

Article Title:
Group treatment in a male low secure mental health service: A treatment description and descriptive evaluation.

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Abstract

Purpose: This paper describes the development, content and structure of an intensive group based intervention designed to address a range of needs common to individuals within low secure forensic mental health settings. Additionally, the feasibility, acceptability, resource implications and levels of participation and understanding are evaluated.

Design/methodology/approach: Data were gathered from a number of sources including staff report, knowledge acquisition and in-group ratings.

Findings: Analysis showed that the intervention was well received by staff and participants and that those with low self reported knowledge at the start showed large improvements. Recorded levels of participation and understanding were lower than expected.

Research limitations/implications: Group based interventions in low secure settings can be developed from existing ‘what works’ information. Such treatments can

feasibly be delivered although participants may need support – something which is not reported in many intervention studies. Research is now needed to assess the impact of the General Treatment & Recovery Programme (GTRP) intervention on participants.

Originality/value: The development of treatment programmes for offending behaviour within low secure forensic mental health settings is still in its infancy. This paper outlines and describes the development of such an intervention, namely the GTRP.

Paper type: Descriptive research paper

Key words: low secure, offender treatment, outcome, recidivism, what works

Word count: 4651 excluding abstract, figures and references

Low secure mental health settings provide “intensive, comprehensive, multidisciplinary treatment . . . for patients who demonstrate disturbed behaviour in the context of a serious mental disorder and who require the provision of security . . . underpinned by the principles of rehabilitation and risk management” (Pereira & Clinton, 2002, p4). Estimates suggest that there are over 1500 individuals detained in the approximately 140 low secure units in the UK (Pereira, Dawson & Sarsam, 2006). Some of these individuals form part of the larger number of around 4000 mentally disordered offenders (MDOs) subject to restriction orders in hospitals in England & Wales (Ministry of Justice, 2010). Given that low secure services act as the final staging post before reintegration back into the community (Prins, 2005), specialist interventions designed to address mental health needs, offending behaviour and risk in this population are important for rehabilitation, community integration and long term risk management.

At present, group interventions are used in secure mental health services to address a range of offending behaviour needs (e.g. Davies & Oldfield, 2009) many of which are based on programmes developed for prison populations. However there is limited outcome evidence for ‘mainstream offender-based treatment programmes’ when applied to forensic inpatient populations (Blackburn, 2004; Nagi & Davies, 2010a). This has led some to develop specialised programmes or adaptations of existing interventions for mentally disordered offenders who have engaged in specific forms of offending (e.g. violence). However the evidence for their use is still being developed (e.g. Braham, Jones & Hollin, 2008; Ireland, 2007). Other offending behaviours such as those considered ‘general offending’ (e.g. burglary, theft, drug and car crime) have not been subject to specific interventions to date despite the comparative high rate of such offences (compared to sexual or violent assault) amongst those in secure settings. Instead, treatment for ‘general offending’ has tended to focus on wider criminogenic factors such as cognitive skills (i.e. *Enhanced Thinking Skills, Reasoning and Rehabilitation*) and social problem solving (e.g. *Think First*; McGuire, 2005 and *Stop and Think!*; McMurran, Fyffe, McCarthy, Duggan, & Latham, 2001; McMurran & McGuire, 2005).

In addition to criminogenic need, a range of other factors require attention within forensic mental health settings. From a traditional risk / harm reduction viewpoint these have sometimes been identified as specific responsivity factors i.e. they need to be addressed because they may interfere with treatment or impact on motivation when addressing criminogenic factors (Andrews & Bonta, 2010). Whilst some evidence suggests that affect, for example, may be important to address in order to maximise engagement with interventions (Howells & Day, 2006), it is becoming more widely accepted that factors such as emotion regulation and management,

mental health / wellbeing and dysfunctional coping (e.g. substance misuse) may be important in their own right in the pathway to offending.

It has been noted that the focus on cognitive skills programmes has resulted in very little emphasis or consideration of emotion in offender decision-making and behaviour (Ward & Nee, 2009). The empirical evidence demonstrates the role of strong emotions in the offence chains for both violent and sexual offending (Howells, Day, & Wright, 2004; Polaschek, Hudson, & Ward, 2001) and that offenders struggle to experience and accurately label their emotional states (Day, Davy et al, 2008). Consequently, psychological interventions designed to increase emotional awareness and emotional regulation may have an important role in offender treatment (Day, Bryan, Davey & Casey, 2006; Day, Gerace, Wilson & Howells, 2008; Ward & Nee, 2009) although further research is needed to establish the criminogenic status of negative emotional states (Day, 2009). In the wider context, mood states and problems with emotional regulation are also known to be important factors in mental health problems and substance misuse (Moses & Barlow, 2006; Axelrod et al, 2011). Therefore the need to address affective determinants to engagement and wider emotional regulation problems are likely to be an important treatment component when working with mentally disordered offenders.

The treatment needs associated with mental health and recovery are also important considerations for low secure settings. The stress-vulnerability model of schizophrenia (Zubin & Spring, 1977) suggests that the severity and cause of symptoms are determined by three different factors: biology, vulnerability and stress / coping skills. Research indicates that whilst 70% of patients show improvement in psychotic symptoms with neuroleptic drugs, many still experience distressing and recurrent symptoms (Curson, Patel & Liddle, 1988). Since major mental illness is a

modest risk factor of violence, psychological treatment addressing stress and vulnerability factors for mental health issues should be incorporated into interventions designed to address offending in mentally disordered populations. In addition, it is well documented that there are high rates of historic substance misuse among mentally disordered offenders detained in forensic settings and that substance misuse is associated with serious violent offending in these populations (D'Silva & Ferriter, 2003; Oddie & Davies, 2009; Quayle, Clark, Renwick, Hodge & Spencer, 1998; Ritchie, Billcliff, McMahon & Thomson, 2003). Substance misuse is the strongest predictor of relapse and reoffending following discharge in mentally disordered populations (Scott, Whyte, Burnett, Hawley & Maden, 2004), with offenders most likely to seriously reoffend being those with significant substance misuse prior to the original offence (Norris, 1984). Other studies have found significant co-morbidity between Axis I and Axis II disorders among offenders (Rotter, Steinbacher, Sawyer & Smith, 2002), highlighting the requirement for treatment targets to be tailored towards personality pathology among offenders, as well as major mental illness.

There is growing support for the argument that interventions should also emphasize the importance of protective factors and strengths (Andrews & Bonta, 2010; Ward & Maruna, 2007), in addition to addressing identified problems and needs. One approach that has been used is the development of ‘good life’ plans which take into account factors including an individual’s strengths and capabilities, the resources required and key environmental and personal barriers to achieving the goals along with ways of overcoming these (Ward & Stewart, 2003).

Based on the available literature, it is evident that low secure mental health settings need to provide interventions which, amongst other things, promote community integration, help individuals develop ‘good life plans’; help address

offending and risky behaviours; support individuals to address alcohol and substance misuse issues; build emotional and interpersonal capabilities and foster recovery and improved mental health. Articles reporting new group based interventions often move directly to reporting group level outcome data without adequate reporting of fundamental issues such as resource implications, the acceptability of the intervention to staff and participants and the engagement, participation and understanding demonstrated by those undertaking the group. Whilst the ‘urge’ to move directly to reporting outcome data is understandable, this leaves a paucity of literature or research reporting the acceptability of new interventions and the issues that arise relating to delivery and participation are largely overlooked. However, these aspects of group interventions are important as they are likely to influence the potential benefit and cost effectiveness of the treatment itself. The broad aims of this paper were to describe the content and provide a descriptive evaluation of a treatment package that has been developed specifically for mentally disordered offenders within a low secure setting based on the breadth of need identified. Specifically this paper seeks to:

- a. Describe the intervention being delivered
- b. Report the level of understanding, participation and support required by participants (as rated by facilitators) and explore any relationship between these factors
- c. Report the resource implications of running the group
- d. Report the impact of the group on self reported knowledge amongst participants

Programme description

The General Treatment & Recovery Programme (GTRP; Nagi & Davies, 2010b; Nagi & Davies, unpublished) is a cognitive-behavioural therapy informed intervention designed specifically to meet the needs of a low secure forensic mental health population. It forms one part of a wider organising framework for support and intervention within the service (Davies, Maggs & Lewis, 2010). The group programme was developed from a) an analysis of the literature for offending behaviour within such settings (Nagi & Davies, 2010a), b) a clinical review of common themes of need amongst those referred to and within the service and c) consideration of existing group treatments being used in forensic mental health settings. The GTRP is comprised of five modules which aim to promote motivation to change, knowledge development, skills development, personal understanding and management of risky behaviours, and relapse prevention skills including establishing goals and plans for the future. Many of the components of the GTRP are to be found in standard CBT treatments for mentally disordered offenders, such as social problem solving (*Stop & Think!*; McMurran et al, 2001); cognitive behaviour therapy for substance misuse (*Mental Disorder and Substance Misuse Treatment Programme*; Thomas & O'Rourke, 2002; Oddie & Davies, 2009) and emotional regulation strategies (Linehan, 1995). However, these have been abbreviated and adapted for this programme. The modules are sequenced to build one on the other and move from engagement and education to personal understanding and planning. The GTRP is delivered as a 21 week psycho-education group supplemented by weekly individual sessions. Group sessions last for one and a half hours and individual sessions approximately 30 minutes. Both group and individual sessions are delivered by

facilitators experienced in group interventions and with the content of the programme. The purpose of the individual sessions are to assist with addressing ‘therapy interfering behaviours’, personalising the content of the group sessions and to support skills acquisition.

The group content is organised into a treatment manual that details the treatment content and materials to be used. However the facilitators can supplement the material to increase participant understanding and vary the pace of the session to respond to participant needs. Information to participants is presented using a number of different methods including pictures, interactive exercises, structured group discussions and role-play. Debriefing sessions are held at the end of each group session between facilitators who discuss and evaluate the progress of members of the group and plan the delivery of future sessions. Supervision is provided fortnightly by a senior staff member not involved in the delivery of the programme or administering any of the evaluation assessments.

Evaluation

Method

As an evaluation of treatment, NHS research ethics approval was not required, however the evaluation was scrutinised by the local service group for governance purposes. Data were analysed using the Statistical Package for the Social Sciences (SPSS Version 17.0; 2008).

Participants

Participants were inpatients in a low secure adult male NHS mental health service. This service provides recovery focussed care which seeks to promote factors such as independence, safety, and quality of life through a multi-disciplinary approach

(Davies, Maggs & Lewis, 2010). In order to participate in the group, individuals had to meet the following criteria: (i) a Full Scale IQ above 70; ii) have exhibited risky behaviours which could (or had) lead to conviction (iii) be deemed suitable for cognitive behaviour therapy; and (iv) be considered suitable for working in a group. Participants were excluded from the group if the multi-disciplinary team regarded them as too mentally unwell to be able to comprehend and / or fully participate in the sessions. Eight individuals in the service eligible for the group participated, although one participant did not attend some of the programme due to a deterioration in mental health part way through, and a second joined the group after the first two sessions had been delivered. Only six completed all pre-group and follow-up measures.

The mean age of participants was 39.17 years (SD; 5.84; range 28-44 years). The average length of total stay in hospital for participants for their current admission was 45 months (SD = 13.05; range 29-72 months) with an average length of time within the service being 15.50 months (SD = 5.16; range 6-19 months) at the end of treatment. All participants were single with an ethnic classification of White. On the basis of the Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition – Text Revision (DSM-IV-TR) (American Psychiatric Association, 2000), all participants had an Axis I diagnosis of schizophrenia and the majority had history of polysubstance misuse (n=8). Nearly all participants had a forensic history (n=7), the one exception had a history of violent behaviour including assaults on staff and patients while in hospital. All index offences were for violent offences, including arson, Grevious Bodily Harm (GBH), possession of an offensive weapon, assault and manslaughter. Of these, six had more than one previous conviction, including drug, violent, acquisitive and miscellaneous offences. All participants were formally

detained under the Mental Health Act (1983); two on section 3 and the remainder on a hospital order with (s37/41; n=3) or without (s37; n=3) a restriction order.

Measures

Formal Assessment:

1. Treatment & Recovery Questionnaire (TRQ; Nagi & Davies, unpublished)

The TRQ is a measure specifically developed to assess knowledge level across a range of domains (i.e. mental health symptoms, substance misuse, stressors, early warning signs, risky behaviours and coping strategies). Respondents are asked a series of questions (see Appendix 1) and are required to provide information relating to their own symptoms, experiences, strengths and needs (idiosyncratic knowledge). Each question is scored for relevance / accuracy. The TRQ total scores are classified into three knowledge bands: poor (<10); adequate (11-20) and good (21-31).

2. Session Information Checklist (Nagi & Davies, unpublished)

The Session Information Checklist is a 11 item tool which allows facilitators to record ratings for each participant against a number of key factors namely: attendance, interactions and/or group dynamics, homework completion, clinical presentation, risky behaviour and management issues (see Appendix 2). Ratings are made on a 10 point scale (ranging from 0 = ‘no’ or ‘clear lack of’ to 10 = ‘very’ or ‘excellent levels of’), in reference to their levels of participation; understanding, contribution and support.

Results

Attendance

The average attendance rate for group sessions was 82% (i.e. 17 out of a total of 21 group sessions). This ranged from 16 to 21 across participants. There were no non-completers although one member did not attend part of the programme due to a deterioration in his mental health. In contrast, the average attendance rate for the associated individual sessions was 58% (i.e. 12 out of a total of 20 individual sessions). This ranged from 4 to 20 across participants.

In session ratings

Participation: the average level of facilitator judged participation across all participants and all group sessions was 4.6 (where 0= clear lack of participation and 10 = excellent participation). This ranged from 0 to 9 across participants. Some sessions (i.e. motivation to change; goals and plans; relapse prevention plan; and my cycle/chain analysis) recorded higher overall levels of participation (total score ranging from 40-47) with other sessions (i.e. thinking errors; strong emotions; and early warning signs) recording the lowest (total score ranging from 20-27).

Understanding: session ratings for facilitator judged understanding of the session content across all sessions and participants was 3.7 (where 0=clear lack of understanding and 10=excellent understanding). Some sessions (i.e. motivation to change) recorded higher overall levels of understanding (total score ranging from 41-44) with other sessions (i.e. thinking errors; strong emotions; emotional regulation skills; and my cycle/chain analysis) recording the lowest (total score ranging from 16-21).

Support: the overall level of support required by participants as judged by facilitators was 4.2 (where 0=no support necessary and 10 = high levels of support necessary). Some sessions (thinking patterns; thinking errors; mental health problems; and stress vulnerability) recorded higher overall levels of support (total score range 40-46) with other sessions (i.e. substance misuse and early warning signs) recording the lowest (total score range 14-23).

Relationships between participation, understanding and support: Higher levels of understanding were associated with greater levels of participation but not support within group sessions. Correlation analyses were conducted to test the association between various in-session ratings at a group level. The results indicated that there was a significant correlation between ‘participation’ and ‘understanding’ ($r = 0.612$, $n = 21$, $p = <0.01$) however a non-significant correlation was found between ‘level of support’ and ‘understanding’.

INSERT TABLE 1 HERE

Acceptability: Evaluation forms were completed by patients ($N=8$) during a feedback session. The results indicated that most patients rated the pace of sessions as ‘about right’ ($N=6$), however there was an equal split ($N=4$) in terms of how they rated the length of course (i.e. either ‘too long’ or ‘about right’). Of those patients who provided additional descriptive information, most identified the work on relapse prevention as particularly helpful (i.e. 3 out of 5). One patient reported no tangible

benefits post treatment, and failed to recognise the relevance of the GTRP with their own criminogenic and mental health needs.

Feasibility: Attendance records indicate that each participant received an average of 29.25 hours of group session input and 6.8 hours of individual session input. This amounted to an average total of input received of 36.05 hours per person. In addition to weekly programme delivery (i.e. group and individual sessions), the following GTRP related activities for facilitators included: group preparation time (1x hour per week); administrative duties (i.e. session notes; clinical notes) (1 x hour per week); staff training/handover (1 x hour per week); and supervision (1 x hour per fortnight). Therefore, the total of 41.5 hours of patient treatment time required a total of 423 hours of staff time (i.e. 140-145 hours of staff time per facilitator)

Impact: For the purposes of this evaluation, the only index of impact used was knowledge acquisition using the TRQ (N=6). On this measure, two participants were classified as ‘poor’ and four as ‘good’ at the start of treatment in relation to self reported knowledge. At the end of treatment, all participants were classified as ‘good’ in relation to knowledge indicating that the two with low scores had showed clinically significant gains over the course of the intervention (based on a move from one category to another; Davies, Jones & Howells, 2010). No participant showed deterioration in knowledge level over the course of the intervention.

Staff views: Overall, positive staff feedback was received in reference to programme content, delivery, format and length. Whilst efforts were made by lead facilitators to provide staff training both prior to and during the GTRP for co-facilitators and to

orientate the wider staff team to the group (via ad hoc weekly staff support sessions; individual sessions; and handover periods), there was a general consensus that a longer staff training package would have been more beneficial. Additionally, facilitator feedback indicated that one aspect of the programme should be simplified further (i.e. thinking errors).

Discussion

Group based interventions tailored to those in low secure care are still in their infancy including the GTRP as outlined in this paper. Unlike many other group treatment programmes, the GTRP is designed to target a wide range of treatment needs in a single package including understanding the function of and alternatives to offending, supporting recovery and developing skills relating to mental health, understanding and managing emotions and planning for the future. The purpose of this paper was to outline the programme and present information relating to a number of delivery and process variables.

Attendance at group sessions was generally high (over 80% overall) which is positive given mentally disordered offenders are generally considered to be difficult to motivate and engage (McMurran, 2002). Further the absence of drop out is encouraging as non-completion rates have been reported to be higher in offender populations (McMurran & McCulloch, 2007; McMurran & Theodosi, 2007; Wormith & Oliver, 2002). Having facilitators based on the unit could have fostered engagement and attendance since a therapeutic alliance may have already been formed prior to group sessions (McInnis, Sellwood & Jones, 2006). This is worthy of further investigation (possibly using participant reports of alliance) as the therapeutic alliance itself has been identified as a significant predictor of successful outcome in

psychological treatment (Marshall & Serran, 2004; Marshall & Burton, 2010). Other reasons which could account for the high attendance rate may include the rehabilitation setting (i.e. based on the ward familiar to all group members); stage of rehabilitation (i.e. close to discharge); feeling compelled or coerced; some may have felt safe in group but ‘exposed’ or on the spot individually; and/or the ethos of recovery incorporated within the unit and the programme. In contrast however, attendance at individual sessions was considerably lower with more than a third of the available sessions not attended. This raises some concerns regarding the impact this could have had on the personalisation of material and opportunities to practice and generalise the skills learnt within group sessions. It may also have compounded levels of understanding within group sessions (as discussed below). However, participants may have been ‘voting with their feet’ indicating that they either didn’t want or need the individual sessions, or perhaps that they didn’t want to meet with their keyworker. For example, two participants attended less than 50% of individual session (i.e. 4-9 sessions) since they either did not view the GTRP as being beneficial to their treatment, or simply declined to engage without providing an explanation. Therefore, individual differences such as personality, intellectual ability and level of insight may play a role.

Facilitator ratings of group member participation were lower than anticipated. There are no known benchmarks against which the findings here can be compared, however, methods for assessing an individuals’ treatment readiness and motivational structure (e.g. Personal Concerns Inventory; Sellen et al, 2009; Violence Treatment Readiness Questionnaire; Day, Howells, Casey, Ward, Chambers & Birgden, 2009) may be beneficial to include as a future outcome measure in order to better understand this result. However, it must be acknowledged that ‘behavioural participation’ (as

measured by the rating) may not reflect ‘cognitive participation’ (i.e. processing of information) which was not assessed here (CF Polaschek et al, 2010).

Levels of facilitator judged understanding amongst participants was much lower than expected. It must be acknowledged that facilitators may not have been able to accurately assess individuals, however, this is a particular area for attention as understanding is almost certainly important for successful integration and use of group programme content. It is possible that understanding levels were affected by the usability of the materials developed, however the materials were, at least in part, adapted from existing materials used elsewhere. Another possible explanation is the effects of cognitive deficits which have been reported to be associated with a diagnosis of schizophrenia (e.g. memory, information processing, attention; Sharma & Antonova, 2003). These factors may have impacted on a participant’s ability to grasp the key concepts and learning points for each session. As a result, it is possible that the content of the GTRP modules will require modification/simplification in future. Even though the intervention utilised repetition and rehearsal techniques to assist with the reinforcement and consolidation of learning (Holyoak & Morrison, 2005), it is possible that a whole systems approach to treatment (c.f. DBT, Linehan, 1995) could maximize understanding within and skills generalisation after programme completion.

Higher levels of understanding were associated with greater levels of participation but not support within group sessions. This may suggest a feedback loop between understanding and participation whereby one fosters the other. It could also be that the rating of these constructs was not sufficiently delineated to create a meaningful difference between the terms. If the lack of relationship between facilitator support and understanding were to be replicated this could have

implications for how facilitators respond to individuals within groups who appear to be struggling with group content.

Idiographic analysis showed clinically significant knowledge acquisition amongst those with the lowest initial scores, however, most of the participants already scored highly for knowledge. This might indicate that the majority of the participants did not need the intervention (which is at odds with the clinical view) or that this measure has too low a ceiling to identify the needs and gains of some. Further consideration of how application of knowledge over and above ‘possession of knowledge’ can be assessed as part of group evaluation is needed.

In line with the Risk-Need-Responsivity principles (RNR, Andrews Bonta & Hoge, 1990; Andrews & Bonta, 2010), this programme was designed to provide a treatment ‘dose’ which is both practical and likely to be in-keeping with the *risk* level of those in low secure services (i.e. 1 x 1.5 hour group session over 21 weeks; and 1 x .5 hour individual session per week over 20 weeks). The GTRP attempted to attend to the *needs* of the client group (c.f. Davies & Oldfield, 2009) although given the heterogeneity of mentally disordered offender populations, it may be that future delivery needs to identify which parts of the programme apply to everyone and which parts do not. As such, it may be that the programme could be offered in a modular way, with all patients attending different modules according to their needs (Arsuffi, 2008). However, this descriptive evaluation demonstrates that such treatments can feasibly be delivered but that participants may need additional support, something which is not reported in many intervention studies. Indeed, recent studies on group sex offender treatment for mentally disordered offenders recommend that weekly group plus individualised sessions should be a standard (Gannon et al, 2011). Whilst this may have resource implications, a good attendance rate at group means less

‘cancelled time’ which could be important in resource challenged services. Also, knowing the amount of staff time given to the programme would make costing very easy.

Given the paucity of research in this area, the need for interventions to be thoroughly evaluated via individual outcomes is critical (e.g. Davies, Howells & Jones, 2007, Davies, Jones & Howells, 2010). There is evidence for treatment acceptability, based on patient and staff feedback, in addition to the finding that knowledge acquisition was demonstrated by those with the lowest pre-group scores. However, treatment impact was not a major focus of the study although investigating programme efficacy will form the next phase of the programme development. This is particularly noteworthy in terms of resource implications for the GTRP, which amounted to the equivalent of 1 day per week for each facilitator. Such formal evaluation will require a multi modal approach to assessing change, including psychometric measures and objective methods (i.e. clinical notes; incident recording). The current study relied primarily on self report data, which as with other self reported assessment, is prone to social desirability responding within forensic contexts. Indeed, some research argues for using self report psychometric tests only as an addendum to clinical interview for treatment evaluation due to their proneness to social desirability responding, and narrow focus which may miss core aspects of clinical relevance (Gannon et al, 2011). Additionally, the staff ratings obtained may have been subject to ‘halo effects’ (i.e. a cognitive bias in performance appraisal). Whilst the group evaluation forms permitted identification of aspects of the programme most beneficial and disappointing from a patient’s perspective, future research should also include service user consultation in the evaluation of the

treatment programme (i.e. qualitative data) (Stewart et al, 2012) to help further assist with programme development.

There are a number of important limitations with the evaluation presented here. As a ‘real world’ evaluation of a new treatment programme, this study has a small sample size and utilises locally developed measures which have not been standardized on a mentally disordered offender population. The results cannot be generalised outside of an adult male mental health low secure setting. There was an absence of formal evaluation of the GTRP so future work will be necessary to gather information on treatment efficacy (i.e. individual and group treatment change). However, this paper demonstrates that evaluating new and innovative treatments can be incorporated into general practice.

Implications for Practice

- A robust evaluation of the GTRP is necessary in order to examine treatment efficacy. This should incorporate methods for service user consultation.
- The Session Information Checklist appears critical to the programme evaluation as evidenced by the quality of in-session data.
- There are a number of points to consider for the future development, including pre-post psychometric assessment methods, content of the core modules and staff training.

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Treatment & Recovery Questionnaire (TRP)

Name..... Date.....

Circle: Pre-group Post-group

List two reasons why it is important to maintain good mental health:

1.
2.

List two ways of maintaining good mental health:

1.
2.

Identify three common mental health disorders:

1.
2.
3.

Name your two most problematic mental health symptoms:

1.
2.

List two early warning signs that your mental health may be deteriorating:

1.
2.

List two ways in which mental health problems may link to substance misuse:

1.
2.

List two ways in which substance misuse may link to mental health problems:

1.
2.

Identify two stressors that cause problems for you:

1.
2.

List three ways of coping with these stressors:

1.
2.
3.

Name the two emotions that you find most difficult to manage or that got you into difficulties:

1.
2.

Name those thoughts that you find impact on your mood or have got you into difficulties:

1.
2.

For each mood and/or thoughts, describe three different ways of coping :

1.
2.
3.
4.

Name your two most risky behaviours:

1.
2.

List two early warning signs that you may act out risky behaviours (take no. 1 & 2 above):

1.
2.

List two ways of that help prevent you acting out risky behaviours:

1.
2.

Identify three things you would like to change for yourself in the future:

1.
2.
3.

**GTRP
CASE NOTE CHECKLIST**

Name: _____ **Date:** _____

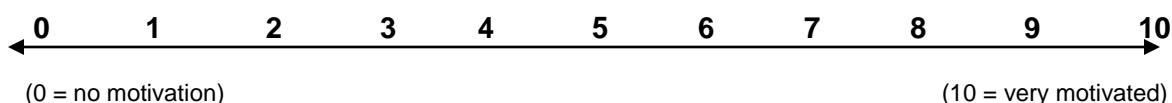
Session Title:

1. Attendance (please circle): Yes No

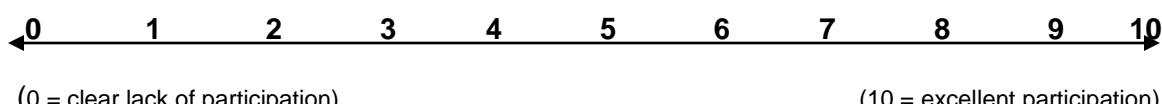
If no attendance or lateness, then please explain why:

For more information about the study, please contact Dr. [REDACTED] at [REDACTED].

2. Please rate level of motivation during session:



3. Please rate level of participation during session:



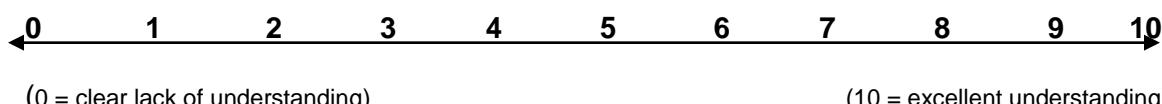
4 Management Problems (please circle): Yes No

If yes, please comment further:

If yes, please comment further:
(e.g. what behaviours were displayed? intensity? duration? what has been the consequence of such behaviours? etc.)

For more information about the study, please contact Dr. John Smith at (555) 123-4567 or via email at john.smith@researchinstitute.org.

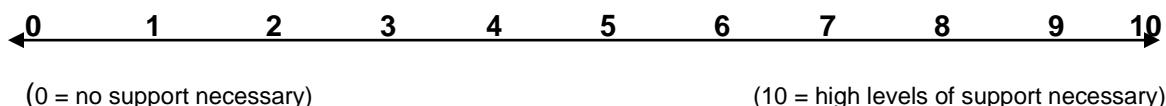
5. Please rate apparent level of understanding during session:



If yes, please comment further:

(e.g. what particular sections were difficult to grasp? pace of session? did they respond better to verbal or visual presentation of information? etc...)

6. Please rate level of support needed during session:



Please comment further:

(e.g. level of self awareness; appraisal of abilities; asking for help etc...)

7. Please comment on interaction:

(e.g. how well did the participant interact with others?)

8. Please comment on group dynamics:

9. Please comment on the participant's level of contribution to the group:

(e.g. were they rather vocal or more of a quiet group member?)

10. Homework Completion (please circle): Yes No

If no, please explain why.

11. If applicable, please describe the participant's clinical presentation
(e.g. responding to any psychotic phenomena)

12. Potential risk issues (please circle): Yes No
(e.g. disclosure of violent sexual thoughts/fantasy).

If so, what are the action points?

Completed by: _____

Signed: _____

Date: _____