A Strengths-Based Approach to Therapy in a High Secure Forensic Hospital (mit Übersetzung)

Liam E. Marshall, PhD, RP, ATSAF

Rockwood Psychotherapy & Consulting

Midland, Ontario, Canada

.rockwoodpsyc.com; liam@rockwoodpsyc.com

University of Toronto Department of Forensic Psychiatry

Introduction

- Why use a Strengths-Based Approach in a forensic psychiatric setting?
- What is a Strengths-Based Approach look like in a forensic psychiatric setting?
- Some outcomes from using a SBA in a forensic psychiatric setting

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Why a Strengths-Based Approach in a Forensic Psychiatric setting?

Goals for providing psychological treatment:

1. Provide evidence-based psychological/ psychosocial treatments to reduce problems associated with mental illness
2. Provide evidence-based psychological/ psychosocial treatments to reduce risk and criminogenic needs

Objective: to meet these goals in empirically supported ways which are respectful toward the client and promote positive patient-staff relations

Accepted Manuscript

Sailing uncharted seas without a compass: A Review of Interventions in Forensic Mental Health

Mary Barnao, Tony Ward

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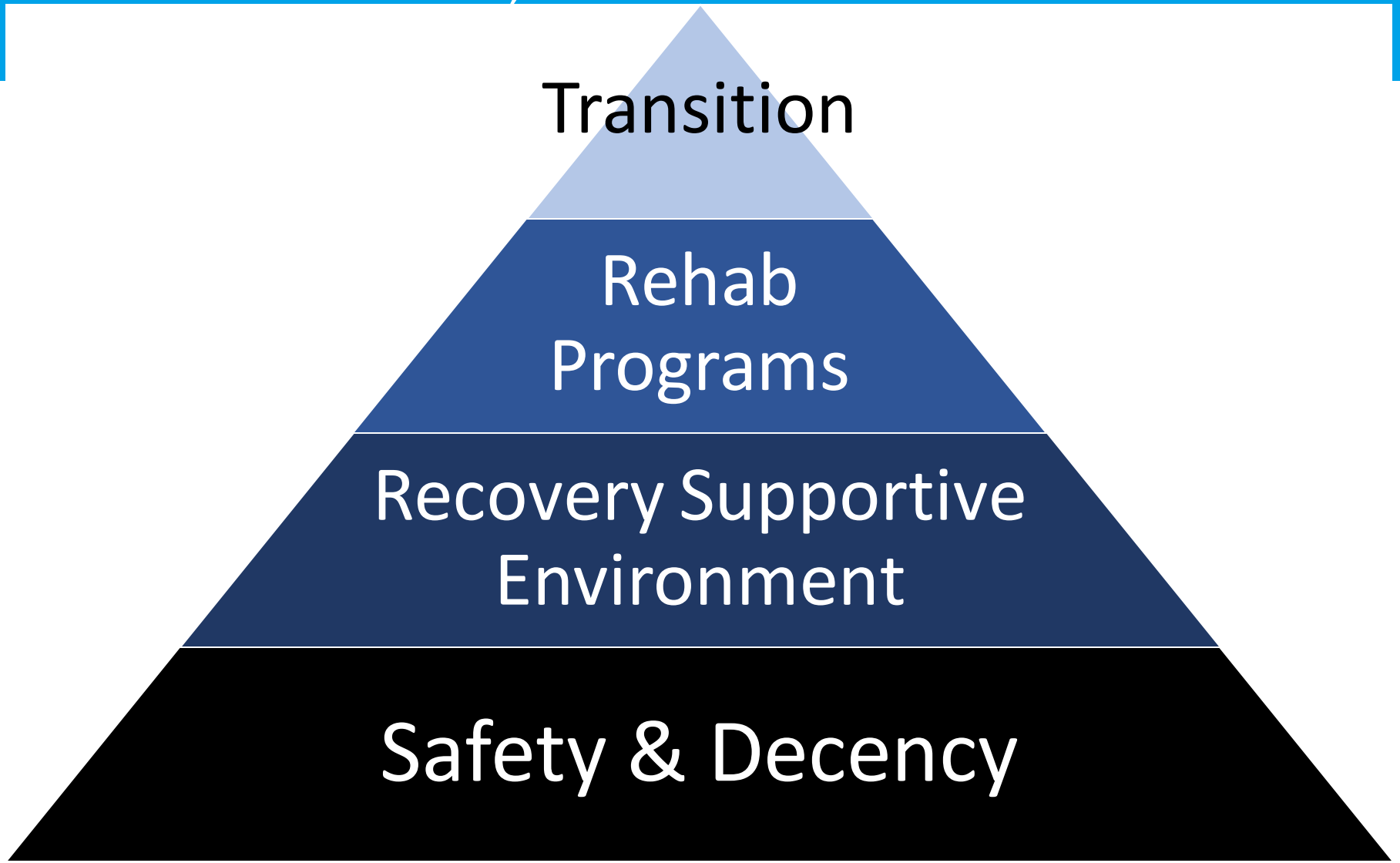
Challenges to recovery in a maximum secure forensic hospital setting

- Separation from families and social networks
- Stigma and labeling
- Exposure to anti-social others
- Lack of “real world” issues and structure
- Lack of autonomy
- Staff and patient safety concerns

(adapted from Mann, 2014)

Hierarchical Features of a Recovery-Based Forensic Hospital

Adapted from R. E. Mann et al., HMPS



Challenges to providing psychotherapy

- Lack of a sense of safety amongst staff – preferred old building
  - Many “high tech” safety systems did not work
  - Patient violence initially decreased but returned to baseline
  - Staff not comfortable to use new opportunities for patients (e.g., workshop, sports field, large gymnasium, swimming pool)
- Anxiety after patient eloped shortly after move
- No appropriate location(s) for psychotherapy

Patient Characteristics

- Onset of offending – first known offending vs first known contact with mental health services
  - 54.4% offended prior to contact with mental health services
  - 45.6% contact with mental health services prior to offending
- High rates of Adverse Childhood Experiences
  - 21.4% - 0 ACEs
  - 20.6% - 1 ACE
  - 16.0% - 2 ACEs
  - 7.6% - 3 ACEs
  - 34.4% - 4+ ACEs
  - High rates of physical (22.7%) and emotional (31.1%) neglect

Treatment/risk management based on Model

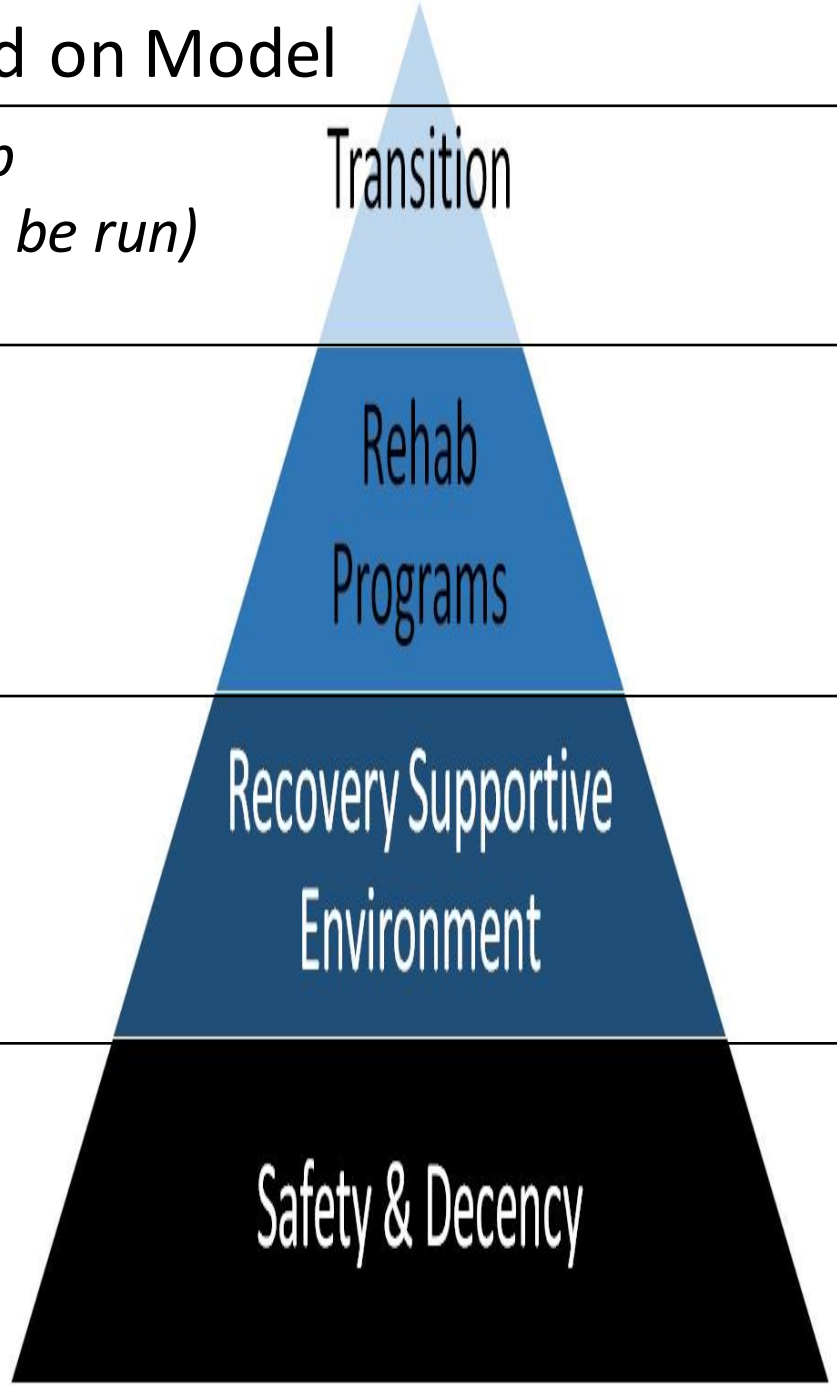
- *Transitioning to another facility group*

(groups in italics are running or ready to be run)

- Motivation Enhancement
- Emotional-Self-Regulation
- CBT for Psychosis
- Concurrent Disorders, Illness-related

- Five Minute Interventions
- Training staff in therapy process
- ACEs

- Area Access Level System
- Risk Assessment
- Elopement
- Water Intoxication



What is a Strengths-Based Approach?

- A way of working with clients/patients more positively
- It does not ignore problems and difficulties
- Identifies resources and strengths in the person that are used to address challenges
- The strengths of a person indicates how things might be and how to bring about change

What an Strengths-Based Approach is not

- Is not inconsistent with a CBT, RNR, or even an RP approach
- Does not require therapists to be soft on clients
- Does not take the responsibility for change away from the client
- Is no more costly to run than other approaches
- Is not a cure

Examples of strengths not usually recognized

"in regione caecorum rex est luscus" Desiderius Erasmus (1500)

- Adaptations to difficult circumstances
- Colluding with other group members
- Not offending at every opportunity
- Reluctantly attending a treatment group
- Attention seeking
- Falling in love with the therapist or other staff member
- Punching a wall
- Bragging/denying/manipulating/arguing

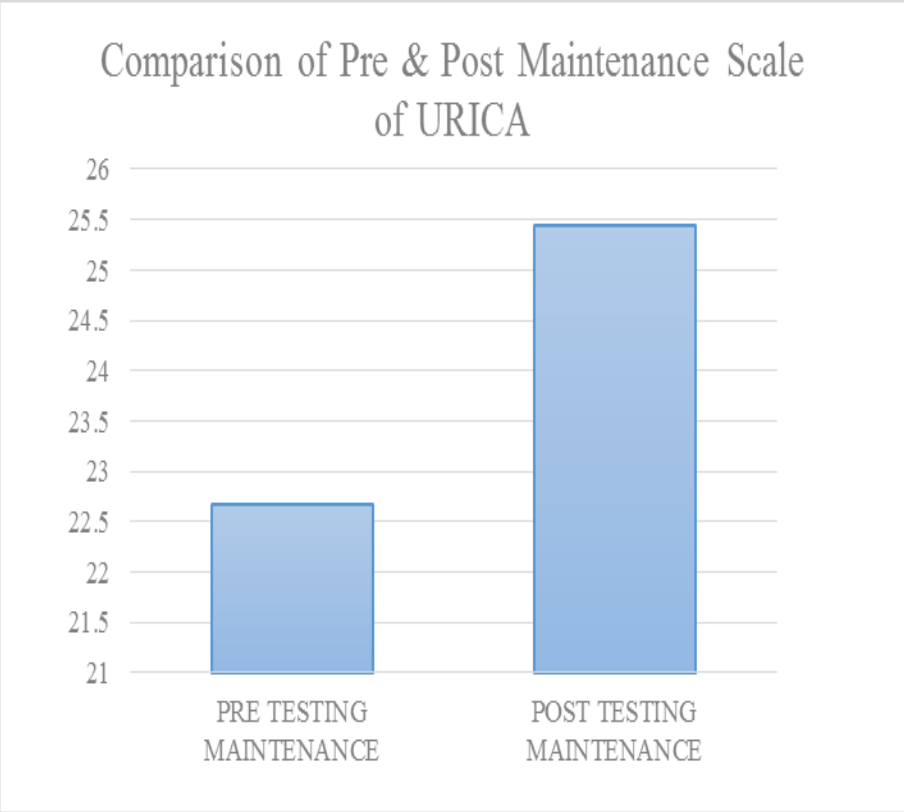
Some outcomes

From a forensic mental health hospital, a mental health prison, and a medium security prison

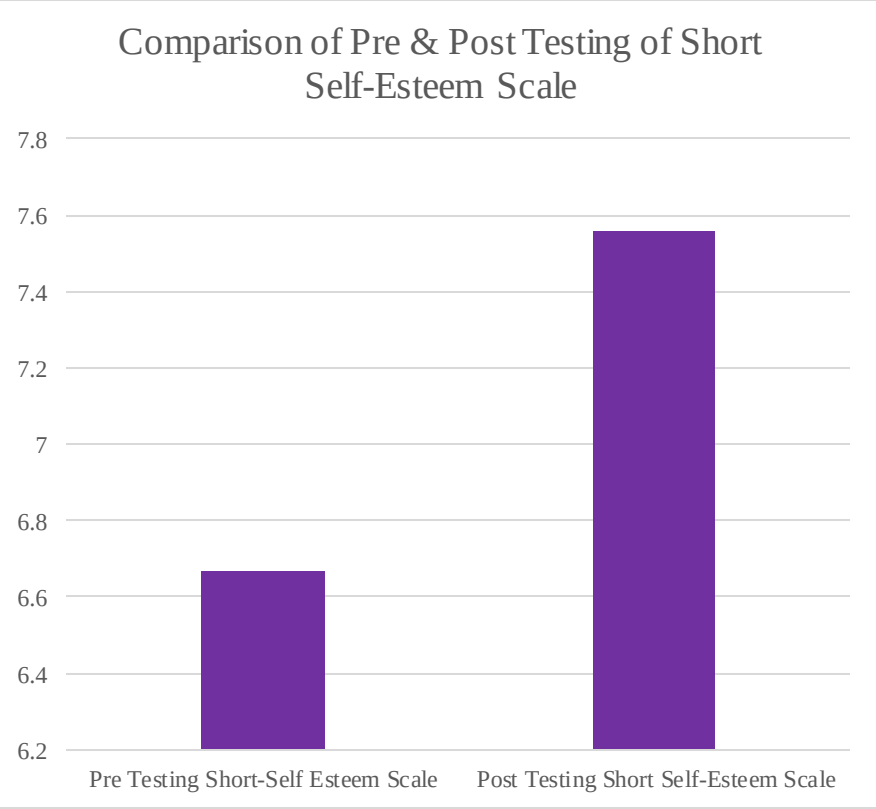
Motivation Enhancement Group

- Targets addressed include self-esteem, hope, shame, managing emotions, goal setting, coping
- Approach used is Strengths-Based and incorporates Motivational Interviewing, Good Lives Model, Positive Psychology, and Approach Goal theories
- Groups include 6-8 patients
- Are run by 2 therapists
- Sessions are 1-2 hours 2 times per week for 8 weeks

Outcome to date



Pre-treatment M = 22.67
Post-treatment M = 25.44
$p < .05$.



Pre-treatment M = 6.67
Post-treatment M = 7.56
$p < .005$.

Previous Anger Management Program

- 2x per week for 14 weeks (28 sessions)
- Psychoeducation, Prescribed Manual
- 8-12 participants

Rationale for changing program

- Facilitator and patient dissatisfaction with program
- High attrition rates
- No effects observed on units

Old Program Results: STAXI (N=34)

	Pre-Treatment		Post-Treatment			
STAXI-II	**M**	**SD**	**M**	**SD**	**t**	**p.**
State Anger	22.1	9.7	20.1	7.1	1.3	**.20**
Trait Anger	21.8	7.7	20.3	6.2	1.8	**.09**
Anger Expression – Out	18.1	5.1	17.5	4.2	0.8	**.46**
Anger Expression – In	19.5	5.3	17.8	3.7	1.9	**.06**
Anger Control – Out	21.7	6.2	20.4	5.4	1.4	**.18**
Anger Control – In	21.3	6.7	19.7	5.7	1.7	**.91**
Anger Index	42.5	17.1	43.2	14.0	-0.3	**.78**

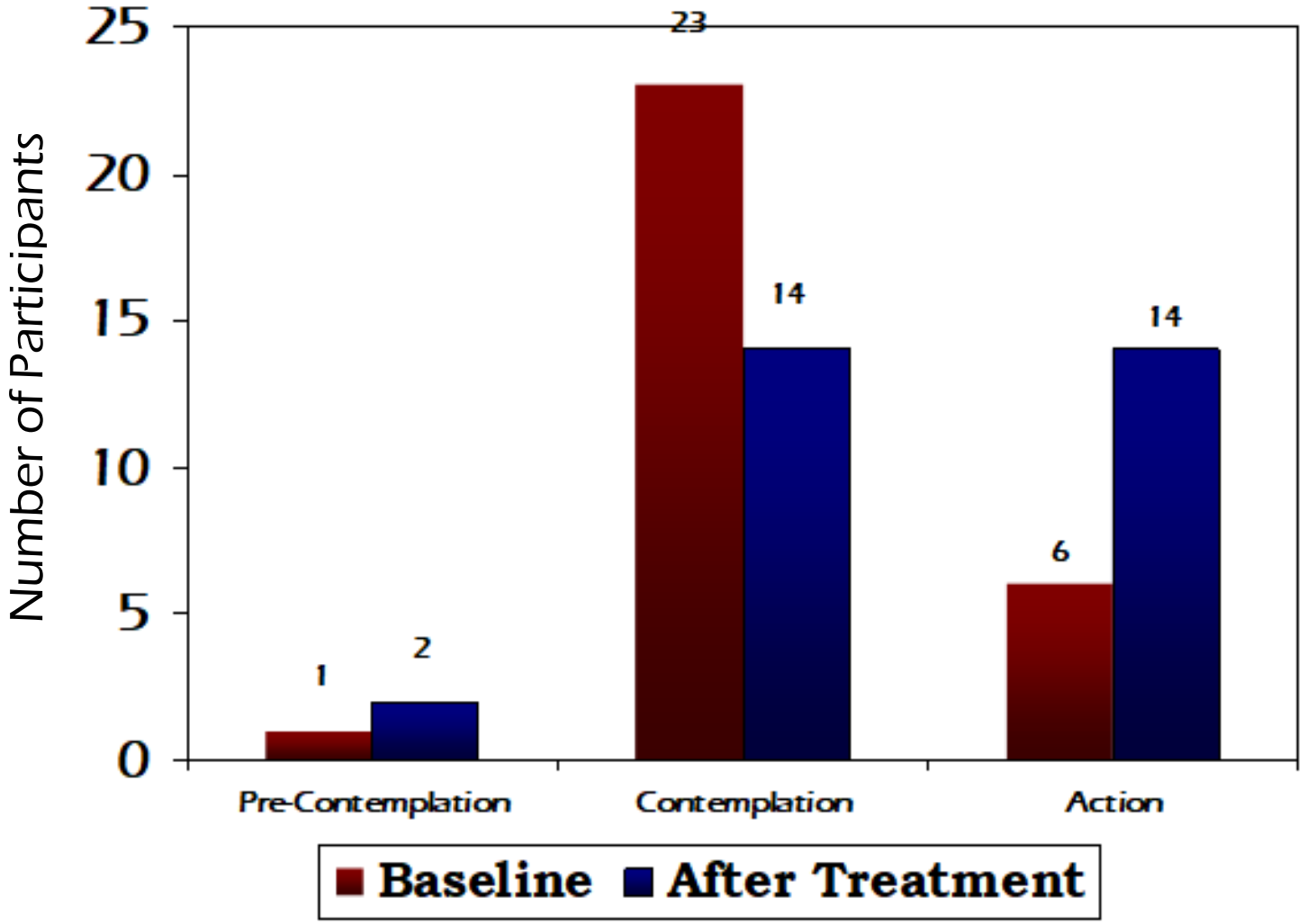
New Emotional Self-Regulation Group

- Strengths-Based
- Open-ended/Rolling format
- 1-2 facilitators
- 8-10 participants
- 2x week, 2hr sessions, ~12 weeks
- Therapeutic process-based
- Seven Primary Assignments

Pre-tx: old and new approach – no differences

	Old		NEW			
STAXI-II	**M**	**SD**	**M**	**SD**	**t-score**	**p.**
State Anger	22.1	9.7	22.4	9.9	-.22	.83
Trait Anger	21.8	7.7	23.5	7.6	-.83	.41
Anger Expression - Out	18.1	5.1	18.8	5.0	-.37	.71
Anger Expression - In	19.5	5.3	20.0	5.7	-.5	.62
Anger Control - Out	21.7	6.2	19.4	5.4	1.6	.12
Anger Control - In	**21.3**	**6.7**	**21.0**	**4.9**	**2.1**	**.04**
Anger Index	42.5	17.1	49.0	15.1	-1.6	.11

Results: Stage of Change (URICA)



*$p < .05$

STAXI RESULTS: NEW PROGRAM

	Pre-treatment		Post-Treatment		Sig	
STAXI-II	**M**	**SD**	**M**	**SD**	**t**	***p***
State Anger	21.3	8.3	17.6	4.6	2.7	**.013**
Trait Anger	23.5	7.5	19.9	7.7	3.0	**.005**
Anger Expression Out	19.2	5.4	16.8	5.2	2.9	**.007**
Anger Expression In	19.6	5.5	17.3	4.9	2.3	**.030**
Anger Control Out	19.2	5.8	22.2	5.3	-2.6	**.016**
Anger Control In	19.0	5.0	22.5	5.1	-3.1	**.004**
Anger Index	48.5	14.8	37.4	14.5	3.7	**.001**

New Program for Intimate Partner Violence

- Primarily Cognitive-behavioural
- Resident takes active role in identifying risks
- Adapts to resident's needs
- Non-confrontational
- Adheres to the Good Lives Model
- Focuses on Healthy Relationships

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New Program for Intimate Partner Violence

- Strengths-Based Approach
- Open-ended/Rolling format
- 2 facilitators – psychometrist & RN
- 8-10 participants
- 2x week, 2hr sessions, 12 weeks

Treatment Attrition

- 72 started group
- 66 (92%) satisfactorily completed the group
  - 37 (51%) fully completed treatment
- 6 (8%) dropped out or were removed
  - 2 better suited for an adapted for cognitive functioning program
  - 2 withdrew to focus on other groups
  - 2 removed from group due to lack of engagement or disruptive behaviour
- 17 (24%) discharged prior to completion

Therapist Post-Treatment Ratings

TRS-2 Scale	Mid Treatment	Post Treatment	t	Sig
Intellectual Understanding	21.62 (3.07)	27.44 (3.58)	7.11	< .001
Acceptance / Demonstration	18.19 (2.86)	23.44 (3.78)	5.33	< .001
Total Score	39.81 (5.59)	50.87 (7.15)	6.67	< .001

Clients' Perspectives

(Group Evaluation Form-Revised, Marshall, Serran, & Cameron, 2010)

Scale	Scale Alpha	Possible Range	Mean	SD	Range	%
Facilitator	.88	4-20	18.59	1.74	15-20	92.5%
Group	.87	6-30	27.59	3.25	19-30	91.9%
Total	.92	10-50	46.18	4.88	35-50	92.4%
Overall Facilitator	Na	1-5	4.77	0.53	3-5	95.4%
Overall Group	Na	1-5	4.62	0.80	2-5	92.4%
Would you recommend this group to others? = 97% said Yes.						

Participant Feedback

“I wish I could have learned the things I was taught at an early age (high school)”

“I learned a lot of new tacticks which I can use when I am released”

“I can’t really think of how it (the group) might be improved because for me they touched everything I wanted to know about and how to look at myself to change”

Olver et al., 2020 (Sexual Abuse)
8-year fixed follow-up

Treatment Program	Reoffence Rate	
Untreated (N=104)	20.2%	
Treatment As Usual (N=616)	10.7%	
Rockwood Program (N=381)	4.2%	
Odds Ratio: Rockwood vs.	Untreated	.17***
	TAU	.37***

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A Cost-Benefit Analysis of a Strengths-Based Program for those who have Offended Sexually

- Observed reoffence rate = 4.2% (N=16/381)
- Expected reoffence rate = 20.2% (N=77/381)
- **Reduction in number of reoffenders = 61**

Marshall & Marshall, 2021, Journal of Sexual Aggression

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A Cost-Benefit Analysis

- Cost of recidivism per offender = $200,000 ($400,000-2020*)
- Cost of SOTP per offender = $3,000

(*$1 in 1990 is about $2 in 2020 – var ests between $1.71 and $2.07)

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Cost savings to the Justice System

	Calculation	Total	Total (2020 $)
Savings	61 reoffenders prevented	$12,200,000	$24,400,000
Cost of SOTP	381 x $3,000	$1,143,000	
Total Savings	**= Savings–Cost of SOTP**	**$11,057,000**	**$23,257,000**

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