———— Research Report ————

Preliminary Evaluation of Dialectical Behavior Therapy within a Women's Structured Living Environment

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Preliminary Evaluation of Dialectical Behavior Therapy within a Women's Structured Living Environment

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EXECUTIVE SUMMARY

This report presents the results of a preliminary evaluation of Dialectical Behavior Therapy (DBT) implemented in the Structured Living Environments (SLE) at the four regional women's facilities, and forms part of a more comprehensive evaluation to follow. DBT is a psychotherapeutic treatment approach developed to treat women suffering from severe emotion dysregulation, such as Borderline Personality Disorder. Based on Linehan's (1993) model, the correctional adaptation of DBT applies cognitive behavioural principles in its treatment approach.

Forty-two staff and 23 women from facilities across Canada took part in semi-structured interviews and 20 staff surveys were completed. Primarily qualitative research techniques were employed in this evaluation and a content analysis formed the basis from which the following results emerged. Staff and participants demonstrate an understanding of the goals and objectives of DBT and more than half feel they are in the process of achieving these goals. While overall results were supportive of the effectiveness of this treatment approach, preliminary analysis suggests some program components within DBT could be ameliorated.

First, it is recommended that the language (vocabulary, acronyms, training manual, skills sessions, etc.) be simplified to better target participants' level of understanding and functioning. In addition, all materials should be readily available in French and English. Second, the treatment tools should be re-examined to ensure clarity and effectiveness. Third, the assessment battery should be reviewed in order to determine if more straightforward alternatives are available. Furthermore, all new staff should be trained in the administration of the assessment battery. Fourth, technical changes should be implemented in the training manual, thereby ensuring easier access to information. Moreover, more formal booster-training sessions should be made available to staff. Fifth, a review of staff scheduling may facilitate more consistent delivery of the skills training sessions. Finally, it is recommended that a standard protocol for the communication of job descriptions for those working in the SLE is enforced, in turn

addressing issues concerning staff involvement and the resulting impact on the treatment philosophy of DBT.

Overall, there appears to be a sufficient number of women within the facilities who are in need of the treatment DBT can provide. The staff describe DBT as a valuable treatment approach and participants report positive behavioural changes learned through the skills training sessions.

Importantly, as part of a more comprehensive evaluation, prospective research will further examine program effectiveness through the implementation of pre-post quantitative analyses.

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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 a preliminary assessment of Dialectical Behavior Therapy (DBT), currently being offered within the Structured Living Environments in the four regional women's facilities across Canada. This document serves as the first of two evaluation reports regarding this treatment approach.

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 the 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 institutions[1].

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 in hopes of addressing the needs of women experiencing mental health difficulties and were subsequently opened in the four regional facilities in 2001. In addition, 2003 brought the opening of the Secure Units and a treatment strategy for women classified as maximum security[2].

[1] 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.

[2] Importantly, a Secure DBT model has been implemented within the secure units.

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) were proposed as approaches that would address the needs of women dealing with 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* as the Structured Living Environments (SLE's) opened at the four regional women's facilities across Canada. As a prologue to a more comprehensive evaluation of these treatment approaches, the following report focuses on the implementation and preliminary outcome of Dialectical Behavior Therapy.

DBT is an approach that was originally introduced to meet the needs of individuals dealing with Borderline Personality Disorder (Linehan, 1993). As part of the Intensive Intervention Strategy, a correctional adaptation (see McDonagh, Taylor & Blanchette, 2002) of DBT was implemented within the Structured Living Environments in each of the women's regional facilities across Canada. The goal of DBT is for individuals to learn and refine skills and identify and change rigid patterns of thinking and behaviour that are associated with significant problems in living.

Dialectical Behavior Therapy (DBT)

Five principles lay the foundation for the development of a programming strategy for women under the care of Federal Corrections (Task Force on Federally Sentenced Women, 1990). DBT 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 are accountable for, and face consequences relating to personal decisions and actions; ***respect and dignity*** as participants learn to respect the efforts and successes of others in the program and staff who surround them 24 hours a day; ***supportive environment*** as women live amicably with one another in the SLE 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.

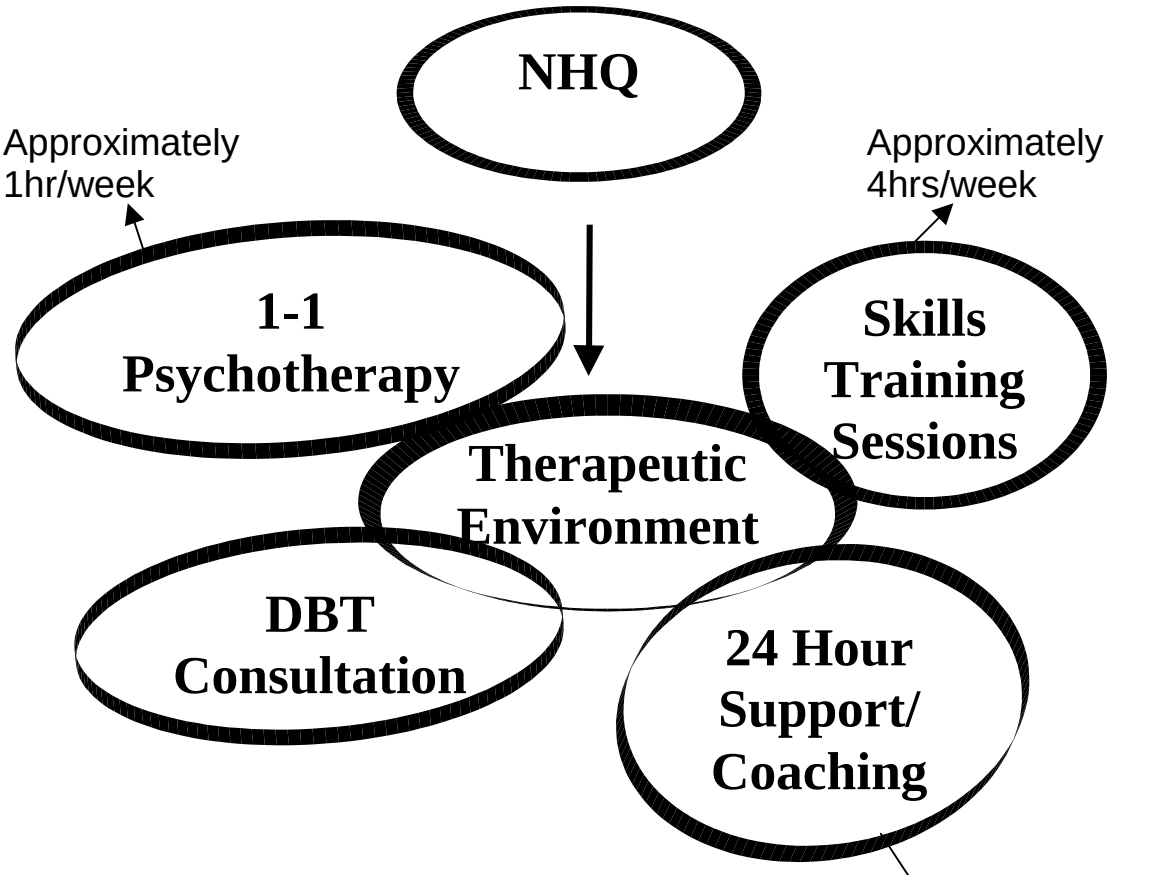
This treatment approach encompasses a therapeutic environment that offers skills training sessions, one-on-one psychotherapy, DBT consultation, 24-hour support and coaching and utilizes a variety of treatment tools. The skills training sessions include four modules: Core Mindfulness, Interpersonal Effectiveness, Emotion Regulation and Distress Tolerance. The treatment tools include Decision Balance Sheets, Behaviour Chain Analysis and Diary Cards[3] (See Figure 1, p. 4).

Goals of DBT

The goals and objectives of DBT can be grouped in terms of their immediate and long-term impacts (See Figure 2, p. 5). The immediate impacts refer to the ability to gain insight into one's behaviour, control emotions and behaviours, and change the institutional environment. The long-term impacts refer to the acquirement and enhancement of life skills, the process of empowerment, an increased quality of living, the ability to function effectively in an institutional setting, and a decreased likelihood of recidivism.

[3] For a comprehensive review of the program, its skills training sessions and treatment tools please see Sly, Taylor & Blanchette, 2003.

Figure 1 Dialectical Behavior Therapy (DBT) Treatment Model (SLE)



SKILLS TRAINING

- Orientation Model
- Core Mindfulness
- Interpersonal Effectiveness
- Emotion Regulation
- Distress Tolerance

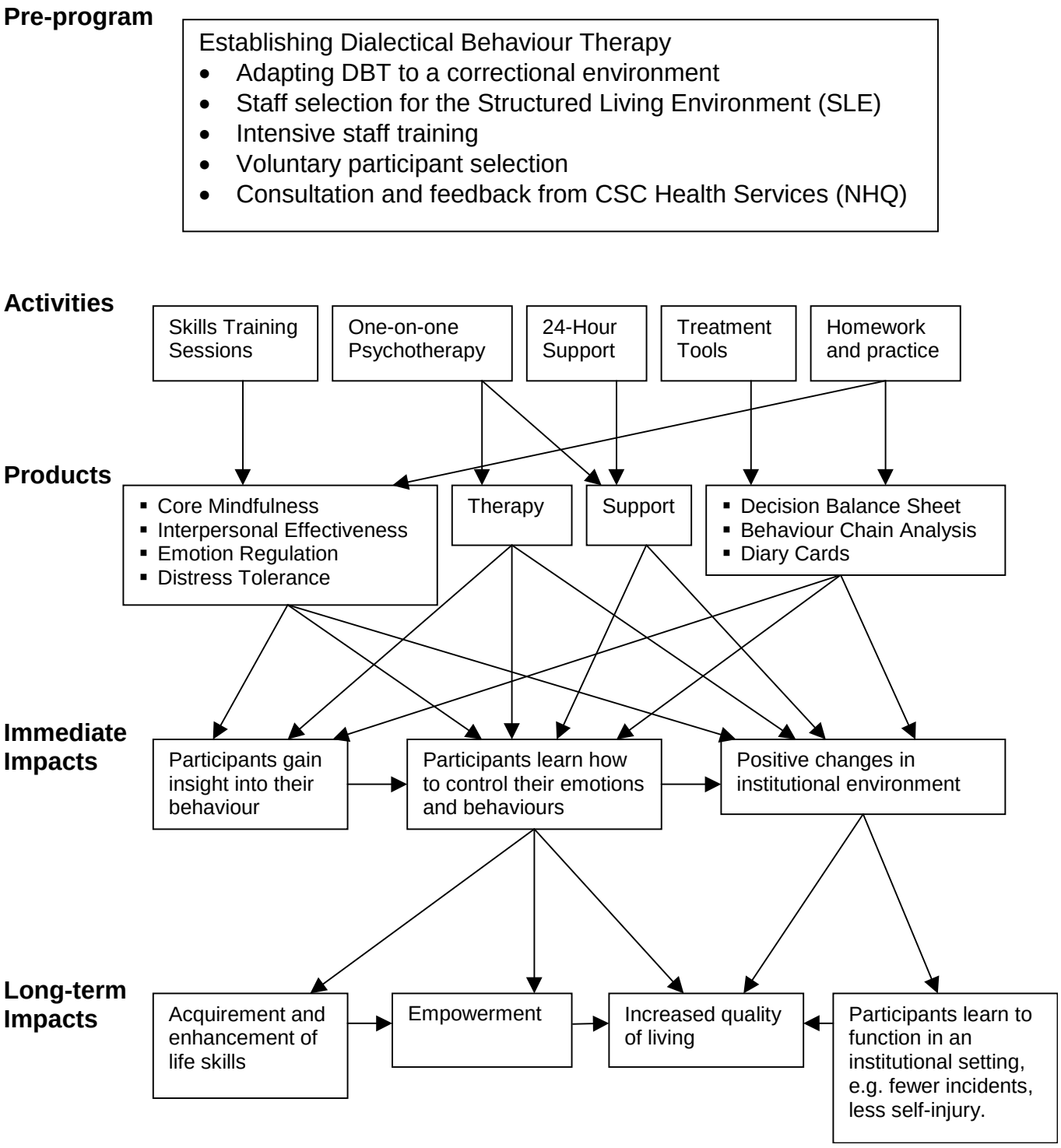
TREATMENT TOOLS

- Decision Balance Sheets
- Behaviour Chain Analysis
- Diary Cards

MISCELLANEOUS

- Crime Cycle
- Homework
- Practice

Figure 2 Dialectical Behavior Therapy: Treatment Logic Model



In addition to immediate and long-term impacts, the logic model presented in Figure 2 provides an overview of the activities and products involved with the DBT treatment approach. This model informs the evaluation matrix as outlined in the Evaluation Framework developed for this project (Sly, Taylor & Blanchette, 2003) and guides the methodology undertaken herein. The comprehensive evaluation will speak specifically to this logic model and an evaluation matrix in its entirety.

Stakeholders

Stakeholders include all parties involved or impacted by DBT: team leaders, assistant team leaders, behavioural counsellors, primary workers, psychologists, nurses, community integration workers, and inmates living in the SLE. Ideally, all staff working within the SLE should receive formal training regarding the delivery of this treatment approach.

History of the DBT Treatment Approach

In 1997, Correctional Service of Canada (CSC) introduced DBT for use with women offenders. Between 1997 and 2000, a variety of CSC facilities for women offenders provided some components of DBT. However, with the opening of the Structured Living Environments (2001) and the implementation of two primary treatment models, DBT and PSR, came a standardized comprehensive DBT Model[4].

[4] Please refer to McDonagh, Taylor & Blanchette (2002) for a more detailed overview of the correctional adaptation of DBT and a discussion regarding three DBT models delivered within CSC: Comprehensive DBT, General DBT, and Secure DBT.

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 DBT at each of the 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 and investigates perspectives of all parties involved or impacted by DBT (women and staff). The above mentioned parties are provided with the opportunity to contribute to the evaluation by expressing personal insights and feelings about DBT. As previously mentioned, this document completes the first stage of a comprehensive evaluation that incorporates a multi-method assessment strategy. This strategy includes: file review documentation, surveys, interviews, and measures of: offender functioning in the institutional environment, changes in psychiatric symptomatology, patterns of psychological symptoms, coping strategies, subjective moods, self-control, and finally, negative experiences and pessimism. Such strategies will be further developed and examined in the comprehensive evaluation of DBT.

Staff and Participant Interviews

Staff and participant interviews (Appendix A) served as an essential source of qualitative data for this initial stage of the comprehensive evaluation. Semi-structured interviews provided respondents with an opportunity to confidentially express personal views, feelings, and ideas about DBT.

Staff Surveys

Surveys (Appendix B) were also utilized as an additional qualitative data source. The surveys not only gave those not interested or able to partake in a formal interview the opportunity to provide feedback regarding DBT, but also measured alternative aspects of DBT not addressed in detail within the interview protocol.

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, 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

The following outlines the number of interviews conducted at each institution:

Institution	Staff	Women
Edmonton Institution for Women	11	7
Grand Valley Institution for Women	10	8
Nova Institution for Women	12 (4 general)	3
Joliette Institution	9 (1 general)	5
Total	**42**	**23**

Importantly, 5 staff members spoke in general terms about DBT rather than completing a detailed interview[5]. In total, 16 behavioural counsellors, 12 primary workers, 4 psychologists, 3 team leaders, 2 assistant team leaders, 3 nurses, 1 mental health coordinator and 1 community integration worker agreed to participate in an interview for a total involvement of 42 staff members. In addition, 20 staff members completed a survey specific to DBT.

[5] 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.

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

- Understanding and attainment of goals of DBT
- Effectiveness and usefulness of training, documentation and measurement tools
- General effectiveness and accomplishments of the treatment approach

RESULTS

As mentioned above, semi-structured interviews regarding Dialectical Behavior Therapy were conducted with 23 participants and 42 staff members (37 in depth and 5 general) including both module facilitators and non-facilitators. In addition, staff completed 20 DBT surveys. Where appropriate, the results of the staff surveys will be included below. 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 DBT and PSR treatment approaches.

Sixty-one percent of the women reported this was the first time they had participated in DBT. The remaining participants had either taken part in programs which they described as similar to DBT or taken DBT in the past at the following institutions: Edmonton Institution for Women (EIFW), Regional Psychiatric Centre (RPC), Grand Valley Institution (GVI), and Springhill.

The majority (70%) of DBT participants explained that they moved to the SLE on their own initiative. Other reasons for entering the SLE appeared to be upon recommendation by staff. Women expressing this also stated that they felt somewhat "forced" into participating.

Interviews with DBT participants reveal conflicting views of the treatment approach. While the majority of participants acknowledge that they are learning information and constructive skills that will assist them, many describe the components involved as "hard", "difficult", and "confusing".

Interviews revealed that the majority of staff find DBT to be positive and worthwhile. There was little negative feedback regarding the underlying principles of DBT, instead criticisms were in the form of suggestions to improve the current approach, such as using simpler language (60%). Almost half (48%) expressed great satisfaction with DBT, stating that they thought it was a "good idea" and describing it as a "wonderful"

treatment approach. In addition, several staff members commented on different aspects of DBT that they find to be advantageous. For example, they explained that DBT addresses the needs of offenders who do not respond to traditional core programming. They also acknowledged the everyday practicality of the underlying principles of DBT. One staff member alluded to the commonsensical concepts when she remarked on her personal goal for DBT:

> …to try to continually model the DBT to them. If they see us modelling some of that, then hopefully they'll realize too that 'it's not just us that needs this program, it's everyone'.

Staff were asked what they see as being the key areas required when developing a therapeutic environment. The most common staff perception is that DBT will work for the women who are motivated and who want to be involved (33%). One staff member summed up a common worry about some of the women's commitment:

> I think more often than not we have the wrong population here in the SLE. I think the women we end up getting are here for the quiet place … or to be protected from the general population…yeah, those not high on the totem pole in general population but when they come here are at the top. I'm not sure if the vision that initially NHQ had is actually what is going on in here.

Other key areas staff think are required to develop a therapeutic environment include choosing the right staff (30%), assigning consistent facilitators of modules and lessons (27%), encouraging team work amongst the staff (24%), and ensuring the staff are properly trained (16%).

The term "therapeutic environment" was interpreted in a variety of ways. Both staff and DBT participants were asked to describe their own personal understanding of this concept. Considering the staff and the participants engage in DBT from opposite sides of the classroom, interestingly there are some very similar interpretations (See Table 1, p. 12). The majority of staff (64%) described a therapeutic environment as being a "supportive atmosphere", a "learning environment for new skills", or an environment

where therapy "exists beyond the actual skills sessions, [where one is] surrounded by therapy". By comparison, the most common descriptions of a therapeutic environment according to the DBT participants were an atmosphere with a great deal of "structure", and "where people watch and fix your behaviour".

Table 1 Descriptions of "Therapeutic Environment": DBT Participants and Staff

Participants	Staff
• 24 hour support • Daily on-going therapy • Stable environment to help with coping skills • Structure (x4) • Place to improve yourself • Peaceful, quiet • Time alone to sort out feelings • Help with problems • Special needs • Group setting • Where people watch and fix your behaviour (x3) • Depends on the staff • I don't know (x4)	• Supportive atmosphere (x13) • Being surrounded by therapy, exists beyond the actual skills sessions (x7) • Learning environment for new skills, coping skills (x7) • Gain basic living skills to reintegrate into society • A validating environment that is safe and consistent (x2) • Conducive to a positive learning experience • Quiet environment where the women can relax, think about what they've done/have to do/their goals (x2) • Soothing, calming, addressing, stabilizing, peaceful • A lot of warmth and empathy and a kind of push towards making changes • An overall holistic type approach • A place where the women can really work on problematic issues, enables staff to observe their progress and the women to notice their progress (x2) • Meeting the needs of women who are dealing with mental health issues • Heal a person in a way that will meet their needs • A clinical environment • The staff will respect that the women will only do what they are able to do, but staff will ask them to do everything they are able to do • Focus on intervention rather than discipline or punishment • Non-judgmental environment • Flexible, willing to look at suggestions • People working together as a team for the betterment of the women • The physical building itself (x2) • Where help is available, people care, people work toward the same goals • An environment that enforces the strategies we teach in skills training, where everyone knows the language and the tools

Issues and Questions: Dialectical Behavior Therapy

Are DBT goals understood and being achieved?

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

Of the 23 DBT participants who were interviewed, only 1 woman claimed that she did not understand the goals of DBT. Several (43%) explained the goal as "changing negative behaviours" while other responses included "dealing with stress and conflict" and "developing self-esteem and healthy relationships". The majority (69%) stated that they feel the goals of DBT are being met.

The goal of DBT, as described by 20 staff members (48%), is to teach women skills to enable them to deal more appropriately with the problematic issues they face. A number of staff (26%) stated the goal of DBT is helping each woman establish "a life worth living as defined in her own terms". The staff recognized how important it is that the women set their own individual goals according to what they would like to achieve while involved. Staff explained additional goals of DBT as teaching the women to "function in the SLE, then general population, then in the community", "improve their relationships", "regulate their emotions", and "enhance their everyday coping and cognitive skills".

With regards to whether the goals are being met, various staff (24%) responded with a definite "yes"; only 2 with a definite "no". Others (29%) recognized that while the objectives are being reached, it is a slow process – one which a few staff members acknowledge "we can make room for improvements here in the SLE", and "we could do better if we had more money, more training". A few staff stated that the goals of DBT are being met for those women who practice the skills. Others expressed that they feel DBT will just not work for all women:

> It seems to me that it only works 50% of the time. I think the women understand when we teach them the skills, but I find there's a problem with

> the integration and application of those skills. I think that is the reason why some of the women are not successful in the program. I don't think it's a cognitive deficit, I think it's all about the integration of what is taught.
>
> …I feel that those who have the cognitive skills are able to succeed. On the other hand, those who do not possess the cognitive skills are less likely to succeed.
>
> …I'm not sure that those who are in the program have what it takes to use it to its full benefit. … Some are not motivated and some don't have the cognitive ability, you can explain something ten times and they still don't understand it.

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

All but two of the participants (91%) who were interviewed reported that they had set personal goals. These goals were stated in both general and specific terms. Generally, the women seek such things as being "mentally healthy", "never going back to federal prison", and changing the ways in which they "think and act". More specifically, the women expressed desires to "stay clean and sober", "improve my self-esteem", "improve my impulsive behaviour", "decrease my anxiety level", "be more assertive and think before I speak", and "reintegrate with my family". Over half (57%) of the women reported that they are making progress towards achieving their personal goals.

Eighty-six percent of staff stated that they had set personal goals, the majority (69%) expressing a personal ambition to increase their knowledge of DBT and improve their delivery skills. Other staff mentioned personal objectives such as, "offering offenders more support than they have traditionally gotten", "gaining insight into my own behaviour through the program material", and "reducing self-injurious behaviour amongst the women".

Of the staff who reported having set personal goals, over half (59%) stated that they feel their objectives are being met or are in the process of being met. Some staff (16%)

remarked that their goals had not been met and one staff member was skeptical of ever accomplishing the personal goal[6]: "I don't realistically see it happening".

Are the treatment materials and built-in assessment battery effective and informative?

Is the training manual an efficient learning tool?

Staff were asked to comment on what they think of the DBT Toolkit Volume 1[7]. Just under half (45%) of staff stated that the manual is clear, compared to 43% who feel it is not clear or who stated that they do not refer to it. One staff claimed, "I don't know if I was ever told that that's what that binder was for". Several staff (including those who filled out the survey) made suggestions to improve the training manual. They pointed out that page numbers and divider tabs should be added so as "to avoid flipping through it constantly". As well, they would like to have "a list of exercises" provided to "reinforce skills" with "more examples [given] or encourage staff to create more appropriate ones" as it is felt that several of the examples (e.g. concentration camps) are not practical, nor appropriate. Other staff remarked that the lessons are "often dry and boring".

A number of staff (29%) expressed satisfaction with the amount of information provided in the DBT Toolkit Volume 2, however; there were also criticisms. Some staff (19%) stated that the training manual was incomplete. Apparently, not only do they feel they have "to dig" for information within the manual, but there are also pages missing (e.g. homework sheets and exam answer keys)[8]. One staff reported having to "go to three different sources in order to compile the information: Volume 1, Volume 2, and talk to those running the program". Conversely, 24% of staff responded "yes" when asked

[6] "Being able to co-facilitate [the skills sessions] on a regular basis. … It's rather disruptive when facilitators are always changing, always someone different doing the group. You can't really build a rapport with the women…. I've rarely co-facilitated because of my shifts, so I don't realistically see it happening."

[7] The toolkit is a document provided during training sessions and available at each site for on-going reference.

[8] These pages have since been replaced.

whether the manual is well organized and easily understood. An additional 19% agreed it is well organized but find it hard to understand, describing the language as "difficult".

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

There are five progressive skills training modules within DBT: Orientation Model, Core Mindfulness, Interpersonal Effectiveness, Emotion Regulation, and Distress Tolerance. Approximately half of the participants (48%) stated that they are progressing through the modules in the proper order.

Overall, the participants seem to enjoy aspects of the sessions and find the skills training useful. In fact, a common response among the women was that the skills they are learning are "helpful". The module that appears to be the favourite is Core Mindfulness, with several women commenting on how much they enjoyed the "Three Minds (Reasonable Mind, Emotion Mind, Wise Mind)" component[9]. The module that appears to be the least favourite is Emotion Regulation which received no positive comments and was described as "childish", "hard", and "stressful". Over half of the participants (57%) reported satisfaction with the amount of time devoted to each skill area. Interestingly, several women remarked that they would prefer the training sessions to be longer making the overall length of DBT shorter (i.e. "Make it longer than two hours twice a week so it is over in less than six months").

With regards to how often the skills training sessions are offered, participants at the same institutions gave different answers except for those at EIFW where there was a consensus of twice a week. The responses at the three other institutions varied from once a week to three times a week with one participant claiming "every day if you

[9] In DBT there are three primary states of mind: Reasonable, Emotion, and Wise. An individual is in Reasonable Mind when she is thinking logically and acting rationally. An individual is in Emotion Mind when her behaviour is controlled by her moods. Wise Mind is the state where Reasonable Mind and Emotion Mind amalgamate and the individual is able to see the "bigger" picture and think and act objectively.

wanted". The majority of participants (82%) stated that they take the DBT skills training sessions in groups (ranging from three to ten women in a group); two participants reported that they do the skills on their own.

One negative aspect of the skills training sessions identified by both staff and participants is the inconsistency of facilitators[10]. Due to the rotating shift work at the institutions, the same staff members are not always available to teach an entire module from beginning to end. This appears to cause problems with respect to clarity of program material as different facilitators interpret and teach lessons differently. As well, it affects the motivation of staff to improve their delivery skills and of participants to complete their homework assignments. One staff member suggested, "…implement a person who has their finger on the pulse of the place, a central person" who can oversee the running of the program.

Like the name of the approach itself, DBT utilizes many acronyms. The purpose of the acronyms is to help the women remember the different concepts. Roughly half of the women (48%) expressed frustration with the use of acronyms and described them as "confusing" and "hard to remember". Several (35%) reported the opposite, stating that they "like them", that the acronyms "make sense", and are "easy to remember". Along with the use of acronyms, living in the SLE and being involved with DBT means becoming familiar with a new vocabulary. Participants were asked to comment on what they think of the new vocabulary. Many women (35%) responded positively, remarking that the new vocabulary is "easy to catch on to", "it's like a game, it's fun", and "it's logical". While others (26%) responded negatively, remarking that they "don't really like it" and "find it hard". One woman stated:

> …I just finished [DBT] now. I found it really hard because of the way it was worded. Sometimes I wonder do they expect us to have college degrees to answer these questions because just the way they're worded, I don't understand.

[10] Importantly, the DBT model strives to maintain an interdisciplinary team approach.

Similarly, interviews with staff revealed that they also find the wording of the materials too complicated for the women. In fact, the difficulty of the language was a common theme. When asked if there is anything they particularly dislike about DBT, several staff members (32%) responded that the program is not "reader-friendly", and the most frequent recommendation to improve the treatment approach was to make the language simpler (35%). Results from the surveys provide additional support for this finding. With regards to the acronyms that are utilized, staff remarked that "the acronyms cause stress with some women" and "the women tend to get caught up in memorizing rather than understanding the points". Another staff commented that goals of the approach were not being met because "the language makes it difficult for many women". As well, one staff member pointed out that the acronyms "don't translate properly [into French], for example, DIVD instead of GAIN"[11].

Is the assessment battery and software effective and informative?

Participants' responses on what they thought of the assessment battery ranged from "difficult", "hard to understand" and "too personal" to "okay" and "easy but I didn't like them". One woman commented that she found it "difficult to decide the intensity" of her response according to the 0 to 7 scoring range and suggested instead that the responses be coded "true or false". Another woman explained that the scales in the assessment battery were a source of frustration

> …'cause I didn't know what they were talking about, like I couldn't understand any of the words. The words were like this long; I had no idea how to pronounce them let alone what they meant.

Interviews with staff revealed that the majority (60%) are not familiar with the scales within the assessment battery. One staff remarked that "only one person is designated to do the scales with the women and that bothers me because I would like the opportunity to look at the scales". Staff members who have administered the scales

[11] DIVD and GAIN are two of the French versions utilized to express the English acronym GIVE (Gentle, Interested, Validate, Easy Manner). These acronyms are used to assist women in remembering the skills used in establishing and maintaining healthy relationships.

provided feedback on their usefulness, even describing them as "enlightening". However, the majority of the comments were critical. Staff reported having difficulties getting the women to fill out the scales as they "seem to be a big task for the women, they're long…the women can't sit still". For this reason, as well as technological problems which seem to have occurred with some of the institutional computers (loss of data, glitches, a faulty mouse), many of the women have been completing the scales with pen and paper and someone else "enters it in the computer" later. One staff member described frustration with the format of the scales, stating, "I don't like that you can't return to a previous screen or skip to the end to enter comments such as 'this client refuses to finish scale'." Other staff expressed skepticism regarding the accuracy of the scales:

> I don't know how accurate the information is as these women can't remember back seven days ago and they have crazy mood swings.
>
> Questions like, 'Have you had an urge to drink?' make the women answer untruthfully as they are worried they will be charged.

With respect to the individual scales themselves, the staff appear to find the Institutional Functioning Scale (IFS) the most useful as it is "adaptable for daily living", "gives you a good starting point", and is "really objective". The scale that the staff appear to find the least useful is the Symptom Checklist-90-Revised (SCL-90-R). Staff described the SCL-90-R as "really long", "confusing", and "probably makes their [the women's] answers not as accurate".

Are the treatment tools working?

Ideally, all staff who work in the SLE participate in DBT. The more staff who are committed to teaching and reinforcing the treatment skills, the more effective the treatment will be. This also includes administering the treatment tools. Staff were asked who usually administers the tools, such as Diary Cards, Decision Balance Sheets (DBS), and Behaviour Chain Analysis (BCA). Just over half (51%) responded that

"everyone" administers the tools, while 46% acknowledged that it is mostly the behavioural counsellors who administer them.

Staff also gave feedback on the applicability and usefulness of the treatment tools. The majority of comments made about the Diary Cards were negative. Staff find the Diary Cards to be "difficult", "confusing", and "not effective for all women". With respect to the DBS, staff describe them as "effective", "helpful", and a "great tool", however, the use of the words 'pro and con' confuse the women and it is recommended that they be substituted with 'good and bad'. The BCA is also described as "effective" and "insightful" but there is a concern that it is "not always filled out properly". Several staff mentioned that the language of the BCA is complicated and women need help completing it. One comment that many staff members relayed is that the women tend to view the treatment tools as punishment instead of a way to gain insight into their behaviour. This can affect the women's motivation to complete the forms as well as the motivation of staff to administer the forms. One staff stated that

> I have no use for those forms or the procedure and I will not give them out, it is a waste of my time because I have to look it over afterwards. I will not give them out, I don't agree with them, and I hate to not be a team player and not part of the program but I don't agree with it. … For example, an inmate doesn't do their chores so we are encouraged to, instead of disciplining the inmate, we give them a DBS.… Personally, myself, I would rather spend a few minutes filling out a DBS instead of washing the floor or cleaning the bathroom….

A few staff members mentioned that they would rather not administer the treatment tools, preferring to speak with the woman about a particular behaviour instead of leaving her alone to fill out a form. This is similar to comments made by some of the women about the treatment tools. Some women find that being requested to fill out a form immediately following a negative behaviour makes them feel worse:

> …it made me relive the situation … and doing the BCA…they gave it to me right away when the situation happened and they would say 'we want you to do this, we don't want you to come out until your BCA is done'.

> How can you do a BCA when you are angry? You have to calm down, you have to relax … I would have rather talked with somebody….

Is DBT accomplishing what it sets out to?

Are women involved in DBT receiving the attention, support, and structure they need to successfully complete the program?

DBT participants were asked if they find the staff in the SLE to be readily available if they are needed. The majority (83%) responded that they are satisfied with the availability of staff; two women commented that there are "too many staff". One woman remarked that she thinks the "staff need more training". Just over half of the women (52%) expressed satisfaction with the amount of staff direction. They feel that while the staff give their input they also encourage the women to take initiative. A number of women (26%) disagreed stating there is too much direction from staff and likened the structured environment to "being babysat" and "nagged".

Half of the women participating in DBT (52%) reported that they are involved in one-on-one therapy and find it helpful. Four women stated they do not find it helpful, explaining that the sessions are often repetitions of previous exchanges with other SLE staff and that rapport has not always been established with the one-on-one therapist.

Participants were asked if they feel that their input is important in the SLE. The majority (57%) responded "yes", that they feel the staff are interested in what they have to say. Only three women stated that they do not feel their contribution is important and one woman reported feeling that her opinion is "just as important as the rest of the other inmates', but that inmates' input overall is not that important".

Overall, participants acknowledge that DBT is useful. They recognize that they are learning skills that will assist them in their relationships and improve their everyday living environments. The aspects that participants seem to enjoy the most are the staff

and the 24-hour support they provide (22%), the self-soothing exercises (22%), the Three Minds component (17%), and the Diary Cards treatment tool (17%). However, only six women (26%) declared particularly liking the entire treatment approach. According to participants, the aspects that they least enjoy and feel need improving are the language (48%), the length (35%), the consistency of the facilitators (17%), and the Diary Cards treatment tool (17%). It is interesting to note that equal numbers of DBT participants seem to like the Diary Cards treatment tool as dislike them.

All staff seem to have something positive to say about DBT. While there are facets of DBT that could be improved, the staff acknowledged the beneficial potentialities of the approach. One staff remarked that "you can see the changes in the women already in the first two weeks" and two staff pointed out that there has been a decrease in the occurrence of self-mutilation, acting out, and aggressive behaviour since the opening of the SLE and the implementation of DBT. The aspects of DBT that staff report enjoying the most are the skills training sessions (65%), the treatment tools (51%), and when the women utilize the skills they have learned (43%). The aspects of DBT that they least enjoy and feel need improving are the language (60%), the consistency of the facilitators (33%), the amount of training (26%), and the exercise examples (17%). Results from the surveys provide additional support for these findings.

How do staff oversee the running of DBT?

Staff members who work in the SLE hold several weekly meetings to discuss issues that involve DBT as well as the SLE environment itself. The staff have diverse interpretations as to what the meetings are called, who attends, and what is discussed. The most commonly cited meetings were Interdisciplinary Team Meeting (41%), Coordinated Care Meeting (30%), and Case Conferences (16%). The majority of staff (49%) reported that everyone on shift during the time of the meeting is, theoretically, expected to attend. However, due to the fact that the SLE must be staffed 24 hours, it is impossible for all staff on duty to attend these meetings. As well, the nature of rotating shift work means that the same staff members are not always present on the

same days, making it difficult to keep everyone informed of what took place at the meetings.

Staff were asked to describe what topics are discussed at the weekly meetings. The most common response was the major issues that the women are experiencing (65%). Additional topics include, staff issues (30%); skills for the coming week's training sessions (24%); women's treatment plans (24%); potential candidates for, and dismissals from, the program (22%); and housekeeping issues (19%). When asked to assess the meetings and other staff's perceived involvement in DBT, 35% of staff stated that the meetings are valuable and that most staff participate in them. Two staff commented that they do not attend the meetings as they have "no voice, no say, no respect", and feel they are "not supported". Thirty-eight percent remarked that more "full team" meetings are needed so that all staff are aware of what is going on in the SLE. A few staff commented that the meetings tend to be long and somewhat repetitive, as there is an attempt to bring the others up-to-date on what has happened at previous meetings.

There appears to be some tension with regards to who is considered dedicated to utilizing the principles of DBT. Some staff feel that "the BCs [behavioural counsellors] are more involved than the PWs [primary workers]" and that "more guidance and accountability of PWs is needed". On the other hand, one primary worker remarked, "I don't really believe in some of the philosophy of the whole thing … I don't want to feel pressured to sit in a classroom helping to deliver [lessons], it's not my job, it's not supposed to be part of my job." Conversely, some staff expressed frustration that they are not being given enough opportunity to help implement the approach. For instance, one nurse commented that "I would like clinical nurses to be included and made use of".

CONCLUSIONS AND RECOMMENDATIONS

Although CSC's adaptation of Dialectical Behavior Therapy is in its early stages, it appears to be positive and worthwhile. The more committed residents and staff of the SLE are to DBT, the more effective it will be. Both DBT participants and staff made suggestions as to how the approach can be improved. These will be discussed further in the following section. One DBT participant summed up her thoughts on DBT and the SLE:

> I just think that it is a really good program and I wish more people would put their mind into it … You know, when they interview people to move in I think they should do a more thorough job on how willing they are to…get the most out of it…. We are given so much freedom that I just cannot believe it and it is really troublesome hearing the other girls bitch about all the work, I'm like, what are you talking about? There are no bars around us, no handcuffs. They want a vacation; we are in jail…. I'm just very happy there is a SLE … I'm on the go all the time, I don't have time to lay around all day….

Summary of Findings

The present report provides a preliminary evaluation of DBT within the Structured Living Environments at four regional women's facilities across the country. It is important to note that at the time of the interviews, DBT was in its initial stages of implementation and continues to evolve in its development. Four main issues were considered:

1) Staff and participants' perceptions of goals (both professional and personal)
2) Success in meeting those goals
3) Effectiveness of treatment tools and assessment battery
4) DBT accomplishments to date

The first issue is concerned with how those involved perceive the goals of DBT. Both staff and participants described the main goal as teaching the women more effective means of dealing with their problems and, thereby, avoiding negative behaviours.

Examples of personal goals for the women include curbing impulsive behaviour and abstaining from drug use.

The second issue addresses the level of success according to both staff and participants. Fifty-three percent of the staff and 69% of the women feel that the goals are being met or are in the process of being met. As well, the vast majority of both staff and participants reported having set personal goals for DBT. Fifty-nine percent of staff and 56% of the women reported that they are making progress towards achieving their personal goals.

The third issue deals with the value of the training manual, treatment tools, and assessment battery. There are conflicting opinions amongst the staff regarding the quality of the training manual. Almost half the staff described the manual as clear, while the other half described it as unclear stating that it is not "reader-friendly". The reason for this criticism is the level of difficulty of the language in which it is written. It appears that many of the staff find it challenging to interpret the manual in order to make the lessons comprehensive for the women. One staff remarked, "When a facilitator has to read it over a couple of times to understand it, it's kind of hard for some of the women to understand it". The most common suggestion for the improvement of DBT was to make the language simpler. For instance, staff commented that the use of acronyms is a drawback as the women tend to concentrate on memorizing the letters as opposed to understanding the concepts. Furthermore, the concepts expressed by English acronyms, while accurately translated in French, do not make much sense when expressed as French acronyms. The majority of participants expressed similar sentiments and stated that they find the acronyms confusing.

With respect to the assessment scales, 60% of staff reported being unfamiliar with them and are sceptical about how accurate the scales are in assessing the women. The women themselves commented that they find the scales difficult to complete due to the language and the extensive number of response options. Regarding the treatment tools, (Behaviour Chain Analysis, Decision Balance Sheets, and Diary Cards) staff

acknowledged that they have value but would benefit from some changes, again, mainly the language. One staff summed up her reservations about the wording of the BCA:

> 'Internal/External Vulnerability', I just did it with one of the women and even I was like, 'Okay, how are we gonna fill this out?' Because her problematic behaviour was that she was tired, she missed group. But the way that all the questions…it just doesn't highlight that behaviour so I was like, 'Oh God, this is a struggle". So if I was having problems, you can imagine how she felt.

The fourth issue addresses the quality of support and structure the participants receive while involved in DBT. In general, the women report that they are learning new skills that are assisting them in making positive behavioural decisions, but on the whole, do not appear to take a great deal of pleasure in completing each of the different components. This is evident in participants' request to increase the session times so that the overall length is reduced. By and large, the staff take the position that DBT is worthwhile but requires some adjustments and improvements in order to have a more positive influence on the women. In particular, staff explained that the women must be motivated and want to be involved in order to succeed.

Study Limitations

It is important to note the limitations of this research. Firstly, due to the nature of this study and the population toward which it is geared, it was not possible to conduct a true random sample of individuals involved with DBT.

Second, as a result of the semi-structured nature of the interview, not all participants and staff responded to every interview question. In turn, this resulted in a lack of substantial information for approximately five questions[12] from which to gauge an accurate overall impression. This made it difficult to determine how the majority of individuals involved in DBT feel about certain aspects of the treatment approach.

[12] Questions impacted included numbers 7, 19, and 20 from the staff interviews and numbers 2 and 21 from the participant interviews, located in Appendix A.

Third, the possibility exists that some overlap between interview and survey respondents may have occurred. All staff who work in the Structured Living Environments at the four facilities were invited to fill out an anonymous survey regarding DBT. Due to the unknown sources of the survey responses it was not possible to distinguish them from the staff who were interviewed. Thus, the comments from the surveys were considered separate and distinct from the interviews.

Recommendations for Potential Improvement

First, it is recommended that the language of DBT be simplified in order to meet the needs of the population it targets. This includes the vocabulary and acronyms, the training manual, the treatment tools, and the scales. Several staff members and participants described the language as difficult and confusing and, in turn, a hindrance to the overall success of the treatment approach. All materials should be reviewed to ascertain that they are clear, concise, and appropriate to the cognitive level of the participants.

In addition, it is recommended that all DBT materials be readily available in French for any French-speaking woman who requests them regardless of the region in which she resides (i.e., outside of Quebec)[13]. The French materials should be scrutinized to ensure proper translation of the vocabulary with special attention paid to any acronyms that are employed. Furthermore, it is recommended that acronyms such as "PLEASE MASTER" and "DEAR MAN" be reviewed as they may be subject to criticism for using words that could be construed as masculine-oriented and which may have the potential to cause unnecessary anguish to women who have been victims of male-perpetrated violence.

It is recommended that the treatment tools be re-examined to ensure clarity and effectiveness. The BCA has been criticized for using challenging language that the

[13] Of note, at the time of publication, it is understood that all DBT materials were readily available in French.

women find hard to understand and the Diary Cards are reported to have a confusing format structure. The DBS could be improved with minor changes to the sentence structure. Furthermore, it is important that both staff and participants perceive the treatment tools as they are intended – as helping instruments, not as punishment. Accordingly, it is recommended that the DBS be administered not only for inappropriate behaviour, but also for instances of appropriate behaviour so as to encourage the women to continue making positive behavioural choices. Finally, the administration of the treatment tools should be reviewed to make certain that the timing is appropriate to each woman's ability to think about her behaviour and ensure that her emotional needs are being met. Care must be taken to ensure that the treatment tools are actually assisting the women and not exacerbating the problem.

Third, considering the low number of staff who have experience with the assessment scales, it is recommended that all staff be given the opportunity to administer them. In this way, staff will become more knowledgeable of the different scales and be in a better position to help the women complete them. Currently, some of the women have trouble with such things as understanding the language of the scales and deciding on the intensity of their responses along the scoring ranges (e.g. 0-7 Likert scale). As a result, some staff question the accuracy of the women's responses. It is recommended the scales be reviewed to determine if there are alternatives that could be implemented which utilize language and scoring methods that are more straightforward.

Fourth, on the suggestion of staff who have become well acquainted with the training manual, a few technical changes are recommended. In order to make locating information within the manual easier, it is recommended that page numbers be inserted, a Table of Contents added, and divider tabs attached. It may be of further support to make the training manual available on computer. To assist staff with the facilitation of the skills training modules, it is recommended that the training manual be equipped with lists of more appropriate and practical examples and a greater number of exercises that can be performed in class. In addition, it would be beneficial to offer more formal booster-training sessions to staff so that they are kept up-to-date on programming

information and, in turn, feel more comfortable delivering the skills training sessions and related treatment tools.

Lastly, according to several staff members, the rotating shift schedule on which the regional facilities operate creates an obstacle to the perceived success of DBT. Both staff and participants commented that they would prefer the same individual to teach the skills training modules from start to finish as opposed to someone new delivering each lesson. In an effort to ensure clarity and continuity of delivery, it is recommended that the shift schedules of module facilitators be re-examined for the possibility of establishing consistency. While this is a major operational undertaking, and one that may not be realistic for all facilities, it is necessary if facilitator stability is to be achieved. By extending the duration of shift rotations staff will be able to work the same shift schedule for longer periods of time. This will not only give them the opportunity to teach a module from beginning to end, but also allow them to attend staff meetings on a more regular basis. The result should be staff who are more comfortable and experienced in delivering the treatment approach and more informed about what is happening in DBT and within the SLE in general.

As noted in the previous chapter, a suggestion was made by staff to "implement a person who has their finger on the pulse of the place" who would be in charge of the day-to-day operations of DBT. Ideally, this individual is the team leader. The team leader should be knowledgeable in all areas of DBT and be able to deliver any skills training modules. In the event that scheduling problems disrupts the availability of a consistent facilitator, the team leader or other members of the inter-disciplinary team should be able to step in and carry on where the class has left off.

Furthermore, the issue of staff involvement needs to be addressed. Currently, there appears to be some miscommunication with regards to what is and what is not part of the job descriptions of employees working in the SLE. In particular, some primary workers expressed that they are being asked to perform tasks which are not their responsibility and for which they have not been properly trained. This is a source of

tension for other staff who feel that every employee in the SLE should be fulfilling all duties. One staff member complained that "there are women working here who don't even want to be here and that is very obvious, so it makes it very difficult for everyone else". There should be a clear understanding of what is required of staff members with regards to treatment delivery in the SLE. It is recommended that a screening process be implemented to ensure that staff assigned to the SLE are fully aware of their responsibilities and are dedicated to the success of the entire treatment approach and the unit as a whole. In addition, staffing positions within the SLE (e.g. clinical nurses) should be re-examined so that significant roles and responsibilities are assigned accordingly to guarantee that the most is made of the skills and abilities of staff. For instance, some clinical nurses report feeling under-utilized with respect to DBT operations and would prefer to play a more active role.

All in all, a preliminary evaluation of DBT provides support for the treatment approach and its value for the client population it serves. Not surprisingly, the value of commitment on behalf of both staff and women involved should not be underestimated, as clearly "buying into" this treatment approach is of paramount importance. Apparently, the goals of DBT are clear and shimmers of its success are already being experienced by the women, and witnessed by staff. Implementation of the above noted recommendations will likely contribute to continued accomplishments provided within CSC's Dialectical Behavior Therapy model.

REFERENCES

Linehan, M. M. (1993). *Cognitive-Behavioral Treatment of Borderline Personality Disorder*. New York: The Guilford Press.

McDonagh, D., Taylor, K., & Blanchette, K. (2002). Correctional adaptation of Dialectical Behavior Therapy (DBT) for federally sentenced women. *Forum on Corrections Research*, 14, 36-39.

Sly, A., Taylor, K., & Blanchette, K. (2003). *An Evaluation Framework for Dialectical Behavior Therapy with Women Offenders*. Ottawa, ON: Correctional Service of Canada.

Task Force on Federally Sentenced Women (1990). *Report of the Task Force on Federally Sentenced Women: Creating Choices*. Ottawa, ON: Ministry of the Solicitor General.

Warner, A. (1998). *Implementing Choices at Regional Facilities: Program Proposals for Women Offenders with Special Needs*. Ottawa, ON: Correctional Service of Canada.

APPENDIX A: Participant & Staff Interview Protocol

Guide for interview with DBT participants

1. What does the term "therapeutic environment" mean to you?

(**Prompt** next question: "I'm going to shift my focus to the entire DBT model now, we will talk briefly about each component separately").

2. Overall, how do you feel about the whole DBT model? This includes all components: skills training, one-on-one psychotherapy, 24-hour support, homework, Behavioural Chain Analysis (BCA), Decision Balance Sheets (DBS), Diary Cards, etc?

3. Do you understand the goals of the treatment? Explain.

4. Do you believe the goals of DBT are being met? If no, explain.

5. Do you have personal goals for being in the SLE? If no, explain why not.

6. Are your personal goals being met? If no, explain.

7. Why do you think you are in the SLE?
(**Prompt:** self-motivation, upon suggestion, requested).

8. How satisfied are you with the availability of staff?

9. Are you involved in one-on-one therapy? If yes, do you find the therapy helpful?

10. Do you feel that your input is important in the SLE? Explain.
(**Prompt:** morning/evening check-ins, a time they all get together).

11. Do you feel that you are being directed to a great extent by the staff? Explain.

12. How often are the DBT skills training sessions offered? (E.g., weekly, bi-weekly)
(**Note:** the interviewee may refer to this as the program).

13. Do you take the DBT skills training sessions individually or in a group?

14. Have you taken any of the DBT skills training sessions before? If yes, when and where?

Prompt next question: "We're now going to focus on the skills training component of the DBT model. We'll talk briefly about each skills training session individually.

15. Overall, how do you find the DBT skills training sessions?

(**Note:** for open ended questions, phrase it "what do you like and dislike about the…. For Likert scale, phrase it "if you had to rate the effectiveness and usefulness of…on a scale from 0-10, 10 meaning the session was extremely useful, 0 meaning the session was not effective and useful at all". Show Likert scale sample).

Orientation Model?
Core Mindfulness?
Interpersonal Effectiveness?
Emotional Regulation?
Distress Tolerance?

16. Is the time devoted to each skill area sufficient?
(**Note:** get details, e.g. not enough or too much).

17. Did you progress through the training sessions in the proper order? (E.g., Orientation Model, Core Mindfulness, Interpersonal Effectiveness, Emotional Regulation, and Distress Tolerance).

18. I understand that a lot of acronyms are used in DBT (e.g., DEAR MAN). How do you feel about the use of acronyms?

19. I also understand that being in the SLE and involved with DBT means becoming familiar with a new vocabulary. How do you feel about this?

20. At this time, have you completed any or all of the six self-report scales on the computer?

21. In general, how did you feel about the scales you completed (re: SCL-90-R, WAYS, POMS, SCS, BHS, BID-R)?

Note: For the next questions, prompt with all aspects of the DBT treatment model if necessary.

22. Is there anything you particularly like about DBT?

23. Is there anything you particularly dislike about DBT?

Note: The following questions may or may not be required depending on the extent of the responses for the previous two questions.

24. Are there any changes to DBT that you would recommend?

25. What aspects of DBT work for you?

26. What aspects of DBT need improvement?

27. What aspects of DBT do you most enjoy?

Guide for interview with staff

1. What does the term "therapeutic environment" mean to you?

2. What do you see as being the key areas required when developing a therapeutic environment specific for the Comprehensive DBT Model implemented in the SLE?

3. What is your general perception of DBT?

4. Do you understand the goals of DBT? If yes, what are they?

5. Do you believe the goals are being met? If no, explain.

6. Do you have personal goals for DBT? If yes, explain.

7. Are your personal goals being met? If no, explain.

8. How would you assess other meetings and other staff's involvement in the program (i.e., DBT consultation or Coordinated Care Committee)?

9. How often do these meetings occur?

10. Who participates?

11. What happens during these meetings?

12. Who administers the treatment tools (Decision Balance Sheets, Behaviour Chain Analysis, Diary Cards)? Do you have the opportunity to administer treatment tools?

13. Is there anything you particularly like about DBT?

14. Is there anything you particularly dislike about DBT?

15. Are there any changes that you would recommend?

16. What aspects of DBT work well for you?

17. What aspects of DBT need improvement?

18. Do you feel that the DBT Toolkit Volume 1 is an effective learning tool? If no, explain.

19. Is the information provided in Volume 1 for each area of DBT sufficient? If no, explain.

20. Is Volume 1 well organized and easily understood? If no, explain.

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

- Institutional Functioning Scale (IFS)?
- Brief Psychiatric Rating Scale (BPRS)?
- Symptom Checklist-90-Revised (SCL-90-R)?
- Ways of Coping?
- Profile of Mood States?
- Self-Control Schedule?
- Beck Hopelessness Scale?
- Balanced Inventory of Desirable Responding?
- Assessment Feedback?

22. What aspects of DBT do you most enjoy?

APPENDIX B: Staff Surveys

Comprehensive DBT Treatment Components

The purpose of this evaluation element is to ensure that various components of DBT are effectively working for you. Your comments and feedback are critical to DBT's success. This evaluation is anonymous and we thank you for your time.

For each of the following areas, please indicate with a Y (yes) or an N (no) if you consider the treatment component to be 'effective', requiring 'changes', and/or requiring 'additions'. For those areas that require changes or additions please provide specific details in the space provided below the rating scale. Please feel free to refer to your Toolkit Volume 1.

Treatment Component	Effective	Changes	Additions
Skills Training			
Orientation Model			
Core Mindfulness			
Interpersonal Effectiveness			
Emotion Regulation			
Distress Tolerance			
Treatment Tools			
Decision Balance Sheets			
Behaviour Chain Analysis			
Diary Cards --- Old or Revised (May 02)			
Miscellaneous			
1 - 1 Psychotherapy			
DBT Consultation			
Staff DBT Skill Review (Feedback Form #9)			
24 Hour Support/Coaching			
Crime Cycle			
Homework			
Practice			

Change or Addition Specifics:

Treatment Component: _____
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Treatment Component: _____
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Treatment Component: _____
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Treatment Component: _____
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Treatment Component: _____
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(Please feel free to use the backs of these pages for additional change/addition specifics.)

Please use the following area (and the back of this page if desired) for additional concerns/comments regarding the treatment components listed above:
_____
_____
_____

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 **Dialectical Behavior Therapy.** 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_____