognitive Behavioural Therapy Group**               |
|                                           | **Session 2: Cognitive Behavioural Therapy and What It Can Do for You**             |
|                                           | **Session 3: Negative Symptoms and Getting Active**                                |
|                                           | **Session 4: Getting Active: Thoughts that get in the way of getting active**       |
|                                           | **Session 5: Thinking Errors: Noticing My Thoughts & Checking Them Out**           |
|                                           | **Session 6: Review: Noticing and Checking Out your Troubling Automatic Thoughts**  |
|                                           | **Session 7: Voice Hearing and other Hallucinations**                              |
|                                           | **Session 8: Voice Hearing and other Hallucinations continued**                    |
|                                           | **Session 9: CBT Strategies for Troubling Thoughts and Hallucinations**            |
|                                           | **Session 10: CBT Strategies for Troubling Thoughts and Hallucinations:**           |
|                                           | **Checking out the Advantages and Disadvantages and Finding Meaning**              |
|                                           | **Session 11: CBT Strategies for Troubling Thoughts and Hallucinations:**           |
|                                           | **Behavioural Experiments**                                                       |
|                                           | **Session 12: CBT Strategies for Paranoid Beliefs**                                |
|                                           | **Session 13: CBT Strategies for Unusual Ideas and Beliefs**                       |
|                                           | **Session 14: Shifting Core Beliefs: Feeling Good about Yourself**                 |
|                                           | **Session 15: Wellness Plan**                                                     |
|                                           | **Session 16: Wellness Plan and CBT after the group**                              |
|                                           | **Session 17: Review of CBT for Psychosis Group:**                                |
|                                           | **What we covered and how it is going.**                                           |

| Location                                  | Solarium FMHS.                                                                      |
| Documentation (What, when and where will information be documented?) | Documentation in Progress notes in EPR. Group interactions/attendance is documented on the monthly/yearly nursing reports. Group attendance will be discussed in IP conferences and nursing shift change report if relevant. |
Evidence or best-practice related to this group | Extensive literature regarding effectiveness of CBT for Psychosis
---|---
Outcome measures | - Clients will attend each session.  
- Each session assessed for comprehension and perceived relevance.  
- Pre-post psychometric assessment.

**GROUP PROTOCOL: Living Well**

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group name</td>
<td>Living Well</td>
</tr>
<tr>
<td>Overall purpose or goal of group</td>
<td>The goal of this group is to enhance client’s understanding of a variety of topics related to psychoeducation and wellness. This is achieved by introducing a new topic each week that is open to all clients to attend (assessment and rehab clients are welcome). Each module will include an introduction, discussion, activity, and question and answers period.</td>
</tr>
</tbody>
</table>
| Group facilitator(s) | OT Reg. (Ont.)  
Psychologist |
| Group size | Open |
| Referral process | Open |
| Inclusion/exclusion criteria | The only criterion required to participate is that clients are respectful during the group (let others speak, mindful that others are at different place in treatment) |
| Group structure and sessions |  |
| Location |  |
| Documentation (What, when and where will information be documented?) |  |
| Evidence or best-practice related to this group |  |
| Outcome measures/Evaluation at Intake & Discharge |  |
| Exit Criteria |  |
### GROUP PROTOCOL: Powerful Emotions

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group name</td>
<td>Powerful Emotions - Pilot</td>
</tr>
<tr>
<td>Overall purpose or goal of group</td>
<td>Using a DBT-informed model to increase interpersonal effectiveness, emotion regulation and distress tolerance skills in forensic mental health inpatients</td>
</tr>
<tr>
<td>Objectives of group – patient goals addressed by this group</td>
<td>1. Decreased incidence of conflicts, 2. Decreased use of ineffective/unhealthy coping, 3. Decreased outbursts, 4. Increased ability of patients to work toward goals via decreased need to restrictions/loss of privileges</td>
</tr>
<tr>
<td>Group facilitator(s)</td>
<td>1. Psychologist</td>
</tr>
<tr>
<td>Facilitator Training</td>
<td>2. Clinician</td>
</tr>
<tr>
<td>Facilitator Training</td>
<td>At least one facilitator must have completed a formal DBT Skills training workshop, be familiar with DBT materials, and have observed the group before leading. The second facilitator must at least be familiar with the materials and have observed the group.</td>
</tr>
<tr>
<td>Group size</td>
<td>6 - 10</td>
</tr>
<tr>
<td>Referral process</td>
<td>All inpatients invited</td>
</tr>
<tr>
<td>Inclusion/exclusion criteria</td>
<td><strong>Exclusion:</strong> Actively psychotic; Moderate to Severe Intellectual Disability or other Major Neurocognitive Disorder or Communication Impairment; Imminent Risk for Aggression</td>
</tr>
<tr>
<td>Group structure and sessions.</td>
<td><strong>Inclusion:</strong> Transdiagnostic; forensic inpatients</td>
</tr>
<tr>
<td>Group structure and sessions.</td>
<td><strong>Format:</strong> Module-based approach, with standalone modules</td>
</tr>
<tr>
<td></td>
<td><strong>Content:</strong> Each module covers core Mindfulness Skills + other Core DBT skills:</td>
</tr>
<tr>
<td></td>
<td>- Distress Tolerance</td>
</tr>
<tr>
<td></td>
<td>- Emotion Regulation</td>
</tr>
<tr>
<td></td>
<td>- Interpersonal Effectiveness</td>
</tr>
<tr>
<td></td>
<td><strong>Frequency:</strong> 3 weeks x 2 sixty-minute sessions per week per module (Monday &amp; Thursday, 1300-1400)</td>
</tr>
<tr>
<td></td>
<td><strong>General Session Overview:</strong></td>
</tr>
<tr>
<td></td>
<td>- Session 1: Introduction, Pre-test, &amp; Mindfulness</td>
</tr>
<tr>
<td>Location</td>
<td>TBD in PCH</td>
</tr>
<tr>
<td>----------------</td>
<td>------------</td>
</tr>
<tr>
<td>Documentation</td>
<td>Patient charts: Attendance, Participation, &amp; Clinical Impressions</td>
</tr>
</tbody>
</table>
| Evidence or best-practice related to this group | • Extensive literature on dialectical behaviour therapy, including application in forensic mental health  
• Note: this group is NOT a full DBT treatment group; rather, it is DBT-informed. As such, it is unknown to what degree the extant treatment literature on outcome applies |
| Outcome Measures/Evaluation at Intake & Discharge | • Pre/post-test: Difficulties in Emotion Regulation – Short Form (DERS-SF)  
• Ongoing: Weekly Diary Card for Distress, Core Skill & Mindfulness use  
• Patient-completed group evaluation form at completion |
| Exit Criteria  | • As this is a Pilot, Exit Criterion have not been finalized. Options include: Attendance, Participation Level, Change of Behaviour (objective? Team decision?) |

### GROUP PROTOCOL: Social Skills

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group name</td>
<td>“Social Skills”</td>
</tr>
<tr>
<td>Overall purpose or goal of group</td>
<td>Purpose is to provide clients with knowledge and skills to enable them to interact socially more effectively</td>
</tr>
</tbody>
</table>
| Objectives of group – patient goals addressed by this group | In this group, clients will learn:  
• Communication skills  
• Assertiveness vs. aggression  
• Identifying challenging social situations and finding strategies to navigate them effectively |
| Group facilitator(s)                                | Psychologist and OT |
| Group size                                          | Projected size is 6-8 participants |
| Referral process                                    | Group will be open format. Assessment and rehab clients will be encouraged to attend weekly. |
| Inclusion/exclusion criteria criterion              | Respectful behaviour during group is expected. |
Group structure and sessions. One-hour group twice per week (Tues. and Thurs. 1:30-2:20) x 8 weeks. General group format includes:
- “Check-in” (how was your week, how are things going generally, what are your thoughts about this group).
- Review the previous session.
- Reflective session discussion related to topic
- Skills practice/roleplays.
- Closing.
- Session content as follows:
  - Introduction to the group with guidelines for participation in groups.
  - Communication Skills
  - Goal Settings
  - Problem Solving
  - Empathy
  - Assertiveness
  - Relationships
  - Vocational
  - Making Health Appointments

Location

Group Room

Documentation (What, when and where will information be documented?)

Documentation of group attendance on ePR. Group interactions/attendance is documented on the monthly/yearly nursing reports. Group attendance will be discussed in IP conferences and nursing shift change report if relevant.

Outcome measures

- Clients will attend each session.
- Each session assessed for comprehension and perceived relevance through review of completed homework.

GROUP PROTOCOL: TDM Peer Support Group- Peer Support South East Ontario

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group name</td>
<td>TDM/Peer Support by Peer Support South East Ontario</td>
</tr>
<tr>
<td>Overall purpose or goal of group</td>
<td>To provide intentional Peer Support to Forensic patients at Providence Care. PSSEO Core Purpose “to be with people who are living with addictions/and or mental health challenges and to support them in being as well as they can be.”</td>
</tr>
</tbody>
</table>
| Objectives of group – patient goals addressed by this group | To provide a relational methodology for sharing a common experience by which “equals” may help each other cope, thrive and flourish.  
- To empower patients through knowledge and reflective discussions
- To foster hope and self-advocacy
- To provide social support
- To promote positive, constructive problem solving by sharing and learning from each other |
<table>
<thead>
<tr>
<th>Parameter</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group facilitator(s)</td>
<td>Peer Support Coordinator (staff of Providence Care through PSSEO).</td>
</tr>
<tr>
<td>Group size</td>
<td>Open to anyone in Unit</td>
</tr>
<tr>
<td>Referral process</td>
<td>Self-referral</td>
</tr>
<tr>
<td>Inclusion/exclusion criteria</td>
<td>Respect</td>
</tr>
<tr>
<td>Group structure and sessions.</td>
<td>One hour group per week with facilitator providing coffee and refreshments.</td>
</tr>
<tr>
<td></td>
<td>General group format includes:</td>
</tr>
<tr>
<td></td>
<td>• “Check-in” (how was your week, how are things going generally).</td>
</tr>
<tr>
<td></td>
<td>• “Icebreaker” question to engage and initiate discussions.</td>
</tr>
<tr>
<td></td>
<td>• Variety of topics and activities related to mental wellness will be</td>
</tr>
<tr>
<td></td>
<td>covered including stigma among others.</td>
</tr>
<tr>
<td></td>
<td>• Closing</td>
</tr>
<tr>
<td></td>
<td>Activities will include interactive art sessions and reflective discussions</td>
</tr>
<tr>
<td>Location</td>
<td>Forensic Unit- most suitable location</td>
</tr>
<tr>
<td>Documentation (What, when and where will information be documented?)</td>
<td>PSSEO will record number of participants attending groups each week. Any other recording, for Providence Care, will be done in conjunction with designated clinician.</td>
</tr>
<tr>
<td>Outcome measures</td>
<td>1. Participation and engagement</td>
</tr>
<tr>
<td></td>
<td>2. Enhanced awareness of self in relation to mental health/and or addictions</td>
</tr>
<tr>
<td></td>
<td>3. Learning and accessing PSSEO Peer Support programs/services on discharge for increased support and success</td>
</tr>
</tbody>
</table>

**GROUP PROTOCOL: Uplift Music Night**

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group name</td>
<td>Uplift Music Group</td>
</tr>
<tr>
<td>Overall purpose or goal of group</td>
<td>The purpose of the group is to provide a welcoming and friendly space for clients to enjoy, share and play music.</td>
</tr>
<tr>
<td>Group facilitator(s)</td>
<td>Spiritual Health and one nursing staff.</td>
</tr>
<tr>
<td>Group size</td>
<td>Room accommodates 25 people.</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>Referral process</td>
<td>Self-referral, and by staff</td>
</tr>
<tr>
<td>Inclusion/exclusion criteria</td>
<td>This is an open group. Assessment and Rehab clients may attend.</td>
</tr>
<tr>
<td>Group structure and sessions.</td>
<td>This group runs on the fourth Thursday of every month from 7:00 to 8:30.</td>
</tr>
<tr>
<td>Location</td>
<td>Activity Room</td>
</tr>
<tr>
<td>Documentation (What, when and where will information be documented?)</td>
<td>ePR and included in Spiritual Health assessments</td>
</tr>
<tr>
<td>Evidence or best-practice related to this group</td>
<td>See Articles in Evidence File in shared drive.</td>
</tr>
<tr>
<td>Outcome measures/Evaluation at Intake &amp; Discharge</td>
<td>Focus group planned to determine the effectiveness and on-going program development.</td>
</tr>
<tr>
<td>Exit Criteria</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**GROUP PROTOCOL: Walking Group**

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group name</td>
<td>TBD</td>
</tr>
<tr>
<td>Overall purpose or goal of group</td>
<td>To encourage healthy living, engagement in group and independent activities, socialization, goal setting, team work and engagement in treatment through behavioural activation and positive reinforcement. To improve negative symptoms of schizophrenia and other psychotic illnesses as well as depression.</td>
</tr>
<tr>
<td>Group facilitator(s)</td>
<td>Behavioural Clinician</td>
</tr>
<tr>
<td></td>
<td>Daily support from nursing and allied staff</td>
</tr>
<tr>
<td>Facilitator training</td>
<td>Group development and monitoring – understanding and training in behavioural science</td>
</tr>
<tr>
<td></td>
<td>Daily implementation of group – any individual trained as a mental health worker on the Forensic Unit i.e. nursing and allied staff</td>
</tr>
<tr>
<td>Group size</td>
<td>As many clients would like to participate can record their steps independently (# of pedometers to be determined by funding allocation)</td>
</tr>
<tr>
<td></td>
<td>Group walk size to be determined by off-unit privileges and ratios</td>
</tr>
<tr>
<td>Referral process</td>
<td>Self-referral – ambulating assessment and rehab clients welcome</td>
</tr>
<tr>
<td>Inclusion/exclusion criteria</td>
<td>Clients may be excluded if privileges or behaviours present a risk to self or others. Those with privileges restricted to the unit will still have access to participate.</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Group structure and sessions. | - Daily recording of # of steps (tracking with pedometers)  
- Daily optional group walk in Yard, indoor gym or track, in hospital or on hospital grounds to accommodate those clients with limited privileges  
- Weekly optional group walk on grounds or in the community to accommodate those clients with more privileges  
- Weekly “reward session” for clients to exchange their tokens for incentives (Tim Hortons coffee) and socialize; intermittent group goals will be set at these meetings |
| Location | Group walks in forensic Yard, indoor track, indoor gym and hospital grounds  
Participants may track their steps wherever they go i.e. community, in hospital, on the unit etc.  
Weekly “reward sessions” in large activity room on the unit |
| Documentation (What, when and where will information be documented?) | ePR Documentation  
pre-and-post surveys will be saved in the shared drive  
daily recording of pedometer readings |
<table>
<thead>
<tr>
<th>Outcome measures/Evaluation at Intake &amp; Discharge</th>
<th>Pre-and-post surveys to assess overall mood, engagement in group activities, engagement in independent activities, desire to engage. To take place at entrance, 3 months and 6 months.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exit Criteria</td>
<td>As this is an open group focused on guided behavioural activation clients may leave the group at any time. They may continue to participate in the group until discharged to community. This group may be adapted to accommodate Forensic Outreach clients in the future depending on efficacy, resources and demand.</td>
</tr>
</tbody>
</table>

**GROUP PROTOCOL: Wellness Recovery Action Plan (WRAP) Group**

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group name</td>
<td>WRAP (Wellness Recovery Action Plan) Group</td>
</tr>
<tr>
<td>Overall purpose or goal of group</td>
<td>Purpose is to support participation in a “self-designed prevention and wellness process that anyone can use to get well and stay well” (Copeland, 2015) via: completion of small components of a personal WRAP.</td>
</tr>
<tr>
<td>Objectives of group – patient goals addressed by this group</td>
<td>By the end of this group, patients will be guided to create elements of a crisis plan as detailed in session outlines. Objectives are related to the step-by-step creation of the crisis plan and related goals. Examples of patient goals:</td>
</tr>
<tr>
<td></td>
<td>• To identify and implement one thing per day that enhances personal wellness.</td>
</tr>
<tr>
<td></td>
<td>• To identify two key elements of a crisis plan.</td>
</tr>
<tr>
<td></td>
<td>The process of creating a WRAP also includes the following objectives:</td>
</tr>
<tr>
<td></td>
<td>• To empower patients through knowledge and reflective discussions that result in simple practical goals and plans.</td>
</tr>
<tr>
<td></td>
<td>• To foster hope.</td>
</tr>
<tr>
<td></td>
<td>• To provide social support and the development of social skills within the group.</td>
</tr>
<tr>
<td></td>
<td>• To promote positive, constructive problem solving.</td>
</tr>
<tr>
<td></td>
<td>• To develop time-management skills.</td>
</tr>
<tr>
<td></td>
<td>• To enable patients to demonstrate responsibility and demonstrate internal initiative to progress towards goal(s). SMART goals, guided by facilitators, ensure that everyone is “set up for success”.</td>
</tr>
<tr>
<td>Group facilitator(s)</td>
<td>Peer Support Worker &amp; Behavioural Clinician</td>
</tr>
<tr>
<td>Section</td>
<td>Description</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Group size</td>
<td>Projected size is 8 participants with a goal to have all NCR patients progress through this group.</td>
</tr>
</tbody>
</table>
| Referral process                 | Discussion re: patients who will be offered attendance at the group will occur among FMHS staff including IP team, Charge Nurse, Director & Manager.  
Participants can repeat the group at intervals of their choosing to deepen and further develop their crisis plan. |
| Inclusion/exclusion criteria     | All NCR patients eligible who possess cognitive abilities to fully participate in group processes. Assessment clients not eligible at this time. Closed group to emphasize group cohesion and development. |
| Group structure and sessions.    | One-hour group per week (Wednesday 3-4pm) x 12 weeks. General group format includes:  
- “Check-in” (how was your week, how are things going generally, what are your thoughts about this group).  
- “Icebreaker” question to engage and initiate discussions.  
- Media as determined in session outlines.  
- Written or verbal discussion of the targeted WRAP element of the week.  
- Closing.  
Session content as follows:  
- Introduction to group including simple goal setting and understanding what WRAP means. WRAP video. Creation of WRAP folder. “Icebreaker” question: Desert island question.  
- Creating a wellness toolbox. “Icebreaker” question: Name that song.  
- Forming a daily maintenance list. “Icebreaker” question: Two lies and a truth question.  
- Identifying triggers and action plan. “Icebreaker” question: What colour would you be?  
- Identifying early warning signs and action plan. “Icebreaker” question: TBD  
- Crisis planning. “Icebreaker” question: TBD  
- (Second session) Crisis planning. “Icebreaker” question: TBD  
- Wrap-up and evaluation. |
Activities will include art experiences, reflective discussions, written components of plan, media source in selected sessions.

<table>
<thead>
<tr>
<th>Location</th>
<th>Forensic Unit- large activity room to access art supplies as needed.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documentation (What, when and where will information be documented?)</td>
<td>EPR documentation. Group interactions/attendance is documented on the monthly/yearly nursing reports. Group attendance will be discussed in IP conferences and nursing shift change report. Discussion will be facilitated re: permission to share WRAP components with the healthcare team and processes that incorporate personal preference.</td>
</tr>
<tr>
<td>Evidence or best-practice related to this group</td>
<td>Will provide relevant literature search.</td>
</tr>
<tr>
<td>Outcome measures</td>
<td>• Components of WRAP will be completed by each group participant. Qualitative information obtained by pre-post survey for participants in first and last session. WRAP information will be shared as appropriate e.g., team conferences, individual care planning.</td>
</tr>
</tbody>
</table>

**GROUP PROTOCOL: Using Medications Effectively**

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group name</td>
<td>“Using Medications Effectively”</td>
</tr>
<tr>
<td>Overall purpose or goal of group</td>
<td>Purpose is to promote and maintain wellness through optimal use of a client’s medication regime.</td>
</tr>
<tr>
<td>Objectives of group – patient goals addressed by this group</td>
<td>In this group, clients will be supported to: • Review and explain the stress-vulnerability model of mental illness. • Obtain and discuss accurate information about medications for mental illnesses, including advantages and side effects. • Express their beliefs about medication use and share experiences. • Examine the advantages versus disadvantages of taking medication. • Develop strategies for optimal use of their own medication regime.</td>
</tr>
<tr>
<td>Group facilitator(s)</td>
<td>CNS with co-facilitators: • Pharmacist Session information can be shared the day prior to enable co-facilitator to review content.</td>
</tr>
<tr>
<td>Group size</td>
<td>Projected size is 8 participants with a goal to have all NCR clients and as many assessment clients as possible to progress through this group.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Referral process</td>
<td>Discussion re: clients who will be offered attendance at the group will occur among FMHS staff including IP team, Charge Nurse and nurses, Director &amp; Manager. Participants can repeat the group at intervals of their choosing to deepen and further develop their understandings.</td>
</tr>
<tr>
<td>Inclusion/exclusion criteria</td>
<td>All clients eligible who possess cognitive abilities to fully participate in group processes. Priority to greatest benefit for particular clients as identified by the clinical team. Closed group to emphasize group cohesion and development.</td>
</tr>
</tbody>
</table>
| Group structure and sessions. | One-hour group per week (Wednesday, 1500-1600) x 4 weeks. General group format includes:  
- “Check-in” (how was your week, how are things going generally, what are your thoughts about this group).  
- Review the previous session.  
- Media/guest (e.g., pharmacist) as determined in session outlines.  
- Reflective session discussion related to weekly topic.  
- Closing. Session content as follows:  
- Introduction to the group with guidelines for participation in groups. The stress-vulnerability model of mental illness. The role of medication in managing symptoms.  
- Identifying and responding to side effects.  
- Making informed decisions about medication.  
- Getting the best results about medication. |
| Location | Dining room FMHS. |
| Documentation (What, when and where will information be documented?) | Documentation in “Group Attendance” section of paper chart. Group interactions/attendance is documented on the monthly/yearly nursing reports. Group attendance will be discussed in IP conferences and nursing shift change report if relevant. |
| Evidence or best-practice related to this group | Will provide relevant literature search as well as IMR documents. |
| Outcome measures | • Clients will attend each session. |
- Qualitative information elicited at last session.
- Group information will be shared as appropriate eg. team conferences, individual care planning.

### GROUP PROTOCOL: Spirituality and Recovery

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group name</td>
<td>Spirituality and Recovery</td>
</tr>
<tr>
<td>Overall purpose or goal of group</td>
<td>To transcend the daily challenges of living on the unit and instill a sense of hope for recovery and the process of change</td>
</tr>
<tr>
<td>Objectives of group – patient goals addressed by this group</td>
<td>Clients will explore their own spiritual resources and have the opportunity to foster a sense of hope, gratitude, and peace in their lives. Clients will be invited in to a safe and relaxing space in which to explore the function of spirituality in their lives.</td>
</tr>
<tr>
<td>Group facilitator(s)</td>
<td>Spiritual Health Practitioner</td>
</tr>
<tr>
<td>Group size</td>
<td>Open group</td>
</tr>
<tr>
<td>Referral process</td>
<td>Anyone may attend. Open invitation for all Forensics clients</td>
</tr>
<tr>
<td>Inclusion/exclusion criteria</td>
<td>SHP will consult with nursing staff before beginning the group and inviting clients but otherwise this is an inclusive group.</td>
</tr>
<tr>
<td>Group structure and sessions.</td>
<td>This group will be offered every Monday at 10:30-11:15</td>
</tr>
<tr>
<td></td>
<td>Outline for session:</td>
</tr>
<tr>
<td></td>
<td>1. Set-up and preparation of the room</td>
</tr>
<tr>
<td></td>
<td>2. Reflective Music</td>
</tr>
<tr>
<td></td>
<td>3. Welcome and gathering meditation or prayer</td>
</tr>
<tr>
<td></td>
<td>4. Introductions and introduction of monthly theme</td>
</tr>
<tr>
<td></td>
<td>5. Group Expectations</td>
</tr>
<tr>
<td></td>
<td>6. Discussion: connecting personal spirituality to the theme</td>
</tr>
<tr>
<td></td>
<td>7. Reading</td>
</tr>
<tr>
<td></td>
<td>8. Closing Mediation or prayer</td>
</tr>
<tr>
<td>Location</td>
<td>Dining Room</td>
</tr>
<tr>
<td>Documentation (What, when and where will information be documented?)</td>
<td>Client participation will be documented on ePR and attendance lists will be kept by SHP.</td>
</tr>
<tr>
<td>Evidence or best-practice related to this group</td>
<td>“Supporting recovery’ and ‘moving on’- the recovery approach applied to group intervention programmes in in-patient settings”</td>
</tr>
<tr>
<td>Outcome measure</td>
<td>Attendance and interest in this type of spirituality group will be monitored. The group will be offered for 10 weeks. Core attendees will be invited to fill out an anonymous evaluation at the end of 10 weeks.</td>
</tr>
<tr>
<td>-----------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>

Helen Miles. Secure Recovery: Approaches to Recovery in Forensic Mental Health Settings ed. Gerard Drennan and Deborah Alred, 2012
SECTION 5: RECOMMENDATIONS

RECOMMENDED MEASURES FOR CURRENTLY IMPLEMENTED GROUPS

A variety of measures were selected based on their suitability to measure the desired outcomes of the different group interventions currently offered.

<table>
<thead>
<tr>
<th>GROUP INTERVENTION</th>
<th>SUGGESTED MEASURES</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDICTIONS</td>
<td>- Drug Taking Confidence Questionnaire</td>
</tr>
<tr>
<td></td>
<td>- Stages of Change Readiness and Treatment Eagerness Scale</td>
</tr>
<tr>
<td>CBT FOR PSYCHOSIS</td>
<td>- Positive and Negative Symptom Scale (PANSS)</td>
</tr>
<tr>
<td></td>
<td>- Reactions to Provocations</td>
</tr>
<tr>
<td></td>
<td>- Shortened COPE Inventory</td>
</tr>
<tr>
<td>LIVING WELL</td>
<td>- Generic Program Performance Measure (GPPM)</td>
</tr>
<tr>
<td>LIFE SKILLS</td>
<td>- Independent Living Scale (ILS)</td>
</tr>
<tr>
<td>MEDICATION GROUP</td>
<td>- Understanding of Medication Questionnaire (UMQ)</td>
</tr>
<tr>
<td>OUT &amp; ABOUT</td>
<td>- Social Problem-Solving Inventory- Revised Short Form (SPSI-R)</td>
</tr>
<tr>
<td>POWERFUL EMOTIONS</td>
<td>- Emotional Regulation Questionnaire (ERQ)</td>
</tr>
<tr>
<td></td>
<td>- Difficulty in Emotion Regulation Scale-Short Form (DERS-SF).</td>
</tr>
<tr>
<td></td>
<td>- Interpersonal Reactivity Index (IRI)</td>
</tr>
<tr>
<td></td>
<td>- Social Problem-Solving Inventory – Revised Short Form (SPSI-R)</td>
</tr>
<tr>
<td></td>
<td>- Reduced Emotional Intensity Scale (REIS)</td>
</tr>
<tr>
<td>RELAPSE PREVENTION</td>
<td>- Psychological Inventory of Criminal Thinking Styles (PICTS)</td>
</tr>
<tr>
<td></td>
<td>- Barratt Impulsivity Scale (BIS)</td>
</tr>
<tr>
<td>SOCIAL SKILLS TRAINING</td>
<td>- Reactions to Provocations (RP)</td>
</tr>
<tr>
<td>WRAP</td>
<td>- Quality of Life Enjoyment and Satisfaction Questionnaire (QLESQ)</td>
</tr>
<tr>
<td></td>
<td>- Shortened COPE Inventory</td>
</tr>
<tr>
<td></td>
<td>- Clinical Outcomes of in Routine Evaluation – Outcome Measure (CORE – OM)</td>
</tr>
<tr>
<td>ART GROUP</td>
<td>➢ The Perceived Stress Scale (PSS)</td>
</tr>
<tr>
<td>-----------</td>
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</tr>
<tr>
<td>BRANCH OUT</td>
<td>➢ The Five Facet Mindfulness Questionnaire (FFMQ)</td>
</tr>
</tbody>
</table>
| PEER SUPPORT | ➢ Self-Compassion Scale (SCS)  
                ➢ Quality of Life Enjoyment and Satisfaction Questionnaire (QLESQ) |
| RELAXATION | ➢ The Perceived Stress Scale (PSS)  
                ➢ Five Facet Mindfulness Questionnaire (FFMQ) |
| WALKING GROUP | ➢ The Short-Form International Physical Activity Questionnaire (IPAQ) |
| YOGA GROUP | ➢ The Perceived Stress Scale (PSS)  
                ➢ Five Facet Mindfulness Questionnaire (FFMQ) |
| BREAKFAST & LUNCH SKILLS | ➢ Generic Program Performance Measure (GPPM) |
| COMMUNITY INTEGRATION | ➢ Work and Social Adjustment Scale (WSAS)  
                            ➢ Shortened COPE Inventory |
| OPEN GYM | ➢ The Short-Form International Physical Activity Questionnaire (IPAQ) |
RECOMMENDED MEASURES FOR SUGGESTED GROUP INTERVENTIONS

A variety of measures were selected based on their suitability to measure the desired outcomes of the different group interventions that should be considered.

<table>
<thead>
<tr>
<th>SUGGESTED GROUP INTERVENTION</th>
<th>SUGGESTED MEASURES</th>
</tr>
</thead>
<tbody>
<tr>
<td>FAMILY THERAPY</td>
<td>➢ Clinical Outcomes in Routine Evaluation - Outcome Measure (CORE-OM)</td>
</tr>
</tbody>
</table>
| PSYCHOEDUCATIONAL GROUP (FOR CLIENTS OR FAMILY MEMBERS) | ➢ Clinical Outcomes in Routine Evaluation - Outcome Measure (CORE-OM)  
  ➢ Understanding of Medication (UMQ)  
  ➢ Drug Taking Confidence Questionnaire (DTCQ) |
| SCHEMA-FOCUSED THERAPY       | ➢ Personality Belief Questionnaire (PBQ) |
| SEXUAL OFFENDERS             | ➢ Barratt Impulsivity Scale (BIS)  
  ➢ Generic Program Performance Measure (GPPM) |
| ANGER MANAGEMENT             | ➢ Barratt Impulsivity Scale (BIS)  
  ➢ Difficulty in Emotion Regulation Scale-Short Form (DERS-SF).  
  ➢ Aggression Questionnaire (AQ) |

The measures are attached in Section 6 of this package if they are not copyrighted. If they are copyrighted, an excerpt of the Mental Measurements Yearbook (MMY) review is inserted. Finally, if the measure cannot be included nor is reviewed in the MMY, a link to the article it was discussed in is included.
POTENTIAL GROUP CYCLE

To ensure a continuous offering of group interventions throughout the year, an eight-month sample schedule was composed. Find the calendar attached as Appendix A. It is recommended to offer psychoeducation groups in an alternating fashion, as such, the calendar depicts alternating weekly sessions of medication group and Living Well.

Living Well can have different topics weekly that apply to different groups of clients. For example, one week can focus on psychoeducation about different illnesses, and another session could be about budgeting for those about to enter the community. Some groups run throughout all the months, such as Art Group, while some rotate throughout the calendar year based on client needs.
SELECTION OF GROUP FACILITATORS

Group facilitators should be knowledgeable about the group contents and should be selected based on:

- **Competency**: Facilitators should have experience and/or training in the groups they are running.
- **Availability**: Facilitators should remain as consistent as possible. Select staff who are available during the times of the group.
- **Ratio**: If more than one staff is needed to facilitate, this should be coordinated.

The criteria for facilitators should be outlined in the group protocols.
GENERAL RECOMMENDATIONS

1. Treatment Planning & Group Intervention Schedule
1.1. Have each client involved in their treatment planning. Let them suggest some of their own rehabilitation goals and refer them to groups based on both clinical self-identified needs and needs identified by the clinical team
1.2. Offer select groups based on overall needs of clients. For example, if there are a number of clients who identify anger as a treatment target, consider implementing an anger management group or when there are numerous clients who can benefit from a group pertaining to treatment of sexual offending behaviour, consider implementing a group of this nature
1.3. Adhere to the RNR principles when possible, for example offer one CBT intervention appropriate for low-risk clients and offer a more intense CBT intervention for high-risk clients
1.4. Identify clients’ level of risk and use this to determine appropriate groups
1.5. CBT and DBT informed groups tended to have the strongest evidence base within the forensic mental health population, so using principles from these two modalities is encouraged
1.6. Interventions with weaker support in the literature often still offer quality of life improvements and benefits. This was reflected quite often when client subjective self-reports or anecdotal support were discussed
1.7. Consistently implement stand-alone psychoeducational modules open to both assessment and NCR clients that discuss different topics. For example:
   - Modules on substance abuse
   - Modules on different mental health disorders (schizophrenia, bi-polar, depression, anxiety, etc)
   - Modules on navigating the system

2. Assessment Measures
2.1. Ensure completion of pre- and post-tests at beginning and end of group and that this data is kept on clients’ charts
2.2. Record attendance for every group, even recreational ones
2.3. Use engagement scales (ex. GPPM) to objectively capture clinical impressions and engagement rates of the clients
2.4. There are suggested measures to use for each group outlined in this document. They have been identified based on a literature search. Consider using these for groups
2.5. Upon discharge, complete the Group Satisfaction Survey to capture clients’ overall impressions, feedback, and progress relating to groups

3. Data Management
3.1. Consider a separate database or electronic data repository for group intervention data, including attendance, pre-post measures, etc. to have all of this information in one accessible spot to make evaluation process easier
3.2. Consider additional administration help for this
SECTION 6: ASSESSMENT MEASURES

Drug Taking Confidence Questionnaire (DTCQ)

As this is a copyrighted test, a copy could not be included in this package.

Acronym: **DTCQ**.

Authors: Annis, Helen M.; Sklar, Sherrilyn M.; Turner, Nigel E

Publication Date: 1997.

Publisher Information: Centre for Addiction and Mental Health, Marketing Services, 33 Russell Street, Toronto, Ontario, M5S 2S1, Canada, info@camh.ca, [http://www.camh.ca](http://www.camh.ca)

Purpose: 'As an assessment tool, the DTCQ identifies a client's coping self-efficacy in relation to 50 drinking or drug-taking situations'

Test Category: Alcohol and Substance Use.


Scores: Situation profiles in two areas: Personal States, Situations Involving Other People; 8 subscales: Unpleasant Emotions, Physical Discomfort, Pleasant Emotions, Testing Personal Control, Urges and Temptations to Use, Conflict with Others, Social Pressure to Use, Pleasant Times with Others.

Administration: Group.

Time: (15) minutes

Price Data: 1998 price data: C$34.95 per user's guide; C$14.95 per 30 questionnaires (specify alcohol or drug); C$39.95 per sample pack including user's guide and 40 questionnaires (10 alcohol and 30 drug); C$75 per 50 uses of computer-administration software (DOS format).

Comments: User's guide written in both English and French; 'French versions of DTCQ have not been scientifically validated.'

Reviewers: Campbell, Michael H; Gelman, Glenn B.

Yearbook Volume: 14.


Published Test Description: Drug-Taking Confidence Questionnaire. Purpose: 'As an assessment tool, the DTCQ identifies a client's coping self-efficacy in relation to 50 drinking or drug-taking situations.' Population: Clients of addiction
treatment. Publication Date: 1997. Acronym: DTCQ. Scores: Situation profiles in two areas: Personal States, Situations Involving Other People; 8 subscales: Unpleasant Emotions, Physical Discomfort, Pleasant Emotions, Testing Personal Control, Urges and Temptations to Use, Conflict with Others, Social Pressure to Use, Pleasant Times with Others. Administration: Group. Price Data, 1998: C$34.95 per user's guide; C$39.95 per sample pack including user's guide and 40 questionnaires (specify alcohol or drug); C$75 per 50 uses of computer-administration software (DOS format). Time: (15) minutes. Comments: User's guide written in both English (160 pages) and French (69 pages); 'French versions of DTCQ have not been scientifically validated.' Authors: Helen M. Annis, Sherrilyn M. Sklar, and Nigel E. Turner. Publisher: Centre for Addiction and Mental Health [Canada]. Accession Number: test.2126

Review of the Drug-Taking Confidence Questionnaire by MICHAEL H. CAMPBELL, Director of Residential Life, New College of University of South Florida at Sarasota, Sarasota, FL:

TEST COVERAGE AND USE. The Drug-Taking Confidence Questionnaire (DTCQ) is a 50-item self-report instrument designed to measure self-efficacy regarding substance abuse in a wide variety of psychological states and social situations. The authors state that the DTCQ is an appropriate tool for the initial assessment of clients entering treatment for alcohol or drug addiction; however, the instrument can be re-administered during the course of treatment to monitor progress or to suggest a honing of treatment focus to particular problem areas. Additionally, the DTCQ can be used as a treatment outcome indicator for either research or clinical purposes.

Once clear advantage of the instrument is flexibility with regard to specific substances. Test materials include two forms. The first measures alcohol-related self-efficacy in each of 50 situations; the second allows clients to specify specific substances. Clients may identify up to three substances (including alcohol).

TEST CONSTRUCTION. The manual does not provide a detailed description of item selection procedures, but the authors do state that the DTCQ is based on Bandura's (1977) theory of self-efficacy applied to eight categories of drinking or drug-taking situations proposed by Marlatt (e.g., 1978, 1979). Self-efficacy is operationalized in terms of the client's anticipatory confidence that he or she "would be able to resist the urge to drink heavily" in each of 50 situations representative of Marlatt's eight categories. The test employs a Likert-style response format ranging in 20-point increments from 0% (not at all confident) to 100% (very confident). The DTCQ items produce subscale scores measuring self-efficacy in situations involving Personal States (Unpleasant Emotions, Physical Discomfort, Pleasant Emotions, Testing Personal Control, and Urges/Temptations to Use) or Situations Involving Other People (Conflict with Others, Social Pressure to Use, and Pleasant Times with Others). Most subscales are composed of 5 items; the scales measuring unpleasant emotions and conflict with others each contain 10 items. Items are face-valid, and test takers could easily fake good or bad.

The authors report on a series of confirmatory factor-analytic studies used to verify the appropriateness of Marlatt's eight-factor model in comparison to several alternatives. Although all models leave a significant amount of covariance unexplained, the eight-factor solution provides the best fit to the data. The manual also details results of a second-order factor analysis suggesting a three-factor structure (negative situations, positive situations, and temptation situations). Overall, the factor-analytic data provide only limited support for the construct validity of an eight-factor subscale structure.

ADMINISTRATION AND SCORING. Ease of use is a major strength of the DTCQ. The manual provides simple, clear instructions, and the instructions to clients are clear and concise. The instrument is available in paper-and-pencil and computerized formats, each of which requires about 15 minutes to complete per substance. The authors report data documenting the equivalence of written and computerized versions of the test.

The result of scoring is a confidence score on each scale for each substance assessed. Test users should be
careful not to confuse the terms confidence score and confidence intervals. The DTCQ does not yield confidence intervals. Rather, the confidence score reflects the strength of the test taker's confidence in his or her ability to "drink heavily" or "use drugs" in each category of situation.

NORMS. The total sample size for normative data was 713, subdivided into 344 alcohol clients, 253 cocaine clients, and 116 other drug clients. The participants were recruited from clients seeking treatment at a facility in Toronto. Characteristics of the sample suggest some caution regarding the range of populations with which the test may be used appropriately. First, many clients were self-selected in that they were in treatment for addictions; those not self-selected were mandated court referrals, which constituted 16.6% of the total sample. Second, samples for each of the three substance groups were predominately male (ranging from 73.9% to 77.9% of each group). Third, over 40% of the total sample were unemployed. Finally, the majority of clients had received prior treatment. The characteristics of the sample suggest that norms are based on a sample with relatively debilitating, chronic patterns of abuse. Therefore, clinicians should use caution when using the DTCQ for clients with less severe or long-standing substance abuse problems (e.g., in a college counseling center setting). The lack of demographic data regarding the sample is a serious limitation of this instrument. The manual does not list the ethnic or racial composition of the sample and no such data are used in any analysis.

RELIABILITY. The internal consistency of the DTCQ appears good. Cronbach's alpha coefficients for each subscale ranged from .79 to .95 in separate analyses of the alcohol, cocaine, and other drug samples. The authors do not report test-retest or alternate form reliability data.

VALIDITY. The authors first focus on validating the DTCQ as a measure of self-efficacy by correlating subscales with consumption variables (e.g., quantity and frequency of use), social context of use (social pressure and percentage of time spent drinking alone), and use-related criteria (e.g., years of drug use and motivation to quit). Second, they correlate subscales with several psychometric instruments. Correlations were generally in the predicted directions, but the strengths of relationship do not provide compelling evidence of validity. A more serious issue, however, is the authors' choice of types of validity evidence to evaluate. The studies reported in the manual do provide evidence of convergent and discriminant construct validity using several self-reported historical behaviors as well as a broad array of criterion instruments (e.g., the Depression Subscale of the SCL-90-R, the Stages of Change Readiness and Treatment Eagerness Scale, and the Beck Depression Inventory). However, no attention is given to the predictive validity of scores from the instrument in terms of treatment prognosis or outcome, with the exception of a reference to previously published data regarding the positive impact of self-efficacy on treatment outcome.

SUMMARY. The available data suggest that the DTCQ shows promise as a convenient, cost-effective tool for assessment of clients in treatment for substance abuse, particularly in programs with a cognitive-behavioral emphasis. However, the initial sampling procedures are vulnerable to several serious criticisms, and further research is needed to provide stronger documentation of validity. In particular, research demonstrating the predictive validity of scores from the DTCQ would increase its viability as a clinical tool.
Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES)

Version 8

SOCRATES is an experimental instrument designed to assess readiness for change in alcohol abusers. The instrument yields three factorially-derived scale scores: Recognition (Rn), Ambivalence (Am), and Taking Steps (Ts). It is a public domain instrument and may be used without special permission.

Answers are to be recorded directly on the questionnaire form. Scoring is accomplished by transferring to the SOCRATES Scoring Form the numbers circled by the respondent for each item. The sum of each column yields the three scale scores. Data entry screens and scoring routines are available.

These instruments are provided for research uses only. Version 8 is a reduced 19-item scale based on factor analyses with prior versions. The shorter form was developed using the items that most strongly marked each factor. The 19-item scale scores are highly related to the longer (39 item) scale for Recognition (r = .96), Taking Steps (.94), and Ambivalence (.88). We therefore currently recommend using the 19-item Version 8 instrument.

Psychometric analyses revealed the following psychometric characteristics of the 19-item SOCRATES:

<table>
<thead>
<tr>
<th>Scale</th>
<th>Cronbach Alpha</th>
<th>Test-retest Reliability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambivalence</td>
<td>.69 -.88</td>
<td>.82</td>
</tr>
<tr>
<td>Recognition</td>
<td>.85 -.95</td>
<td>.88</td>
</tr>
<tr>
<td>Taking Steps</td>
<td>.83 -.96</td>
<td>.91</td>
</tr>
</tbody>
</table>

Various other forms of the SOCRATES have been developed. These will be migrated into shorter 8.0 versions as psychometric studies are completed. They are:

8D 19-item drug/alcohol questionnaire for clients
7A-SO-M 32-item alcohol questionnaire for significant others of males
7A-SO-F 32-item alcohol questionnaire for SOs of females
7D-SO-F 32-item drug/alcohol questionnaire for SOs of females
7D-SO-M 32-item drug/alcohol questionnaire for SOs of males

The parallel SO forms are designed to assess the motivation for change of significant others (not collateral estimates of clients' motivation). The SO forms lack a Maintenance scale, and therefore are 32 items in length.

Prochaska and DiClemente have developed a more general stages of change measure known as the University of Rhode Island Change Assessment (URICA). The SOCRATES differs from the URICA in that SOCRATES poses questions specifically about alcohol or other drug use, whereas URICA asks about the client's “problem” and change in a more general manner.

Source Citation:

## Personal Drug Use Questionnaire (SOCRATES 8D)

**INSTRUCTIONS:** Please read the following statements carefully. Each one describes a way that you might (or might not) feel about your drug use. For each statement, circle one number from 1 to 5, to indicate how much you agree or disagree with it right now. Please circle one and only one number for every statement.

<table>
<thead>
<tr>
<th>Statement</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I really want to make changes in my use of drugs.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Sometimes I wonder if I am an addict.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. If I don’t change my drug use soon, my problems are going to get worse.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. I have already started making some changes in my use of drugs.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. I was using drugs too much at one time, but I’ve managed to change that.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Sometimes I wonder if my drug use is hurting other people.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. I have a drug problem.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>8. I’m not just thinking about changing my drug use, I’m already doing something about it.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. I have already changed my drug use, and I am looking for ways to keep from slipping back to my old pattern.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. I have serious problems with drugs.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Statement</td>
<td>NO! Strongly Disagree</td>
<td>NO Disagree</td>
<td>Undecided or Unsure</td>
<td>Yes Agree</td>
<td>YES! Strongly Agree</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>-----------------------</td>
<td>-------------</td>
<td>---------------------</td>
<td>-----------</td>
<td>---------------------</td>
</tr>
<tr>
<td>11. Sometimes I wonder if I am in control of my drug use.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12. My drug use is causing a lot of harm.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>13. I am actively doing things now to cut down or stop my use of drugs.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>14. I want help to keep from going back to the drug problems that I had</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>15. I know that I have a drug problem.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>16. There are times when I wonder if I use drugs too much.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>17. I am a drug addict.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>18. I am working hard to change my drug use.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>19. I have made some changes in my drug use, and I want some help to</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>keep from going back to the way I used before.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Positive and Negative Syndrome Scale (PANSS) Review from the Mental Measurements Yearbook

As this is a copyrighted test, a copy of the scale cannot be included in the appendices.

Title: Positive and Negative Syndrome Scale

Acronym: PANSS

Authors: Kay, Stanley R.; Opler, Lewis A.; Fiszbein, Abraham


Publisher Information:

Purpose: Designed to assist in the assessment of schizophrenia

Test Category: Personality.

Population: Psychiatric patients.

Scores: 9 clinical dimensions: Positive Syndrome, Negative Syndrome, Composite Index, General Psychopathology, Anergia, Thought Disturbance, Activation, Paranoid Belligerence, Depression.

Administration: Individual.

Time: (30-40) minutes

Price Data: 1993 price data: $95 per complete kit including manual, 25 QuikScore forms, and 25 Structured Clinical Interview forms; $30 per manual; $30 per 25 QuikScore forms; $50 per 25 SCI-PANSS Structured Clinical Interview forms.

Comments: Completed by clinician

Reviewers: Kaplan, Barbara J.; Reynolds, Cecil R.

Yearbook Volume: 12.


Acronym: PANSS. Scores: 9 clinical dimensions: Positive Syndrome, Negative Syndrome, Composite

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Accession Number: 1357

Positive and Negative Syndrome Scale

Review of the Positive and Negative Syndrome Scale by BARBARA J. KAPLAN, Psychologist, Western New York Institute for the Psychotherapies, Orchard Park, NY:

Use of the Positive and Negative Syndrome scale (PANSS) requires that the individuals to be assessed already be diagnosed as schizophrenic. This 30-item instrument looks at the symptomatology of schizophrenia primarily in terms of two clusters of "positive" and "negative" symptoms. Positive symptoms are those that represent an addition of certain specific characteristics in schizophrenia compared to normal mental status, such as hallucinations, delusions, grandiosity, and suspiciousness. Negative symptoms are those that represent absences in schizophrenia compared to normal mental status, such as blunted affect, emotional withdrawal, passivity, and difficulty in abstract thinking. Additional scales include a Composite (Positive minus Negative), General Psychopathology, and Aggression Risk. A series of studies covering the various scales, their standardization, reliability, and validity has been published.

The original normative sample consisted of 240 schizophrenic inpatients, with a high proportion of minorities and males. Several additional studies have since been conducted that enhance the validity of the instrument and indicate its usefulness in discriminating chronic from acute schizophrenics, helping to direct the choice of pharmacological treatment and evaluating posttreatment effects. Particularly interesting are the studies of the PANSS that address the PANSS' validity in predicting drug responsiveness and aggression.

Administration and scoring of the PANSS are fairly straightforward; however, this is not a diagnostic instrument. It is most usefully administered to schizophrenic patients when some additional information as to the profile of symptoms is desirable. It should not be administered or interpreted by someone without considerable knowledge of schizophrenic patients. The ratings of severity are made on a 7-point scale by the person administering the test. Although there are guidelines in rating the severity of symptoms, it is important that interrater reliability be established and periodically reassessed when the PANSS is used because the instrument itself depends to a great extent on clinical experience. The anchor points for the scales are likely to drift without reestablishing interrater reliability on a periodic basis.

The scoring manual for the test details the limitations and aptness of the instrument for various purposes. Although the PANSS is not a diagnostic instrument, the information it provides should function to illuminate some of the finer differentiations in schizophrenic patients.

The PANSS appears to be most appropriately used in trying to determine whether patients will be drug-responsive or drug-resistant to neuroleptics. The profile of symptoms focuses on what psychopharmacological agent might be effective. In addition, the PANSS offers some provocative data relevant to improving predictions of the risk of violent behavior. Additional use of the PANSS for these purposes would provide useful and welcome information.
Reactions to Provocations (RP)

### Clinical Outcomes of Routine Evaluation- Outcome Measure (CORE – OM)

**Over the last week**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Not at all</th>
<th>Only occasionally</th>
<th>Sometime</th>
<th>Often</th>
<th>Most or all of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I have felt terribly alone and isolated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I have felt tense, anxious or nervous</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. I have felt I have someone to turn to for support when needed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. I have felt OK about myself</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. I have felt totally lacking in energy and enthusiasm</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>6. I have been physically violent to others</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>7. I have felt able to cope when things go wrong</td>
<td></td>
<td></td>
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<tr>
<td>8. I have been troubled by aches, pains or other physical problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. I have thought of hurting myself</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>10. Talking to people has felt too much for me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Tension and anxiety have prevented me doing important things</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>12. I have been happy with the things I have done</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. I have been disturbed by unwanted thoughts and feelings</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>14. I have felt like crying</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**Please turn over**

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Supported by www.coreyms.co.uk
**Barratt Impulsivity Scale (BIS)**

**DIRECTIONS:** People differ in the ways they act and think in different situations. This is a test to measure some of the ways in which you act and think. Read each statement and put an X on the appropriate circle on the right side of this page. Do not spend too much time on any statement. Answer quickly and honestly.

<table>
<thead>
<tr>
<th></th>
<th>Rarely/Never</th>
<th>Occasionally</th>
<th>Often</th>
<th>Almost Always/Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I plan tasks carefully.</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>I do things without thinking.</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>I make-up my mind quickly.</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>I am happy-go-lucky.</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>I don’t “pay attention.”</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>I have “racing” thoughts.</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>I plan trips well ahead of time.</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>I am self controlled.</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>I concentrate easily.</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>I save regularly.</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>I “squirrel” at plays or lectures.</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>I am a careful thinker.</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>I plan for job security.</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>I say things without thinking.</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>I like to think about complex problems.</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>I change jobs.</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>I act “on impulse.”</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>I get easily bored when solving thought problems.</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>I act on the spur of the moment.</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>I am a steady thinker.</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>I change residences.</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>I buy things on impulse.</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>I can only think about one thing at a time.</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>I change hobbies.</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>I spend or charge more than I earn.</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>I often have extraneous thoughts when thinking.</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>I am more interested in the present than the future.</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>I am restless at the theater or lectures.</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>I like puzzles.</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>I am future oriented.</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Over the last week

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Only occasionally</th>
<th>Sometimes</th>
<th>Often</th>
<th>Most or all of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>I have felt panic or terror</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>16</td>
<td>I made plans to end my life</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>17</td>
<td>I have felt overwhelmed by my problems</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>18</td>
<td>I have had difficulty getting to sleep or staying asleep</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>19</td>
<td>I have felt warmth or affection for someone</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>20</td>
<td>My problems have been impossible to put to one side</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>21</td>
<td>I have been able to do most things I needed to</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>22</td>
<td>I have threatened or intimidated another person</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>23</td>
<td>I have felt despairing or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>24</td>
<td>I have thought it would be better if I were dead</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>25</td>
<td>I have felt criticised by other people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>26</td>
<td>I have thought I have no friends</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>27</td>
<td>I have felt unhappy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>28</td>
<td>Unwanted images or memories have been distressing me</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>29</td>
<td>I have been irritable when with other people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>30</td>
<td>I have thought I am to blame for my problems and difficulties</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>31</td>
<td>I have felt optimistic about my future</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>32</td>
<td>I have achieved the things I wanted to</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>33</td>
<td>I have felt humiliated or shamed by other people</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>34</td>
<td>I have hurt myself physically or taken dangerous risks with my health</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**THANK YOU FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE**

**Total Scores**

**Mean Scores**

(W) (F) (R) All items All minus R

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Find it here: courses.wcupa.edu/ttreadwe/cognitivepdrma/Cognitivescales/PBQ-LF/pbq2.doc
Aggression Questionnaire

Aggression Questionnaire (Buss & Perry, 1992)

Instructions:

Using the 5 point scale shown below, indicate how uncharacteristic or characteristic each of the following statements is in describing you. Place your rating in the box to the right of the statement.

1 = extremely uncharacteristic of me
2 = somewhat uncharacteristic of me
3 = neither uncharacteristic nor characteristic of me
4 = somewhat characteristic of me
5 = extremely characteristic of me

1. Some of my friends think I am a hothead  
2. If I have to resort to violence to protect my rights, I will.  
3. When people are especially nice to me, I wonder what they want.  
4. I tell my friends openly when I disagree with them.  
5. I have become so mad that I have broken things.  
6. I can’t help getting into arguments when people disagree with me.  
7. I wonder why sometimes I feel so bitter about things.  
8. Once in a while, I can’t control the urge to strike another person.  
9.* I am an even-tempered person.  
10. I am suspicious of overly friendly strangers.  
11. I have threatened people I know.  
12. I flare up quickly but get over it quickly.  
13. Given enough provocation, I may hit another person.  
14. When people annoy me, I may tell them what I think of them.  
15. I am sometimes eaten up with jealousy.  
16.* I can think of no good reason for ever hitting a person.  
17. At times I feel I have gotten a raw deal out of life.  
18. I have trouble controlling my temper.  
19. When frustrated, I let my irritation show.  
20. I sometimes feel that people are laughing at me behind my back.  
21. I often find myself disagreeing with people.  
22. If somebody hits me, I hit back.  
23. I sometimes feel like a powder keg ready to explode.  
24. Other people always seem to get the breaks.  
25. There are people who pushed me so far that we came to blows.
26. I know that “friends” talk about me behind my back. □ H
27. My friends say that I’m somewhat argumentative. □ VA
28. Sometimes I fly off the handle for no good reason. □ A
29. I get into fights a little more than the average person. □ PA

Scoring

The two questions with the asterisk are reverse scored.

The Aggression scale consists of 4 factors, Physical Aggression (PA), Verbal Aggression (VA), Anger (A) and Hostility (H). The total score for Aggression is the sum of the factor scores.

References

Reduced Emotional Reactivity Scale (REIS)

Difficulties in Emotion Regulation Scale – Short Form (DERS-SF)

Please indicate how often the following apply to you.

<table>
<thead>
<tr>
<th>Difficulties</th>
<th>Almost Never (0–10%)</th>
<th>Sometimes (11–35%)</th>
<th>About Half of the Time (36–65%)</th>
<th>Most of the Time (66–90%)</th>
<th>Almost Always (91–100%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I pay attention to how I feel</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. I have no idea how I am feeling</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. I have difficulty making sense out of my feelings</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. I care about what I am feeling</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. I am confused about how I feel</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. When I’m upset, I acknowledge my emotions</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. When I’m upset, I become embarrassed for feeling that way</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. When I’m upset, I have difficulty getting work done</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. When I’m upset, I become out of control</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. When I’m upset, I believe that I will end up feeling very depressed</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. When I’m upset, I have difficulty focusing on other things</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12. When I’m upset, I feel guilty for feeling that way</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>13. When I’m upset, I have difficulty concentrating</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>14. When I’m upset, I have difficulty controlling my behaviors</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>15. When I’m upset, I believe there is nothing I can do to make myself feel better</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>16. When I’m upset, I become irritated with myself for feeling that way</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>17. When I’m upset, I lose control over my behavior</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>18. When I’m upset, it takes me a long time to feel better</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
SCORING
Scales can be scored using sums or averages of items. If the goal is comparison to the original DERS questionnaire, consider using averages of each subscale so that the scores are in the metric of the response scale. Please note that all three items in the Awareness scale should be reverse coded. All subscales are scored so that higher values reflect greater difficulty with emotion regulation.

Subscales:

Strategies
10. When I’m upset, I believe that I will end up feeling very depressed.
15. When I’m upset, I believe there is nothing I can do to make myself feel better.
18. When I’m upset, it takes me a long time to feel better.

Non-acceptance
7. When I’m upset, I become embarrassed for feeling that way.
12. When I’m upset, I feel guilty for feeling that way.
16. When I’m upset, I become irritated at myself for feeling that way.

Impulse
9. When I’m upset, I become out of control.
14. When I’m upset, I have difficulty controlling my behavior.
17. When I’m upset, I lose control over my behavior.

Goals
8. When I’m upset, I have difficulty getting work done.
11. When I’m upset, I have difficulty focusing on other things.
13. When I’m upset, I have difficulty concentrating.

Awareness
1. I pay attention to how I feel. [reverse code]
4. I care about what I am feeling. [reverse code]
6. When I’m upset, I acknowledge my emotions. [reverse code]

Clarity
2. I have no idea how I am feeling.
3. I have difficulty making sense out of my feelings.
5. I am confused about how I feel.

Emotion Regulation Questionnaire (ERQ)

This questionnaire is designed to assess individual differences in the habitual use of two emotion regulation strategies: cognitive reappraisal and expressive suppression.

Citation

Instructions and Items
We would like to ask you some questions about your emotional life, in particular, how you control (that is, regulate and manage) your emotions. The questions below involve two distinct aspects of your emotional life. One is your emotional experience, or what you feel like inside. The other is your emotional expression, or how you show your emotions in the way you talk, gesture, or behave. Although some of the following questions may seem similar to one another, they differ in important ways. For each item, please answer using the following scale:

1. **strongly disagree**
2. **neutral**
3. **agree**

1. ____ When I want to feel more positive emotion (such as joy or amusement), I change what I’m thinking about.
2. ____ I keep my emotions to myself.
3. ____ When I want to feel less negative emotion (such as sadness or anger), I change what I’m thinking about.
4. ____ When I am feeling positive emotions, I am careful not to express them.
5. ____ When I’m faced with a stressful situation, I make myself think about it in a way that helps me stay calm.
6. ____ I control my emotions by not expressing them.
7. ____ When I want to feel more positive emotion, I change the way I’m thinking about the situation.
8. ____ I control my emotions by changing the way I think about the situation I’m in.
9. ____ When I am feeling negative emotions, I make sure not to express them.
10. ____ When I want to feel less negative emotion, I change the way I’m thinking about the situation.

**Note**
Do not change item order, as items 1 and 3 at the beginning of the questionnaire define the terms “positive emotion” and “negative emotion”.

**Scoring (no reversals)**
Reappraisal Items: 1, 3, 5, 7, 8, 10; Suppression Items: 2, 4, 6, 9.
Social-Problem Solving-Inventory – Revised (SPSI – R)


Find it here: https://www.mhs.com/MHS-Assessment?prodname=spsi-r
Work and Social Adjustment Scale

Five Facet Mindfulness Questionnaire

Description:
This instrument is based on a factor analytic study of five independently developed mindfulness questionnaires. The analysis yielded five factors that appear to represent elements of mindfulness as it is currently conceptualized. The five facets are observing, describing, acting with awareness, non-judging of inner experience, and non-reactivity to inner experience. More information is available in:

Please rate each of the following statements using the scale provided. Write the number in the blank that best describes your own opinion of what is generally true for you.

1. When I’m walking, I deliberately notice the sensations of my body moving.
2. I’m good at finding words to describe my feelings.
3. I criticize myself for having irrational or inappropriate emotions.
4. I perceive my feelings and emotions without having to react to them.
5. When I do things, my mind wanders off and I’m easily distracted.
6. When I take a shower or bath, I stay alert to the sensations of water on my body.
7. I can easily put my beliefs, opinions, and expectations into words.
8. I don’t pay attention to what I’m doing because I’m daydreaming, worrying, or otherwise distracted.
9. I watch my feelings without getting lost in them.
10. I tell myself I shouldn’t be feeling the way I’m feeling.
11. I notice how foods and drinks affect my thoughts, bodily sensations, and emotions.
12. It’s hard for me to find the words to describe what I’m thinking.
13. I am easily distracted.
14. I believe some of my thoughts are abnormal or bad and I shouldn’t think that way.
15. I pay attention to sensations, such as the wind in my hair or sun on my face.
16. I have trouble thinking of the right words to express how I feel about things.
17. I make judgments about whether my thoughts are good or bad.
18. I find it difficult to stay focused on what’s happening in the present.
19. When I have distressing thoughts or images, I “step back” and am aware of the thought or image without getting taken over by it.
20. I pay attention to sounds, such as clocks ticking, birds chirping, or cars passing.
21. In difficult situations, I can pause without immediately reacting.
22. When I have a sensation in my body, it’s difficult for me to describe it because I can’t find the right words.
23. It seems I am “running on automatic” without much awareness of what I’m doing.

24. When I have distressing thoughts or images, I feel calm soon after.

25. I tell myself that I shouldn’t be thinking the way I’m thinking.

26. I notice the smells and aromas of things.

27. Even when I’m feeling terribly upset, I can find a way to put it into words.

28. I rush through activities without being really attentive to them.

29. When I have distressing thoughts or images I am able just to notice them without reacting.

30. I think some of my emotions are bad or inappropriate and I shouldn’t feel them.

31. I notice visual elements in art or nature, such as colors, shapes, textures, or patterns of light and shadow.

32. My natural tendency is to put my experiences into words.

33. When I have distressing thoughts or images, I just notice them and let them go.

34. I do jobs or tasks automatically without being aware of what I’m doing.

35. When I have distressing thoughts or images, I judge myself as good or bad, depending what the thought/image is about.

36. I pay attention to how my emotions affect my thoughts and behavior.

37. I can usually describe how I feel at the moment in considerable detail.

38. I find myself doing things without paying attention.

39. I disapprove of myself when I have irrational ideas.

Scoring Information:
Observe items:
1, 6, 11, 15, 20, 26, 31, 36
Describe items:
2, 7, 12R, 16R, 22R, 27, 32, 37
Act with Awareness items:
Nonjudge items:
Nonreact items:
4, 9, 19, 21, 24, 29, 33

Reference:
The Perceived Stress Scale (PSS)


Quality of Life Enjoyment and Satisfaction Questionnaire (QLESQ)

Name: ________________________________     Date: __________________

Quality of Life Enjoyment and Satisfaction Questionnaire – Short Form
(Q-LES-Q-SF)

Taking everything into consideration, during the past week how satisfied have you been with your...........

<table>
<thead>
<tr>
<th></th>
<th>Very Poor</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
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<td>1</td>
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<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>mood?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>work?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>household activities?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>social relationships?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>family relationships?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>leisure time activities?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>ability to function in daily life?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>sexual drive, interest and/or performance?*</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>economic status?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>living/housing situation?*</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>ability to get around physically without feeling dizzy or unsteady or falling?*</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>your vision in terms of ability to do work or hobbies?*</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>overall sense of well being?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>medication? (If not taking any, check here and leave item blank.)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>How would you rate your overall life satisfaction and contentment during the past week?</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

*If satisfaction is very poor, poor or fair on these items, please UNDERLINE the factor(s) associated with a lack of satisfaction.
Scoring the Quality of Life Enjoyment and Satisfaction Questionnaire – Short Form (Q-LES-Q-SF)

The scoring of the Q-LES-Q-SF involves summing only the first 14 items to yield a raw total score. The last two items are not included in the total score but are stand-alone items. The raw total score ranges from 14 to 70. The raw total score is transformed into a percentage maximum possible score using the following formula:

\[
\frac{\text{raw total score} - \text{minimum score}}{\text{maximum possible raw score} - \text{minimum score}}
\]

The minimum raw score on the Q-LES-Q-SF is 14, and the maximum score is 70. Thus the formula for % maximum can also be written as \((\text{raw score} - 14)/56\). The table below converts total raw scores into % maximum scores.

<table>
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<tr>
<th>Raw Score</th>
<th>% Maximum</th>
<th>Raw Score</th>
<th>% Maximum</th>
<th>Raw Score</th>
<th>% Maximum</th>
<th>Raw Score</th>
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<td>36</td>
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Copyright notice: The Quality of Life Enjoyment and Satisfaction Questionnaire – Short Form (Q-LES-Q-SF) is copyrighted by Jean Endicott, Ph.D. Permission has been granted to reproduce the scale on this website for clinicians to use in their practice and for researchers to use in non-industry studies. For other uses of the scale, the owner of the copyright should be contacted.

Citation: Endicott J, Nee J, Harrison W, Blumenthal R. Quality of Life Enjoyment and Satisfaction Questionnaire: A New Measure. Psychopharmacology Bulletin 1993;29:321-326.
Shortened COPE Inventory

These items deal with ways you’ve been coping with the stress in your life since you found out you were going to have to have this operation. There are many ways to try to deal with problems. These items ask what you’ve been doing to cope with this one. Obviously, different people deal with things in different ways, but I’m interested in how you’ve tried to deal with it. Each item says something about a particular way of coping. I want to know to what extent you’ve been doing what the item says. How much or how frequently. Don’t answer on the basis of whether it seems to be working or not—just whether or not you’re doing it. Use these response choices. Try to rate each item separately in your mind from the others. Make your answers as true FOR YOU as you can.

1 = I haven’t been doing this at all  
2 = I’ve been doing this a little bit  
3 = I’ve been doing this a medium amount  
4 = I’ve been doing this a lot

1. I’ve been turning to work or other activities to take my mind off things.
2. I’ve been concentrating my efforts on doing something about the situation I’m in.
3. I’ve been saying to myself “this isn’t real.”
4. I’ve been using alcohol or other drugs to make myself feel better.
5. I’ve been getting emotional support from others.
6. I’ve been giving up trying to deal with it.
7. I’ve been taking action to try to make the situation better.
8. I’ve been refusing to believe that it has happened.
9. I’ve been saying things to let my unpleasant feelings escape.
10. I’ve been getting help and advice from other people.
11. I’ve been using alcohol or other drugs to help me get through it.
12. I’ve been trying to see it in a different light, to make it seem more positive.
13. I’ve been criticizing myself.
14. I’ve been trying to come up with a strategy about what to do.
15. I’ve been getting comfort and understanding from someone.
16. I’ve been giving up the attempt to cope.

17. I’ve been looking for something good in what is happening.

18. I’ve been making jokes about it.

19. I’ve been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.

20. I’ve been accepting the reality of the fact that it has happened.

21. I’ve been expressing my negative feelings.

22. I’ve been trying to find comfort in my religion or spiritual beliefs.

23. I’ve been trying to get advice or help from other people about what to do.

24. I’ve been learning to live with it.

25. I’ve been thinking hard about what steps to take.

26. I’ve been blaming myself for things that happened.

27. I’ve been praying or meditating.

28. I’ve been making fun of the situation.


Scales Computed as Follows

Self-distraction, items 1 and 19

Active coping, items 2 and 7

Denial, items 3 and 8

Substance use, items 4 and 11

Use of emotional support, items 5 and 15

Use of instrumental support, items 10 and 23
Behavioral disengagement, items 6 and 16
Venting, items 9 and 21
Positive reframing, items 12 and 17
Planning, items 14 and 25
Humor, items 18 and 28
Acceptance, items 20 and 24
Religion, items 22 and 27
Self-blame, items 13 and 26
Generic Program Performance Measure (GPPM)


<table>
<thead>
<tr>
<th></th>
<th>-2 Needs a lot of improvement</th>
<th>-1 Needs some improvement</th>
<th>0 Satisfactory</th>
<th>+1 Good</th>
<th>+2 Excellent</th>
<th>Rating (Score)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Punctuality (E)</td>
<td>Frequent unauthorized late arrivals</td>
<td>Occasional unauthorized late arrivals</td>
<td>Unauthorized late arrivals. Some authorized late arrivals</td>
<td>No unauthorized late arrivals. Very few authorized late arrivals</td>
<td>He/she is always punctual. Minimal authorized late arrivals.</td>
<td>Post only</td>
</tr>
<tr>
<td>2. Participation (E)</td>
<td>Rarely or never participates in group discussions and exercises.</td>
<td>Occasionally participates in group discussions and exercises.</td>
<td>Usually participates in group discussions and exercises.</td>
<td>Consistently participates in group discussions and exercises.</td>
<td>Always participates in group discussions and exercises.</td>
<td>Post only</td>
</tr>
<tr>
<td>3. Completes required assigned work (E)</td>
<td>Rarely or never completes assigned work.</td>
<td>Occasionally completes assigned work.</td>
<td>Usually completes work.</td>
<td>Consistently completes assigned work.</td>
<td>Always completes assigned work.</td>
<td>Post only</td>
</tr>
<tr>
<td>4. Attentive to program (E)</td>
<td>Rarely or never pays attention to program information.</td>
<td>Occasionally pays attention to program information.</td>
<td>Usually pays attention to program information.</td>
<td>Demonstrates good attention to and interest in program information.</td>
<td>Always demonstrates high interest in all aspects of the program information</td>
<td>Post only</td>
</tr>
<tr>
<td>5. Applies program content to own personal situation (P)</td>
<td>Cannot apply the content to himself or does not see it is relevant.</td>
<td>Makes an effort, but not able to apply much program content to own personal situation.</td>
<td>Usually applies program content to own personal situation.</td>
<td>Good application of program content to own personal situation and is able to generalize material to many areas of his life.</td>
<td>Always applies program content to own personal situation and generalizes the content to many problematic areas of his life.</td>
<td>Post only</td>
</tr>
<tr>
<td>6. Interpersonal relationship with facilitator(s) (R)</td>
<td>No working alliance established. Very resistant, or confrontational or argumentative, or disruptive or unresponsive with facilitator(s).</td>
<td>Less than satisfactory working alliance with facilitator. Somewhat resistant, or argumentative and/or disruptive with facilitator.</td>
<td>Attitude and behaviour towards facilitator(s) are not problematic.</td>
<td>Good working alliance. Responsive to the facilitator(s).</td>
<td>Excellent working alliance established. Always very responsive to facilitator(s).</td>
<td>Pre Post</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-2 Needs a lot of improvement</td>
<td>-1 Needs some improvement</td>
<td>0 Satisfactory</td>
<td>+1 Good</td>
<td>+2 Excellent</td>
</tr>
<tr>
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</tr>
<tr>
<td>7. Mutual agreement on goals of treatment (R)</td>
<td></td>
<td>Does not work with facilitator(s) on establishing and meeting mutual goals of treatment.</td>
<td>Makes minimal attempt to work with facilitator(s) on establishing and meeting mutual goals of treatment.</td>
<td>Usually works with facilitator(s) on establishing and meeting mutual goals of treatment.</td>
<td>Works well with facilitator(s) on establishing and meeting mutual goals of treatment.</td>
<td>Always works consistently and well with facilitator(s) on establishing and meeting mutual goals of treatment.</td>
</tr>
<tr>
<td>8. Motivation to change behaviour (R)</td>
<td></td>
<td>Not motivated to change, no perceived interest in changing problem behaviour, or no belief that s/he can change or that change is worthwhile. (Precontemplation)</td>
<td>Motivation to change is inconsistent or transient; thinking about making changes but not yet committed to taking action. (Contemplation)</td>
<td>Shows motivation to change and may be taking some steps towards making changes. (Preparation/Action)</td>
<td>Actively engaged in making changes. (Action)</td>
<td>Maintains high level of motivation even in the face of possible setbacks or challenges. (Action or Maintenance)</td>
</tr>
<tr>
<td>9. Prosocial goal setting (P)</td>
<td></td>
<td>Has not set goals to address criminogenic needs, or goals are very unrealistic, or not prosocial</td>
<td>Has set some goals to address criminogenic needs, but goals are somewhat vague, unrealistic or inappropriate or does not plan or take responsibility for achieving goals.</td>
<td>Has set realistic goals to address criminogenic needs and has some idea how to achieve goals.</td>
<td>Sets appropriate goals to address criminogenic needs and has a realistic plan to achieve goals.</td>
<td>Always does excellent work on setting appropriate goals to address criminogenic needs, sees the importance of short and long term goals, and has a realistic plan to achieve goals.</td>
</tr>
<tr>
<td>10. Understands the consequences of criminal, antisocial, and/or problematic behaviour to self and others (P)</td>
<td></td>
<td>Does not understand the consequences to self and others.</td>
<td>Insufficient, vague or inconsistent understanding of the consequences to self and others.</td>
<td>Satisfactory understanding of the consequences to self and others.</td>
<td>Good understanding of the consequence of his/her behaviour to self and others including victim(s), family and community.</td>
<td>Thorough understanding of the short and long term consequences for the full range of targets – victim(s), self, work, family, friends, community and society.</td>
</tr>
<tr>
<td></td>
<td>Rating (Score)</td>
<td>1. Excellent</td>
<td>1. Good</td>
<td>0. Satisfactory</td>
<td>-1 Needs improvement</td>
<td>-2 Needs a lot of improvement</td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td>11. Shows concern for consequences of criminal, antisocial, and/or problematic behaviour to self and others (P)</td>
<td>Consistently shows genuine and deep concern for the consequences of behaviour to self and others.</td>
<td>Good level of appropriate concern for the consequences to self and others. Actions are usually consistent with expressed concern.</td>
<td>Shows satisfactory level of concern for the consequences to self and others.</td>
<td>Insufficient or inconsistent concern for consequences of behaviour to self and others.</td>
<td>Does not show concern for consequences of behaviour to self and others.</td>
<td>Pre</td>
</tr>
<tr>
<td>12. Prosocial attitudes, beliefs and values (P)</td>
<td>Always and fully demonstrates prosocial attitudes, beliefs and values.</td>
<td>Consistently demonstrates prosocial beliefs, attitudes and values.</td>
<td>Usually demonstrates prosocial attitudes, beliefs and values.</td>
<td>Sometimes demonstrates prosocial attitudes, beliefs and values.</td>
<td>Never or rarely demonstrates prosocial attitudes, beliefs and values.</td>
<td>Pre</td>
</tr>
<tr>
<td>13. Knows a range of self management skills (e.g., thought stopping, problem solving, relaxation and social skills) (e.g., active listening) (P)</td>
<td>Thorough understanding of a full range of skills, including personalizing and integrating information.</td>
<td>Demonstrates good knowledge of many self management and social skills (e.g., paraphrases to show understanding, provide appropriate examples).</td>
<td>Satisfactory knowledge of self management and social skills (e.g., describes some skills, provides some examples of skills use).</td>
<td>Limited awareness of self management and social skills.</td>
<td>No knowledge of self management and social skills.</td>
<td>Pre</td>
</tr>
<tr>
<td>14. Demonstrates use of a range of self management skills (P)</td>
<td>Always uses a range of self management and social skills very competently.</td>
<td>Competently uses a range of self management and social skills where required.</td>
<td>Satisfactory use of a range of self management and social skills.</td>
<td>Demonstrates only partial or insufficient use of self management and social skills.</td>
<td>Demonstrates no use of self management and social skills.</td>
<td>Pre</td>
</tr>
<tr>
<td>15. Recognition of relevant factors related to his/her offence pattern (P)</td>
<td>Thorough recognition of the relevant factors.</td>
<td>Recognizes most of the relevant factors.</td>
<td>Recognizes some relevant factors.</td>
<td>Recognizes one relevant factor.</td>
<td>No recognition of the relevant factors.</td>
<td>Pre</td>
</tr>
<tr>
<td></td>
<td>-2 Needs a lot of improvement</td>
<td>-1 Needs some improvement</td>
<td>0 Satisfactory</td>
<td>+1 Good</td>
<td>+2 Excellent</td>
<td>Rating (Score)</td>
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</tr>
<tr>
<td>16. Develops a self management/relapse prevention plan to address the relevant risk factors (P)</td>
<td>Did not develop a plan.</td>
<td>Plan is insufficient or unrealistic.</td>
<td>Plan is fairly realistic and addresses many of the relevant risk factors. It is adequate.</td>
<td>Good plan is realistic and addresses most of the relevant risk factors.</td>
<td>Excellent plan is very detailed and realistic, including application of skills, personal strengths and community resources to address all of the relevant risk factors.</td>
<td>Pre</td>
</tr>
<tr>
<td>17. Ability to learn program material (R)</td>
<td>Substantial problems learning material (e.g., agitated or restless; poor attention or concentration; unable to assimilate content; disorganized; evidence of learning disability or being heavily medicated).</td>
<td>Some problems learning material.</td>
<td>Usually appears able to learn program materials (e.g., rarely agitated, rarely lapses in attention; no learning disability or medication).</td>
<td>Good ability to learn program material.</td>
<td>Excellent ability to learn program material (e.g., attentive, learns quickly; sees relevance of the material).</td>
<td>Pre</td>
</tr>
</tbody>
</table>
The Psychological Inventory of Criminal Thinking Styles (PICTS)


Interpersonal Reactivity Index (IRI)


INTERNATIONAL PHYSICAL ACTIVITY QUESTIONNAIRE
(August 2002)

SHORT LAST 7 DAYS SELF-ADMINISTERED FORMAT

FOR USE WITH YOUNG AND MIDDLE-AGED ADULTS (15-69 years)

The International Physical Activity Questionnaires (IPAQ) comprises a set of 4 questionnaires. Long (6 activity domains asked independently) and short (4 generic items) versions for use by either telephone or self-administered methods are available. The purpose of the questionnaires is to provide common instruments that can be used to obtain internationally comparable data on health-related physical activity.

Background on IPAQ
The development of an international measure for physical activity commenced in Geneva in 1998 and was followed by extensive reliability and validity testing undertaken across 12 countries (14 sites) during 2000. The final results suggest that these measures have acceptable measurement properties for use in many settings and in different languages, and are suitable for national population-based prevalence studies of participation in physical activity.

Using IPAQ
Use of the IPAQ instruments for monitoring and research purposes is encouraged. It is recommended that no changes be made to the order or wording of the questions as this will affect the psychometric properties of the instruments.

Translation from English and Cultural Adaptation
Translation from English is supported to facilitate worldwide use of IPAQ. Information on the availability of IPAQ in different languages can be obtained at [www.ipaq.ki.se](http://www.ipaq.ki.se). If a new translation is undertaken we highly recommend using the prescribed back translation methods available on the IPAQ website. If possible please consider making your translated version of IPAQ available to others by contributing it to the IPAQ website. Further details on translation and cultural adaptation can be downloaded from the website.

Further Developments of IPAQ
International collaboration on IPAQ is on-going and an International Physical Activity Prevalence Study is in progress. For further information see the IPAQ website.

More Information
More detailed information on the IPAQ process and the research methods used in the development of IPAQ instruments is available at [www.ipaq.ki.se](http://www.ipaq.ki.se) and Booth, M.L. (2000). Assessment of Physical Activity: An International Perspective. Research Quarterly for Exercise and Sport, 71 (2): s114-s20. Other scientific publications and presentations on the use of IPAQ are summarized on the website.
INTERNATIONAL PHYSICAL ACTIVITY QUESTIONNAIRE

We are interested in finding out about the kinds of physical activities that people do as part of their everyday lives. The questions will ask you about the time you spent being physically active in the last 7 days. Please answer each question even if you do not consider yourself to be an active person. Please think about the activities you do at work, as part of your house and yard work, to get from place to place, and in your spare time for recreation, exercise or sport.

Think about all the vigorous activities that you did in the last 7 days. Vigorous physical activities refer to activities that take hard physical effort and make you breathe much harder than normal. Think only about those physical activities that you did for at least 10 minutes at a time.

1. During the last 7 days, on how many days did you do vigorous physical activities like heavy lifting, digging, aerobics, or fast bicycling?

   _______ days per week

   [ ] No vigorous physical activities  →  Skip to question 3

2. How much time did you usually spend doing vigorous physical activities on one of those days?

   _______ hours per day
   _______ minutes per day

   [ ] Don’t know/Not sure

Think about all the moderate activities that you did in the last 7 days. Moderate activities refer to activities that take moderate physical effort and make you breathe somewhat harder than normal. Think only about those physical activities that you did for at least 10 minutes at a time.

3. During the last 7 days, on how many days did you do moderate physical activities like carrying light loads, bicycling at a regular pace, or doubles tennis? Do not include walking.

   _______ days per week

   [ ] No moderate physical activities  →  Skip to question 5

SHORT LAST 7 DAYS SELF-ADMINISTERED version of the IPAQ. Revised August 2002.
4. How much time did you usually spend doing moderate physical activities on one of those days?
   
   _____ hours per day
   _____ minutes per day
   
   □ Don't know/Not sure

Think about the time you spent walking in the last 7 days. This includes at work and at home, walking to travel from place to place, and any other walking that you have done solely for recreation, sport, exercise, or leisure.

5. During the last 7 days, on how many days did you walk for at least 10 minutes at a time?
   
   _____ days per week
   
   □ No walking → Skip to question 7

6. How much time did you usually spend walking on one of those days?
   
   _____ hours per day
   _____ minutes per day
   
   □ Don't know/Not sure

The last question is about the time you spent sitting on weekdays during the last 7 days. Include time spent at work, at home, while doing course work and during leisure time. This may include time spent sitting at a desk, visiting friends, reading, or sitting or lying down to watch television.

7. During the last 7 days, how much time did you spend sitting on a week day?
   
   _____ hours per day
   _____ minutes per day
   
   □ Don't know/Not sure

This is the end of the questionnaire, thank you for participating.

SHORT LAST 7 DAYS SELF-ADMINISTERED version of the IPAQ. Revised August 2002.

Taken with permission from: https://sites.google.com/site/theipaq/
Overall Group Satisfaction Questionnaire

One of the goals at Providence Care Forensic Mental Health Services is to provide our clients with the best care possible while they are with us for treatment. This survey will ask about your experience with the different groups available and help us identify how we can improve our services. Your feedback is valuable!

Client Satisfaction Survey: Groups

Please rate how much you agree with each statement below.

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<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
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<td>I felt well informed about the groups on the unit</td>
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<td>The group content and objectives were explained to me</td>
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<td>I was actively involved in my treatment</td>
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<td>• Ex. treatment goal setting</td>
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<td>The team listened to and addressed my concerns or problems regarding the groups</td>
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<td>There were groups offered that met my specific needs</td>
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<td>There were groups offered that met my personal goals for recovery</td>
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<td>I was referred to groups that were relevant to my treatment needs/goals</td>
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<td>The group schedule was well advertised</td>
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<td>The group schedule was acceptable</td>
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<td>• Ex. didn’t conflict with other groups/activities/appointments in my schedule</td>
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<td>I was informed if there were any changes regarding timing/scheduling of the group</td>
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<td>• Ex. group cancellations or rescheduling</td>
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<td>I learned something new or gained a new skill from the group(s) I attended</td>
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<td>I was engaged and participated appropriately in the group(s) I attended</td>
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<td>Attending groups was a positive experience</td>
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Please answer the following questions based on your own personal experiences attending groups:
What groups did you attend while on the unit?

What was the best thing about attending group(s)?

What was the worst thing about attending groups?

What do you think could make the groups better?

What is one thing you will take with you that you learned while at group?
References


Champagne, T. (2005, March). Expanding the role of sensory approaches for acute inpatient psychiatry. Mental Health Special Interest Section Quarterly.


Farnworth, L., Nikitin, L., & Fossey, E. (2004). Being in a secure forensic psychiatric unit: Every day is the same, killing time or making the most of it. *British Journal of Occupational Therapy, 67*(10), 430-438. doi:10.1177/030802260406701003


## Appendix A

Eight – Month Sample Group Calendar (April 2018 – December 2018)

### April 2018

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<tr>
<td>Living Well</td>
<td>Walking Group</td>
<td>Peer Support Wrap</td>
<td>Branch Out</td>
<td>ART Group</td>
<td>Group</td>
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<tr>
<td></td>
<td>Community Integration (Shopping)</td>
<td>Uplift Music Night</td>
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</table>
END OF EVALUATION PLAN
### Appendix E

**Evaluation Framework**

This indicates the evaluation questions, where to find the answers, and how to collect the data.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Evaluation Questions</th>
<th>Indicators</th>
<th>Data Sources/Collection Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. INPUTS</td>
<td>Is the FMH program maximizing resources?</td>
<td>1.1. Are the appropriate resources being utilized to support the implementation of group interventions?</td>
<td>Staff utilization</td>
</tr>
<tr>
<td>2. PROCESS</td>
<td>Is the programming meeting the needs of the clients?</td>
<td>2.1. What are the group intervention attendance and engagement rates?</td>
<td>Participation by group members in closed groups</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Participation by clients in open groups</td>
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<td></td>
<td></td>
<td></td>
<td>Group completion rate</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Client engagement</td>
</tr>
<tr>
<td></td>
<td>2.2. Are the clients satisfied with various aspects of the group programming?</td>
<td>Feedback regarding:</td>
<td>Client surveys Feedback forms</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Group Menu</td>
<td></td>
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<td></td>
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<td>• Time the groups are offered</td>
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<td></td>
<td></td>
<td>• Accessibility</td>
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<td></td>
<td></td>
<td>• Group content</td>
<td></td>
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<td></td>
<td></td>
<td>• Applicability/usefulness of the group</td>
<td></td>
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<td></td>
<td></td>
<td>• Strengths/areas of improvement</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.3. Are the clients being referred to appropriate group interventions?</td>
<td>Client treatment plans</td>
<td>Individualized treatment/care plans that include suggestions for group treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cognitive ability</td>
<td>Cognitive assessments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Treatment plans</td>
<td></td>
</tr>
</tbody>
</table>
2.4. Is group intervention based on evidence-based practices?
   - Literature review
   - Other forensic institutions
   - Research

3. IMPACT

<table>
<thead>
<tr>
<th>Question</th>
<th>Methodology</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1. What role does group intervention have in fostering positive individual change?</td>
<td>Literature review, Other forensic institutions, Positive behaviour changes, Symptom management/reduction, Increased privileges, Increased independence</td>
</tr>
<tr>
<td>3.2. Does the group programming decrease likelihood of readmission?</td>
<td>Participation in groups, Chart review, Participation in groups, Readmission rates, ePR</td>
</tr>
<tr>
<td>3.3. Do clients meet their treatment goals?</td>
<td>Pre-post measures, Staff interviews, Pre-post measures, Client feedback, Staff observations</td>
</tr>
<tr>
<td>3.4. To what extent is improved quality of life/functional improvement a result of the group interventions?</td>
<td>Pre-post measures, Group participation, Pre-post measures, Clinical and progress notes, ORB, Risk assessments</td>
</tr>
<tr>
<td>3.5. Did the intervention produce the intended results in the short, medium and long term? If so, for whom, to what extent and in what circumstances?</td>
<td>Pre-post measures, Group participation, Pre-post measures, Clinical and progress notes, ORB, Risk assessments</td>
</tr>
</tbody>
</table>
Appendix F
Recommended Measures for Existing Group Interventions

Table 2. Recommended Measures for Existing Group Interventions

<table>
<thead>
<tr>
<th>GROUP INTERVENTION</th>
<th>SUGGESTED MEASURES</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDICTIONS</td>
<td>Ø Drug Taking Confidence Questionnaire</td>
</tr>
<tr>
<td></td>
<td>Ø Stages of Change Readiness and Treatment Eagerness</td>
</tr>
<tr>
<td></td>
<td>Scale</td>
</tr>
<tr>
<td>CBT FOR PSYCHOSIS</td>
<td>Ø Positive and Negative Symptom Scale (PANSS)</td>
</tr>
<tr>
<td></td>
<td>Ø Reactions to Provocations</td>
</tr>
<tr>
<td></td>
<td>Ø Shortened COPE Inventory</td>
</tr>
<tr>
<td>LIVING WELL</td>
<td>Ø Generic Program Performance Measure (GPPM)</td>
</tr>
<tr>
<td>LIFE SKILLS</td>
<td>Ø Independent Living Scale (ILS)</td>
</tr>
<tr>
<td>MEDICATION GROUP</td>
<td>Ø Understanding of Medication Questionnaire (UMQ)</td>
</tr>
<tr>
<td>OUT &amp; ABOUT</td>
<td>Ø Social Problem-Solving Inventory- Revised Short Form</td>
</tr>
<tr>
<td></td>
<td>Ø Emotional Regulation Questionnaire (ERQ)</td>
</tr>
<tr>
<td></td>
<td>Ø Difficulty in Emotion Regulation Scale-Short Form</td>
</tr>
<tr>
<td></td>
<td>Ø Interpersonal Reactivity Index (IRI)</td>
</tr>
<tr>
<td></td>
<td>Ø Social Problem-Solving Inventory – Revised Short Form</td>
</tr>
<tr>
<td></td>
<td>Ø Reduced Emotional Intensity Scale (REIS)</td>
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<tr>
<td>POWERFUL EMOTIONS</td>
<td>Ø <em>Psychological Inventory of Criminal Thinking Styles</em></td>
</tr>
<tr>
<td></td>
<td>Ø Barratt Impulsivity Scale (BIS)</td>
</tr>
<tr>
<td>RELAPSE PREVENTION</td>
<td>Ø Reactions to Provocations (RP)</td>
</tr>
<tr>
<td>SOCIAL SKILLS TRAINING</td>
<td>Ø Quality of Life Enjoyment and Satisfaction Questionnaire (QLESQ)</td>
</tr>
<tr>
<td>WRAP</td>
<td>Ø Shortened COPE Inventory</td>
</tr>
<tr>
<td></td>
<td>Ø Clinical Outcomes of in Routine Evaluation – Outcome Measure (CORE – OM)</td>
</tr>
<tr>
<td>ART GROUP</td>
<td>Ø The Perceived Stress Scale (PSS)</td>
</tr>
</tbody>
</table>
BRANCH OUT ➢ The Five Facet Mindfulness Questionnaire (FFMQ)

PEER SUPPORT ➢ Self-Compassion Scale (SCS)
➢ Quality of Life Enjoyment and Satisfaction Questionnaire (QLESQ)

RELAXATION ➢ The Perceived Stress Scale (PSS)
➢ Five Facet Mindfulness Questionnaire (FFMQ)

WALKING GROUP ➢ The Short-Form International Physical Activity Questionnaire (IPAQ)

YOGA GROUP ➢ The Perceived Stress Scale (PSS)
➢ Five Facet Mindfulness Questionnaire (FFMQ)

BREAKFAST & LUNCH SKILLS ➢ Generic Program Performance Measure (GPPM)

COMMUNITY INTEGRATION ➢ Work and Social Adjustment Scale (WSAS)
➢ Shortened COPE Inventory

OPEN GYM ➢ The Short-Form International Physical Activity Questionnaire (IPAQ)
## Appendix G
Suggested Groups and Measures

Table 3. *Suggested Groups and Measures*

<table>
<thead>
<tr>
<th>SUGGESTED GROUP INTERVENTION</th>
<th>SUGGESTED MEASURES</th>
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<tbody>
<tr>
<td>FAMILY THERAPY</td>
<td>Clinical Outcomes in Routine Evaluation - Outcome Measure (CORE-OM)</td>
</tr>
<tr>
<td>PSYCHOEDUCATIONAL GROUP (FOR CLIENTS OR FAMILY MEMBERS)</td>
<td>Clinical Outcomes in Routine Evaluation - Outcome Measure (CORE-OM)</td>
</tr>
<tr>
<td></td>
<td>Understanding of Medication (UMQ)</td>
</tr>
<tr>
<td></td>
<td>Drug Taking Confidence Questionnaire (DTCQ)</td>
</tr>
<tr>
<td>SCHEMA-FOCUSED THERAPY</td>
<td>Personality Belief Questionnaire (PBQ)</td>
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<tr>
<td>SEXUAL OFFENDERS</td>
<td>Barratt Impulsivity Scale (BIS)</td>
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<tr>
<td></td>
<td>Generic Program Performance Measure (GPPM)</td>
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<tr>
<td>ANGER MANAGEMENT</td>
<td>Barratt Impulsivity Scale (BIS)</td>
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<tr>
<td></td>
<td>Difficulty in Emotion Regulation Scale-Short Form (DERS-SF).</td>
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<td>Aggression Questionnaire (AQ)</td>
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