Promoting Program Participation with Adolescent Males in a Youth Justice Setting

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PROMOTING PROGRAM PARTICIPATION

Dedication

To my family, thank-you for supporting me through this experience, listening to what interests me and encouraging me to be a life long learner.

To my wife, thank-you for your kind heart and passion for helping others. You are an amazing example and supporter of my beliefs.

To Scott Brown, your participation in my Progressive Muscle Relaxation video was much appreciated. You and Jon have been wonderful distractions and friends throughout.
Abstract
Young offenders receive counselling and educational services to decrease recidivism and increase the likelihood of occupational success (Andrews & Bonta, 2010). Personal and environmental factors can limit motivation towards facility programming (Williams & Murray, 2009). Framing personalized goals as client directed and autonomous can improve engagement (Lambie, & Randell, 2013). This study examined the impact of goal setting on male youth motivation during personal counselling, group counselling and educational periods in an open custody male population. Motivation was divided into the categories of participation, initiative, goal setting and positive attitude. The hypothesis was that overall motivation would increase as a result of the goal setting intervention. Four youths (n=4) participated in the goal-setting sessions and added to their personal calendars throughout intervention. Two participants increased and two participants decreased motivation from baseline to intervention phase. Three of the participants demonstrated positive trends during intervention. The combined percentage of change was -2.715%. Intervention demonstrated an ability to increase the goal-setting techniques attained and motivation to a limited degree. Further research is required to evaluate the intervention effectiveness and the correlation between goal setting youth motivation.
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Chapter I: Introduction

The management and programming of young offenders is a complex social topic that is concerning for those balancing personal safety and the youths’ wellness (Hoge, 2001). Zinger (2016) stated that the recent political agenda towards crime has focused on meeting the voters’ demand for safety rather than the most effective and ethical treatment of offenders. Despite a political demand for ‘tough on crime’ legislation, research suggests that incarceration has a minimal effect on recidivism (Green & Healy, 2003). Imprisonment and probation do not necessarily target the criminogenic needs or teach the appropriate behaviours (Andrews & Bonta, 2010). Additionally, incarcerated youth are at increased risk for mental health and negative behavioural consequences (Altamura, Lattanzi, Pomerani, & Seno, 2015; Lambie, & Randell, 2013). Lambie and Randell (2013) state that without rehabilitation, incarceration can lead to increases in future contact with the justice system and illegal behaviour. Zinger (2016) found that financially and clinically it would be advantageous to implement programs focusing on rehabilitation rather than punishment.

Research literature into the effectiveness of counselling and the importance of education emphasises that each is important for youth justice facilities (Andrews & Bonta, 2010). The most effective counselling occurs when the individual receiving services is an active participant (McMurran & Ward 2004). Evaluating client’s desire to change and supporting them towards voluntarily improving behaviour often involves using Motivational Interviewing (MI) techniques (Lilienthal, Pignol, Holm, & Vogeltanz-Holm, 2014). The MI model refers to the clients actively desiring change as the action stage and during this stage counselling and educational programming is more effective (McMurran & Ward 2004). A program that motivates positive personal change will increase the likelihood of contact and participation with effective services.

The design of Promoting Program Participation (PPP) sessions is to motivate change and improve participation across all facility programming. The PPP intervention will attempt to shift the client’s view of the programming from extrinsically motivated to intrinsically motivated by implementing a simple and client-centred goal setting intervention designed to direct youths’ towards personal and socially beneficial aspirations. The goal setting and self-monitoring will do this by shaping the session to help the client see how facility programming can help them and how they can use every period or interaction to reach intrinsically motivated goals. The hypothesis is that the amount of PPP sessions attended would correlate with improved scores in motivation during facility programming. This treatment will be successful if the recorded motivation scores increase from the baseline to intervention phase, and throughout the intervention phase the scores maintain a positive trend as each youth continues to participate with PPP sessions.
Chapter II: Literature Review

Media has traditionally depicted male adolescent youth as irresponsible and impulsive (Simpson, 2008). Although the common stereotype depicted in media often overestimates youth behaviour, research into the male adolescent brain provides supporting evidence that the brain of a male adolescent is underdeveloped (Satterthwaite et al., 2014). They found that this limited development could lead to challenges effectively managing emotions, evaluating consequences, and balancing complex multi-tasking requirements. Additionally, during puberty the male brain continues to develop and mature, specifically the front section of the cerebral cortex undergoes the primary development related to behaviour and social maturity. Pera-Guardiola et al. (2016), describe the frontal section of the cerebral cortex, or the prefrontal cortex as a primary area of study for neurological research into the differences between genders and longitudinal studies focusing on adolescent brains. The prefrontal cortex is responsible for assisting in the self-management aspects of planning, problem solving, and task analysis (Simpson, 2008).

Two primary developments occur from the youth’s maturation from the start of puberty to the proximal age of 25 years old (Juraska, & Willing, 2016). Myelination and synaptic pruning both occur during adolescence; each process improves the speed and effectiveness of combination of the brain function (Simpson, 2008). The process of myelination involves the further isolation of nerve fibres that better insures the rate and accuracy of nerve messages is improved (Lander, Linder-Shacham & Gaisler-Salomon, 2016). Synaptic pruning involves the removal of unnecessary nerve growth, which allows for more direct and inhibited nerve communication (Kano, & Hashimoto, 2009). These primary developments allow the prefrontal cortex to communicate more effectively with more regions of the brain insuring that all areas of the brain can further participate in the evaluation of situations and the problem-solving process (Kano, & Hashimoto, 2009). Simpson (2008), states that maturation of the prefrontal cortex provides individuals improved efficiency and accuracy of problem solving, future planning and regulation of emotions. Although during adolescence these behaviours are completed, the severity of the maturation allows these processes to have a lower behavioural cost improving the likelihood that behaviour occurs. Giedd (2004) found that the process of myelination and pruning of neurons is not limited to puberty. This process is not fully complete until individuals reach their mid-20s.

Gonçalves, Endrass, Rossegger, and Dirkzwager, (2016) found that brain maturation in areas responsible for decision-making is limited in adolescent males, often resulting in illogical decision-making and impulsive behaviours. Researchers state that the poor decision-making and impulsive behaviours often provide barriers to treatment and service for both the individual and systems attempting to support the youth. Additionally, the reduced maturation is another factor added to the multiple mental health concerns already identified for those incarcerated. Colins et al., (2010) found that mental health disorders are common in approximately 70% of young offenders. This high prevalence of mental health disorders for incarcerated youth creates a variety of challenges for effective service programming and well-being within youth justice facilities (Felson, Silver, Remster, 2012). Mental health can manifest into violence, isolation, self-harm, negative self-esteem and reduced motivation (Doty, Smith, Rojek, 2012). Baillargeon, Binswanger, Penn, Williams and Murray (2009), found that the reduced motivation is a large point of concern because of the programming intended to target a variety of wellness and rehabilitation is dependent on the willingness of participant participation. A cycle of mental health can occur where those incarcerated have more symptoms of mental health and participate
less with the services designed to support their wellness needs, which adds to the mental health concerns and the demand required of the health care services (Gonçalves et al., 2016).

Mental health concerns in the youth justice population are specific to the individual. Many of the youth’s personal traits and psychosocial history influence their wellness when in custody (Hassan et al., 2011). Studies designed to identify correlations between mental health symptoms and personal risk factors have identified that ethnicity (Caucasian), low-income families, poor academic or occupational achievement, history of trauma (e.g. early childhood abuse), insufficient social support system, limited coping skills, substance abuse and acquired brain injuries are personal risk factors for youth mental health symptoms within correctional facilities (Cesaroni & Peterson-Badali, 2010; Johnson et al. 2011). These findings are not staggering as they represent many of the similar challenges that medical professionals face in the adult incarcerated population (Gonçalves et al., 2016). Beijersbergen, Dirkzwager, Eichelsheim, Van der Laan, & Nieuwbeerta, (2014), identified that individuals have more than a single cause or factor leading to mental health concerns and challenges.

Beijersbergen et al. (2014) states that in addition to the personal factors it is important to review the quality and the design of the environment in which the youth is placed in while they are within the justice system. When reviewing environmental factors contributing to youth mental health researchers Cesaroni & Peterson-Badali, (2010) found that: limited peer support; negative interactions with staff; and limited programming for the young persons reduces the overall well being of the youth and emotional wellness during their stay in the facility setting. Additionally, they state that the facility must work to eliminate any of the youth’s feelings of victimization, as that can play a large role in isolation and negative mental health symptoms. Van der Helm, Stams, Van der Laan, (2011) reviews the concerns of those in justice facilities. They found that many of the offenders identify environmental attributes such as: privacy, security, consistent scheduling, support, emotional responsivity, positive social interaction, programming and independence as major concerns within the correctional environment. Facilities must be proactive in designing their facility programming and daily scheduling because of the impact the environment can have on the young offender (Gonçalves et al., 2016). Additionally, services within the facility must attempt to identify the specific needs of their client based on their mental health risk factors, psychological needs and behaviours (Hassan et al., 2011), especially when working with the younger population (Colins et al., 2010).

Similar to their mental health and wellness needs, it important from the youth justice perspective to identify and focus on young offenders specific concerns related to recidivism (Andrews & Bonta, 2010). Risk factors, client needs and factors related to offences are specific to each individual; a specific program that accounts for individual needs is more effective than a blanket program (Mulder, Brand, Bullens, & Van Marle, 2010). Andrews and Bonta (2010), state that facilities for young male offenders should adhere to the Risk, Need, Responsivity Model (RNR). This model matches client’s level of risk with the appropriate amount of therapeutic contact, targets criminogenic needs specific to each client, and utilizes the most effect evidence based practice (Andrews, Bonta, & Wormith, 2006). Cognitive behavioural therapy focused on the criminogenic needs has demonstrated successful reduction of recidivism rates and dynamic risk factors (Henwood, Chou, & Browne, 2015). An almost 30% reduction in recidivism is reported in interventions that implement programming that effectively meets the three principles of the RNR model (Andrews & Bonta, 2010). Implementation of this model for reducing recidivism is used in Canada, United States of America, selected Western European countries,
Australia, and New Zealand (Haqanee et al., 2015). The initiative to implement this model and continue practicing the principles comes from the empirical findings supporting effective rehabilitation, case-management and reduction of recidivism when the program is properly implemented (Andrews & Bonta, 2010). Zingler (2016) found that financially and clinically it would be advantageous to implement programs focusing on rehabilitation rather than punishment.

Andrews, Bonta, and Hoge (1990) identified eight risk factors (“Central Eight”) for criminal behaviour. They highlighted four of the eight risk factors as the “Big Four” because of their increased correlation with recidivism. The “Big Four” includes: history of antisocial behaviour, antisocial personality, antisocial cognitions and antisocial associates. The remaining risk factors within the “Central Eight” include: family and marital; school and work; leisure and recreation; and substance abuse. Hoge (2016) states that each of these eight factors has a variety of underlying causes and thereby a specific individualized treatment is required. While criminal history is a static factor related to history and thereby unchangeable, it is important to recognize it as a major factor for reoffending (Andrews & Bonta, 2010). Static factors are items in a youth’s life that cannot be changed, but correlated statistically with an individual’s likelihood of reoffending (Hoge, 2016). For example, research has shown that the age that a person is first in conflict with the law correlates with reoffending and an overall higher risk of recidivism. Static factors play an important role in the assessment of risk level, which is critical for the placement and allocation of resources within the RNR model (Andrews & Bonta, 2010). The need principle of the RNR model mandates that the other seven criminogenic needs should be the primary focus for intervention because they are dynamic and able to be improved (Haqane, Peterson-Badali, & Skilling, 2015). Andrews and Bonta (2010) state that dynamic factors are similarly very important for identifying an individual's risk level, in addition, they are primary targets for treatment because of the ability to improve and lower recidivism risk level.

Clinical intervention and counselling primarily focuses on the dynamic risk factors, which can be changed such as: peers’ relations, recreational activities or substance abuse (Mulder, Brand, Bullens, & Van Marle, 2010). Natsuaki, Ge, and Wenk, (2008), found that high school completion is a protective static factor for reducing of lifelong criminal activity. Graduating provides young offenders a personal positive achievement and an increased likelihood of employment (Melkevik, Hauge, Bendtsen, Reneflot, Mykletun, & Aarø, 2016). When youth experience success in pro-social activities they are less likely to offend and are more likely to continue these advantageous activities (Randolph, Rose, Fraser, & Orthner, 2004). Additionally Andrews and Bonta (2010) found that employment reduces the likelihood of offending by providing a sense of achievement, structuring time and reducing idle leisure time. Unfortunately, young offenders have a decreased likelihood of achieving their high school education. This can be because of the missed time due to incarceration, mental health complications, limited family success, cognitive impairments or other barriers for success (Aizer & Doyle, 2015; Gonçalves et al., 2016). Stevens (2015) states that a review of the literature from 1963 to 1993 compiled of 97 articles suggested a solid positive relationship between educational programming in facilities and reduced recidivism. Of the 97 articles, 83 (85%) reported positive correlations between education and recidivism control, while the remaining 14 (15%) reported negative relationships between educational programming and reoffending.

McMurran and Ward (2004) found that a lack of motivation or desire for behavioural change could hinder educational and counselling program effectiveness. Involuntary programs
have been shown to be beneficial for program participation and short-term harm reduction strategy planning for college substance abuse intervention (Carey, Scott-Sheldon, Garey, Elliott, & Carey, 2016). However, negative views of the same programs may occur because of the absence of the best practice uses including autonomy, informed consent and least restrictive alternatives (Nace et al., 2007). Nace et al. (2007) add that in situations for individuals with severe mental health, substance abuse or mental disorders that would result in great harm to them or to others involuntary treatment may be appropriate. These types of interventions can be effective in the short term for reducing harm, but the nature of the intervention, stability of the participants and ethical challenges surrounding involuntary treatment has limited the long-term results (Carey et al., 2016).

Some clients may be required to participate with therapy or are choosing therapy over sentencing within other correctional options, the role of the therapy may be challenging because potentially the willingness of the client is absent (Johnson, 1996). It is important that the participants do not feel pressured into participating, and that they know they have the right to withdraw from treatment at any time without any consequences (Marshall et al., 2014). Although it is ethically responsible for the counsellor to inform the client of the proceedings (Marshall et al., 2014), it is also important for the accuracy of the findings for the client to participate willingly (Cahana, & Hurst, 2008). Cahana, and Hurst, (2008) state that clients that feel coerced to participate are subject to emotional distress and anxieties related to the program. Additionally, altered responding may occur due to an unwillingness to submit answers, commit to a process, or listen to requests. Best practice for ethical responsibility and data accuracy relies on the effective implementation of informed consent (Cahana, & Hurst, 2008; Marshall et al., 2014). Although motivational interviewing strategies can assist clients in recognizing whether or not treatment may or may not be beneficial for them, it is important for the client to accept the treatment voluntarily and have the ability for treatment withdrawal (Cahana, & Hurst, 2008; Stewart, Siebert, Arlt, Moise-Campbell, & Lehinger, 2016).

Ledgerwood and Petry (2006) reviewed the motivational interviewing stages of change model: pre-contemplation, contemplation, action, and maintenance. They found that clients with a greater motivation or self-desire to change are more likely to be successful during therapy. Stewart, Siebert, Arlt, Moise-Campbell, and Lehinger, (2016) found similar results that a youth’s specific desire of change was important in the changing of negative behaviours. Additionally, they found that individuals on their waiting list demonstrated a reduction of substance abuse although it was smaller than the youth in the motivation interviewing study. They suggested that the results from the waiting list participants, support further research that the will of an individual is an important factor in changing behaviour. A client progressing through the stages of change model increases their likelihood of clinical success (Vik, Culbertson & Sellers, 2000; Ledgerwood & Petry 2006). Preforming interventions or directing youth towards change is unsuccessful for lasting behaviour patterns, as research suggests a high probability of behavioural change for clients desiring changes when compared to clients when the intervention is imposed (Gilder et al., 2011).

The effectiveness of therapy is dependent on the client’s willingness to change and a personal desire to change (Bertrand et al., 2015). Bertrand explains that counsellors must work with the clients to motivate change and link troubling consequences with current behaviours. Johnson (1996) explains that counsellors that effectively cooperate with the client, by focusing on targets that mutually benefit the external forces and the participant’s desires, can be
successful for shifting involuntary therapy towards voluntary therapy for change. McMurran and Ward (2004) state that motivation is essential for therapeutic success, as voluntarily completed treatments are often required to comply with policies and reduce the cost for healthcare when clients do not desire change. Lilienthal, Pignol, Holm, & Vogeltanz-Holm (2014) suggest that for behavioural change to occur clients must be in an action stage, which means that they intrinsically desire personal change. Intrinsically motivated activities are more likely to be successful over time and reproduced when compared to extrinsically motivated goals (Sheldon & Elliot, 1998). In addition, they found that interventions with a client-centered focus would promote the likelihood that the goals and future desires remain intrinsically motivated throughout and adapted, as the client’s needs change. Malmberg, Pakarinen, Vasalampi, and Nurmi, (2015) also built on the importance of autonomous goals, stating that clients with a complete sense of willingness and choice are more likely to attain goals when compared to clients with externally controlled goals.

Complementary to goal setting, self-monitoring is the practice of reviewing goals and progress towards objectives related to achievement (Oliver, Wehby & Nelson, 2015). Harkin et al., (2016) found that self-monitoring is a critical component for behavioural change. They continued, stating that self-monitoring also increases the likelihood of goal attainment and that intention or willingness alone has an overall lower success rate. The generalization of motivation can be observed in a variety of settings, which is cost effective and applied in diverse applications (Chacón-Moscoso, Anguera, Sanduvete-Chaves, & Sánchez-Martín, 2014).

Haqanee et al. (2015) found that some professionals working with young offenders are hesitant to request multiple goals from their clients because past clients have previously been unable to complete a variety of requirements. They continue to state that barriers for multiple goal completion are lack of willingness or desire to participate, learning impairments, and overall maturity level of the youths. Probation officers working with youths identified that motivation towards goal completion was greatly dependent upon whether or not the young person believed that the goals were attainable (Haqanee et al., 2015). Selecting a limited number of direct targets can remain effective by intentionally choosing goals that demonstrate direct and indirect positive implications (Haqanee et al., 2015). With awareness of the criminogenic needs (Andrews & Bonta, 2010), presenting general goals that will directly improve the youth’s leisure/recreational behaviour which then indirectly reduce the recidivism score for both anti-social peers and substance abuse will increase the overall value of each goal (Haqanee et al., 2015). Presenting a goal, which can directly improve targets while being behaviourally incompatible with other risk factors, is an effective and efficient method for goal setting (Haqanee et al., 2015). Education and employment can be effective direct targets because of the strong correlation with financial stability. Additionally, these targets can often be effective for indirectly targeting a youth’s criminogenic needs related to recreational activities and antisocial peers providing a greater overall reduced risk of reoffending (Haqanee et al., 2015). Similar to directly targeting leisure/recreation, directly targeting participation with counselling can influence a variety of criminogenic risk factors of recidivism (Haqanee et al., 2015). Mulvey and Glasheen (2011), also identify that substance abuse is another multi-faceted criminogenic target because youth are more likely to interact with negatively impactful peers, leisure activities, and antisocial attitudes when consuming substances. Setting goals that mutually benefit the client and professional’s targets can increase the willingness to participate, these goals should focus on objectives that
directly and indirectly influence criminogenic needs, and the structure of the client centred goals should involve action based goal planning intervention (Day & Tosey, 2011).

Action planning is the process of setting attainable goals and forming individualized steps that an individual will use to achieve their goals (Day & Tosey, 2011). As previously, discussed, the adolescent brain is not completely matured to reason and problem-solve efficiently (Juraska, & Willing, 2016). Additionally, youth are in a demanding social stage of development that has many challenging choices and responsibilities (Simpson, 2008). These choices and responsibilities can be in the form of peer assimilation, self-identity, and relational development (Shulman, & Steinberg 2016). Effective decision planning and evaluation future aspirations can be critical for personal wellness and occupational satisfaction (Lambie, & Randell, 2013). The completion of goal setting is in an informal or formal setting depending on the content of the goals, qualifications of the clinician, and the quality of the professional rapport (Johnson, 1996). This style of continual progressing goal setting begins with an initial review of the participants’ situation, interests and motivators related to goals (Day & Tosey, 2011). Further action goal meetings additionally include reports of successes and challenges relate to the goals and other motivating factors (Day & Tosey, 2011). Those working with the youth should attempt to direct the conversation around appropriate targets for intervention while using the dialog to support and build rapport (Sheldon & Elliot, 1998). The depth of the conversation depends on the therapeutic rapport between the professional and client, quality of the professional and willingness of the youth to participate (Bullock & Wikeley, 2004). Those requiring a large amount of support appear to benefit the most from action focused goal-setting interventions (Bullock & Wikeley, 1999). Day & Tosey, (2011) identify that potential benefits of this treatment include; increased motivation to learn, raised self-awareness and confidence, situational awareness, and improved task oriented planning. In addition, they state that although potential harm is minimal, clients could experience discomfort with the subject material or shift learning towards exclusively externally motivated.

The SMART model is a common example of action planning (Day & Tosey, 2011). This model maximizes potential benefits while minimizing potential harms (Day & Tosey, 2011). Doran (1981) states that this method requires participants to set goals; which are specific, measurable, attainable, realistic and have a clear timeline. Specific requires making highly detailed goals, rather than choosing to “be a better person,” a specific goal could be to “not break breach the conditions of my parole.” Measurable requires the goal to have an objective identifier for successful completion. An example would be selecting an amount of weight to lose instead of setting a generic goal to lose weight. Attainable and realistic work together to insure that the goal set appropriately to balance motivation while not discouraging further participation if goals are not met. Important for professionals working with youth to moderate the goal forming by taking into account their baseline behaviour, desire to change, cognitive or physical abilities and overall setting (Haqanee et al., 2015). Timely requires the goal to have an identified start and end (Duran, 1981). This insures that goal motivation continues to progress and allows for identified times for reconsideration of goals (Duran, 1981).

Implementing each of the five principles provides effectively structured and conceive goals for both the client and professional assisting them Day & Tosey, 2011. Although it is challenging to isolate the variables and systematically evaluate the effectiveness of SMART goal based interventions, clinical judgement supports the continued use because of the sound theory surrounding appropriately selecting specific and individualized goals to be completed within a
time based schedule (Locke & Latham, 2002). Giroux et al., (2014) found that clients believed that SMART goals could help make positive and long-term lifestyle changes when included as part of educational programming. Viewing motivation as an external reinforcer is a potential risk related to this form of goal setting, which would be limiting the participant’s intrinsic motivation (Bullock & Wikeley 2004). When using SMART goal based goal setting interventions it is best practice to encourage feedback and reflection surrounding the positives created by their attainment, to reduce the likelihood of making goals extrinsically reinforced (Day & Tosey, 2011).

A metacognitive focus for goal setting can be extremely beneficial for the development of self-motivated learners (James, Black, McCormick, Pedder & Wiliam. 2006). Watkins and Lodge (2007) explain that it is important for the client to self-identify their feelings and emotions related to learning and completing task. They encourage the exploration of participant’s feelings and emotions because of the large role it has on the attention, and motivation. A client challenging with an emotional stressor during programming activities can pair the negative experience with a previously neutral subject or activity (Posner & Rothbart 2007).

There are programs designed for young offenders that can reduce recidivism and improve the futures of young offenders (Andrews & Bonta, 2010; Colins et al., 2010; Henwood et al., 2015 Melkevik et al., 2016). Participation with programming can be limited for the young offender population due to negative perceptions of counselling (Cahana & Hurst, 2008), personal factors (Hassan et al., 2011), and environmental conditions (Beijersbergen et al., 2014). It is important that these barriers are removed because the effectiveness of therapy is dependent on the client’s motivation and willingness to participate during counselling and educational sessions (Bertrand et al., 2015; Lilienthal et al., 2014). Creating client-centred goals (Giroux et al., 2014) and practicing self-monitoring (Harkin et al., 2016) improve the intrinsic motivation towards behavioural change. Increased motivation during facility programming periods increases likelihood of treatment effectiveness and reduces recidivism (Malmberg et al., 2015; McMurran & Ward (2004).

Chapter III: Method

Participants and Selection Procedures

The participants (n=4) were 12-18 year old young males in conflict with the law, detained by the courts, or sentenced to open custody. Each of the youths resided in an open custody Youth Justice Facility. Each young offender was in detention or sentenced to the youth justice facility for a duration greater than seven days. This was important to insure that the program had sufficient time to gather baseline and intervention data. Participation with the daily programming was a prerequisite for intervention eligibility. Direct Care Workers, Clinical Psychotherapists and Community Service Professionals provided their professional opinion when deciding whether the client would be able to actively participate with the intervention requirements or benefit from the goal setting sessions. Staff provided their input on the youth’s cognitive understanding, learning skills and memory. The youth had to be able to retain information, process goal setting objectives and remain actively participating for periods extending one minute. Failure to meet these expectations excluded youth because the design of the study did not have the resources to accommodate the lengthy teaching sessions and additional supports. The facility setting has limited time for lengthy interventions in addition to scheduled programming.
The student identified that clients with recent violent behaviour or persistent oppositional attitudes may be counter-productive for the research intervention and not asked to participate in the intervention. Violently offending youth may be at great risk for extended suspension periods outside of the group. Extended absences and suspensions would reduce the frequency of PPP sessions and increases the likelihood that variables like maturation or peer influence could influence motivation. Oppositional behaviour may be counter-productive to the findings because they may create false goals or objectives. False goal setting would undermine the integrity of the research.

In addition, participants did not meet the criteria if they could not functionally understand the material. Exclusions from the PPP sessions included clients who were unable to comprehend goal setting or goal monitoring activities. If they were unable to cognitively comprehend the material the youth would not be adhering to the validity of the study and interfering with the accuracy of the research.

The youth would not be asked to participate if a clinical professional had predicted that the treatment would not be suitable, or the sessions would not be advantageous. Instructions were presented in both visual and audible form to remove potential participant barriers. Providing accommodations with time reduced anxiety, insured an accurate participant performance and provided an inclusive environment. Participants would have received redirection towards facility appropriate behaviour if they did not participate accordingly. Continued inappropriate behaviour would have resulted in expulsion from the program. Failure to abide by the youth justice agency rules was viewed as inappropriate behaviour. Youth were required to respect the intervention procedures and the student providing the direction. The topics and goals discussed could not use profanity, sexist, or racist language, and the youth could not discuss goals for self-harming activities or future illegal behaviour.

Youth completed informed consent procedures to comply with college and agency requirements. The completing of informed consent insured that the youth was aware of the proceeding. Clinically and ethically, it was important to have the youth participation before entering the first PPP session to discuss goal setting and monitoring. Parents received informed consent over the phone for one youth because of the guardian’s geographical location. In addition, informed consent was provided to one youth who was under the age of 16 and the student explained the intervention before having the youth sign. The three other youths were over the age of 16 and did not require the consent of a guardian. The three youth over the age of 16 asked questions and signed the consent during scheduled personal time. A request to each of the youth over 16 was made to discuss the treatment with their guardians, and each of the youth agreed to allow the student to inform the guardians of the intervention proceedings. All primary guardians received verbal or visual information covering the confidentiality, intervention design and risks. All guardians verbally approved of the treatment.

Design and Variables

The current study was a within subject case study, designed to compare the participants’ results from the baseline and intervention phases to evaluate behavioural change. Intervention was completed as an AB design; as the program had a single baseline and intervention phase. To observe the program effectiveness, the student calculated the difference between phases, rates of percentage change and reviewed potential significant changes. The independent variable was the goal setting and self-monitoring PPP sessions. The dependent variables examined were participation, initiative, goal setting, and positive attitude with professionals.
Prior to the youth participating in a PPP session, they received and voluntarily submitted a Youth Engagement and Motivation Intake Form (Appendix E). The design of this form is to evaluate some of the dynamic and static factors related to recidivism and motivation. The form attempts to identify anti-social peers’ patterns, anti-social attitudes and criminal history. In addition, completing this activity provides material for conversations and specific targets for goal setting.

Factors of motivation and indicators of stage of change were included. Completing this form also followed the beginning of the intervention phase throughout the participant’s term at the facility. Depending on the availability and duration of the participants stay at the facility, the Youth Engagement and Motivation Intake Forms were completed. The primary intention was to receive a baseline, intervention and discharge submission for analysis. This form is supportive of the direct observation baseline and intervention data collected for the assessment of progress and treatment effect. Following completion of the form, observers used the ‘Facility Programming Motivation Recording Instrument’ (Appendix F) to collect baseline data from direct observation of the youths during facility programming periods. Following three or more days of baseline data, the intervention phase began. The student contacted the guardian of each participant under the age of 16 and explained the intervention in detail. If possible, this writer met with the guardian in person and provided the guardians with the Informed Consent: Parental under 16 (Appendix A). If an in person interaction was unavailable, this writer contacted the guardian and implement the Verbal Consent Script (Appendix B). Following the Verbal Consent Script, the student asked the guardian to verbally check off the Verbal Consent Checklist (Appendix C) and the intervention phase proceeded. Residents 16 year of age or older had the consent form explained and were able to sign following the Student answering any questions that proposed by the youth (Appendix D). Guardians of youth over the age of 16, also received an overview of the interventions and expectations.

The Student completed the treatment sessions with supervision from the agency’s Faculty Manager, College Supervisor, Direct Care Workers, and/or the Reintegration Worker. The Reintegration Worker or a direct care Worker reviewed the treatment integrity by being in the room for each of the first meetings between the participants and Student. The Student explained and supported the completion of the Goal Setting Graphic (Appendix G) and Goal Setting Calendar (Appendix H). During following sessions the Student independently worked with the participants, a Direct Care Worker was present to adhere to the agency’s protection policy. The agency policy requires youth to be in the presence of agency staff in the circumstance that the youth is causing harm to themselves or others or causing extensive property damage. Students at the agency are not permitted to be one-on-one for both their safety and the safety of the youth because students are not trained or instructed to restrain youth. Conducting the sessions with one youth at a time reduced distractions and provided a safer environment for youth to share pro-social goals. In addition, the individual setting ensures that the confidentiality of the youth and their crimes under the YCJA remain protected. Implementing the Facility Programming Motivation Recording Instrument in both the intervention and baseline phase provides data for analytical comparisons. Behavioural observations throughout the daily schedule allowed the Student to evaluate changes that needed to be made to improve the quality of program design. In the final days before their discharge the participants were asked to complete a program Modified Clinical Trial Participant Satisfaction survey (Schron, Wassertheil-Smoller, Pressel, 1997) (Appendix I) to obtain information about their overall treatment experience. This survey focused
on feedback for program improvement and their thoughts about completing a similar pre-session program moving forward with research development. Collection of data was completed under the supervision of an agency professional. The data was coded on each of the files and unidentifiable to outside readers. Securing the consent and data into their agency files followed their discharge. The agency followed the privacy standard of the YCJA for all youths. Changing the names used in the paper occurred to protect the youth’s confidentiality, and the results were placed in the youth’s files for two years following their 18th birthday year to comply with the privacy act.

**Setting and Materials**

The participants completed the PPP sessions in a quiet setting within the facility that was familiar to the youth. Prior to receiving documents each participant was provided visual and oral instructions. The student encouraged participants to ask any questions throughout the visual and oral instructions. The Student answered any questions related to their goals and interests. The student provided the necessary supplies for completing the PPP sessions. The participants received a writing instrument, along with copies of the informed consent, Engagement and Motivation Intake form, Goal Setting Graphic, Monthly Calendars and a modified Clinical Trial Participant Satisfaction survey. At the beginning of each form the client was provided the required instructions for the completion of intervention activities. Upon request the instructions were reread to the participant.

**Measures**

The Student administered the Engagement and Motivation Intake form. This form targets conversation points and interests to support both the programming staff and Student. This document evaluated areas of motivation, youth’s peers, beliefs of the consequences, and overall belief of not reoccurring criminal reoffending. The form is not norm referenced nor has it undergone research to ensure validity, but it does provide subjective information to help the student and staff members build rapport with the youth. The participants completed the Engagement and Motivation Intake form during intake, intervention phase and discharge to evaluate changes in responses. Clients staying for extended periods completed an additional mid intervention review gather further information. The hypothesis is that a longer length of stay would correlate with improved scores in some of the areas of recidivism, and would improve the participant’s ideals towards the facility programming importance. The longer the stay, the greater the exposure the youth had with the PPP intervention and facility programming.

The Student and programming staff completed the Facility Programming Motivation Recording Instrument during programming sessions for both the baseline and intervention phases. The design of this instrument is to operationalize motivation and organize motivation behaviour into a structured rubric. Motivation was recorded when the youth actively attempted to improve themselves or there situation by engaging with the programming, seeking more resources, planning positive goals or objectives and overall pro-social interactions with those attempting to help them. The rubric contains four categories: participation, initiative, goal setting and positive attitude. Each category is scored from 0 – 3 for an overall motivation score between 0 -12. For each category, a score of three was the greatest score attainable, and an overall score of 12 indicated high motivation during the observation periods. Comparing and analyzing the data scores from the recorded sessions helps evaluate potential changes in motivation resulting from implementation of the PPP intervention.
To assess areas of improvement moving forward with the PPP sessions, participants completed the Modified Clinical Trial Participant Satisfaction survey following the intervention. This was a simple document with ‘yes’ and ‘no’ questions designed to effectively shape the Student’s ability to properly implement the program and develop meaningful results.

At the beginning of each intervention, the clients reviewed the Goal Setting Graphic and Goal Setting Calendar. Throughout the program, directions to the participants were to continually review their goals and set new goals as they are completed. The Student provided additional prompts to update the documents and reassess what goals could be realistic for their time within the facility and upon discharge. The prompts were verbal and gestural to redirect the youth when they became off topic. They were not recorded in the data, but they were provided discretely with low latency of off task behaviour to ensure that the youth were respected and efficiently completing the task. Off task behaviour could be talking about other topics not related to their goals, looking away from the page or attempting to have a conversation with the supervising staff member.

Procedure

First, the student asked the clients to voluntarily complete the Engagement and Motivation Intake form. The youth received this form along with the intake package on the first day of arrival. The Student was available to support the client with any questions or concerns related to the form. Baseline data was then recorded using the Facility Programming Motivation Recording Instrument by the staff monitoring programming and the student. Data collection occurred for a minimum of three days during the baseline phase.

Informed consent for youth 16 years of age or older was obtained and returned before the completion of the baseline phase to comply with agency and college protocol. Similarly, for youth under 16, their legal guardian provided signed consent or telephone consent for the continuation of the intervention. The Student provided an informed consent letter or communicated on the telephone the details of the intervention and explanation of the proceedings to both the client and legal guardian. During each initial meeting, the participants paraphrased the points of the consent to demonstrate knowledge of the conditions. Regardless of the youths age they signed the consent form demonstrating that they had read and agreed to participate. The participants were willing to participate throughout; the program was completed on a voluntarily basis to adhere to ethical and clinical best practice. Throughout the intervention the student reminded the clients that their participation is appreciated, but at anytime the client may refuse the intervention without any consequence or reprimand. In addition to the formalized consent procedures, the Student verbally requested assent from the youth during each PPP session and the Student consistently monitored the youth’s body language to review whether it was appropriate to engage in a PPP session. If the body language was poor, treatment may be postponed to the next day and the staff or Student would debrief with the youth in an attempt to identify any of the youth’s wellness needs.

Participants received instruction to effectively complete Goal Setting Graphic; and Goal Setting Calendar. To complete the Goal Setting Graphic the youth must select a main goal that would be the centre larger goal that all the goals would frame form. For example, goals of completing college, not reoffending, making a sporting team or getting a job demonstrate a prosocial desire and client centred direction. The youth would then continue to create counselling, personal time, staff interaction, education, and change in behaviour goals to assist or complement their efforts in achieving the main goal. The Student provided examples for each and the
SMART goal acronym was explained. With support from the Student, the youth selected complementary goals that were specific, measurable, attainable, realistic and timely. The Student verbally prompted the participants to ask questions related to the completion of the task or to clarify concerns. The participants at any time were able to ask further questions to the Student regarding the program and expectations. Following the completion of the Goal Setting Graphic, youth participation with programming, number of youth in the facility, and duration of stay. The student attempted to meet with each participant twice weekly, but depending on the variables within the facility the PPP sessions only occurred once weekly.

Two observers were present for a percentage of the observation periods to evaluate IOA recording. In addition, post-treatment, modified Clinical Trial Participant Satisfaction surveys were completed. Implementation of a multiple baseline intervention was used because of the coming and going of young offenders into the open custody facility. Each client received a minimum of one meeting and additional meetings following each week remaining in the facility. Meetings lasted five to ten minutes depending on the goals and interest of the client. The participants had no time limit to complete the Engagement and Motivation Intake form and the modified Clinical Trial Participant Satisfaction form. The Student was the primary contact with the participants related to the program and was answering questions or concerns during the regular week, as he was at the facility supporting other activities at the facility.
Chapter IV: Results

Overview

The intervention design identified the effectiveness of goal setting and self-monitoring as treatment to improve motivation for youth in conflict with the law. During the baseline and intervention phase the student and agency staff observers used the Facility Programming Motivation Recording Instrument to record behaviour. This measure recorded youth motivation towards facility programming by evaluating participation, initiative, goal setting and positive attitude. The recording length varied depending on the length of the youth’s sentence or detainment. The graphs and tables in the following section provide visual representation of the data analysis completed using the data form each phase. Each figure contains an explanation to assist with the communication of the findings. Changes to the participant names have occurred for purposes of anonymity.

Outcome Measures

The baseline and intervention rubric scores for the Facility Programming Motivation Recording Instrument are visually presented in figures 1-24. Figures 1-4 illustrate the overall group results analyzing the Facility Programming Motivation Recording Instrument. Figures 5-24 present the Overall, Participation, Initiative, Goal Setting, and Participation scores for each of the four participants.
Figure 1: Overall Scores of Youth Participants during the Baseline and Intervention Phases for the Facility Programming Motivation Recording Instrument
Average Combined Overall Baseline and Intervention Scores for the Facility Programming Motivation Recording Instrument

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Intervention</th>
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</thead>
<tbody>
<tr>
<td>Overall</td>
<td>8.618</td>
<td>8.384</td>
</tr>
</tbody>
</table>

Figure 2: The Combined Overall Participant Scores of the Baseline and Intervention Phase
Table 1: Summary of Individual Overall and Category Scores During Treatment

<table>
<thead>
<tr>
<th></th>
<th>Bruce</th>
<th>Jerry</th>
<th>Allen</th>
<th>Brian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>9.167</td>
<td>7.3</td>
<td>9</td>
<td>9.391</td>
</tr>
<tr>
<td>Participation</td>
<td>2.5</td>
<td>1.967</td>
<td>2.389</td>
<td>2.326</td>
</tr>
<tr>
<td>Initiative</td>
<td>2.333</td>
<td>1.7</td>
<td>2.5</td>
<td>2.457</td>
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<tr>
<td>Goal Setting</td>
<td>1.867</td>
<td>1.217</td>
<td>1.722</td>
<td>2.109</td>
</tr>
<tr>
<td>Positive Attitude</td>
<td>2.467</td>
<td>2.35</td>
<td>2.389</td>
<td>2.478</td>
</tr>
</tbody>
</table>

Table 2: Participant Category and Overall Scores Across the Baseline and Intervention Phases

Table 2: Summary of Overall Mean, Category Means and Standard Deviation During Treatment

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>8.487</td>
<td>1.784</td>
</tr>
<tr>
<td>Participation</td>
<td>2.227</td>
<td>0.559</td>
</tr>
<tr>
<td>Initiative</td>
<td>2.143</td>
<td>0.622</td>
</tr>
<tr>
<td>Goal Setting</td>
<td>1.669</td>
<td>0.662</td>
</tr>
<tr>
<td>Positive Attitude</td>
<td>2.416</td>
<td>0.547</td>
</tr>
</tbody>
</table>

Table 3: Combined Overall and Category Scores and Calculated Z-Scores From Treatment

<table>
<thead>
<tr>
<th></th>
<th>Combined Scores Mean (Mean)</th>
<th>Standard Deviation Mean</th>
<th>Intervention Mean</th>
<th>Z-Score of Intervention Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>8.487</td>
<td>1.784</td>
<td>8.384</td>
<td>-0.058</td>
</tr>
<tr>
<td>Participation</td>
<td>2.227</td>
<td>0.559</td>
<td>2.186</td>
<td>-0.073</td>
</tr>
<tr>
<td>Initiative</td>
<td>2.143</td>
<td>0.622</td>
<td>2.07</td>
<td>-0.117</td>
</tr>
<tr>
<td>Goal Setting</td>
<td>1.669</td>
<td>0.662</td>
<td>1.64</td>
<td>-0.044</td>
</tr>
<tr>
<td>Positive Attitude</td>
<td>2.416</td>
<td>0.547</td>
<td>2.442</td>
<td>+0.048</td>
</tr>
</tbody>
</table>

Table 3: Combined Overall Scores, Combined Category Scores and Calculated Z-Scores
Two participants had demonstrated an increase in motivation from baseline to intervention phases and two participants demonstrated a decrease in motivation. The overall results from this primary visual illustration suggest that the intervention had no statistical difference on the youth motivation. The experiment observed 77 facility programming periods. The staff completed the Facility Programming Motivation Recording Instrument during 34 baseline facility program periods and 43 intervention facility programming periods. The youth had a decreasing -2.715\% percentage of change from the baseline to intervention phase (Appendix J). The median in the baseline phase was 8.75 (Appendix K). In the intervention phase 19 / 43 points exceeded the baseline median. The combined PEM is 44.186\%. The Overall and specific category scores were not changed at a statistically significant rate (Appendix L). The z-scores were -0.058 Overall, -0.073 Participation, -0.117 Initiative, -0.044 Goal Setting, and +0.048 Positive Attitude.

**Participant 1: Bruce**

Bruce was the first young offender to participate with the intervention. He was 18 years old at the time of the intervention. Observations occurred during eight programming periods during the baseline phase and seven programming periods during the intervention phase. During the intervention phase, Bruce participated three times with the PPP sessions. The youth had an increasing +7.043\% percentage of change from the baseline to intervention phase (Appendix J). The median in the baseline phase was 8.75 (Appendix K). In the intervention phase 6 / 7 points exceeded the baseline median. His PEM is 85.714\%. The Overall and specific category scores were not changed at a statistically significant rate (Appendix L). The z-scores were +0.179 Overall, +0.0 Participation, +0.22 Initiative, +0.179 Goal Setting, and +0.189 Positive Attitude.

![Figure 3: Bruce’s Overall Scores of the Combined Four Categories](image-url)
Figure 4: Bruce’s Participation Scores Using the Facility Programming Motivation Recording Instrument During Direct Observation

Figure 5: Bruce’s Initiative Scores Using the Facility Programming Motivation Recording Instrument During Direct Observation
Figure 6: Bruce’s Goal Setting Scores Using the Facility Programming Motivation Recording Instrument During Direct Observation

Figure 7: Bruce’s Positive Attitude Scores Using the Facility Programming Motivation Recording Instrument During Direct Observation
**Bruce’s Individual Results**

Bruce demonstrated an Overall trend that was positive (Figure 3). In each of the four categories the participant demonstrated a negative or neutral slope in the trajectory of the there recorded motivation (Figure 4-7). The Participation category appeared to have the most negative slope during baseline, which suggested that the youth’s Participation score was continuing to decrease (Figure 4). The lowest recorded periods were five and seven during baseline. On the fifth session, Bruce recorded his lowest score in Goal Setting, and the lowest throughout the duration of treatment (Figure 6). The observation of the seventh period recorded his lowest scores in Participation and Positive Attitude (Figure 4,7). The Overall variance throughout baseline appeared moderate, as the participant demonstrated motivation primarily at two for each category and eight as an Overall score (Figure 3).

Although the Overall scores during intervention did not produce significant change in any of the categories, the trends in the intervention section suggest that the behaviours were positively improving (Figure 3). The Overall trend was positive and the category trends similarly have positive direction (Figure 3). In the intervention phase there is a similar moderate variance through the data. The Participant appears to demonstrate similar levels of motivation across periods (Figure 4). Similar to the baseline phase, the scores are for each category are primarily two with the Overall scores primarily eight. During period 11, Bruce has his worse category score of intervention in the area of Goal Setting (Figure 6). In period 11 Bruce was recorded as having a one in Goal Setting while maintaining a seven Overall for that period (Figure 3,6).
Participant 2: Allen

Allen was the second youth offender to participate with the intervention. He was 17 years old at the time of the intervention. Observations occurred during four programming periods during the baseline phase and five programming periods during the intervention phase. During the intervention phase this youth participated two times with the PPP sessions. The youth had a decreasing -7.2% percentage of change from the baseline to intervention phase (Appendix J). The median in the baseline phase was 10.0 (Appendix K). In the intervention phase 1/5 points exceeded the baseline median. His PEM is 20.0%. The Overall and specific category scores were not changed at a statistically significant rate (Appendix L). The z-scores were -0.165 Overall, +0.02 Participation, +0.0 Initiative, -0.612 Goal Setting, and -0.148 Positive Attitude.

Overall Facility Programming Motivation Recording Instrument Score During Facility Programming Period

Figure 8: Allen’s Overall Scores of the Combined Four Categories
Figure 9: Allen’s Participation Scores Using the Facility Programming Motivation Recording Instrument During Direct Observation

Figure 10: Allen’s Initiative Scores Using the Facility Programming Motivation Recording Instrument During Direct Observation
Goal Setting Facility Programming Motivation Recording Instrument Score

![Graph showing Goal Setting Facility Programming Motivation Recording Instrument Score](image)

Figure 11: Allen’s Goal Setting Scores Using the Facility Programming Motivation Recording Instrument During Direct Observation

Positive Attitude Facility Programming Motivation Recording Instrument Score

![Graph showing Positive Attitude Facility Programming Motivation Recording Instrument Score](image)

Figure 12: Allen’s Positive Attitude Scores Using the Facility Programming Motivation Recording Instrument During Direct Observation
Allen’s Individual Results

Allen demonstrated an Overall trend that was positive during the baseline and intervention phase (Figure 8). The Overall trend in the baseline phase was more positive than the intervention phase (Figure 8). Although the Overall score from baseline to intervention phase was a decrease, the trend in each category had no trend or a positive trend (Figures 9-12). In the baseline phase during periods three and four Allen demonstrated a consecutive 11 scores. In both recorded period this participant scored perfect in each area other than Goal Setting (Figure 11). The lowest baseline overall score was recorded during period two, he scores two in Goal Setting and 1.5 in the three other categories (Figure 11). The Overall variance was moderate; similarly Participation, Initiative, and Positive Attitude demonstrate moderate variance as well (Figures 8-10, 12). The correlation between the Participation, Initiative, and Positive Attitude graphs (Figures 9,10,12) suggest that the three categories may have some statically relevant relationship. Goal Setting in the baseline phase has low variance, remaining at two for the duration of the baseline phase (Figure 11).

Each category and the Overall score demonstrated a positive trend during the intervention phase (Figures 8-12). In each category the youth experienced their lowest score within the first three recorded periods (Periods 5-7; Figures 8-12). The lowest recorded score was Goal Setting (Figure 11). In period seven Allen recorded a score of one in Goal Setting (Figure 11). During the intervention phase the participant received his highest score during period nine. In period nine Allen received an Overall score of 11, scoring maximum category scores of three in Participation, Initiative, and Positive Attitude (Figures 8-10, 11). The variance in the intervention phase appears to be low to moderate Overall and within each category (Figures 8-12).
**Participant Three: Brian**

Brian was the third youth offender to participate with the intervention. He was 18 years old at the time of the intervention. Observation occurred during 14 programming periods during the baseline phase and nine programming periods during the intervention phase. Brian participated four times with the PPP sessions during the intervention phase. The youth had a decreasing -3.87% percentage of change from the baseline to intervention phase (Appendix J). The median in the baseline phase was 9.5 (Appendix K). In the intervention phase 5 / 9 points exceeded the baseline median. His PEM is 55.556%. The Overall and specific category scores were not changed at a statistically significant rate (Appendix L). The z-scores were -0.189 Overall, -0.3.82 Participation, -0.434 Initiative, +0.275 Goal Setting, and +0.146 Positive Attitude.

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**Overall Facility Programming Motivation Recording Instrument Score During Facility Programming Periods**

Figure 13: Brian’s Overall Scores of the Combined Four Categories
Figure 14: Brian’s Participation Scores Using the Facility Programming Motivation Recording Instrument During Direct Observation

Figure 15: Brian’s Initiative Scores Using the Facility Programming Motivation Recording Instrument During Direct Observation
Goal Setting Facility Programming Motivation Recording Instrument Score

Figure 16: Brian’s Goal Setting Scores Using the Facility Programming Motivation Recording Instrument During Direct Observation

Positive Attitude Facility Programming Motivation Recording Instrument Score

Figure 17: Brian’s Positive Attitude Scores Using the Facility Programming Motivation Recording Instrument During Direct Observation
Brian’s Individual Results

Brian had a much larger collection of data collected when compared with the first two participants. In the baseline phase he received Overall scores that produced a neutral slope (Figure 13). His scores in the baseline phase had a low variance across the categories and Overall score (Figures 13-17). His scores in Goal Setting produced the least variance of any of the categories observed (Figure 16). In each of the categories during the baseline phase Brian received a score of two or greater, and an Overall of eight or greater (Figures 13-17). Overall Brian received his lowest baseline score of eight three times, during periods three, five and eight (Figure 13).

In the intervention phase Brian’s Overall score had a slight negative trend (Figure 13). Similarly Initiative and Goal Setting observed similar slightly negative trends in the intervention phase (Figures 15, 16). Participation and Positive Attitude appeared to have neutral or slightly negative trends as well (Figures 14, 17). An outlier in the data collection appears during period 19. In period 19 Brian received a score of one in both Initiative and Positive Attitude (Figures 15, 17). These were the only observed periods that Brian received a score lower than two in a category. The Overall during period 19 was his lowest at six, which was at least two points greater difference than any other Overall score received across the duration of treatment (Figure 13). The Overall variance of data is moderate based on the outlier period 19 (Figure 13).

Participation and Goal Setting scores had low variance, while the Initiative and Positive Attitude score were moderate to highly variable (Figures 14-17).
**Participant Four: Jerry**

Jerry was the fourth youth offender to participate with the intervention. He was 12 years old at the time of the intervention. Observation occurred during eight programming periods during the baseline phase and 22 programming periods during the intervention phase. Jerry participated four times with the PPP sessions during the intervention phase. He had a +19.785% percentage of change from the baseline to intervention phase (Appendix J). The baseline phase median was 6.75 (Appendix K). In the intervention phase 18 / 22 points exceeded the baseline median. His PEM is 81.818%. The Overall and specific category scores were not changed at a statistically significant rate (Appendix L). The z-scores were +0.223 Overall, +0.144 Participation, +0.183 Initiative, +0.19 Goal Setting, and +0.066 Positive Attitude.

**Overall Facility Programming Motivation Recording Instrument Score During Facility Programming Period**

![Graph showing observed facility programming periods and scores during baseline and intervention phases.](image)

*Figure 18: Jerry’s Overall Scores of the Combined Four Categories*
Figure 19: Jerry’s Participation Scores Using the Facility Programming Motivation Recording Instrument During Direct Observation

Figure 20: Jerry’s Initiative Scores Using the Facility Programming Motivation Recording Instrument During Direct Observation
Goal Setting Facility Programming Motivation Recording Instrument Score

Baseline Intervention

Figure 21: Jerry’s Goal Setting Scores Using the Facility Programming Motivation Recording Instrument During Direct Observation

Positive Attitude Facility Programming Motivation Recording Instrument Score

Baseline Intervention

Figure 22: Jerry’s Positive Attitude Scores Using the Facility Programming Motivation Recording Instrument During Direct Observation
Jerry’s Individual Results

Jerry during the baseline phase demonstrated a slightly positive trend in data (Figure 18). The lowest Overall score was 3.5, during period four of baseline. The highest in the baseline phase was 7.5 recorded during periods one, three and six. The variance in the Overall score is moderate with the majority of the data points falling between 5.5 and 7.5 (Figure 18). In Participation the graph demonstrates a moderately negative trend and high variance in the data (Figure 19). Two Participation scores present as outliers during baseline, period four was scored 0.5 and period six one. The high in participation was 2.5 recorded in the first period. The baseline Initiative score was slightly positive with low to moderate variance with all scores falling between one and two (Figure 20). Goal Setting during the baseline phase trends moderately positive and has a moderate to high probability. Receiving no points (0.0) during periods two and five of baseline, and a high of two in period six (Figure 21). The baseline Positive Attitude score was neutrally trending and moderate to high variance (Figure 22). Jerry’s Positive Attitude was 1.5 in period four, and he demonstrated his most Positive Attitude during periods three and eight receiving a maximum three points (Figure 22).

The Overall trend during the intervention phase is sloped positively (Figure 18). The intervention data had moderate to high variance. The lowest Overall score was three, recorded during period 17. The highest score was an Overall of 10 recorded in the intervention phase was observed in period 19 (Figure 18). The Positive Attitude scores had a neutral trend, while the three other categories presented slightly positive trends in the intervention phase (Figures 18-22). Variance was moderate to high as the data presented multiple outliers. During period 17 Jerry received his lowest scores in Participation, Initiative and Goal Setting (Figures 19-21). Similarly, he received no points in Goal Setting in period 16 and a score of one in Positive Attitude in period 21 (Figures 21,22).
Discussion

Treatment Summary

This study included PPP intervention of various lengths depending on the youths’ length of residency and amount of participation with the facility programming. For purposes of this research study, observation of four participants was observed during facility programming periods prior to intervention and facility programming periods following the first PPP session. Observations and recording of Participation, Initiative, Goal Setting and Positive Attitude were the categories used to evaluate Overall motivation. The Facility Programming Motivation Recording Instrument is a rubric completed by the clinical staff, direct care workers or this writer (Appendix F). This instrument operationalizes each category and scores them from 0-3 points, for an Overall score ranging from 0-12. The hypothesis of the study was to identify if teaching effective goal setting to male young offenders could increase the participant’s motivation in facility programming periods. It was hypothesized that increased motivation in facility programming periods would likely increase the impact of treatments and improve internal motivation towards pro-social self-goals. Combined Overall mean scores were 8.618 for baseline and 8.384 for intervention (Figure 2). Two participants demonstrated increase in Motivation and two participants demonstrated a decrease in motivation. The combined Overall percentage of change in behaviour was -2.715%. Despite a slight Overall decrease in youth motivation, multiple goal setting skills and practices were taught during intervention.

Examination and Analysis of Treatment Results

Motivation can be challenging to evaluate because of the ambiguity and number of overt and covert discriminative stimuli in the environment. Although challenging to identify the causes both extrinsic and intrinsic variables involved in motivation, the Facility Motivation Recording Instrument provided an objective review of the overt behaviours related to motivation to access client’s level of motive. The number of periods recorded using this instrument during both phases of treatment was too low to evaluate change in behaviour and effectiveness of treatment. An increase in the observed periods would lower the standard deviation if the data remained stable throughout the additional periods. This would increase the likelihood of intervention data demonstrating change that exceeded +/- 1.00 standard deviation, demonstrating some change when evaluating the z-scores. Although the intervention would highlight more positive or negative effects on motivation if the number of periods observed was increased, based on the results of this study is questionable that any category would experience positive significant change exceeding +2.00 standard deviation change from baseline to intervention. Although the youth mentioned that they enjoyed setting goals and reviewing progress, each presented with histories of poor attendance, low achievement in schooling, and unwillingness to interact with supportive staff. Changes in learning histories would require extended exposure to goal setting and self-monitoring PPP sessions, and increases of positive interactions with staff during facility programming periods.

As reactivity and learning histories could cause potential barriers to motivation it is important that the intervention phase is long enough for data to be an accurate representative of Participation, Initiative, Goal Setting and Positive Attitude. Three of the four participants (Bruce, Allen & Jerry) demonstrated positive trends during the intervention phase (Figures 3,8,18). This suggests that with continued observations of the behaviour the individual intervention scores would produce increased Overall Motivation. This is particularly the case of Allen, as he received the least observations (5) in the intervention phase. The positive trends in three of the
four Overall intervention phases suggest that with more observation periods that the percentage of change from baseline to intervention would increase. Although three of the trends are positive, it is important to state that any of the participant’s motivation trends could change. The trends do not insure that more observation periods would equal a positive percentage of change, but it does provide support to continue research into the impact of PPP sessions. Further research would require more observed periods in the intervention phase to reduce the likelihood of reactivity and provide more time for the intervention to overcome previous learning histories.

Many extraneous variables are present within the youth justice facility setting. Youth entered and exited the facility regularly, changing the complex social context on a daily basis. Similarly, the staff alternate shifts between four pairs, while casual staff circulate through the rotation to provide additional support or substitute with full-time staff. The youth react differently with each staff present based on the personal rapport between the youth and direct care worker. The staff member supervising the facility-programming period can influence the Participation, Initiative, Goal Setting, Positive Attitude and Overall motivation of the specific youth. Although goal setting and self-monitoring are potentially beneficial for increasing youth motivation, observations suggests that the current environment during the programming period is more impactful on the client’s behaviour. Direct observation using the Facility Programming Motivation Recording Instrument to compare and contrast the behaviours cross environment variables could demonstrate significant change. Observation should occur for variables such as number of youth participating in the period, graduated youth’s impact on non-graduated youth’s performance in school, isolated specific Direct Care Worker statistics, and substitute teaching professionals. Reviewing each variable during future interventions is important to isolate variables and identify potential areas for service improvements.

Similarly, the impact of social influence, age and stage of development can play an important factor in motivation categories. Goal setting can be challenging for youth who are not participating in schooling or an occupation. Jerry was the youngest to participate in the intervention. He was in grade six working on grade three to four level assignments. This produced motivational challenges as the elementary educational system relies heavily on internal motivation and external motivation from parental influence. If the youth is not internal motivated to participate and there are no external motivators it is challenging to promote a learning environment because the youth will graduate based on age of cohort. Compared to receiving secondary education credits, which are dependent on material completed to progress towards graduation. Without credits, elementary students do not have concrete goal indicators like secondary students. This combined with the developmental age suggests reasons for the Overall motivation of Jerry was the lowest scores observed among participants.

Relevance of Thesis to Literature Review

The findings from the treatment do not directly support the intervention, as the results from the intervention phase were lower than the baseline phase demonstrating an Overall decrease in motivation collectively. Although the combined Overall score decreased, two of the four participants had positive changes in motivation. Analysing the raw data independently suggests that the intervention may not work effectively for improving youth motivation towards facility programming. Based on the limited sample size and the observations within the facility it would be premature to state that the intervention has no ability to promote motivation in the young offender population. Attempts with this intervention should be repeated under similar conditions and population. For further research, various variables should be isolated to evaluate
correlation, increase sample size, and extend the length of the intervention phase to increase the accuracy of intervention evaluation. A program that could increase motivation in the young offender population would have immediate benefits for the client and the systems providing services. The Student designed the program to reduce recidivism and increase occupational success; a program that improves the contact with service would increase the likelihood that the services could be effective.

**Strengths**

A fundamental strength in the treatment is the goal setting skills attained by the youth participating in the program. Youth responses from the Modified Clinical Trial Participant Satisfaction survey (Appendix I) provided support that the young males found the scheduling skills useful and planned to use some SMART goal planning techniques. All of the youth who participated in the study identified that they had limited structure during their weekly schedule. Planning appointments and filling a calendar with positive goals can better insure that youth can make important appointments and structured personal goals. This program identified that goal setting may be a common deficit for this population. The targeted goal setting is a direct, simple and practical approach. Additionally, the skills were taught repeatedly and practiced insure that the techniques were effectively communicated to the youth.

The student providing the PPP sessions participated with the youth in daily activities. Responses in the Modified Clinical Trial Participant Satisfaction survey suggested that the youth liked working with someone that they had a rapport with because they were more comfortable. The youth also liked how the student shared examples from his daily schedule related to completing assignments and fitness. It is essential for the participants to trust the individual assisting with the goal setting. Trust insures that the youth will share accurate information and that they will be less likely to find this new activity uncomfortable.

**Limitations**

The largest limitation of the study is the overall sample size of the population. These four youth presented a small sample of young offenders in Canada. The limited number of clients does not produce enough statistical power for the findings. The over view of male young offenders cannot be effectively created because the observation group is minimal in relation to the population size. The limitation impact could be minimized by extending the length of treatment, but the nature of the monitored group does not allow for extended exposure to youth justice facility programing interactions as many youth are in short term detention, changing facilities often or non-compliant with the programming. Many youth were in the facility for one or two days prior to court; they might be sentenced, released or remanded. It was challenging to observe the youth for consistent lengths of time. Additionally, youth may be in the open setting for multiple short stays depending on their crimes and court process. Short stays provide challenges to the teaching professionals and clinical staff because they do not have continuous sessions to gather information, develops plans and build rapport. Motivation for youth coming and going would be challenging to accurately measure do to the variability of behaviours around attending court and being in a new environment.

Similarly, this study observed youth exclusively in an open custody facility. Although not
feasible for the student to collect data in multiple settings for this program, male and female data in mainstream classrooms, alternative learning locations, and secure facilities would produce potentially useful information for youth goal setting programs. Comparisons could identify a norm for ages, trends for youth motivation, and potentially risk factors for criminogenic needs.

Although the results did not demonstrate clinically significant change in motivation behaviour, observation suggests that the youth gained some improved goal-setting skills. Monthly scheduling, SMART goal setting, and self-monitoring are some of the skills taught to the youth. A potentially more accurate measure would operationally identify the skills attained. A longitudinal look at the participants’ motivation may demonstrate positive trends in the future due to the skills obtained. Measuring treatment in alternative ways to observe skills gained and further observation of the youth may reveal impact in motivation when combined with variables related to adulthood and maturation. Variables like parenthood, intimate relationships, or financial independence may result in the utilizing of goal setting skills obtained to create increased motivation towards pro-social objectives.

**Multilevel Challenges to Service Implementation**

**Overview**

The Corrections Service of Canada (CSC) model appears to follow research and literature to insure implementation of the best practice for the care and services provided to young offenders. Unfortunately, some incongruities are present in the current system related to allocation of resources, consistency of staff competency and facility adherence to literature on a board spectrum.

**Client Level**

The Youth Criminal Justice Act (YCJA) focuses on least intrusive measure, and encourages programming that meets the severity of the offence. The design of the system is to progress youth along the spectrum from secure facilities to open custody, and then on to community reintegration. A challenge occurs in this system when youth request to be in the secure system due to the ‘prison-like’ freedoms of gambling canteen, ability to ‘self-police’ and ability to discuss personal charges openly. Despite literature that warns against these activities, youth state that they can freely participate and enjoy the freedom without retrospective concern of the dangers they may cause. In the open custody setting youth, desire the freedoms that they once held within secure, because they do not recognize or disregard the dangers of these behaviours long term. The open custody, while designed to be the next step in community success, often serves as perceived punishment for youth.

**Program Level**

The abilities of staff working in youth corrections vary in education and experience. Each education provider offers a different perspective for service implementation. It is important to have different views and opinions for creating models and engaging daily, but literature and research must be at the forefront of program delivery regardless of the professional working with the youth treatment informed interventions. Training and licensing of who are important to re-teach models and build further skills to assist facility programming.

**Organizational Level**

The level system is being implemented in a variety of settings successfully, it is currently not used in all facilities. If implemented as designed this program can allow youth to have a clear contingency of their behaviour and there consequences. Youth may have difficulty understanding
abstract concepts like trust or respect, a level system can motivate behaviour and operationalize expectations. Although it can be challenging to implement, a scaled system of progressing youth access is parallel with the YCJA’s approach of moving youth towards a least constricting condition. This method also can provide many opportunities for the staff to positively scan and praise the accomplishments of the youth.

**Societal Level**

The funding system for youth justice and youth housing requires overhaul and realignment to adhere to best practice. Secure facilities appear to be receiving more funding for staffing and programming. Additionally, secure facilities implement a guard-like setting, reducing positive role model interactions and supervision quality. Similarly, group homes tend to operate on the private funding pay frame. Homes may be tempted to absorb more intakes against their best practice limit for bedding or staff capabilities.

Additionally, systemic barriers remain at multiple levels within the education system: youth justice, Ontario Works and youth housing, enabling the efficiency of case management and success planning following discharge.

**Contributions and Recommendations to the Field of Behavioural Psychology**

Although the results did not demonstrate positive results for motivation, the study did suggest that goal setting is an underdeveloped skill for male young offenders. The combined Overall Goal Setting score was 1.669, which was the lowest of all four categories (Table 2). Goal setting skills may be an indicator for conflict with the law; similarly poor goal setting may be linked with lower school performance, financial and occupational achievement. This thesis found a common factor of poor goal setting among the participants within the limited sample size.

Recommendations for future research in the field of psychology would build on this thesis. Completing research into youth goal setting could likely to reinforce the findings within the thesis and identify if the results are different within different populations. Adolescents in standard public school systems, alternative-learning sites, open and secure custody should complete a similar intervention to evaluate and observe differences between demographics. The treatment (PPP) in the thesis requires a larger sample size and longer intervention phases to better evaluate the effectiveness of treatment. Following further examination of the thesis treatment, research should continue to modify efforts to improve goal setting in youth because of the importance and generalizable applications in various areas of wellness, occupations and desires.
References


Appendix A
Informed Consent: Parental (Under 16)

Invitation
Your child is being invited to take part in a research study. I am a student in my fourth year of the Behavioural Psychology program at St. Lawrence College. I am currently on placement at an Open Custody youth Justice Facility. As a part of this placement, I am completing a research project for an applied thesis. I would like to ask you for your child’s help to complete this project. The information in this form will help you understand my project. Please read the information carefully and ask all the questions you might have before you decide if you want your child to take part.

Why is this study being done?
This project is designed to motivate participation in the current Dialectical Behavioural Therapy (DBT), Cognitive Behavioural Therapy and educational sessions in order to increase the effect of programming. DBT and CBT involve talking or acting through situations connected to events with historical difficulty. We believe that participating in these programs will help children manage their behaviour and reduce recidivism. Your child’s opinions and thoughts are important in this project.

What will your child need to do if he takes part?
If you choose to allow your child to take part in this study, he will be asked to meet with me for multiple meetings to discuss his goals. We will talk about the program and the proceeding role he will play in it. Your child will be asked about their future interests and will complete a short goal setting activities related to their goals.

What are the potential benefits to your child if they take part?
Potential benefits of taking part in this research study may include your child learning more about vocational opportunities. Your child may improve the rate of programming participation. Participating more in client-based treatment may improve how he manages emotions and behaviours.

What are the potential benefits of this research study to others?
The potential benefits of this research study to others may include improving programming designed to tailor client needs. Also provide evidence for this population that goal setting is effective for improving participation.

What are the potential disadvantages or risks to my child if s/he takes part?
Risks from taking part in this research study are minimal but may include feeling upset, bored, or uncomfortable about the subject of self-evaluating.

What happens if something goes wrong?
Every individual is different. If your child has a strong reaction towards any of the questions or session, your child may speak further with the agency counsellor or myself.

Will the information you collect from my child in this project be kept private?
We will make every attempt to keep any information that identifies your child strictly confidential unless required by law. No names or identifiers will be used. Your child will be assigned a code name to use on the questionnaires. The consent forms, my project notes, and completed questionnaires will be kept in a locked filing cabinet at the agency. The computer files with the study data will be kept in a password protected file on a secure, password-protected computer. All study documents and results will be kept securely for 7 years at the agency, and
then they will be destroyed. Your child’s name or other identifiers will not be used any reports, publications, or presentations resulting from this project.

**Does my child have to take part?**
Taking part is voluntary. It is up to you to decide whether or not allow your child to take part. I will also ask your child if he wants to take part. If you decide to allow your child take part, you will be asked to sign this consent form. If you decide to allow your child to take part in this project, you and/or your child are still free to stop at any time without giving any reason and without experiencing any penalty or negative effects. If your child stops taking part, please have your child tell the agency counsellor or myself.

**Contact for further information**
This research project has received ethical clearance from the Research Ethics Committee for Behavioural Psychology (REC-P) under the authority of the St. Lawrence College Research Ethics Board (SLC-REB). The project was developed under the supervision of Dr. Melissa Bolton, C.Psyc. (Supervised Practice), my supervisor from St. Lawrence College. I appreciate your cooperation and if you have any additional questions, feel free to ask me, Barry Hogeboom (bhogeboom18@sl.on.ca). You can also contact my College Supervisor Dr. Melissa Bolton (melissa.bolton@csc-scc.gc.ca). If you have concerns about the way this research is being conducted or about your rights as a participant you may contact the SLC-REB Chair at reb@sl.on.ca.

**Consent**
If you agree to allow your child to take part in this research project, please complete the following form and return it to me as soon as possible. A copy of this signed document will be given to you for your own records. We will keep an additional copy of your consent at the agency. The data and consent will be stored with each youth’s current confidential files. These files are placed in a locked room within a secure filing cabinet. The files will be stored in the cabinet for seven years following their 18th birthday. The files will be shredded at that point.

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

I hereby consent for my child, ________________ to take part.

<table>
<thead>
<tr>
<th>Parent/Guardian Name</th>
<th>Signature of Parent/Guardian Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student Printed Name</td>
<td>Signature of Student</td>
</tr>
</tbody>
</table>

Date
Appendix B
Informed Consent: Phone Script

Student:
Your child is being invited to take part in a research study. I am a student in my fourth year of the Behavioural Psychology program at St. Lawrence College. I am currently on placement at an Open Custody youth Justice Facility. As a part of this placement, I am completing a research project for an applied thesis.
Do you have any questions?

Student:
This project is designed to motivate participation in the current agency programming. Agency programming includes educational and counselling sessions. We believe that participating in these programs will help children manage their behaviour and reduce recidivism.
Do you have any questions?

Student:
During the project your child will be asked to meet with me for multiple meetings to discuss his goals. We will talk about the program and the proceeding role he will play in it. Your child will be asked about their future interests and will complete a short goal setting activities related to their goals.
Do you have any questions?

Student:
Potential benefits of taking part in this research study may include your child learning more about their own goals and potentially improve their rate of programming participation. Participating more may improve how he manages emotions and behaviours.
Do you have any questions?

Student:
Risks from taking part in this research study may include feeling upset, bored, or uncomfortable about the subject of self-evaluating.
Do you have any questions?

Student:
Every individual is different. If your child has a strong reaction towards any of the questions or session, your child may speak further with the agency counsellor or myself.
Do you have any questions?

Student:
We will make every attempt to keep any information that identifies your child strictly confidential unless required by law. No names or identifiers will be used. Your child will be assigned a code name to use on the questionnaires. The consent forms, my project notes, and completed questionnaires will be kept in a locked filing cabinet at the agency. The computer files with the study data will be kept in a password protected file on a secure, password-protected computer. All study documents and results will be kept securely for 7 years at the agency, and then they will be destroyed. Your child’s name or other identifiers will not be used any reports, publications, or presentations resulting from this project.
Do you have any questions?

Student:
Taking part is voluntary. It is up to you to decide whether or not allow your child to take part. I will also ask your child if he wants to take part. If you decide to allow your child take part, you
will be asked to verbally consent. If you decide to allow your child to take part in this project, you and/or your child are still free to stop at any time without giving any reason and without experiencing any penalty or negative effects. If your child stops taking part, please have your child tell the agency counsellor or myself.

Do you have any questions?

Student:
This research project has received ethical clearance from the Research Ethics Committee for Behavioural Psychology (REC-P) under the authority of the St. Lawrence College Research Ethics Board (SLC-REB). The project was developed under the supervision of Dr. Melissa Bolton, C.Psyc. (Supervised Practice), my supervisor from St. Lawrence College. I appreciate your cooperation and if you have any additional questions, feel free to ask me, Barry Hogeboom (bhogeboom18@sl.on.ca). You can also contact my College Supervisor Dr. Melissa Bolton (melissa.bolton@csc-scc.gc.ca). If you have concerns about the way this research is being conducted or about your rights as a participant you may contact the SLC-REB Chair at reb@sl.on.ca. The data and consent will be stored with each youth’s current confidential files. These files are placed in a locked room within a secure filing cabinet. The files will be stored in the cabinet for seven years following their 18th birthday. The files will be shredded at that point. Do you have any questions?

Student:
By verbally consenting this form, I agree that

- The study has been explained to me.
- All my questions were answered.
- Possible harm and discomforts and possible benefits to my child of this study have been explained to me.
- I understand that my child has the right not to participate and the right to stop at anytime.
- I am free now, and in the future, to ask any questions I have about the study.
- I have been told that my child’s personal information will be kept confidential.
- I understand that no information that would identify my child will be released or printed without asking me first.
- I understand that I will receive a signed copy of this consent form.
Appendix C
Verbal Guardian Consent Checklist

Name of Guardian:
Name of Youth:
Name of Student on the Phone:
Name of Agency Supervisor:

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

Signature that the Student and Agency Supervisor spoke with the guardian and received confirmation that they agreed with the verbal consent statements listed above.

Signature of Student
__________________________________________
Date: _________________

Signature of Supervisor
__________________________________________
Date: _________________
Appendix D
Informed Consent: Youth 16 Years or Older

**Invitation**
You are being invited to take part in a research study. I am a student in my fourth year of the Behavioural Psychology program at St. Lawrence College. I am currently on placement at an Open Custody youth Justice Facility. As a part of this placement, I am completing a research project for an applied thesis. I would like to ask you to help complete this project. The information in this form will help you understand my project. Please read the information carefully and ask all the questions you might have before you decide if you want to take part.

**Why is this study being done?**
This project is designed to motivate participation in the current Dialectical Behavioural Therapy (DBT), Cognitive Behavioural Therapy and educational sessions in order to increase the effect of programming. DBT and CBT involve talking or acting through situations connected to events with historical difficulty. We believe that participating in these programs will help you manage their behaviour and reduce recidivism. Your opinions and thoughts are important in this project.

**What will you need to do if he takes part?**
If you choose to take part in this study, you will be asked to meet with me for multiple meeting to discuss your goals. We will talk about the program and the proceeding role you will play in it. You will be asked about your future interests and will complete a short goal setting activities related to the goals.

**What are the potential benefits to you taking part?**
Potential benefits of taking part in this research study may include you child learning more about vocational opportunities. You may improve the rate of programming participation. Participating more in client-based treatment may improve how you manage emotions and behaviours.

**What are the potential benefits of this research study to others?**
The potential benefits of this research study to others may include improving programing designed to tailor client needs. Also provide evidence for this population that goal setting is effective for improving participation.

**What are the potential disadvantages or risks to you taking part?**
Risks from taking part in this research study are minimal but may include feeling upset, bored, or uncomfortable about the subject of self-evaluating.

**What happens if something goes wrong?**
Every individual is different. If you have a strong reaction towards any of the questions or session, you may speak further with the agency counsellor or myself.

**Will the information you collect from this project be kept private?**
We will make every attempt to keep any information that identifies you strictly confidential unless required by law. No names or identifiers will be used. You will be assigned a code name to use on the questionnaires. The consent forms, my project notes, and completed questionnaires will be kept in a locked filing cabinet at the agency. The computer files with the study data will be kept in a password protected file on a secure, password-protected computer. All study documents and results will be kept securely for 7 years at the agency, and then they will be destroyed. Your name or other identifiers will not be used any reports, publications, or presentations resulting from this project.

**Do I have to take part?**
Taking part is voluntary. It is up to you to decide whether or not to take part. If you decide to take part, you will be asked to sign this consent form. If you decide to take part in this project, you are still free to stop at any time without giving any reason and without experiencing any penalty or negative effects. If you stop taking part, please tell the agency counsellor or myself.

Contact for further information
This research project has received ethical clearance from the Research Ethics Committee for Behavioural Psychology (REC-P) under the authority of the St. Lawrence College Research Ethics Board (SLC-REB). The project was developed under the supervision of Dr. Melissa Bolton, C.Psyc. (Supervised Practice), my supervisor from St. Lawrence College. I appreciate your cooperation and if you have any additional questions, feel free to ask me, Barry Hogeboom (bhogeboom18@sl.on.ca). You can also contact my College Supervisor Dr. Melissa Bolton (melissa.bolton@csc-scc.gc.ca). If you have concerns about the way this research is being conducted or about your rights as a participant you may contact the SLC-REB Chair at reb@sl.on.ca.

Consent
If you agree to take part in this research project, please complete the following form and return it to me as soon as possible. A copy of this signed document will be given to you for your own records. We will keep an additional copy of your consent at the agency. The data and consent will be stored with each youth’s current confidential files. These files are placed in a locked room within a secure filing cabinet. The files will be stored in the cabinet for seven years following their 18th birthday. The files will be shredded at that point.

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

I hereby consent for, ________________ to take part.

<table>
<thead>
<tr>
<th>Youth’s Name</th>
<th>Signature of Youth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Student Printed Name</th>
<th>Signature of Student</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td></td>
</tr>
</tbody>
</table>
Appendix E
Youth Engagement and Motivation Intake

YOUTH ENGAGEMENT & MOTIVATION – INTAKE

| Name (First and Last Initial): | Gender: |
| Age: | Facility (Secure-Female, Open-Male): |
| Admission Date: | Discharge Date: |

The purpose of this survey is to obtain feedback on a youth’s level of understanding of the Youth Justice System, and to assess for individual motivation and participation for facility programming. Please rate your understanding in the following areas by circling the number that best measures your opinion.

**General**
Have you been at this facility before? Yes No

How aware are you of your recent legal proceedings?
Little Understanding Understanding All of My Charges
1 2 3 4 5 6 7 8 9 10

Would you like someone to better explain? Yes No

If ‘Yes’, how aware are you of your most recent legal proceedings?
1 2 3 4 5 6 7 8 9 10

Do you know why you are at this facility? Yes No
If no, why do you think?

Do you think what you did was wrong?
1 2 3 4 5 6 7 8 9 10

“I deserve to be at this facility”
Disagree 1 2 3 4 5 6 7 8 9 10 Agree

“Breaking rules has consequences”
Disagree 1 2 3 4 5 6 7 8 9 10 Agree

“One mistake will define me”
Disagree 1 2 3 4 5 6 7 8 9 10 Agree
**Education**
How much do you want to do like school?
1 2 3 4 5 6 7 8 9 10

How hard do you work during school?
1 2 3 4 5 6 7 8 9 10

Can education help you reach your goals?
Disagree 1 2 3 4 5 6 7 8 9 10 Agree

Canada would be better without Schools?
Disagree 1 2 3 4 5 6 7 8 9 10 Agree

How can you use schooling to help you?

______________________________________________________________________________
______________________________________________________________________________

**Peers**
Do your friends influence you toward illegal activity?
Disagree 1 2 3 4 5 6 7 8 9 10 Agree

Do your friends obey the law?
Disagree 1 2 3 4 5 6 7 8 9 10 Agree

**Beliefs**
“If I break the law, I receive consequences”
Disagree 1 2 3 4 5 6 7 8 9 10 Agree

“Breaking the law impacts only me”
Disagree 1 2 3 4 5 6 7 8 9 10 Agree

“I would make a few different decisions”
Disagree 1 2 3 4 5 6 7 8 9 10 Agree
# Appendix F

Facility Programming Motivation Recording Instrument

Name: ______________________  Date: ______________________
Time: ______________________  Activity: ______________________

<table>
<thead>
<tr>
<th>Participation</th>
<th>Level 0</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>No participation with the programing, no response or complete refusal</td>
<td>Some participation. Programing started later, doodling throughout or quitting earlier than expected.</td>
<td>Participation throughout the majority of the programing. May have minor breaks of attention or participation but meets the expectation.</td>
<td>Participation throughout with the programing. Asks questions to clarify concerns.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Level 0</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does not begin task. No response or complete refusal</td>
<td>Requires many prompts to begin tasks.</td>
<td>Requires minimal prompts to begin the task.</td>
<td>Requires no prompts to begin the task or is asking for the next activity. Requests further information on subject areas.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goal Setting</th>
<th>Level 0</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does not set goals for either short or long term.</td>
<td>May have unclear long term or short term goals. Limited details and plan to reach goals.</td>
<td>Has both unclear long and short term goals.</td>
<td>Clear long term goals and the short term goals designed to reach them.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Positive Attitude</th>
<th>Level 0</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head down no response to staff, or verbally aggressive/abuses when communicating</td>
<td>Partial greeting of the staff, infrequent smiling, and some respect of the staff.</td>
<td>May greet some of the staff, smiles at times, and is generally respectful.</td>
<td>Greets the staff with appropriate responses, smiles throughout, and is respectful.</td>
<td></td>
</tr>
</tbody>
</table>

## Overall Grade

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |

## Area to Work On

- Participation
- Initiative
- Goal Setting
- Positive Attitude

## Strength

- Participation
- Initiative
- Goal Setting
- Positive Attitude
Appendix G

Goal Setting Graphic

Goal Setting

Name:
Date:
My main goal is
_____________________________________
It is my main goal because
_____________________________________

My education goal is
______________________________________________________
I will use education to
______________________________________________________

My personal time goal is
________________________________________
I will use my personal time to
________________________________________

My counselling goal is
________________________________________
I will use my counselling to
________________________________________

My staff interaction goal is
______________________________________________________
I will use my staff interactions to
______________________________________________________

My change in behaviour goal is
_______________________________________________________
I will use the change in behaviour to
_______________________________________________________
Appendix H
Goal Setting Calendar

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
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<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
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<td>12</td>
<td>13</td>
<td>14</td>
<td>15</td>
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<td>26</td>
<td>27</td>
<td>28</td>
<td>29</td>
<td>30</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

GOALS

- Personal Goal:
- Educational Goal:
- Relational Goal:
Appendix I

Modified Clinical Trial Participant Satisfaction

A 10-item satisfaction/attitude questionnaire was designed to evaluate (1) what personal benefits people expect from participation in this trial, (2) motivation for joining, and (3) satisfaction with clinic staff and operations. Each question had a response category asking for a measure of agreement, satisfaction, or importance.

1. Helped me get better   Yes/No
2. Gathered New Ideas About My Future   Yes/No
3. Easy to Complete Program   Yes/No
4. Good Relationship With Student   Yes/No
5. Trusted Student   Yes/No
6. Available Alternatives   Yes/No
7. Large Disruption of Routine   Yes/No
8. Difficult to Participate   Yes/No
9. What did you like? And Why?
10. What Would You Change? And Why?
Appendix J
Percentage of Change

Increase = Intervention – Baseline
Baseline = (Baseline Scores Added)/(Maximum Score x Number of Baseline Scores) x 100 = y
Intervention = (Intervention Scores Added) / (Maximum Score x Number of Intervention Scores) x 100 = z
z – y = Change
Percentage of Change = Change / Original Number × 100

Combined Overall Scores
(293) / (12 x 34) x 100 = 71.814
(360.5) / (12 x 43) x 100 = 69.864
69.864 – 71.814 = -1.95
-1.95 / 71.814 = (-2.715%)

Bruce
(71) / (96) x 100 = 73.958
(66.5) / (84) x 100 = 79.167
79.167 - 73.958 = 5.209
5.209 / 73.958 x 100 = (+7.043%)

Allen
(37.5) / (48) x 100 = 78.125
(43.5) / (60) x 100 = 72.5
72.5 – 78.125 = -5.625
-5.625 / 78.125 = (-7.2%)

Brian
(133.5) / (168) x 100 = 79.464
(82.5) / (108) x 100 = 76.389
76.389 – 79.464 = -3.075
-3.075 / 79.464 x 100 = (-3.87%)

Jerry
(51) / (96) x 100 = 53.125
(168) / (264) x 100 = 63.636
63.636 - 53.125 = 10.511
10.511 / 53.125 x 100 = (+19.785%)
Appendix K
Calculating PEM and IOA

Combined
Baseline Median = 8.75
19 / 43 Point During Intervention Exceed the Baseline Median
PEM = 44.186%

Bruce
Baseline Median = 8.75
6 / 7 Point During Intervention Exceed the Baseline Median
PEM = 85.714%

Allen
Baseline Median = 10.0
1 / 5 Point During Intervention Exceed the Baseline Median
PEM = 20.0%

Brian
Baseline Median = 9.5
5 / 9 Point During Intervention Exceed the Baseline Median
PEM = 55.556%

Jerry
Baseline Median = 6.75
18 / 22 Point During Intervention Exceed the Baseline Median
PEM = 81.818%

Calculating Interobserver Agreement

IOA = (# times the observers agree/ total number of observations) X 100
= (171) / (196) x 100
= 87.245%
## Appendix L
Calculating Z-Scores

<table>
<thead>
<tr>
<th>Category</th>
<th>Combined Scores (Mean)</th>
<th>Standard Deviation</th>
<th>Intervention Mean</th>
<th>Z-Score of intervention Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>8.487</td>
<td>1.784</td>
<td>8.384</td>
<td>-0.058</td>
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<tr>
<td>Participation</td>
<td>2.227</td>
<td>0.559</td>
<td>2.186</td>
<td>-0.073</td>
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<tr>
<td>Initiative</td>
<td>2.143</td>
<td>0.622</td>
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<tr>
<td>Goal Setting</td>
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<td>0.662</td>
<td>1.64</td>
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<tr>
<td>Positive Attitude</td>
<td>2.416</td>
<td>0.547</td>
<td>2.442</td>
<td>+0.048</td>
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**Bruce**

<table>
<thead>
<tr>
<th>Category</th>
<th>Combined Scores (Mean)</th>
<th>Standard Deviation</th>
<th>Intervention Mean</th>
<th>Z-Score of intervention Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>9.167</td>
<td>1.858</td>
<td>9.5</td>
<td>+0.179</td>
</tr>
<tr>
<td>Participation</td>
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<td>0.627</td>
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<tr>
<td>Initiative</td>
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<td>2.467</td>
<td>0.55</td>
<td>2.571</td>
<td>+0.189</td>
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</table>

**Allen**

<table>
<thead>
<tr>
<th>Category</th>
<th>Combined Scores (Mean)</th>
<th>Standard Deviation</th>
<th>Intervention Mean</th>
<th>Z-Score of intervention Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
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<td>1.82</td>
<td>8.7</td>
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<tr>
<td>Participation</td>
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<td>0.546</td>
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<td>Initiative</td>
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<td>2.5</td>
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<tr>
<td>Goal Setting</td>
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<td>0.363</td>
<td>1.5</td>
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<tr>
<td>Positive Attitude</td>
<td>2.389</td>
<td>0.601</td>
<td>2.3</td>
<td>-0.148</td>
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</table>

**Jerry**

<table>
<thead>
<tr>
<th>Category</th>
<th>Combined Scores (Mean)</th>
<th>Standard Deviation</th>
<th>Intervention Mean</th>
<th>Z-Score of intervention Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>7.3</td>
<td>1.506</td>
<td>7.636</td>
<td>+0.223</td>
</tr>
<tr>
<td>Participation</td>
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<td>0.54</td>
<td>2.045</td>
<td>+0.144</td>
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<tr>
<td>Initiative</td>
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<td>0.519</td>
<td>1.795</td>
<td>+0.183</td>
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<tr>
<td>Goal Setting</td>
<td>1.217</td>
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<td>1.341</td>
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<td>0.544</td>
<td>2.386</td>
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</table>

**Brian**

<table>
<thead>
<tr>
<th>Category</th>
<th>Combined Scores (Mean)</th>
<th>Standard Deviation</th>
<th>Intervention Mean</th>
<th>Z-Score of intervention Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>9.391</td>
<td>1.187</td>
<td>9.167</td>
<td>-0.189</td>
</tr>
<tr>
<td>Participation</td>
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<td>Initiative</td>
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<td>Positive Attitude</td>
<td>2.478</td>
<td>0.533</td>
<td>2.556</td>
<td>+0.146</td>
</tr>
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</table>
Appendix M
Graphs of Individual Scores
Overall Facility Programming Motivation Recording Instrument Score (Bruce)

Figure 5: Bruce’s Overall Scores of the Combined Four Categories

Figure 6: Bruce’s Participation Scores Using the Facility Programming Motivation Recording Instrument During Direct Observation
Figure 7: Bruce’s Initiative Scores Using the Facility Programming Motivation Recording Instrument During Direct Observation

Figure 8: Bruce’s Goal Setting Scores Using the Facility Programming Motivation Recording Instrument During Direct Observation
Figure 9: Bruce’s Positive Attitude Scores Using the Facility Programming Motivation Recording Instrument During Direct Observation

Figure 10: Allen’s Overall Scores of the Combined Four Categories
Figure 11: Allen’s Participation Scores Using the Facility Programming Motivation Recording Instrument During Direct Observation

Figure 12: Allen’s Initiative Scores Using the Facility Programming Motivation Recording Instrument During Direct Observation
PROMOTING PROGRAM PARTICIPATION

Goal Setting (Facility Programming Motivation Recording Instrument Score Allen)

Figure 13: Allen’s Goal Setting Scores Using the Facility Programming Motivation Recording Instrument During Direct Observation

Positive Attitude Facility Programming Motivation Recording Instrument Score (Allen)

Figure 14: Allen’s Positive Attitude Scores Using the Facility Programming Motivation Recording Instrument During Direct Observation
Overall Facility Programming Motivation Recording Instrument Score (Brian)

Figure 15: Brian’s Overall Scores of the Combined Four Categories

Participation Facility Programming Motivation Recording Instrument Score (Brian)

Figure 16: Brian’s Participation Scores Using the Facility Programming Motivation Recording Instrument During Direct Observation
Figure 17: Brian’s Initiative Scores Using the Facility Programming Motivation Recording Instrument During Direct Observation

Figure 18: Brian’s Goal Setting Scores Using the Facility Programming Motivation Recording Instrument During Direct Observation
Positive Attitude Facility Programming Motivation Recording Instrument Score (Brian)

Figure 19: Brian’s Positive Attitude Scores Using the Facility Programming Motivation Recording Instrument During Direct Observation

Overall Facility Programming Motivation Recording Instrument Score (Jerry)

Figure 20: Jerry’s Overall Scores of the Combined Four Categories
PROMOTING PROGRAM PARTICIPATION

Participation Facility Programming Motivation Recording Instrument Score (Jerry)

Figure 21: Jerry’s Participation Scores Using the Facility Programming Motivation Recording Instrument During Direct Observation

Initiative Facility Programming Motivation Recording Instrument Score (Jerry)

Figure 22: Jerry’s Initiative Scores Using the Facility Programming Motivation Recording Instrument During Direct Observation
Goal Setting Facility Programming Motivation Recording Instrument Score (Jerry)

Figure 23: Jerry’s Goal Setting Scores Using the Facility Programming Motivation Recording Instrument During Direct Observation

Positive Attitude Facility Programming Motivation Recording Instrument Score (Jerry)

Figure 24: Jerry’s Positive Attitude Scores Using the Facility Programming Motivation Recording Instrument During Direct Observation