

————— **Research Report** —————

**Evaluation of Psychosocial Rehabilitation
within the
Women's Structured Living Environments**

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**Evaluation of Psychosocial Rehabilitation within the
Women's Structured Living Environments**

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EXECUTIVE SUMMARY

This report presents the results of an evaluation of Psychosocial Rehabilitation (PSR) implemented in the Structured Living Environments (SLE) at four regional women's facilities across Canada: Nova Institution for Women, Joliette Institution for Women, Grand Valley Institution for Women, and Edmonton Institution for Women. PSR is an approach that was developed to meet the needs of individuals dealing with severe psychiatric disabilities and cognitive impairments. The goal of PSR is to contribute to an improved quality of life while assisting individuals to assume responsibility and function as actively and independently as possible.

Forty staff and three women from facilities across Canada took part in semi-structured interviews and 18 staff surveys were completed. Primarily qualitative research techniques were employed in this evaluation and a thematic content analysis formed the basis for which the following results emerged. Overall, both staff and women identified the core objective of PSR as teaching basic life skills and all of the participants who were interviewed confirmed that they feel they are making progress towards accomplishing their personal goals. Importantly, however, only 50% of staff feel that the program goals are being met.

Staff expressed interest in taking part in refresher courses in order to maintain and enhance the training previously received. Assessing readiness and determining what to do with a client who is not yet "ready" emerged as significant areas of concern for the staff. When asked about the training manual, staff commented that the language is complicated, French translations are inadequate, and that overall, the manual is not user-friendly. Similar criticisms were voiced about the program materials (i.e., technology sheets and the assessment scales).

Women stated that they enjoy the living environment in the SLE and describe the staff as supportive and communicative. On the other hand, staff expressed concerns that women's volition regarding moving into the SLE is coerced and that there is not sufficient follow-up once the women have completed the program and moved out of the SLE. Overall, staff expressed mixed feelings about the effectiveness of PSR. Those who are most directly involved with PSR have a more positive outlook, however the majority of respondents stated that PSR has the potential of greatly assisting the women to improve their lives, but many do not seem overly confident that it will actually succeed.

Five recommendations for potential program improvement are put forth. First, the complexity of the language in which the training manual and technology sheets are written is at a higher level of difficulty than may be appropriate. They should therefore be modified accordingly. Second, given the low number of women who are deemed "ready" for PSR and thus the low number of staff who are involved in the program, it is recommended that formal booster-training sessions be available to staff. Third, the current assessment scales should be

re-examined and all staff involved with the program should become familiar with the various scales. Fourth, the technology sheets should be re-examined to determine if any can be combined or omitted. Fifth, a protocol should be established that will allow each of the regional facilities to maintain consistent lines of communication with one another and with National Headquarters regarding unsuccessful experiences and best practices with this programming.

In addition to the qualitative data analysis, a quantitative summary of the assessment battery implemented as an on-going program component is provided.

ACKNOWLEDGMENTS

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A special note to the staff and women from across the country who agreed to participate in interviews and surveys, thereby allowing for the successful completion of this project. We look forward to hearing from you again soon.

TABLE OF CONTENTS

EXECUTIVE SUMMARY	i
ACKNOWLEDGMENTS	iii
TABLE OF CONTENTS	iv
LIST OF TABLES	v
LIST OF FIGURES	v
INTRODUCTION	1
Psychosocial Rehabilitation.....	2
<i>Goals of PSR</i>	5
METHOD	7
Evaluation Framework.....	7
<i>Staff and Offender Interviews</i>	7
<i>Staff Surveys</i>	7
<i>Quantitative Assessment Battery</i>	8
<i>Procedure</i>	9
<i>Sample Size</i>	10
RESULTS	12
ISSUES AND QUESTIONS: PSYCHOSOCIAL REHABILITATION	14
Program and Personal Goals	14
Staff training, skills training sessions, assessment battery and software: Are they effective and informative?.....	16
Is PSR accomplishing what it sets out to?.....	19
RESULTS FROM THE QUANTITATIVE ASSESSMENT BATTERY	21
UCLA Expanded Brief Psychiatric Rating Scale (BPRS).....	22
Institutional Functioning Scale (IFS).....	23
Quality of Life Scale and Rosenberg’s Self-Esteem Scale	24
Daily Behavioural Checklists and Baseline Information Form	25
CONCLUSIONS AND RECOMMENDATIONS	26
Summary of Findings	26
Study Limitations	27
Recommendations for Potential Program Improvement.....	28
REFERENCES	31
APPENDIX A: INTERVIEW PROTOCOLS	33
APPENDIX B: SURVEY	36
APPENDIX C: INFORMED CONSENT	38

LIST OF TABLES

Table 1: Number of Interviews Conducted at Each Institution	10
Table 2: General Staff Feedback Regarding the PSR Program.....	13
Table 3: UCLA Expanded Brief Psychiatric Rating Scale Subscales.....	23
Table 4: Institutional Functioning Scale Subscales.....	24

LIST OF FIGURES

Figure 1: Psychosocial Rehabilitation (PSR) General Overview	4
Figure 2: Psychosocial Rehabilitation: Program Logic Model	6

INTRODUCTION

In support of contributing to the successful reintegration of offenders and enriching the health and wellness of staff and inmates, the following document provides an assessment of the Psychosocial Rehabilitation Program (PSR), currently being offered within the Structured Living Environments (SLE) in four regional women's facilities across Canada: Nova Institution for Women, Joliette Institution for Women, Grand Valley Institution for Women and Edmonton Institution for Women¹.

In 1989, a Task Force on Federally Sentenced Women was established to address longstanding concerns with the inequitable treatment of women offenders, which resulted in the April 1990 Report entitled *Creating Choices* (Task Force on Federally Sentenced Women, 1990). In response to recommendations outlined in this document, between 1995 and 1997, five new federal women's facilities began operations. Following the opening of the four regional facilities and Healing Lodge, a number of incidents made it necessary for women classified as maximum security to be temporarily transferred to co-located units within men's institutions².

In 1999, then Solicitor General Lawrence MacAulay announced the Intensive Intervention Strategy (IIS) for Women Offenders. The implementation of the Strategy called for the closure of the co-located units in men's institutions and the return of the women to the regional facilities. The Strategy addresses the needs and risk factors of two specific populations: women classified as 'maximum' security and those classified as 'minimum' or 'medium' security that experience severe mental health difficulties. In response to the IIS, Structured Living Environments were built to address the needs of women experiencing mental health difficulties and were subsequently opened in the four regional facilities in 2001³. In addition,

¹ Fraser Valley Institution for Women also delivers PSR but was not included within this evaluation because the program was not running at the time of data collection.

² Co-located units are isolated units for women established within men's institutions. Prior to implementation of the IIS, women classified as maximum-security were living within such co-located units.

³ Fraser Valley Institution for Women opened in 2004.

2003 brought the opening of the Secure Units and a treatment strategy for women classified as 'maximum' security.

Warner (1998) introduced two new initiatives in relation to realizing the vision that was originally defined in *Creating Choices*. Psychosocial Rehabilitation (PSR) and Dialectical Behavior Therapy (DBT)⁴ were proposed as treatment approaches that would address the needs of women dealing with significant mental health issues. PSR focuses on basic skill deficits and cognitive challenges and DBT was designed to address emotional distress needs and severe behavioural difficulties. These initiatives were a major step toward *implementing choices* (Warner, 1998) as the Structured Living Environments opened at the four regional women's facilities across Canada. The following report focuses on the implementation and preliminary evaluation of Psychosocial Rehabilitation.

Psychosocial Rehabilitation

PSR is an approach that was developed to meet the needs of individuals dealing with severe psychiatric disabilities. The goal of PSR is to contribute to an improved quality of life while assisting individuals to assume responsibility and function as actively and independently as possible. Emphasis is placed on client empowerment and client choice. As part of the Intensive Intervention Strategy, PSR is delivered within the Structured Living Environments in each of the regional facilities across Canada.

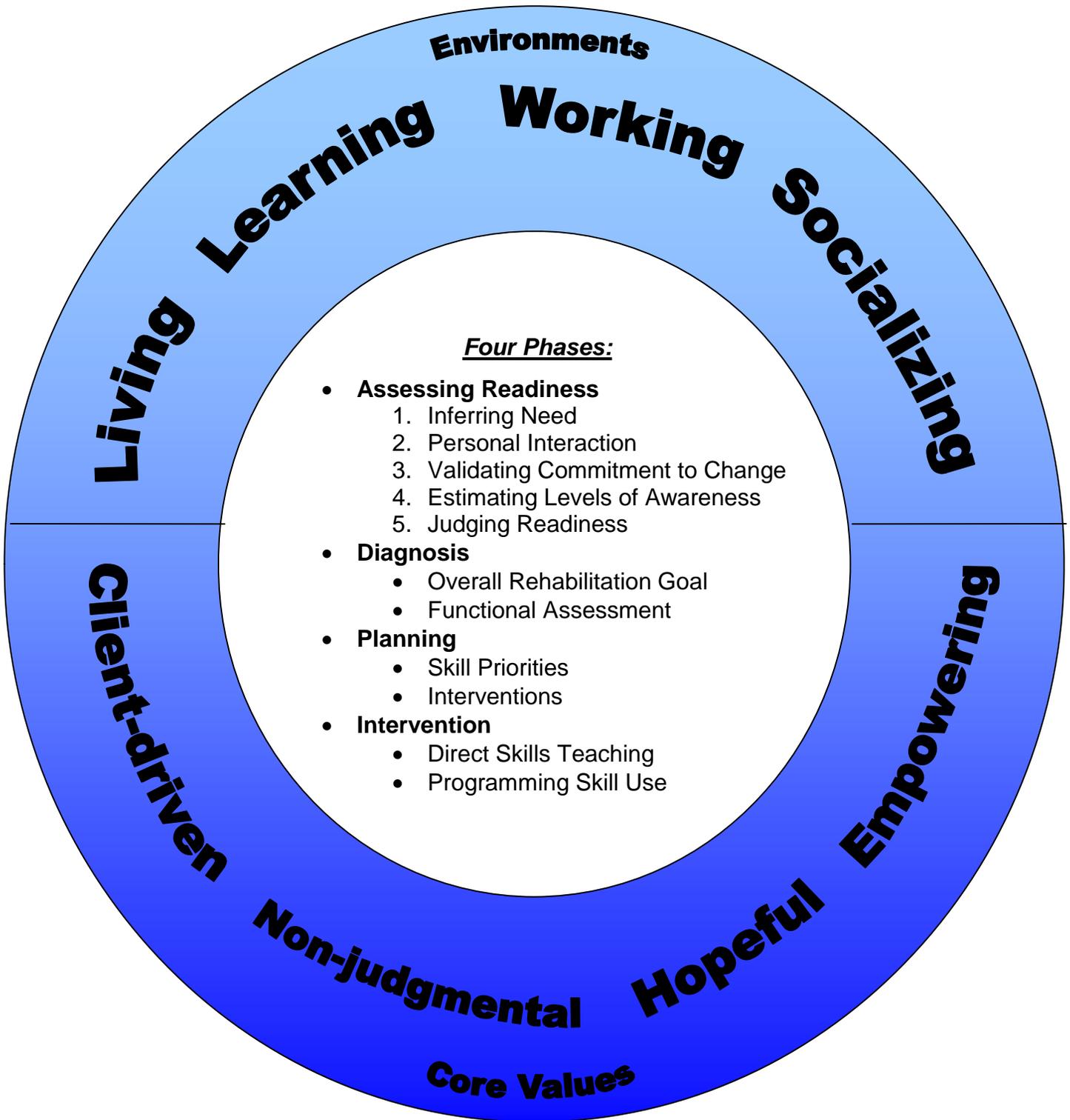
Five principles lay the foundation for the development of a programming strategy for federally sentenced women (Task Force on Federally Sentenced Women, 1990). PSR is designed to embody each of these principles: **empowerment** as it raises self-esteem through accomplishments resulting directly from personal efforts; **responsible choices** as women make decisions regarding their progression through the program and are made accountable for their actions; **respect and dignity** as participants learn to respect the efforts and successes of others in the program and staff surrounding them 24 hours a day; **supportive environment** as women live amicably with one another in the house

⁴ For a more detailed description of DBT please refer to McDonagh, Taylor & Blanchette, 2002.

while adhering to rules and receiving 24 hour support from staff; and **shared responsibility** as a result of learning to take responsibility and act as independently as possible.

Psychosocial Rehabilitation encompasses four phases in all (See Figure 1), assessing readiness, diagnosis, planning, and intervention. Assessing rehabilitation readiness is one of the first steps in which staff, together with each woman, assess need, validate a commitment to change, estimate level of awareness, and judge readiness. After readiness has been assessed, a rehabilitation diagnosis is made in which staff and each woman generate an agreement about the environment (living, learning, working, and social) in which the woman intends to function in the future. During the planning stage, the woman's values and additional helpful behaviours are identified and she defines her ideal environments and selects an Overall Rehabilitation Goal (ORG). In addition, functional assessments are undertaken to determine a woman's critical skills: physical, emotional, and intellectual, and begin to describe and evaluate her skill use and functioning. The intervention can take one of two forms: Programming Skill Use or Direct Skills Teaching. The former is used when the woman has knowledge of a skill but needs some support around its use, the latter involves systematic teaching and is used when there is an actual skill deficit. During this process the staff use Technology Sheets in order to assist the women with her progression through the program. There are 14 work sheets in total, providing assistance in 5 different areas: assessing readiness (5 sheets), setting a rehabilitation goal (3 sheets), functional assessment (3 sheets), rehabilitation planning (one sheet) and intervention (2 sheets). The sheets also act as a useful tool in collecting quantifiable data that can be measured for evaluation purposes.

Figure 1: Psychosocial Rehabilitation (PSR) General Overview



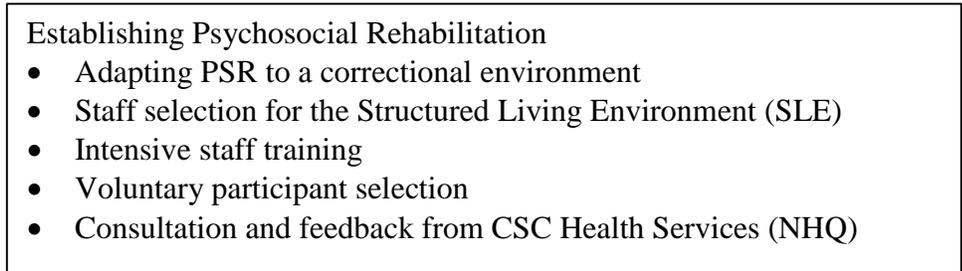
Goals of PSR

Ultimately, the program strives to ensure that each woman achieves her personally set Overall Rehabilitation Goal. Importantly, the goal of rehabilitation within PSR is to help each woman become satisfied and successful in the environments of her choice (Living, Learning, Working, Social) and refrain from focusing on individual deficits.

The goals and objectives of PSR can be further grouped in terms of their immediate and long-term impacts (Figure 2). The immediate impacts refer to the participant's ability to develop basic life skills and learn to function independently, in turn resulting in positive changes in the institutional environment. Long-term impacts refer to the acquirement and enhancement of life skills, increased quality of living, gaining empowerment, and functioning effectively in the institutional environment. It is anticipated that these immediate and long-term impacts will result from the products and activities provided in the program.

Figure 2: Psychosocial Rehabilitation: Program Logic Model

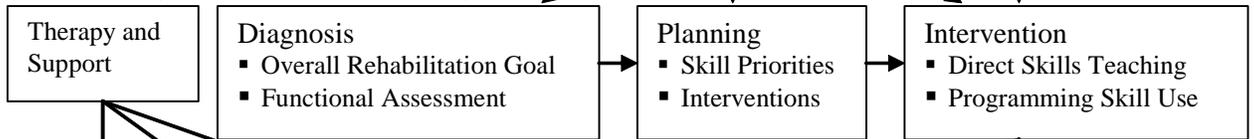
Pre-program



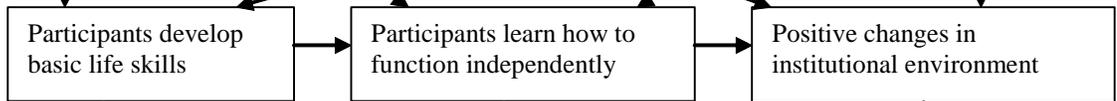
Activities



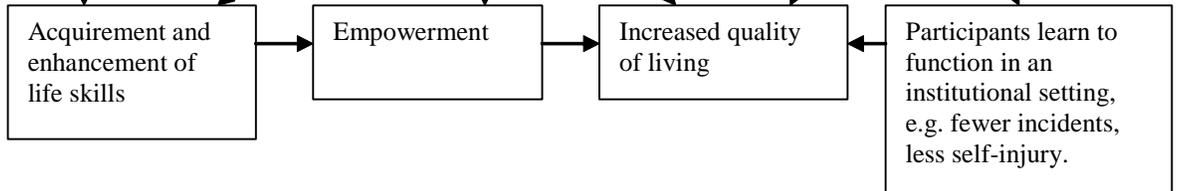
Products



Immediate Impacts



Long-term Impacts



METHOD

Evaluation Framework

The methodology outlined by Sly, Taylor, and Blanchette (2003) was developed through examination of relevant literature and consultation with the Women Offender Sector and Health Services, and was applied to the evaluation of PSR at each of four regional facilities. The framework discusses three evaluation options (basic, moderate, and comprehensive). The comprehensive option was selected because it provides the most thorough and in depth evaluation as it investigates perspectives of all parties involved or impacted by PSR (women and staff). The above mentioned parties are provided with the opportunity to contribute to the evaluation by expressing personal insights and feelings about PSR. This evaluation document incorporates a multi-method assessment strategy, including: file review documentation, surveys, interviews, measures of offender functioning in the institutional environment, changes in psychiatric symptomatology, individual inmate functioning unrelated to the institutional environment, quality of life, and self-esteem. Such strategies will be further developed and examined throughout the remainder of this report.

Staff and Offender Interviews

Staff and offender interviews (Appendix A) served as an essential source of qualitative data in this evaluation. Semi-structured interviews provided respondents with an opportunity to confidentially express personal views, feelings, and ideas about the Psychosocial Rehabilitation program.

Staff Surveys

Staff surveys (Appendix B) were implemented to ensure that the Psychosocial Rehabilitation Technology Sheets⁵ were effectively working for the staff and women. Staff were provided with the opportunity to suggest changes,

⁵ As previously described, the Technology Sheets are work sheets that staff use as they assist the women through the PSR process. There are 14 sheets in total, assisting in 5 key programming areas.

make recommendations for additions or simply inform the researchers whether or not they felt the technology sheets were working effectively.

Quantitative Assessment Battery

A quantitative assessment battery was implemented as an on-going program component. The battery assesses the impact of the program on its participants. Both staff and participants were involved in the completion of this battery. The evaluation of the PSR program was designed such that the measures utilized in the battery are both clinically and empirically useful. In other words, facility staff can use the measures to assess each woman's current level of functioning and progress, and research staff can use the measures for an overall assessment of the program.

The *Baseline Information Form* (BIF) is completed by staff upon an inmate's arrival at the SLE to participate in PSR. Staff record personal information about the inmate, such as inmate status (e.g. transfer, new admission, etc), previous accommodation (e.g. independent, treatment institution, etc), and psychiatric/medical history.

The *Daily Behavioural Checklist* (DBC) assesses an inmate's functioning on a day-to-day basis. The DBC, completed by staff, considers an inmate's behaviour in 12 categories, including physical and verbal activity, physical and verbal aggression (and/or threats of physical aggression), emotional display, compliance with medication, self-care, sexual and social behaviours and living environment.

The *UCLA Expanded Brief Psychiatric Rating Scale* (BPRS) (Ventura, Green, Shaner, & Liberman, 1993) is used to assess changes in an individual's psychiatric symptoms. It consists of 24 symptom constructs; rated on a seven-point severity scale ("Not present" to "Extremely severe"). Four subscales have been advocated for use with this scale (Faustman & Overall, 1999): 1) Thinking Disturbances, 2) Hostile-Suspiciousness, 3) Withdrawal-Retardation, and 4) Anxiousness/Depression.

The *Institutional Functioning Scale* (Correctional Services Canada, 2001) evaluates inmates on how well they are functioning in a correctional institution

setting. The IFS is completed by staff who rate the inmate on a three-point scale (poor, fair, good). The scale consists of 28 items within six different areas: daily living; interpersonal relations; personal involvement/development; institutional behaviour; work conduct; and mental health issues.

Quality of Life Scale (QOL) (Correctional Services Canada, 2001b) a self-report scale that measures an inmate's general "quality of life" (satisfaction or dissatisfaction with life). It consists of 18 statements regarding emotional well-being, interpersonal satisfaction, and having access to meaningful therapeutic, educational and vocational experiences. Inmates rate their degree of concurrence with each statement on a four-point scale ("Strongly disagree" to "Strongly agree"). After reverse-scoring 3 of the scales items, higher scores represent higher levels of satisfaction with life.

Rosenberg's Self-Esteem Scale (SES) (Rosenberg, 1965) is a self-report scale that measures a respondent's attitudes of approval or disapproval of oneself. It consists of ten statements that respondents rate their degree of concurrence with on a four-point scale ("Strongly agree" to "Strongly disagree"). Lower scores indicate higher levels of self-esteem. The SES is quick and easy to complete and has been found to be valid and reliable (see Blascovich & Tomaka, 1991).

Procedure

During the summer of 2002, a research team interviewed and audio-taped staff and women from each of the Structured Living Environments across Canada. During the visits to each of the regional facilities, surveys were made available to all staff and those interested completed them at the time or mailed them back at their convenience. Participation was voluntary and all interviewees signed consent forms (Appendix C). Confidentiality and anonymity were ensured, as the respondents were not required to identify themselves on tape or within the survey documentation.

Sample Size

Table 1: Number of Interviews Conducted at Each Institution

Institution	Staff	Women
Edmonton Institution for Women	11 (all general)	2
Grand Valley Institution for Women	6 (all general)	0
Nova Institution for Women	14 (7 general)	1
Joliette Institution	9 (8 general)	0
Total	40	3

Importantly, 32 staff members spoke in general terms about PSR rather than completing a detailed interview⁶. In total, 14 behavioural counsellors, 12 primary workers, 4 psychologists, 3 team leaders, 1 assistant team leader, 3 nurses, 1 mental health coordinator, 1 clerk, and 1 community integration worker agreed to participate in an interview for a total involvement of 40 staff members. Three women involved with PSR agreed to take part in an interview⁷. In addition, 18 staff members completed a survey specific to PSR.

The interview protocol was designed with the following issues in mind:

- understanding and attainment of the goals of PSR;
- effectiveness and usefulness of training, documentation, and measurement instruments and;
- general effectiveness and accomplishments of the treatment approach.

In addition to the interviews and surveys, as part of a multi-method approach to this evaluation, an on-going pre and post test assessment battery was introduced during the program's implementation.

⁶ Because staff have training in both Dialectical Behavior Therapy and Psychosocial Rehabilitation and interact with both client populations, they were asked to choose the program they would prefer to speak about in detail and spoke only generally about the alternative program.

⁷ This apparently low response rate is actually reflective of the minimal number of women involved in the program and/or incarcerated at the time of interview completion.

As outlined above, an intake information form provided basic demographic data about the women involved in the program. A behaviour checklist, completed by staff, assessed the inmate's daily functioning in various domains. A battery of standardized assessment measures was administered two weeks after admission, at regular (6-month) intervals, and upon program discharge.

RESULTS

As described, semi-structured interviews regarding Psychosocial Rehabilitation were conducted with 3 program participants and 40 staff members (8 in depth and 32 general) including both program facilitators and non-facilitators. Results of the staff surveys will be addressed where applicable. It is important to note that many of the staff who agreed to participate in an interview are involved with, and/or have received training for, both PSR and Dialectical Behavior Therapy (DBT). Given that the majority of staff who spoke about PSR (80%) did so in general terms, preferring instead to speak more in depth about DBT, this may indicate that they are more comfortable or experienced with DBT relative to PSR, possibly the result of having worked with more DBT participants. Furthermore, a lack of experience or low comfort level with PSR has the potential of influencing the type of feedback provided herein (See Table 2).

Although these findings are obviously limited in their ability to be generalized, the participants interviewed expressed satisfaction with PSR. Two of three women interviewed stated that they liked the program (one mentioned the living environment (SLE) and the skills sessions in particular). While the third participant was not as satisfied, she did state that the program would help her when she is released from the institution. One woman described the environment as being a quiet place where the staff offer support and assistance.

Turning to the staff, more than half of those interviewed (62%) identified the purpose of PSR as teaching the women life skills. Two staff members commented that the acquisition of such skills will assist the women with the reintegration process. Concerns raised by the staff include issues of program "*readiness*" and the lack of a client-driven environment (as previously explained as key to the program). Importantly, the staff readily identified women who have had some success as a result of the program and felt that the structure of the program makes sense.

Generally, staff members suggest that PSR has a positive influence on those who participate. They commented that it gives the women a safe and secure environment in which to reflect on how they can improve themselves by

learning basic skills to make the eventual transition to the community easier. Results also indicate that PSR gives the women confidence, self-esteem, and a sense of independence. However, the general staff feedback was diverse in nature, in turn leading to a somewhat perplexing scenario. Additional representative segments of the staff feedback are provided in Table 2.

Table 2: General Staff Feedback Regarding the PSR Program

POSITIVE	MIXED	NEGATIVE
<ul style="list-style-type: none"> • PSR is a very good program. • PSR is a program that has been a long time coming. • Some offenders make substantial gain from the program. • I wish we had more PSR women, I really like PSR. 	<ul style="list-style-type: none"> • I definitely think the program has good goals, objectives, purpose, but I feel like I'm missing the boat. • Good theory behind it. In an ideal world it would work really good, but DBT is easier – more women, bigger strides, more experience. 	<ul style="list-style-type: none"> • It seems like a lot of work and takes a lot of time. • PSR women are difficult to work with. • I don't see a structure, not like DBT set-up. • We shouldn't mix DBT and PSR in one SLE. It's hard for staff to switch back between two modalities. • I think it will take a lot of work to meet the goals of the program. • A bit unrealistic, it sets the women up for failure. • Seems like a complicated process. • PSR is awkward to work with, too much paperwork; I would rather do DBT.

ISSUES AND QUESTIONS: PSYCHOSOCIAL REHABILITATION

Program and Personal Goals

Do staff and participants understand the program goals of PSR and are they being met?

As anticipated, each woman involved in PSR interpreted the goals of the program in relation to her own needs and life circumstances. In general, the program participants acknowledge that PSR is designed to teach them skills that will assist them with daily living, both within the facility and in the community. The participants cited the following as being goals of PSR: "*to make things easier*", "*to take my medication, get up every morning and go to work and do my programs*", and "*to learn to manage money, get groceries, and get a place to live*".

The goal of PSR, as described by all staff members, is to help the women learn basic life skills. Several staff also mentioned that it is important to empower the women by helping them establish and achieve personal goals by breaking them down into manageable steps. More specifically, staff mentioned such things as teaching low-functioning women basic life skills, such as personal hygiene and helping them to improve the quality of their living environment. Staff spoke about getting the women to be more social and live in a common environment, teaching the women about the tools required for successful reintegration, and helping them to change behaviours and learn to deal with problems.

Regarding the accomplishment of program goals, 50% (4 of 8) of staff reported that they think the goals are being achieved thus far. Those who do not feel that the goals are being met suggested that, although inmate participation in PSR is voluntary, some women may feel coerced to engage; "*the SLE seems like a bit of a cure-all of sorts...we could just put them in the SLE*". Another staff member expressed concern about the dependency of the women once they finish the program and move out of the SLE. There is trepidation that the women

will revert back to their previous behaviours once the support and supervision offered through the program has come to an end. It was further suggested that while *"six months in the SLE might get them thinking differently, it might not get them doing a different behaviour"*.

Do staff and participants have personal goals for PSR and are they being met?

All three participants reported that they are making progress towards achieving their Overall Rehabilitation Goals. Examples of participants' ORGs are *"to get out of the SLE"*, *"to accomplish and finish everything, [all of] my programs"*, and *"to prepare myself for reintegration into society"*.

The majority of staff (75%) stated that they had set personal goals for PSR. These goals include:

- *"to see a lot more structure surrounding the goals and the skills that we set out for our women, more one-on-one"*
- *"to be creative, encourage visual learning, make sure everyone in the program knows what ORG [Overall Rehabilitation Goal] is and has one"*
- *"to instill in them [the women] healthy body, healthy mind, make them responsible for their own health"*
- *"to learn more about PSR, be more active in program delivery"*
- *"to computerize the program"*
- *"to gain a better understanding of the program"*

The majority of staff (67%) who reported having set personal goals for the program feel that their goals are either being met or are in the process of being achieved. Two staff members who stated that their goals are not being met gave the following explanations:

- *"I have not been able to practice what was learned in the training sessions and so have not retained as much PSR information";*
- *"I feel as though we are often used as merely an intimidating presence on the unit and not as the programming resource that we could be".*

**Staff training, skills training sessions, assessment battery and software:
Are they effective and informative?**

Is the staff training sufficient?

According to the staff, the PSR training they received was rushed. Several staff members described the training sessions as "*tedious*", "*complicated*", and "*a lot more work than DBT*". Seven staff members (18%) stated that they would like to have on-going training and refresher courses made available, and suggested that PSR staff be given more support and clinical supervision. Only a couple of staff described the training as comprehensive, but stated they find it difficult now as they have not had the opportunity to put it into practice. Some of the staff indicated that the number of women meeting the criteria and wanting to take part in PSR is limited, and only a small number of women are assessed as "*ready*" to participate effectively. Other issues raised pertain to the need for clarification regarding when to assess "*readiness*" and a "*contingency plan*" for those women assessed as not yet ready to participate. Staff also proposed that more training should be dedicated to understanding and dealing with the type of clients PSR serves and less time with program tools such as technology sheets.

Is the training manual well organized and easily understood?

Interviews with staff suggest that the training manual could be improved. Staff described the layout of the manual as organized, but stated that the language used is often unclear and the French translation is not always accurate. Some staff stated that the manual is complicated as it contains too much information and is often repetitive. In fact, 82% (33 of 40) could not remember the manual, simply did not use the manual, or found the manual to be "*hard to understand*" and "*complicated and frustrating for the women*". The remaining 18% of staff report that the training manual is effective, with one staff member describing the manual as a good resource if a lot of time has elapsed since working with PSR. Overall, comments provided in the surveys concur, suggesting that some of the concepts are abstract and the training manual is

vague, in turn not providing specific information to answer questions that may arise. There seems to be a general agreement that the training manual should be made more "user-friendly".

Are the skills and lessons helpful, clear, and easily understood?

All of the participants reported being satisfied with the amount of time that is spent learning skills, each agreeing that the critical skills training sessions are well organized, clear, and easily understood. Two of three participants stated that they found the technology sheets to be helpful in assisting them with their progress. The third participant felt that the language of the technology sheets was difficult to understand.

Are the program scales and software effective and informative?

Two of three participants completed the self-report scales – one on the computer and one with pen and paper. The participant who used the computer stated that while she did not enjoy completing the scales, she found the computer easy to use as she works with one at school. The participant who used pen and paper found the scales difficult to fill out and reported not being required by staff to fully complete them. Incidentally, two staff members reported that women have complained of headaches and eye irritation as a result of using the computer.

According to staff, the software and assessment battery need improvement. Interviews revealed that only 18% of staff consider themselves familiar with the scales. Those who have administered the scales feel that while they are helpful, some sections are quite difficult. They explained that the scales are confusing as a result of the number of options the women have to choose from. For example, one PSR participant when answering the question "*Have you felt depressed lately?*" (Item within the Quality of Life Scale) responded: "*Quite a bit sick to my head*". Understandably, the staff had a hard time interpreting and coding responses such as these. As well, the women tend to become frustrated when they cannot distinguish their thoughts and feelings from the list provided. It

was suggested that limiting the possible choices or making them simpler would make for a more accurate depiction of how the women are feeling. The staff expressed further concerns that the complexity of the language used as well as the set-up of the scales are above the cognitive abilities of the PSR participants and that this may be causing invalid results. One staff member explained that

The differences between the numbers aren't very clear to the women. They tend to answer always at one end [of the scale] or the other or the middle. [The scales] should use the same terminology, like "1" should have the same meaning for all the scales.

Staff recommended that the language be simplified and that some of the scales and technology sheets be condensed or omitted. In fact, several of the staff criticized the technology sheets, referring specifically to the Daily Behavioural Checklist (DBC) as being problematic. Survey results also show that staff members find the DBC too subjective and vague. The suggestion was made that a checkmark does not adequately reflect what has happened over the course of one day and that a grading scale might be more appropriate to record a participant's behaviour. When describing a participant whose positive behaviour at the beginning of the day had turned negative, one staff member stated that

Half the time the women are already checked in and that's not gonna happen, we don't go back and change it. Honestly, mostly, people don't go back and erase it, it's the last thing to do when you're trying to talk to a person who thinks she's having puppies...the data [from the DBCs] isn't realistic of what their behaviour was like.

Is PSR accomplishing what it sets out to?

Are PSR participants receiving the attention, support, and structure they need to successfully complete the program?

Overall, participants seem to enjoy the program. They appreciate the style of living that PSR and the SLE provides as they have the flexibility to do their "*own thing*". They commented that there are fewer women in the SLE so it is easier to get along with everyone, and the staff are very communicative and supportive. Participants expressed satisfaction with the 24-hour staffing and feel that they are in charge of their individual programs but are able to consult staff and accept staff direction and encouragement when necessary. They find that there is a sufficient amount of time spent on the skills and that they are learning a lot from the sessions. Participants failed to suggest any substantial recommendations for potential changes to the program; however, they did suggest making the technology sheets easier to complete and mentioned that they would prefer consistency on the part of staff with respect to program rules (i.e. if the rule is zero tolerance then zero tolerance should be enforced).

All of the staff indicated that they think PSR is an effective learning tool that can be improved upon by delivering the program in a creative way and adapting it to the needs and skill levels of the participants. They also agreed that working on the personal goals of the individual women is one of the most rewarding aspects of the program. In addition, they mentioned how useful they believe the skills and principles of the program to be and that they enjoy the interaction and communication between staff and participants.

However, there were three main criticisms of the program: the training manual, the technology sheets, and the importance of PSR as an institutional program. As previously mentioned, staff found the training manual and technology sheets problematic and stated that improvements are necessary. In fact, a few staff members suggested "*combining*" or "*eliminating the tech sheets*" altogether. In addition, some staff members expressed concern regarding the amount of attention that is given to PSR participants. It was expressed that the

women who take part in PSR are not considered as much of a priority as are DBT participants. In fact, three staff who concentrated on DBT and commented only generally on PSR stated that women involved in PSR are often ignored compared to women involved with DBT.

Although Psychosocial Rehabilitation is in its early stages, it shows some promise as a positive and worthwhile program. The more commitment given to PSR by residents and staff in the SLE, the more effective the program will be. Both PSR participants and staff made suggestions regarding how the program can be improved. These will be discussed further in the following section.

RESULTS FROM THE QUANTITATIVE ASSESSMENT BATTERY

Between August, 2001 and January, 2004, 15 women completed all or a portion of the assessment battery for the PSR program. During the completion of the battery, women are provided with the opportunity to receive assistance if they request supervision. The majority of assessments completed (74%) required moderate supervision, 15% required only minimal supervision and 11% strong supervision. In total, 28 assessments were completed; 7 women have only one assessment, 6 women have two assessments 1 woman has four assessments and 1 woman has five assessments. The assessments completed represent women from four of the regional facilities, with 36% of the assessments coming from Edmonton Institution for women, 28% from Joliette Institution for Women, 25% from Nova Institution for Women and 11% from Grand Valley Institution. Fifty percent of the assessments were completed upon admission to the program, 14% as follow-up during the program and 36% at program discharge. Unfortunately, this low level of involvement in the program and in turn, few pre-post assessments, precludes the researchers from conducting any formal statistical comparative analyses. However, descriptive information from the quantitative battery is provided.

The majority (53%) of women involved in the program during this time frame were Aboriginal, 40% were Caucasian and 7% African American. At the time of their assessment, several of the women (43%) had a grade six level of education or less, 39% had between grades seven and twelve, 11% had some post-secondary education and 7% had their post secondary diploma. Excluding those serving life sentences ($n = 8$), at the time of assessment, the average sentence length for the women involved was 37 months ($SD = 15$, $min. = 24$, $max. = 90$). The average age of the women, at the time of the assessment was 40 years of age ($SD = 8$).

When considering the living arrangements of this group of women, we find that prior to entering the program, 59% of women had been living in the general population within the federal correctional facility, 29% had been in the community, 6% a psychiatric facility and 6% came from an "other" or unknown

location. At the time of the assessment completion, 93% of the women were living within the Structured Living Environment, however one woman was living in the secure unit and one in the general population.

As mentioned above, 36% ($n = 10$) of the assessments were completed as women were discharged from the program. Four possible reasons for program discharge were identified, 4 being discharged due to statutory release, 3 being transferred from the structured living environment to the general population, 2 released on parole and 1 transferred to maximum security locations. Of note, at the time of assessment, the majority of women (89%) were classified as medium security, however 7% were classified as minimum security and 4% as maximum security.

Four main scales form the basis of the assessment battery. Unfortunately, low program involvement precludes the possibility of running any comparison analyses for these measures. However, given the anticipation of continued use of this assessment battery for PSR, descriptive means, standard deviations and minimum and maximum scores will be provided for each of the scales.

UCLA Expanded Brief Psychiatric Rating Scale (BPRS)

Table 3 provides a summary of the women's scores on the four subscales recommended for use with this scale. Importantly, it seems that staff completing the BPRS were fairly confident with their assessments. On a scale from 1 (not at all confident) to 5 (very confident), the mean score was 3.77 ($SD = .95$). In addition, 7 items that evaluate the validity of the BPRS reveal that it is extremely rare that staff feel results are impacted by: symptoms being drug induced, under-reporting due to a lack of rapport with the staff member, under-reporting due to negative symptoms, over-reporting, the inmate being uncooperative or difficulty in the assessment as a result of a formal thought disorder.

Table 3: UCLA Expanded Brief Psychiatric Rating Scale Subscales

Factor	Mean	SD	Min.	Max.
Thought Disturbance (<i>n</i> = 21)	2.44	1.12	1	5.33
Hostile/Suspicious (<i>n</i> = 26)	3.12	1.43	1.5	6.33
Withdrawal/Retardation (<i>n</i> = 23)	2.42	1.02	1	4.67
Anxiety/Depression (<i>n</i> = 27)	3.64	1.09	2	5.67

Some have argued that the use of norms with this scale is limited (Faustman & Overall, 1999), however, it is noteworthy that the mean scores exhibited by this sample may be of significance. More specifically, when considering the symptom indicators (directly contributing to the factor scores), it is assumed that individuals from non-clinical populations will rarely score higher than 2. Scores above 2, on any symptom item, indicate a departure from the 'norm' (Faustman & Overall, 1999).

Institutional Functioning Scale (IFS)

The average total score on the IFS was 1.85 (*SD* = .42). Descriptive information for the 6 subscales is provided in Table 4. The IFS is rated on a three-point scale (poor, fair, good), with higher scores representing more positive institutional functioning in each of the assessed areas. One would hope to see increases in the mean scores following intervention.

Table 4: Institutional Functioning Scale Subscales

IFS Subscale	Mean	SD	Min.	Max.
Daily Living (<i>n</i> = 28)	1.70	.57	1	3
Interpersonal Relations (<i>n</i> = 28)	1.51	.45	1	3
Personal Development/Involvement (<i>n</i> = 27)	1.53	.54	1	3
Institutional Behavior (<i>n</i> = 28)	2.13	.52	1	3
Work Conduct (<i>n</i> = 21)	2.18	.53	1	3
Mental Health Issues (<i>n</i> = 28)	1.58	.50	1	3

Quality of Life Scale and Rosenberg's Self-Esteem Scale

The average score on the quality of life scale was 48.87 (*SD* = 10.54) and the average score on the self-esteem scale was 28.35 (*SD* = 4.39)⁸. The quality of life scale was composed by the Correctional Service of Canada (CSC), specifically for use with this program. However, Rosenberg's Self-Esteem Scale has been utilized in previous research initiatives conducted by CSC and others. As a result, CSC researchers had the opportunity to gather normative data for this scale. An aggregated sample (*n* = 235) based on five samples of women offenders⁹ with a mean age of 34 years yielded a mean score of 17.92 (*SD* = 5.66). Given that lower scores on this scale represent higher levels of self-esteem, it seems feasible that this sample of PSR participants exhibit significantly lower levels of self-esteem as compared to the aggregated sample of federal women offenders (*M* = 28.35 vs. *M* = 17.92, respectively).

⁸ The quality of life scale has a minimum score of 18 and a maximum score of 72 (higher scores representing higher quality of life) and the self-esteem scale has a minimum score of 10 and a maximum score of 40 (lower scores representing higher self-esteem). Because there is a built-in assessment component of PSR, the descriptive data provided herein may act as a baseline reference point for on-going program data analysis.

⁹ The five samples are as follows: Negy, Woods & Carlson, 1997; Blanchette & Eljdupovic-Guzina, 1998; Syed & Blanchette, 2000a; Syed & Blanchette, 2000b; Taylor & Blanchette, 2001.

Daily Behavioural Checklists and Baseline Information Form

As previously described, measures chosen for the assessment battery were chosen in order to permit both clinical and empirical function. Both the Daily Behavioural Checklists (DBC) and the Baseline Information Form (BIF) provide excellent feedback for clinical outcomes and concerns, in turn, the focus of their utilization is more clinical than empirical. However, on-going feedback regarding results from each woman's DBC was provided to staff within the institutions (via charts) which track the progress in each of the 12 categories on the checklist. Because of low rates of program involvement and short periods of time within the program, it has been difficult to observe any conclusive trends in this area. Nevertheless, a couple of women have been in the program for a substantial period of time and an examination of their progress does provide preliminary support for positive changes in the areas targeted by the program. Specifically, results provide preliminary evidence for increases in physical activity, decreases in physical and verbal aggression, increases in more positive and appropriate social behaviours and more appropriate emotional display.

Descriptive information from the BIF reveals that when considering the psychiatric/medical history of this group of women, many women report that they have never or do not recall receiving an official psychiatric diagnosis (56%), experiencing psychiatric symptoms (46%) or being hospitalized in a psychiatric institution (46%). Nonetheless, 44% report having an official psychiatric diagnosis, 55% report experiencing symptoms and 54% report being hospitalized. The most common diagnoses being reported by the women are personality disorders (32%), schizophrenic disorders (21%) and substance related disorders (16%).

CONCLUSIONS AND RECOMMENDATIONS

Summary of Findings

Results of the present report provide a preliminary evaluation of the PSR program currently being offered at four female regional facilities across Canada. It is important to note that this program is in its initial stages of operation and continues to evolve in its development. Four main issues were considered:

- 1) Staff and participants' perceptions of program goals (professional and personal)
- 2) Success in meeting program goals
- 3) Effectiveness of program tools and measures
- 4) PSR accomplishments to date

The first issue dealt with how the goals of PSR were perceived by staff and participants. Both the staff and the women identified the core objective of PSR as teaching basic life skills. These life skills are individually determined based on the needs of each woman and can range from activities such as learning proper personal hygiene to counting money. Staff assist the women in establishing and achieving their personal goals by breaking them down into manageable steps.

The second issue was concerned with the level of success of the program in the eyes of both staff and program participants. Importantly, all of the participants who were interviewed confirmed that they feel they are making progress towards accomplishing their personal goals. However, when considering program goals, only half of staff felt that these goals were being met. Some staff have also set personal goals for themselves, such as improving their program delivery skills. Interestingly, sixty-seven percent of such staff stated that their personal goals are being met.

The third issue addressed the effectiveness of the tools and measures utilized in the program, such as the training sessions, training manual, technology sheets, and scales. Staff reported dissatisfaction with the amount of time that

was spent on training. The general feeling was that it was rushed; several staff members expressed a desire for refresher courses. One area in particular that staff find unclear is how to assess "*readiness*" and what to do with women who are not yet "*ready*" to participate in the program. With regards to the training manual, staff remarked that the language is complicated, the French translations are inadequate, and that overall, it is not user-friendly. Similar criticisms were made about the technology sheets (the Daily Behavioural Checklist in particular) and the scales. Staff reported that the formats of the scales are confusing (i.e., the women have a hard time choosing the best response from the list of options), the language is difficult, and there are generally too many scales and technology sheets to administer. Likewise, the women find the language of the technology sheets difficult to understand.

The fourth issue considers whether the women in PSR are receiving the structure and support that the program specifies. In general, participants seem to take pleasure in the program and find the skills training sessions helpful. The women stated that they enjoy the living environment in the SLE and describe the staff as supportive and communicative. The staff, on the other hand, expressed concerns that not all of the women moving into the SLE are doing so without coercion and that there is not sufficient follow-up once the women have completed the program and moved out of the SLE. Overall, staff have mixed feelings about the effectiveness of PSR. The majority acknowledge the possibility that PSR could greatly assist the women in improving their lives, but many do not seem overly confident that it will actually succeed. The staff who were more directly involved with PSR had a more positive outlook than those who had less involvement. Finally, some staff felt that PSR participants are not given the same priority as are DBT participants and would like to see this improved upon in the future.

Study Limitations

There are some limitations to the present research. First, due to the nature of this study and the population toward which it is geared, a true random sample of individuals involved in the program was not possible. Second, at the

time of the interviews the number of women taking part in PSR was low; thus there were few PSR clients available to participate in an interview. In turn, there was also a limited number of staff involved in and available to speak about the program. As a result, the sample sizes of PSR participants and staff are quite small. The fact that the majority of staff in the SLE chose to be interviewed about DBT and spoke only generally about PSR may have been influenced by a lack of experience and/or low comfort level with the program, in turn potentially impacting the feedback provided regarding PSR. Furthermore, limited numbers of women participate in PSR and even fewer have completed the program. Future research should examine the reasons behind the small numbers of women enrolling in PSR programs.

Third, it is possible that some overlap between interview and survey respondents may have occurred. All staff who work in the Structured Living Environments were invited to fill out an anonymous survey regarding PSR. Due to the anonymity, comments from the surveys could not be differentiated from responses elicited in the interviews and were, therefore, coded as separate and distinct.

Recommendations for Potential Program Improvement

The following recommendations are suggested for further development of the program. First, considering the population that PSR is intended for, it appears that the complexity of the language in which the training manual and technology sheets are written is at a higher level of difficulty than may be appropriate. It is recommended that the language be made simpler and more suitable to the cognitive abilities of the participants. Moreover, it is recommended that all PSR materials be readily available and accessible in French for any French-speaking woman who requests them regardless of her geographic location (i.e., Quebec). As well, the French materials should be scrutinized to ensure proper translation of the vocabulary with special attention paid to any acronyms that are utilized.

Second, given the low number of women who are deemed "*ready*" to participate in PSR and thus a low number of staff who have been involved in the

program, it is recommended that formal booster-training sessions be offered to staff. Those facilities with smaller numbers of PSR clients may benefit from implementing on-going training sessions in which the staff are kept up-to-date on programming information and, in turn, feel comfortable delivering the program. This could be done via a "train the trainer" approach whereby one staff member trains new SLE employees on-site. Further, there appears to be confusion surrounding the concept of "readiness"; specifically how staff determine whether a woman is "ready" to partake in PSR and how to keep her occupied if she is not yet "ready". It is recommended that the guidelines for assessing "readiness" be clarified and that a contingency plan be created for those women in the SLE who have not yet met the program criteria.

Third, it is recommended that the current scales be re-examined. Scales that limit the options the women have to choose from and/or are stated in easier language may lessen the women's confusion and, in turn, increase the accuracy of their responses. As well, very few staff members reported having experience administering the scales. It is recommended that all staff who are involved with the program become more familiar with the different scales.

Fourth, it is recommended that the technology sheets be re-examined in order to determine if any can be combined or omitted. Staff feel that the program presently requires too many technology sheets and that some of them ask for the same information. If possible, it would be more efficient to condense the similar technology sheets; leaving more time for participants to work on program skills and less homework for staff to review.

Lastly, it is recommended that a protocol be established to allow each of the regional facilities to maintain consistent lines of communication with one another and with National Headquarters regarding successful and unsuccessful experiences with programming. One staff member suggested creating a periodical of sorts on the subject of Structured Living Environments across Canada. This would be one way of keeping people across the country informed, for example, of best practices and new techniques, exercises, and examples that facilities may want to implement. Perhaps a less costly proposal would be to

create a web site where staff could logon to a virtual bulletin board to post their thoughts and suggestions on programs in the SLE and read the contributions of others.

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APPENDIX A: INTERVIEW PROTOCOLS

PSR Semi-Structured Interview (Offender)

Date: _____ Interviewer: _____

Length of Sentence: _____ Institution: _____

1. How long have you been in the SLE?
2. What is your general perception of the psychosocial rehabilitation program (PSR)?
3. Do you understand the goals of the program? What are they?
4. What is your Overall Rehabilitation Goal (ORG)?
5. Do you feel like you are getting closer to reaching this goal? If no, why not?
6. Are the lessons, teaching and preparation helpful?
7. Is the time devoted to each of the skills you learn sufficient?
8. Are the critical skills you are working on well organized, clear and easily understood? If no, explain.
9. Do you find the "technology sheets" (sheets staff fill out when they interview you) helpful in assisting you with your progress?
10. At this time, have you completed any or all of the 2 self-report scales on the computer? If no, go to question 21.
11. In general, how did you feel about the scales you completed (re: Quality of Life Scale (QOL), Rosenberg's Self-Esteem Scale)
12. How satisfied are you with the availability of the program staff to have consultations/discussions with you when you need them?
13. Do you feel that you are in charge of your own program? Explain.
14. Do you feel that you are being directed to a great extent by the staff? Explain.
15. Is there anything you particularly like about the program?
16. Is there anything you particularly dislike about the program?

17. Are there any changes to the program that you would recommend?
 18. What aspects of the program work well for you?
 19. What aspects of the program need improvement?
 20. What aspects of the program do you most enjoy?
-
-

PSR Semi-Structured Interview (Staff)

Date: _____ Interviewer: _____
Length of Service (total): _____ Length of Service in SLE: _____
Institution: _____ Position: _____

1. What is your general perception of the psychosocial rehabilitation program (PSR)?
2. Do you feel that the PSR program is an effective learning tool?
3. Do you feel that the PSR training manual is an effective training tool?
4. Is the time devoted to each topic in the training manual sufficient?
5. Is the training manual well organized and easily understood? If no, explain.
6. Is there anything you particularly like or dislike about program?
7. Are there any changes that you would recommend?
8. Do you understand the goals of the program? What are they?
9. Do you believe the goals of the program are being met (i.e., is it helping the women)? If no, explain.
10. Do you have personal goals for the program? If yes, explain.
11. Are your personal goals for the program being met? If no, explain.
12. How do you believe the PSR helps the women? (e.g., quality of life, life skills, transition to general population, reintegration to the community, etc.)
13. What aspects of the program work well for you?

14. What aspects of the program need improvement?

15. How do you find the software?

16. How do you find the feedback you receive (i.e., DBC)?

17. Could the feedback be improved?

18. Do you find the measurements to be effective and informative?

- Baseline Information Form (BIF)?
- Daily Behavioural Checklist (DBC)?
- Brief Psychiatric Rating Scale (BPRS)?
- Institutional Functioning Scale (IFS)?
- Quality of Life Scale (QOL)?
- Rosenberg's Self-Esteem Scale (SES)?

(Open ended followed by ratings on a 1-10 scale.)

19. What aspects of the program do you most enjoy?

APPENDIX B: SURVEY

PSR Technology Evaluation

*The purpose of this evaluation component is to ensure that the **Psychosocial Rehabilitation Technology Sheets** are effectively working for you. Your comments and feedback are critical to the program's success. This evaluation is anonymous and we thank you for your time.*

For each of the following technology sheets please indicate with a Y (yes) or an N (no) if you consider the sheet to be 'effective', requiring 'changes', and/or requiring 'additions'. For those sheets that require changes or additions please provide specific details in the space provided below the rating scale. Please feel free to refer to your curriculum and or the technology sheets.

Technology Sheet	Effective	Changes	Additions
ASSESSING READINESS			
T1 Scale for Rating Inferring Need			
T2 Scale Rating for Commitment to Change			
T3 Rating for Level of Personal Interaction			
T4a Rating for Awareness – Environmental			
T4b Rating Scale for Awareness - Self			
SETTING A REHABILITATION GOAL			
T6 Identifying Personal Criteria - Clarifying Values			
T7 Describing Alternative Environments			
T8 Choosing a Goal			
FUNCTIONAL ASSESSMENT			
T9 Listing Critical Skills			
T10 Describing Skill Use			
T11 Behavioural Checklist			
REHABILITATION PLANNING			
T12 Rehabilitation Plan			
INTERVENTION PHASE			
T13 Programming Worksheet			
T14 Skills Program			

Change or Addition Specifics:

Technology Sheet # _____

(Please use the backs of these pages for additional technology sheet change/addition specifics.) Please feel free to provide additional concerns/comments regarding the technology sheets as a whole:

Thank you for your feedback and time, your involvement is greatly appreciated.

APPENDIX C: INFORMED CONSENT

INFORMED CONSENT FORM Correctional Service Canada, Women Offender Research

This form is intended to make sure that you are aware of your rights concerning participation in this evaluation and to make sure you are well informed to be able to decide whether you wish to participate. Please read the following carefully and sign below to show that you understand your rights as a voluntary participant in this evaluation.

I understand that this evaluation is looking at **Psychosocial Rehabilitation Program**. I am willing to participate in an interview and understand it will take approximately thirty to forty-five minutes. I am aware that I may choose not to answer specific questions or I **may leave at any point** in the process for any reason without punishment. I also understand that I will not incur any gains or losses for my participation in this evaluation.

I understand that my name will not be shown in any way on the interview format and thus my secrecy is guaranteed. The data, once collected, will be pooled, and kept strictly **confidential** and will not be used in any way other than for the research purposes outlined above.

Date: _____ 2002

Signature of Participant _____

Signature of Researcher _____

I have agreed to participate in an interview and understand my rights as a voluntary participant in this evaluation. I agree to have this interview **audio recorded** and I understand that these recordings will remain confidential and be used only for the purposes of this evaluation. I am aware that my name will not be identified in any way in this recording and thus my anonymity is guaranteed. I also understand that I had the right to refuse having this interview recorded without penalty.

Date: _____ 2002

Signature of Participant _____

Signature of Researcher _____