Occupational therapy assisting women residents in a community-based correctional facility: a program development plan

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Occupational Therapy Assisting Women Residents in a Community-Based Correctional Facility:

A Program Development Plan

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Note: This document describes a Capstone Dissemination project reflecting an individually planned experience conducted under faculty and site mentorship. The goal of the Capstone experience is to provide the occupational therapy doctoral student with a unique experience whereby he/she can demonstrate leadership and autonomous decision-making in preparation for enhanced future practice as an occupational therapist. As such, the Capstone Dissemination is not formal research.
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Executive Summary

Between 1980 and 2008, the U.S. population rose 33%, violent crime rose by 3%, property crime fell by 20% and the number of people in U.S. jails and prisons rose by more than 350%. In 2008, over 2.3 million Americans were incarcerated in the United States Correctional System costing local, state and federal governments about $75 billion (Schmitt, Warner & Gupta, 2010). A major reason for these striking statistics is that approximately 2/3 of released inmates return to prison within three years (Langan & Levine, 2002). Over half of U.S. prisoners have been diagnosed or treated for mental illness in the past (James & Glaze, 2006) and about 80% have had drug or alcohol related issues (Nink & MacDonald, 2009). Women inmates have a higher likelihood than men to suffer from mental illness, have a history of physical or sexual abuse, lack employment or job skills, and have additional special needs such as added family responsibility (Covington, 2000; James & Glaze, 2006; Stafford, 1999).

The goal of the C.O.C.O.O.N. (Changing Ourselves by Celebrating Our Occupational Nature) Project of Toledo, Ohio’s Correctional Treatment Facility (CTF) is to promote the motivation, habits, and skills necessary for women residents to engage in rich and fulfilling occupational lives. This goal will be accomplished through the creation of occupational therapist-led groups and individual sessions in which women will be encouraged to practice and explore the roles and occupations they consider interesting or valuable. The occupational therapist will also help residents learn about and accept their personal strengths and areas for improvement that will enable or challenge their success. Objectives will address resident behavior, communication and interaction skills, volition, habituation, and performance capacity,
discovery of meaningful and enjoyable new leisure pursuits, and avoidance of future criminal charges. Approximately 97 residents will participate during the first year of the program. Program evaluation will involve analysis of data from interviews with program participants, standardized assessments from the Model of Human Occupation (MOHO) (Kielhofner, 2002), the occupational therapist’s records, CTF records, and Northwest Ohio Regional Information System.
Introduction

Program Goal

The goal of the C.O.C.O.O.N. (Changing Ourselves by Celebrating Our Occupational Nature) Project of Toledo Ohio’s Correctional Treatment Facility is to promote the motivation, habits, and skills necessary for women residents to engage in rich and fulfilling occupational lives. Motivation encompasses residents’ openness to try new occupations, self efficacy beliefs, attitude toward challenging occupations, ability to identify enjoyable occupations, and willingness to participate in treatment. Habits that will be promoted involve consistently organizing aspects of life into effective occupational patterns, as well as timing, planning, and pacing occupations appropriately. Skills refer to the intrapersonal, interpersonal, emotional, cognitive, and physical abilities residents will work to improve in order to be more successful in the roles and occupations they identify as important. These may include accurate insight into the underlying causes of one’s habits or behavior, clear communication, relaxation skills, the ability to remember and follow directions, and physical endurance as examples of each skill area.

Sponsoring Agency

The C.O.C.O.O.N. Project will take place within the Female Unit of the Correctional Treatment Facility (CTF) in Toledo, Ohio. CTF is a community-based correctional facility operated by the Ohio Department of Rehabilitation and Corrections. Residents are sentenced to spend a maximum of 6 months progressing through both inpatient and outpatient programming. Residents perform chores and attend classes and groups such as Meditation, Adult Basic Education, “Thinking for a Change,” Anger Management, Recreation, Chemical Dependency
Education, Relationship Skills, and Self Efficacy, from 7:00 AM until 7:30 PM, Monday through Friday and on Saturday mornings. The Mission Statement of CTF is: “Maintaining a safe and secure environment while providing an opportunity for change.” They go on to state:

We at the Correctional Treatment Facility, work to serve the community by providing clients with the tools, knowledge and values that will help them become more productive members of society. Our program empowers clients through an abstinence based and holistic approach by providing strategies that instill hope, knowledge, self-worth and the opportunity to change” (Correctional Treatment Facility, p.3).

Embedded within the mission of CTF are the core principles of occupational therapy that will be used to develop the C.O.C.O.O.N. Project. Allowing women at CTF to actively apply the tools, knowledge, and values they are learning in other CTF programs through occupation will be an empowering experience; including occupational therapy will make the program more holistic; and allowing for participation in new occupations will instill hope, knowledge and self-worth while providing an opportunity to demonstrate, to themselves and others, the changes CTF residents are making.

**Organizational Structure**

The organizational structure of CTF was summarized in a chart that was created based on a “Table of Organization” approved by CTF administration in July of 2011 and provided to the grant writer by Unit Manager Jeff Keith (See Appendix A). CTF is part of the Ohio Department of Rehabilitation and Correction (ODRC). An organizational chart was taken from the ODRC website (2011) and relevant areas were summarized (See Appendix B).
The occupational therapist that will plan and carry-out the program will be employed under the Recovery Services Bureau of the ODRC, headed by Ron Woods, who reports to ODRC Assistant Director Linda Janes, who is serving under Director Ernie L. Moore. The director of the ODRC reports to the governor of the state of Ohio, who is ultimately responsible for the operation of the ODRC. Within CTF, the therapist will report to the shift supervisor on duty as well as the unit manager, Jeff Keith, and will coordinate services with the case managers, chemical dependency counselors, and mental health counselor who also report to the shift supervisor. By working in conjunction with these professionals under the same managers, the occupational therapist will be in an optimal position to contribute to treatment planning and goal writing for residents and align occupational therapy services to address resident goals in a way that is complimentary to the other rehabilitation programs offered at CTF. The occupational therapist would be in especially close contact with Dawn Leiss and Colleen Hartford, the case managers working exclusively in the Female Unit. Open communication will also be expected between the occupational therapist and Sandra Cox, the chemical dependency counselor specializing in trauma recovery and relationship skill building whose office is connected to the women’s unit.

**Investigating the Need for Programming**

A comprehensive needs assessment was conducted to plan occupational therapy services for the women at CTF (see Appendices C and D for a more detailed report of the survey portions of the assessment and complete key informant interviews). The assessment began with a survey of the target population. Determining needs as expressed directly by the target population is
suggested as a priority by Fazio (2008). A survey was chosen because it can address many respondents at one time and will be fairly easy to administer to the entire population of women residents at CTF (usually about 20-25 women). Witkin and Altschuld (1995) point out that surveys are relatively easy to manage with little opportunity for sidetracking and irrelevant information. They add that surveys can be completed anonymously and do not necessarily require the presence of the needs assessor. All of these are important considerations with this population because, based on observations and communication with stakeholders, the women at CTF can be overly ingratiating, and it is often difficult to keep their discussions on-track. An advantage with this highly specific population is that their intelligence was noted by Hartford as a relative strength and based on observations, most, if not all, current residents can read and write with English being their primary language. The items addressed demographic issues identified as problematic (such as employment and childcare), skill areas in which deficits have been noted, current programming, potential programming, and willingness to work with an occupational therapist.

A total of 20 residents completed the survey in May of 2011 (see Appendix C). The results indicated that the women plan to be more active in various demanding occupations (such as “employment,” “further education,” “volunteer work,” and “Mandatory community service”) than they were previously. Residents generally gave themselves positive assessments in the areas their case managers identified as problematic. For example, on a scale from 0-5, with 4 being “good” and 5 being “excellent” residents’ average scores for themselves were 4.075 for “How well do you get along with others most of the time?” and 4.474 for “Describe your ability to
have fun or relax without using or doing anything illegal.” They were also very confident in their ability to maintain sobriety. When asked “On a scale from 0-10 how likely are you to stay sober after leaving CTF? (0 = impossible, 10 = confident):” 13 of the 20 residents answered 10. Unfortunately, these responses do not coincide well with (a) the recidivism of several recently released residents (b) observed work and behavior of residents within CTF, and (c) staff and case manager's verbal accounts as well as written behavior reports. This may reflect a deficit of insight, which has also been identified by staff as an area of need, it may be an accurate reflection of their abilities when clean, sober, and in a more calm environment, or it may be a defensive response to questions perceived as intrusive, patronizing, or insulting.

In their evaluation of current CTF programs, the residents favored Thinking for a Change, Chemical Dependency, and Epictetus Club. However, there was a great deal of variation and residents generally responded positively to all of the programs they attend. Programs such as Trauma Empowerment and Recovery, which are not attended by all residents, were seen as very valuable by many of the residents who presumably do attend. In response to the question “What would you like to learn more about?” followed by several occupational therapy-related programming possibilities, residents responded most positively to “How to plan life after CTF,” “My goals, strengths, and areas for improvement,” and “How to improve my thinking and learning abilities,” although again there was a lack of consensus among the responses to this item. In an open question, residents were asked to identify what is most important in their lives. Some residents gave multiple answers with 50% identifying their children or mothering role, 35% identifying sobriety or recovery, and 15% identifying other family as their main priority in
life. Most residents (80%) were willing to work with an occupational therapist and 75% preferred working on an individual basis. The wide range of responses to items regarding program preferences and areas of interest also suggested that individual work might be more beneficial for this diverse group. Furthermore, the residents were relatively uninterested in learning to work together with others. This may reflect the fact that most CTF programming is done in a group format and the women live together in tight quarters with few opportunities to avoid one another. On the other hand, the ability to work cooperatively in a group format is important, despite residents’ reluctance, and may help resident’s achieve their self-identified goals. Therefore, it may be beneficial to offer some combination of group and individual treatment.

The second respondent group to be solicited for this needs assessment included general staff members at CTF. Due to a lack of interest among staff for participating in a focus group, a brief, anonymous survey was placed in the staff lounge along with an envelope to place completed surveys in, a brief explanation of occupational therapy shared in Appendix E, and a bag of candy for respondents to choose from as an incentive for completing the survey. A total of 10 staff members completed and returned the survey in May of 2011 (See Appendix C).

Staff were first asked to rank 11 different resident issues identified through literature review, observation, and discussion with women’s unit case managers. They chose “impulsivity,” “poor ability to cope with stress,” and “inattention/inability to focus” as most troublesome, but scores were wide ranging for each issue. Notably, those identified as most troublesome correspond with symptoms of AD/HD (Waite, 2010). The potential interventions also received
conflicting responses with at least a few staff members considering almost all the interventions to be redundant with current programming, unfeasible, or unhelpful, while each potential intervention also received at least 1 response indicating a staff member would like to see the intervention offered at CTF. The only intervention receiving unanimous approval as having some potential benefit for some residents was helping them explore healthy recreation opportunities. The potential intervention receiving the highest ratings as something staff members would like to see offered was teaching residents organization strategies including time and money management. Only one response indicated that any of the potential interventions might be harmful and this was helping residents engage in community service projects. However, most staff responded positively to this intervention idea, likely making the assumption that appropriate precautions would be taken to ensure safety of the residents and the community. Most staff indicated little interest in using art or craft projects to help residents practice social and cognitive skills. It may be that this intervention would be less meaningful on men’s units where arts and crafts are not a part of their culturally accepted occupational repertoire. Most respondents in this survey believe they have at least some understanding of what occupational therapy is and 9 of the 10 respondents were not opposed to including an occupational therapist on staff at CTF (when asked “Would you be open to including an occupational therapist on staff at CTF” 1 staff member circled “no,” 5 circled “maybe” and 4 circled “yes”). The lack of openness to including an occupational therapist on staff at CTF may have been due to budgetary considerations which have been an issue at the facility as of late with one expected lay-off to occur within the next year.
Key informant interviews were the third method for continuing the needs assessment. Lysack, Luborsky, and Dillaway (2006) state that key informant interviews are especially helpful for illuminating the history and policies of groups and organizations and can provide “more intense in-depth follow-up” than interviews with ordinary informants (p.348). Forsyth and Kviz (2006) add that face-to-face interviews allow the interviewer to establish credibility.

Understanding the history and culture of CTF will be necessary in order for an occupational therapy program to operate successfully within this context. Additionally, establishing credibility with notable figures in the field will be beneficial for supporting this program. Fazio (2008), suggests that at this stage in the needs assessment, interviews should be more structured than the initial conversations and Lysack, Luborsky, and Dillaway warn interviewers to be well prepared when interviewing key informants, who may be less patient with newcomers to their area of expertise. In following with this advice, a structured interview format was prepared for respondents who agree to participate in an interview. The questions reflected the particular respondent’s background, agency, or organization, as well as their understanding of the potential contributions an occupational therapist could bring to CTF. Key informants interviewed included Colleen Hartford, BIS and Dawn Leiss, MSW, the case managers for the Women’s Unit at CTF, Sandra Cox, LSW, LCDC, the mental health counselor at CTF, Danielle Kidd, a corrections officer who works on the Women’s Unit at CTF, Sari Adelson, the coordinator of membership and special projects for the Prison Creative Arts Project, Dianne Shuford, MS, OTR/L, an occupational therapist working at Summit Behavioral Healthcare, and Harry Cummins, the founder of Toledo’s International Boxing Club and respected mentor to at risk youth in the
Toledo community. For complete paraphrased transcripts of these interviews see Appendix D.

The CTF employees were asked similar questions in separate and private interviews. They were not aware of the content of the others’ responses. There was general agreement that the women residents at CTF are resilient “survivors.” Areas identified as problematic for the residents included building healthy relationships, being honest, issues related to past abuse, and “thinking errors”/irrational thoughts. Related to the issue of abuse, the staff agreed that personality disorders are common in the women they work with; estimates ranged from “25-40%” to “all of them.” They also agreed that the main strength of CTF programming is that it is “holistic” covering a range of different topics in different ways and appropriate for a wide variety of people. Shortfalls of the current programming involved not having enough time to work with the residents inpatient and in aftercare, and not having enough stable housing options available for residents after they leave. As Ms. Hartford added “They need to work on the ability to schedule so they don’t get overwhelmed by trying to swallow the whole elephant all at once instead of taking small bites.” What residents surround themselves with after leaving CTF was identified by the staff that was interviewed as crucial to the success of their recovery. Whether they continue to seek out support and structure their environment in a positive way or return to the people, places, and habits of their drug using life, according to Hartford, Leiss, Cox, and Kidd, seems to make the difference, between success and relapse. The most notable discrepancies among the answers given by these four interviewees came when they were asked to envision the potential role of an occupational therapist at CTF. Kidd thought that an occupational therapist could work part-time to help residents obtain and prepare for employment.
She was the only staff member opposed to the idea of a full-time occupational therapist. Her understanding of occupational therapy may have been limited by the “occupation” part of the profession’s titled because when asked to describe her understanding of occupational therapy she stated that it focused on “Skills and preparation to handle a job.” Cox was especially concerned with the role of the environment in recovery and expressed a desire for an occupational therapist to work with residents on structuring their home environment. She also believed that an occupational therapist who was simply open to listening to residents would be helpful stating “They always need people to just listen to them.” Leiss saw the potential for an occupational therapist to address physical rehabilitation for residents with issues related to the physiological consequences of drug abuse and accidents. She also recognized the potential value of an occupational therapist’s perspective for residents struggling with AD/HD issues. Hartford, who has worked most closely with the developer of this program, advocated for occupational therapy as a means of introducing new ideas and forms of expression to residents, stating “An OT adds to the holistic nature of the program and gives residents opportunities to explore areas within themselves and teaches them to work well with others.”

In addition to gathering input directly from staff, residents, and other informants, the creator of this program spent approximately 16 hours per week over the course of 16 weeks working as an intern at CTF. This time was spent primarily in the Women’s Unit where she observed, participated in, and led programs for the women residents. She also observed and completed standard CTF intake interviews and assessments as well as assessments from the Model of Human Occupation with residents, reviewed court files, CTF disciplinary and
observational reports, and other documents, and observed the creation and execution of residents’ individualized treatment plans. This provided her with further knowledge of both the diversity of this population as well as some of the more common issues and stories that characterize CTF’s women residents.

In structuring this program, needs identified based on the data collected throughout the above needs-assessment process was considered along with the literature review that follows. Needs that would be better addressed by another professional currently working at CTF or within the criminal justice system, such as mental health counselors, chemical dependency counselors, case managers, parole officers, or social workers will be deferred to those specialists. Needs that can and should be addressed by an occupational therapist will be prioritized based on the expressed values and interests of the program participants during each programming cycle. The occupational therapist operating the program will also exercise discretion regarding what is practical and pertinent for each group and individual session considering the general needs identified in the above assessment, the specific needs of current participants, the strengths and comfort level of the therapist, and evidence-based wisdom from the literature, including principles of the Model of Human Occupation.

**Literature Review**

The Bureau of Justice Statistics’ latest census report (Stephan, 2008) states that the number of Prisoners held in State and Federal correctional facilities rose by 10% from 2000 to 2005, at which time there were over 1.4 million people in custody. Over 44,000 of these individuals were incarcerated in the state of Ohio, which holds about 390 inmates per 100,000 residents. In
comparison, the American Cancer Society reports that the incidence of cancer deaths in 2006 was 180.7 per 100,000.

Nink and MacDonald (2009) elaborate on the crisis facing the United States prison system, the effects of which ripple throughout the government and society. As the number of inmates rises, so does the corrections budget, with states alone spending approximately $49 billion in 2008. Nink and MacDonald point out that this puts a tremendous strain on state government budgets, which saw an increase in corrections spending of 127% during a time-span in which funding for higher education increased by only 21%. A summary of Ohio’s state debt and estimated new issuance amounts (Ohio Office of Budget and Management, 2009) indicates that Ohio owes over $678 million in debt related to adult corrections, which is among the state’s most expensive “Special Obligations,” overshadowing areas such as administrative services and parks and recreations.

Many researchers argue that spending less on corrections, without compromising public safety, can be achieved if more money is invested in programming aimed at reducing recidivism. Nink and MacDonald (2009) point out that although prison population is on the rise, property and violent crime rates are actually falling. This discrepancy can be explained by an increase in parole violations, which accounted for 35.7% of state prison admissions in 2007. In their most recent large-scale investigation of recidivism, The Bureau of Justice Statistics (Langan & Levin, 2002) tracked the majority of prisoners released in 1994 and found that over 2/3 of the 272,111 individuals studied committed at least 1 new offense during the following 3 years, and over half returned to prison. The study also found that these 272,111 individuals were arrested an average
of 18 times during their criminal careers. However, this level of recidivism need not be accepted as an inevitability in our society. In a review of systematic reviews, Lipsey and Cullen (2007) determined that rehabilitation treatment had a “consistently positive and relatively large” effect on recidivism in comparison with approaches focused exclusively on supervision and sanctions. Nink and MacDonald assert that, “With effective correctional programs in place, recidivism can be reduced by 26%-40%” (p.1). As an example, in an overview report of an evaluation of the Allegheny County Jail Collaborative (Yamatani, 2008), which included the work of occupational therapists, it was stated that the recidivism rate among participants in the collaborative was only 16.5% while that of a matched comparison group was 33.1%. Upon analyzing the average cost of services provided to inmates in this program compared with the average cost of incarceration ($43,662), it was estimated that each dollar invested in this program has yielded $6.00 in cost savings. Similarly, in a report by the “Little Hoover” Commission on the California State Government (Marks, 2003) found that each dollar spent on drug and alcohol treatment can return up to $7.00 in incarceration cost savings.

Drug and alcohol treatment is a major area of focus at CTF, which specializes in the rehabilitation of criminal offenders with substance abuse problems. This focus is well-warranted by reports indicating that 80% of incarcerated adults have had drug or alcohol related issues, and about 50% meet DSM-IV criteria for drug dependence or abuse (Nink & MacDonald, 2009). Bujisse, Caan, and Davis point out that occupational therapy is an underused resource in the treatment of addictive behaviors and they described the work of two occupational therapists at the Cambridge Drug and Alcohol Service where they addressed daily living skills as well as
interpersonal and intrapersonal functioning with an emphasis on the use of occupation to foster independence in the community. Kwitny (1998) and Wand (1998) have also described the value of occupational therapy in the treatment of substance abuse, identifying the role of the occupational therapist as encouraging a proactive versus reactive lifestyle, and helping clients understand how drug use affects their lives and ability to achieve self-identified goals, as well as addressing skill deficits such as ineffective social and/or coping skills that may contribute to substance abuse or prevent engagement in a healthier lifestyle.

Many inmates at CTF and in the prison population in general have co-occurring mental health disorders in addition to substance use disorders. According to the Bureau of Justice Statistics (James & Glaze, 2006), over half of all state prisoners and 64% of jail inmates have either been diagnosed and/or treated for a mental illness, or have experienced symptoms within the past 12 months (compared with a rate of approximately 11% in the general population). These individuals are more likely to be charged with violating facility rules or become injured in fights; they exhibit higher rates of substance abuse and dependence; and they are more likely to be recidivists, with 25% having been incarcerated 3 or more times in the past. Also more common among inmates with mental health problems is a history of homelessness, foster care, physical and sexual abuse, and family drug use and incarceration. According to CTF case managers interviewed as part of the needs assessment (Hartford, 2011; Leiss, 2011), the population at CTF is consistent with this report. They state that as many as 80-90% of residents are being treated for a mental health disorder aside from substance abuse and dependence at any given time.
Education is another obstacle facing many inmates. Nink and MacDonald (2009) report that more than half of U.S. inmates have less than an 8th-grade education and cannot read nor write. They assert that educational training is a potent means of combating recidivism, as evidenced by studies in which prisoners enrolled in college courses where significantly less likely to re-offend. In accordance with Nink and MacDonald’s suggestions, GED courses and testing are already available at CTF, and observations and discussions with staff indicate that most women residents there are relatively intelligent and literate. The goal of the C.O.C.O.O.N. project will be to build on these basic skills and the mental health and substance abuse treatment currently offered with opportunities to practice what is being learned in different contexts and consider how they will reorganize their lives around the changes they must make to maintain their recovery.

The C.O.C.O.O.N. Project will specifically target the women at CTF. Women in correctional facilities have unique needs. According to the Bureau of Justice Statistics (James & Glaze, 2006), women offenders are more likely than their male counterparts to experience mental health disorders. Additionally, an investigation of women in secure hospitals in the U.K. (Stafford, 1999) found that compared to men in secure settings: women have less employment experience; a lower age at admission; and less severe criminal charges filed against them. They are more likely to have been sexually abused, and have a greater tendency to abuse alcohol. They are more likely to have parental responsibilities (and certainly more likely to be pregnant). Children or being a mother was identified by 50% of CTF residents surveyed as the most important aspect of their lives. Covington (2000) points out that many women who are
incarcerated experience tremendous guilt and anxiety regarding their absence from their children and ability to retain custody and this is consistent with the concerns women at CTF frequently voice. Additionally, many incarcerated women have a history of trauma compounding the mental health and substance abuse issues previously discussed, and women in secure environments are more likely than men to meet diagnostic criteria for personality disorders. Covington (2000) reports that almost 80% of women prisoners in the U.S. have suffered some form of abuse. Interviews with CTF staff echo the staggering statistics in the literature regarding abuse and related issues including personality disorders among women offenders.

When discussing the mental health and other needs and obstacles facing prisoners, personality disorders are the elephant in the room, which must be addressed. Personality disorders are defined by the American Psychiatric Association (APA) (2000) as:

> An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to stress or impairment (p. 685).

Eleven various personality disorders have been classified by the APA. The personality disorders diagnosed most frequently in a study of female inmates (Warren et al, 2002) were antisocial personality disorder (43%), paranoid personality disorder (27%), and borderline personality disorder (24%); however, the authors negated the prevalence of paranoid personality disorder based on problems of definition (it co-varied with all other personality disorders) and over-diagnosis due to the adaptive quality of these traits within correctional environments. Both
borderline and antisocial personality disorders are “Cluster B” disorders. Individuals with these disorders are described by Morrison (2006) as, “Dramatic, emotional, and attention-seeking; their moods are labile and often shallow. They often have intense interpersonal conflicts” (p. 459). Antisocial personality disorder is characterized by irresponsible, reckless, impulsive, and often criminal behavior, usually not followed by remorse. Individuals with borderline personality disorder are also impulsive and have difficulty with interpersonal relationships. They tend to show intense, inappropriate anger or other unstable emotions. They tend to feel “empty or bored,” fear abandonment, and do not have a sound understanding of their identity. These descriptions are highly congruent with my observations of residents and discussions with personnel at CTF, and this may be the area in which an occupational therapy program could have the greatest impact. Couldrick (2004) proposes, “The core skills of occupational therapy are valuable in the management and treatment of people diagnosed with a personality disorder within both health and prison services” (p.207).

Couldrick (2004) goes on to state that:

Activity can provide a framework to assess functional skills, social skills and intrapersonal understanding. It can be used to increase self-exploration and awareness. It can be structured to reinforce or develop patterns of behavior and provide feedback. It can help individuals identify the need to change, and it can support rehearsal and practice in changing. Furthermore, establishing an appropriate balance of occupation can maintain individuals after release or discharge (p.207).

This is why the presence of an occupational therapy program would greatly benefit residents at
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CTF and the society they will be re-entering. Although the residents at CTF engage in a number of educational and psychosocial programs, the current repertoire lacks the essential element of “activity” or occupation. Salz (1983) also elaborated on the theoretical utility of occupational therapy in addressing the deficits displayed by individuals with borderline personality disorder, particularly their inability to engage in play or exploratory behavior, their lack of values and interests, their inability to modulate sensory stimulation, and their tendency toward alternating between grandiose fantasies and harsh self-criticism. Goodman (1983) and Hirons, Rose, and Burke (2010) documented successful group occupational therapy interventions for this population, while Lima (2008) carried out a very successful case study in which a single individual with borderline personality disorder received intensive treatment with an occupational therapist over the course of a year.

Other issues related to trauma, as well as substance abuse, have been identified in the literature as well as observation and needs assessment at CTF including difficulty with cognition, chronic pain, and low self-esteem. In Kendall-Tackett’s *Handbook of women, stress, and trauma* a mountain of evidence was presented linking early life trauma with irritability, impulsivity, AD/HD, and poor reactions to stress later in life; linking child abuse to deficits in attention, abstraction, memory, reasoning, and executive performance; linking sexual and intimate partner violence with chronic pain disorders, insomnia, and social dysfunction; and linking rape with risky behavior, self-mutilation, and eating disorders among other issues. AD/HD and its symptoms of impulsivity, inattention, and/or hyperactivity are linked to both a history of trauma as well as substance abuse and have been identified as problematic for CTF residents. According
to Waite (2010), AD/HD affects approximately 9 million American adults. Although the main primary cause of AD/HD is genetic, Waite points out that secondary causes of the disorder include intoxication and head trauma, but even primary AD/HD shares a relationship with post-traumatic stress disorder and alcohol and drug use disorders, as well as depression, stress, anxiety, chronic pain, chronic fatigue syndrome, fibromyalgia, decreased self-esteem, eating and sleep disorders, especially in women not diagnosed until adulthood. Furthermore, individuals with AD/HD are more likely to divorce and/or become single parents, while they are less able to consistently manage jobs, households or parental responsibilities. Harris (2004) adds that 20% of adults with substance use disorders have AD/HD while 50% of people with AD/HD have a substance use disorder, and individuals with AD/HD tend to be less health-conscious and more likely to engage in risky sexual practices. Harris points out that education has been shown to be the most effective form of intervention for people with AD/HD although cognitive behavioral therapy, social skills training, and life skills training are also useful. Gutman and Szczepanski (2005) advocate for the role of occupational therapists in addressing AD/HD, suggesting such interventions as assisting individuals to monitor and regulate their sensory stimulation, organize their physical environment, optimize their time management, increase their social awareness, and improve their ability to management stress.

The principles of occupational therapy, since the dawn of the profession, have been consistent with the principles of correctional rehabilitation. In 1778, Benjamin Rush and others organized a movement to reform the penal code of 1718, moving society away from harsh sentences of physical punishment or death in favor of public labor (Schoenher, 2009). In 1931,
Rush’s nephew, William Rush Dunton Jr., described outbreaks occurring in federal prisons after the discontinuation of occupations in an article advocating for the profession of occupational therapy (Dunton, 1931). In 1974 The *American Journal of Occupational Therapy (AJOT)*, published an article about the role of an occupational therapist working in Virginia’s juvenile correctional system. This occupational therapist was charged with addressing sensory integrative and visual-motor deficits, which were common amongst the youth housed in facilities within the correctional system, but was also involved with a vocational day care training program for teenaged women as well as developing a range of recreation and crafts programs to suit the various ability levels of the young people and orienting other staff members to occupational therapy principles. In 1977 *AJOT* published the story of two Level I Fieldwork Students from Eastern Michigan University who set out with a faculty member to see how occupational therapists can function in a non-medical setting (Platt, Martell & Clements, 1977). At a Federal Correctional Institution they worked with a group of six men convicted of crimes such as car theft, armed robbery, and dealing in narcotics, who had resisted participation in other prison groups. These men expressed interest in preparing job applications and improving their job interview skills so this was the group’s initial focus. Later they moved on to other aspects of readjusting to life in the community including money management, proper use of credit cards, locating appropriate housing, purchasing food and clothing, and working out a realistic budget. Although the attendance of original group members dropped from six to two, the students and faculty member were assigned fifteen additional inmates preparing for release. No formal evaluations of the program were conducted but those leading the group noticed a more positive
view of the community and increased openness among the participants to share their inner thoughts, frustrations, needs, and ambitions as the program progressed. In 1978, *AJOT* published an overview on correctional institutions that pointed out the similarities and differences in programming between prisons and psychiatric institutions and advocated for the availability of voluntary occupational therapy service programs within prisons (Penner, 1978). Since that time, “forensic occupational therapy” has taken off in countries such as the United Kingdom, which hosted its tenth National Forensic Occupational Therapy Conference in December 2009 (National Forensic Occupational Therapy Conference, 2009) and recently a National Forensic Occupational Therapy Study Day in March 2011 (College of Occupational Therapists Mental Health Specialist Section, 2011). The United Kingdom is also home to the authors and editors of the book *Forensic Occupational Therapy* (Couldrick & Aldred, 2003).

Unfortunately, as Eggers, Munoz, Sciulli, and Crist (2006) point out, when compared with other English-speaking nations, “U.S. practitioners have been slow to develop occupational therapy programming in correctional settings” (p.17). Their program, “The Community Reintegration Project,” has contributed to the success of the aforementioned Allegheny County Jail Project. Through this project, Duquesne University’s Occupational Therapy Program provided group and individual sessions with inmates, addressing vocational and community living skills, as well as functional assessments, goal setting, and community follow-up. Of the 52 offenders enrolled in the first 11 months of the program and released, only 1 has returned to jail, in stark contrast to the 60% overall recidivism rate estimated by the Allegheny County Jail Warden (Eggers et al, 2006).
Tayar (2004) described a substance abuse relapse prevention program in a U.S. women’s prison that represented a collaborative effort between occupational therapy and psychology students. Groups of about 10 women incarcerated for drug-related offenses attended seven weekly sessions, the first three led by a psychology student, the fourth led by both students, and the final three led by an occupational therapy student. After the psychology student educated the group about the psychology and physiology of cravings, coping techniques and communication styles, the occupational therapy student was incorporated in during a lesson in which the students and women role-played various communication styles. While the occupational therapy student led the group, discussions focused on basic concepts from the Model of Human Occupation, the importance of healthy leisure, identifying triggers associated with drug use, determining values and how they influence one’s lifestyle, exploring vocational interests, and mastering life skills such as financial management. Occupations in which women were asked to plan a typical day, complete an interest checklist and pass around cards so other group members could write down their positive attributes, were used to reinforce ideas about occupational balance, habits, and volition.

Other documented occupational therapy programs in U.S. correctional settings include Steltner and Whisner’s (2007) “Opportunities Promoting Self-Responsibility (O.P.S)” program for mentally ill offenders in Texas. They created sheltered workshops where these individuals could try-out increasingly demanding worker roles on paper-making, leather-crafting, or ceramic “crews.” To add meaning to these occupations, the products were sent to nursing home residents, which prompted one offender to state, “I want to help those people. They get lonely and don’t
have much” (p. 75). Steltner and Whisner used case examples to illustrate how the program had provided challenges and helped participants establish performance skills, respond flexibly to unplanned events, evaluate themselves, behave pro-socially, solve problems, and gain an internal “locus of control and sense of mastery” (p.79).

Another example of a grant-funded program allowing U.S. occupational therapists to work with inmates was developed at Philadelphia University (2007). This project is notable because it targeted women. It was designed to prepare women inmates with mental illness for the task of managing their healthcare needs upon release and was awarded a 2-year $264,614 grant by the Jacob and Valeria Langeloth Foundation. The program’s creator, an occupational therapy professor at the university, states, “Prisons have been identified as an area of need where we could be of great service” (para. 11).

Other occupational therapy programs in United States correctional facilities have been documented in the AOTA publication *OT Practice*. Flowers, Hardwick, & Smith (2002) described a “word garden” created at the Pender Correctional Day Program in North Carolina by two COTA Level II Fieldwork students, their academic fieldwork coordinator, horticulture therapy staff, and inmates with mental, physical, or social disabilities engaging in a 1 year prison diversion program. The project, which involved growing gardens created around different themes guided by “touchstone” words painted on rocks, promoted group experience, introspection, communication, motor, and process skills, and landscape trade learning. Brachtesende (2004) described a program initiated by Elizabeth Ciaravino, Ph.D., OTR/L and carried out with the help of her occupational therapy graduate students at the University of Scranton designed to
address life skills with people involved in the county’s drug treatment court. The drug treatment court specializes in rehabilitating non-violent offenders arrested for substance abuse. The occupational therapy group Ciaravino and her students created became a requirement for 8-12 clients involved in the treatment court’s program. The group was titled, “Better Living Through Life Skills” and worked with clients on utilizing their non-treatment time effectively. Areas such as time management, budgeting, appropriate attire, and job interview skills were addressed in weekly group meetings and individual meetings as necessary. Subjective data on the program was largely positive, and the clients stated that they found the group format in which they could work together as the most useful aspect of the program.

Prison rehabilitation as an area of need is becoming well-recognized. Krisberg and Marchionna (2006) found that the majority of U.S. voters support prisoner rehabilitation. They report that 87% are in favor of rehabilitative services as opposed to punishment only; 78% would support legislation allocating federal funding for prisoner reentry; and the majority felt that job training, drug treatment, mental health services, family support, mentoring, and housing are all important services for prisoners. In response to rising prison populations propelled by recidivism, the U.S. Department of Justice’s Office of Justice Programs and the National Institute of Justice have created the Reentry Partnership Initiative to develop new strategies for preparing incarcerated individuals to return to their communities (Community Shelter Board, 2002). The first phase of their three-phase model, “Protect and Prepare” (p. 6) describes institution-based programs that provide education, mental health and substance abuse treatment, job training and mentoring, and risk assessment. The role for occupational therapists in this phase is not explicit;
however, the initiative encourages local communities to “fill gaps” and pioneer new reentry strategies to be incorporated in national models of best-practice.

Based on this review, it is apparent that the inclusion of occupational therapy services within correctional settings should be further explored and eventually established as a model of best-practice. To this end, the incorporation of an occupational therapy program at CTF would not only benefit the women residents and their Toledo community, but would be a step in the right direction nationally. Helping to reduce subsequent crime and incarceration through comprehensive correctional rehabilitation incorporating occupational therapy will address the Centers for Disease Control and Prevention’s (CDC) (2007) Health Protection Goals and Objectives: 19, 22, 25, 29, 30, 42, 58, 60, and 61, among others, which address mental health, safety, and violence among adolescents (up to age 19) and adults, as well as safer communities and institutional environments that promote health. Additionally, it will address the following objectives from the U.S. Department of Health and Human Services’ Office of Disease Prevention and Health Promotion’s Healthy People 2020 (2010): PA-1 Reduce the proportion of adults who engage in no leisure time physical activity; PA-2 Increase the proportion of adults meeting federal physical activity guidelines; SA-11 Reduce cirrhosis deaths; SA-12 Reduce drug-induced deaths; SA-13.3 Reduce the proportion of adults who drank excessively in the previous 30 days; SA-19 Reduce the past-year non-medical use of prescription drugs; SA-20 Decrease the number of deaths attributable to alcohol; ECBP-10.9 Increase the number of community-based organizations providing population-based primary prevention services in the area of physical activity; IVP-39 Reduce violence by current of former intimate partners; IVP-33
Reduce physical assaults; and IVP-38 reduce nonfatal child maltreatment, among others.

**Model of Practice:**

The C.O.C.O.O.N. Project will use The Model of Human Occupation (MOHO) (Kielhofner, 2002) to guide occupational therapy assessment and services. Eggers and others (2006) utilized the model’s Occupational Self Assessment (OSA) (Baron, Kielhofner, Iyenger, Goldhammer, & Wolenski, 2002) during their program’s pre-release stage, The occupational therapy aspect of the program described by Tayar also used MOHO, and it was identified by Steltner and Whisner (2007) as one of only a few models of practice that have been applied in correctional settings. MOHO was identified in eight different chapters of Couldrick and Alred’s (2003) Forensic Occupational Therapy text. In that text, Duncan (2003) points out that MOHO is the most comprehensive occupational therapy model of practice with over 20 years of development in theory and application, and it is increasingly being adopted as the core model for British occupational therapists working in secure settings. Kielhofner (2004) boasts that MOHO has been used to develop a wide range of programs including two for prison and correctional settings (Michael, 1991; Schindler, 1990), as well several for clients who are homeless, mentally ill, emotionally disturbed, or have been diagnosed with attention deficit hyperactivity disorder or borderline personality disorder. One such program for homeless, mentally ill clients was documented by Kavanagh and Fares (1995) who presented a very successful case study in which a woman with a mild learning disability and a traumatic upbringing was able to transition into independent living after staff at a residential facility for individuals with mental illness were able to capitalize on her valued roles and interests to promote literacy and help her overcome the
anxiety that limited her community mobility. Froehlich (1992) used MOHO to promote empowerment, choice, and personal causation with survivors of sexual abuse. This article described helping women express their values and interests, including self defense training and taking action in society to prevent further abuse. Other intervention techniques involved emphasizing occupational and role balance, exploring leisure occupations, and engaging in movement therapy or other physical activity as an anger outlet. Buijsse, Caan, and Davis (1999) found MOHO to be “useful” when implemented to structure occupational therapy programming at the Cambridge Drug and Alcohol Service. Helfrich and Aviles (2001) described MOHO as an ideal framework for assessing and understanding women who have experienced domestic violence. Salz (1983) relied heavily on MOHO, particularly the concept of volition, in creating her “Model of Borderline Occupational Functioning.” Nearly 30 years later Hirons, Rose, and Burke (2010) used MOHO in an occupational group work program for people with personality disorders which “Explor[ed] through engagement in occupation the meaning, purpose, and quality of what people do in their daily lives” (p.53) and greatly improved the quality of life six months after programming for at least one participant who was followed as a case study.

MOHO features a rich theory, lengthy research background, and a number of published case examples to help guide its application. Additionally, it has generated and provided validation for numerous assessments including the aforementioned OSA, as well as The Model of Human Occupation Screening Tool (MOHOST) (Parkinson, Forsyth & Kielhofner, 2006), and The Assessment of Communication and Interaction Skills (ACIS) (Forsyth, Salamy, Simon & Kielhofner, 1998), which will be used to inform intervention and evaluate the C.O.C.O.O.N.
MOHO conceptualizes the person as consisting of three elements: (a) volition, (b) habituation, and (c) performance capacity. Volition is further broken down into values, interests, and personal causation, while habituation can be broken down into habits and roles. The environment can be broken down into the physical and social environment. In the model of human occupation, values, interests, personal causation, roles, habits, performance capacity and the physical and social environment are constantly linked as a transforming whole that guides one’s thoughts feelings and actions. A core belief of the model is that all humans require constant maintenance and reorganization that is also dependent upon occupation. The term adaptation is used in this model to describe competence within one’s environment over time along with the establishment of a positive identity. Another belief of the model of human occupation is that only clients can accomplish their own change through the process of occupation and for occupation to be therapeutic, it must be real and meaningful to the individual. Potential positive changes that can be addressed with this model include: increased understanding of one’s strengths and weaknesses, increased acceptance of limitations and pride in abilities, acquisition of new habit patterns, development of values supporting positive choices, increased awareness of responsibilities associated with success in various roles, and increased participation in things of interest.

The MOHOST (Version 2.0) (Parkinson, Forsyth & Kielhofner, 2006) consists of 24 items in six different sections. In the volition/motivation for occupation section, the individual is assessed on his or her appraisal of ability, expectation of success, interests, choices. In the
habituation/pattern for occupation section, the individual is assessed on his or her routine, adaptability, roles, and responsibility. In the communication and interaction skills section the individual is assessed on his or her non-verbal skills, conversation, vocal expression, and relationships. In the process skills section, the individual is assessed on his or her knowledge, timing, organization, and problem solving. In the motor skills section, the individual is assessed on his or her posture and mobility, coordination, strength and effort, and energy. In the environment section the individual is assessed on the physical space, physical resources, social groups, and occupational demands, that make up his or her environment. Each item is scored on a 4-point scale using the acronym “FAIR” with 4/F meaning performance in that specific area facilitates occupational participation, a 3/A indicates it allows occupation participation, a 2/I indicates it inhibits occupational participation, and a 1/R indicates that it restricts occupational participation. Information for determining ratings is gathered through informal and formal observation in a variety of settings, discussion with clients or caregivers, case notes, and the completion of other formal assessments. An addition to the MOHOST assessment are OCAIRS questions that can be used to guide occupational interviewing and can be used in place of or to support data gathering for the MOHOST if clients are capable of being interviewed. OCAIRS questions are available in three different forms including two for mental health and forensics settings. The MOHOST was incorporated as the mandatory initial assessment in the integrated care pathway at a secure psychiatric facility in Carstairs as part of an effort to promote evidence-based practice and standardized clinical guidelines during the modernization of the U.K.’s National Health Service.
The ACIS (Forsyth, Salamy, Simon & Kielhofner, 1998) examines social skills in physical, informational, and relational domains. In the physical domain, the individual is assessed based on physical contact, gaze, gesturing, maneuvering, body orientation, and posture. In the informational domain, the individual is assessed based on his or her ability to articulate, express feelings, ask questions, initiate interaction, display affect, modulate his or her voice, share information, make himself or herself understood, and sustain speech. In the relational domain the individual is assessed based on collaboration, conforming to social norms, focusing, establishing rapport, and accommodating others’ reactions and requests. The rater must take into account the context, social group, and other relevant influences and then determine how effective the individual’s behavior was in various interaction. A score of 4 for a skill indicates that it supported social action, 3 indicates that the individual’s skill was “questionable” but did not disrupt the occupation, 2 indicates that ineffective performance in the skill did impact the occupation, while a score of 1 indicates a deficit that caused the occupation to “break down.” The rater may record that a skill was “not assessed” if it was not required by the situation. Using data from 117 clients, 52 occupational therapists, and 244 completed assessments, Forsyth (1996) found that the ACIS items represented a single construct with good internal validity. This study also supported the inter-rater reliability of the scale and its ability to logically distinguish between many different levels of communication and interaction. Helfrich and Aviles (2001) listed the ACIS as an important tool for assessing women who have experienced domestic violence.

MOHO was chosen due to its broad focus on motivation, roles, habits, and the environment, all of which may be problematic with this population. Also, Kielhofner points out
that it is, “One of the first models to develop with a strong focus on occupation” (p.162), which contributes to creating a unique role for occupational therapists. The use of occupation will be central to the success of the C.O.C.O.O.N. Project. Women at CTF already engage in numerous programs that promote educational and psychosocial development. These programs are operated by qualified teaching and counseling professionals. The missing piece in their programming is the opportunity to engage in meaningful occupation. The C.O.C.O.O.N. Project will focus on the “doing” rather than the thinking and feeling components of rehabilitation by engaging participants in various productive and therapeutic roles and occupations, as well as concrete planning for the roles, occupations, and environmental changes they will be responsible for after leaving CTF.

**Objectives**

**Program Goal**

The goal of the C.O.C.O.O.N. (Changing Ourselves by Celebrating Our Occupational Nature) Project of Toledo Ohio’s Correctional Treatment Facility is to promote the motivation, habits, and skills necessary for women residents to engage in rich and fulfilling occupational lives. Motivation encompasses residents’ openness to try new occupations, self efficacy beliefs, attitude toward challenging occupations, ability to identify enjoyable occupations, and willingness to participate in treatment. Habits that will be promoted involve consistently organizing aspects of life into effective occupational patterns, as well as timing, planning, and pacing occupations appropriately. Skills refer to the intrapersonal, interpersonal, emotional, cognitive, and physical abilities residents will work to improve in order to be more successful in
the roles and occupations they identify as important. These may include accurate insight into the underlying causes of one’s habits or behavior, clear communication, relaxation skills, the ability to remember and follow directions, and physical endurance as examples of each skill area.

**Objectives**

1. Residents will complete a higher percentage of assigned “homework” tasks after participating in the program for at least 4 weeks compared with the first 4 weeks the resident was participating in programming.

2. Residents will participate in a higher percentage of C.O.C.O.O.N. Project groups after participating in the program for at least 4 weeks compared to the percentage of optional groups they participated in during the first 4 weeks after being admitted to CTF.

3. At the conclusion of inpatient programming 80% of participants interviewed will identify one occupation they performed in the program that they found “enjoyable or satisfying.”

4. By the end of inpatient programming, 80% of participants interviewed will identify one aspect of the C.O.C.O.O.N. Project that was “helpful or valuable in maintaining recovery.”

5. At the conclusion of inpatient programming, 60% of relevant participants (participants scoring 60 points or below on the pre-test then subsequently post-tested) will receive a post-test score of at least 5 points higher, compared with a pre-test score, on the Assessment of Communication and Interaction Skills (ACIS) (Forsyth, Salamy, Simon, & Kielhofner, 1998).
6. At the conclusion inpatient programming, 60% of participants interviewed will show improvement on at least 3 items on the MOHOST (Version 2.0) (Parkinson, Forsyth & Kielhofner, 2006), excluding the 4 environmental items, when compared with pre-test scores.

7. During the pre and post-programming interview process, 60% of participants will be able to identify a greater number of healthy or productive roles they occupy during the post-programming interview compared with the pre-programming interview.

8. At least 25% of program participants will attend at least one optional CTF alumni group meeting in the first 3 months after being discharged from CTF.

9. For the first 12 months following initial release from CTF into the community, 70% of program graduates for whom data is available will avoid future criminal charges as evidenced by the Northwest Ohio Records Inventory

Programming

The C.O.C.O.O.N. Project will involve a variety of occupational therapy interventions for women residents of CTF, guided by the Model of Human Occupation (MOHO) and directed by a licensed and registered occupational therapist. Interventions will address the areas identified in the needs assessment and literature review process as interfering with the motivation, habits, and abilities necessary for women residents to engage in rich and fulfilling occupational lives. Based on the individual needs of each resident, participation in certain interventions will be mandatory. However, some occupational therapy groups will be offered to residents on a voluntary basis. In
keeping with MOHO’s emphasis on meaningful, relevant occupational forms and “change through doing,” programming will be primarily occupation-based, with education and discussion elements always leading to some type of occupation and/or planning of an occupation for residents to complete after leaving CTF. Based on the work of Duncan and Moody (2003), occupational therapy intervention for each resident will be outlined using the integrated care pathway (see appendix E).

Each resident admitted to the women’s unit at CTF will be interviewed by the occupational therapist within the first week of her stay using a modified version of the OCAIRS questionnaire for forensic settings (Parkinson, Forsyth & Kielhofner, 2006) (see Appendix F). This information and interaction experience will be used in conjunction with observation of the resident in groups and discussion with the resident’s case managers to complete the MOHOST (Parkinson, Forsyth & Kielhofner, 2006) and ACIS assessments (Forsyth, Salamy, Simon & Kielhofner, 1998) within 10 days of the resident’s arrival.

All residents not enrolled in GED education courses will participate in the “Self Regulation and Community Integration” group led by the occupational therapist for an hour two times per week. This group was established by an occupational therapy student with the help of Dawn Leiss, MSW, and Colleen Hartford, BIS, the case managers on the women’s unit in the spring and summer of 2011 (see Appendices G and H for an outline of the group and statement of its purpose that was presented to CTF administration and example materials used for the group while it was being led by the occupational therapy student). The group consists of four units: (a) self awareness, (b) self acceptance, (c) community exploration, and (d) community
involvement. The self awareness aspect of the group challenges women to examine their roles, capacities, values, and goals, including assignments in which they must write a personal mission statement and structure short-term and long-term goals for themselves. The self acceptance aspect of the group challenges women to examine where their negative self-beliefs have evolved from and work to overcome these harmful messages. Proposed occupations for this portion of the group include viewing and creating artwork with positive messages about womanhood and/or size acceptance, self-acceptance-focused meditation exercises, and keeping positive thought journals. Community exploration will involve identifying and pursuing interests, as well as addressing obstacles to successful social participation such as anxiety, AD/HD traits, or other detrimental habits. The community involvement portion of the group will promote assertiveness and action among the women residents by challenging them to develop a community service project and speak out about social issues that are important to them. This aspect will also include a community service occupation the women can participate in such as making cards for hospitalized children or writing notes of thanks and encouragement to deployed troops. Steltner and Whisner (2007) found that altruistic occupations can be very meaningful for people in correctional environments and 12-step groups encourage members to give back to society as means of maintaining sobriety (Seppala, 2001). Residents will be required to attend the “Self Regulation and Community Integration” group for the first 10 weeks or 20 group sessions of their stay at CTF. After completing 20 sessions, residents will receive a certificate of completion for the group and will have the option to continue attending until they are discharged.
Residents with a score of 60 or below on the ACIS will be required to attend a bi-weekly hour-long “Skill Building” group until they are discharged or re-assessed with a score above 60 on the ACIS. Other residents may voluntarily attend this group and may be requested (but not required) to attend as peer models. This group will be primarily occupation-based and will take place off the unit in the gym, recreation yard, or visitation room of CTF. During this group, participants will spend the majority of the hour engaging in occupations that require teamwork and communication. The rest of the time not spent listening to instructions will be dedicated to reflecting on the group experience and sharing feedback with one another. Action Speaks Louder: A Handbook of Structured Group Techniques (Remocker and Sherwood, 1999), which uses MOHO as a theoretical framework, will be a useful tool for occupational therapist planning this group.

One day per week, residents not excused for medical reasons will be required to participate in occupational therapist led recreation time. This aspect of the C.O.C.O.O.N. Project was suggested by Case Manager Dawn Leiss, MSW, who, when asked about the potential role of an occupational therapist at CTF envisioned, “No more recreation as we know it.” During one observation of CTF residents on recreation time in the yard, some women chatted while standing against the wall or sitting on a bench, several women rolled up their clothing as much as possible to lay in the sun and tan, while only a few women spent a short time walking laps around the yard or playing with a basketball. Staff has communicated frustration with the lack of physical activity occurring during recreation time which is generally the only opportunity the women have to be active outside of their cramped unit. For this reason, as well as the positive results
demonstrated by the Atwood Hall Health Promotion Program (Peterson & Johnstone, 1995), which provided aerobics classes and exercise sessions for women offenders with a history of polysubstance abuse or dependence leading not only to positive changes in oxygen capacity, muscle strength, and diastolic blood pressure, but also self discipline and socialization among the 43 participants, structured active occupations will be provided twice per week as part of the C.O.C.O.O.N. project with participation in at least one session per week mandatory for all women residents who are safely able. Residents will be made aware of the date and content of both planned occupations at beginning of each week so they can choose which session they would prefer. They also have the option of participating in both sessions. The occupational therapist will often lead these sessions, but other staff and residents will also have the opportunity to organize an active occupation for structured recreation time by making arrangements with the occupational therapist. In cases in which the occupational therapist does not lead the group, he or she will participate and provide support the leader to motivate group members and modify elements of the group as necessary to provide the appropriate level of challenge for residents with different levels of ability. Potential sessions may involve exercise programs on tape or DVD, choreographed routines or free dancing, exercise stations, yoga, kickball, crab soccer, relay races, and resistance band workouts.

Residents with noted deficits in any of the items or domains of the MOHOST not covered by the ACIS and subsequently addressed in the “Skill Building” group which include: motivation for occupation; pattern of occupation; process skills; motor skills; and environment, will meet with the occupational therapist in small groups or individually depending on how many residents
share similar challenges and how sensitive the issue is to the resident. In the survey, residents voiced a desire to work with the occupational therapist individually rather than in groups and this may be a useful format for addressing specific issues interfering with the occupational performance of specific residents. A noted deficit will be defined as a score of 10 or lower in the MOHOST domain or any item from the MOHOST scored as “restricts occupational participation.” The occupational therapist will meet with these residents based on their needs and the occupational therapist’s ability to address those needs within the context of CTF. In meeting with individual residents or small groups to work on specific issues, the occupational therapist will write objective and realistic goals for the intervention cooperatively with the resident(s), document progress toward each goal for each meeting, and discontinue meetings once goals have been met or progress has ceased. In so doing, the occupational therapist will not be given discretion to practice favoritism toward certain residents at the expense of others. Meetings will occur in the visitation area or professional visitation area at CTF.

The final aspect of the C.O.C.O.O.N. Project will take place outside of CTF in the form of optional alumni meetings for women who are no longer residents. These meetings will take place on Saturdays to help provide structure to the weekend schedules of former residents and avoid scheduling conflicts with other groups using the facility. In reviewing “What Works” with mentally disordered offenders, Blackburn (2004) found that post-release community follow-up and transitional services are among the most effective interventions when working with this population. Women participating in the outpatient portion of the CTF program will be allowed to attend these meetings and will be given credit for them as part of their mandatory recovery
meeting attendance. Alumni group meetings will be held at Toledo’s International Boxing Club headquarters less than a mile from CTF. At this facility, the group will have access to a computer lab, vocational training center, kitchen, and boxing gym. Occupations will be guided by alumni interests and the availability of guest speakers and volunteers. Potential group plans could involve self-defense training, boxing or other physical exercise regimes, cooking lessons or group meal preparation, “do it yourself” and home maintenance workshops, resume building and job searching, computer classes, and trips to other community sites such as the YWCA, Toledo Zoo, Botanical Gardens, or Museum of Art. A monthly schedule of group plans will be mailed to all women discharged from CTF since the start of the C.O.C.O.O.N. Project.

All groups in the C.O.C.O.O.N. project will be open and continuous so that CTF residents will have access to as much programming as possible over the limited amount of time they stay at the facility (usually between 60-90 days). Some structured recreation groups will require residents to sign up and will only include a number of slots less than the number of residents due to limited space or equipment. However, the sign-up process will only be used as a precaution and it is doubtful that women who wish to participate will be turned away often because groups will not be limited below 14 participants. If a group does generate more interested participants than can sign up, it will be repeated as quickly as possible for those residents who were unable to participate the first time. No one will be excluded from the alumni group as long as they stay in recovery, follow the group’s rules including adherence to all legal obligations, and choose to attend. They may attend as little or often as they wish. Although residents are able to complete the Self Regulation and Community Integration group after 20 sessions, graduates will be
encouraged to continue attending. They may find the group beneficial even as programming is repeated because new residents will have different thoughts to share and the occupations and assignments will evolve as the occupational therapist sees fit.

The occupational therapist will be responsible for leading all groups or making arrangements with other staff and residents to provide appropriate leadership for the group. The occupational therapist will also meet with the case managers on the women’s unit briefly each morning and at for consultation purposes least twice per week. He or she will also attend CTF staff meetings at least once per month in order to stay up-to-date on facility-wide issues. The occupational therapist will keep records on each group that is run as part of the C.O.C.O.O.N. Project including: the names of residents or alumni in attendance; the planned occupation, content, or focus of the group; notable observations; any assigned or collected tasks to be completed outside of group including the names of group members who completed the assignments and who did not; and any changes necessary to the material presented or to the structure or facilitation method of the group (e.g. “provide thicker paper for drawing assignment next time so residents will not trace” or “do not allow resident X to sit next to resident Y during group time”). When not leading groups or completing documentation, the occupational therapist will work with individuals or small groups on goals related to needs identified on the MOHOST assessment (see Appendix I for a sample schedule for the C.O.C.O.O.N. Project’s occupational therapist).
Marketing and Recruitment of Participants

Marketing

Marketing for the C.O.C.O.O.N. Program will be aimed at four very different groups. In order for the C.O.C.O.O.N. Program to be successful, it must be appealing to the administration of CTF, the staff, the residents, and the community. Each of these groups will be approached in a way that is suited to their specific needs and interests.

Both Braveman (2006) and Fazio (2008) advise individuals marketing services to begin with a needs assessment or “market analysis.” The needs assessment for this program has been described previously. The information from this need assessment will be vital when marketing to the administration of CTF and other potential allies involved in correctional rehabilitation.

Marketing to this group will mainly involve face-to-face meetings. During these meetings, the occupational therapist will clearly define the C.O.C.O.O.N. Program, including an introduction to the profession of occupational therapy, the services that will be provided, and the support requested from the facility. The occupational therapist will justify the development of this program using the information from the needs assessment and literature review and emphasize the potential benefits of occupational therapy programming at the facility. Attractive and professional visual materials such as PowerPoint presentations or tri-fold posters, will be produced for these meetings and informational packets will be created and distributed to attendees. This marketing effort will first be directed toward the 6 members of the CTF Governing Board and the Director of the facility. Similar presentations may also be delivered to potential funding agencies, potential future sites for additional programming, and other
professionals involved in the Ohio Department of Rehabilitation and Corrections. Braveman points out that this form of promotion can be lower cost, depending on the frequency of meetings, and allows the marketer to customize and alter the message and more easily evaluate customer reaction. Fazio describes this form of “personal selling,” or interfacing with potential partners and collaborators, as, “perhaps the most critical part of health promotion, intervention, and the entire scope of program development” (p.250). She encourages programmers to continue selling their services and making people aware of their effectiveness throughout programming using “marketing logic,” an attitude of selling oneself, ideas, and beliefs while treating the program as an extension of oneself. This confidence and motivation will be crucial when meeting with important stakeholders.

The staff of CTF will be approached in a similar fashion as the administration and other professional stakeholders, with brief informational meetings describing the C.O.C.O.O.N. Program as well as brief announcements and involvement from the occupational therapist during normally scheduled staff meetings. In addition, prior to the beginning of programming and during breaks between cycles, the occupational therapist will offer educational workshops for case managers and counseling professionals to help them incorporate ideas and techniques from the profession of occupational therapy in their work. According to Braveman (2006), seminars such as these help to establish relationships. The director of CTF has endorsed the possibility of staff education provided by an occupational therapist (e-mail correspondence from Bud Hite, July 24, 2011). This will be a form of public relations, described by Fazio (2008) as “the direct intent of interfacing with your public in such a way that the image of you and your service
delivery remains positive” (p.250). As with the administrative meetings, educational seminars can be used to gain support in other facilities if the program expands.

Although participant recruitment should not be a major priority of the C.O.C.O.O.N. Project because the target population has been court-ordered to participate in CTF programming, participant motivation will be addressed through the use of marketing. Residents will be introduced to the C.O.C.O.O.N. Project and occupational therapy during individual meetings with the occupational therapist as part of their pre-programming assessment and during initial participation in “Self Regulation and Community Integration” groups. Brochures will also be provided to residents explaining occupational therapy and the C.O.C.O.O.N. project as part of the intake paperwork given to them by their case managers (see Appendix J for an example brochure). Educational materials provided will take into consideration the wide range of educational levels and cognitive abilities of the residents. Nink and MacDonald (2009) state that over half of Americans in state and federal prisons cannot read, and many have less than an 8th grade education. They suggest that educational programming delivered in correctional facilities “must be designed to match the different learning styles, cultural backgrounds, and multiple literacies of offenders” (p.4). An occupational therapist is well equipped to meet this challenge and will do so by using written materials in combination with verbal explanations, visual aids, and interactive occupations. In addition to the pamphlets, a flyer advertising the program will be posted on the unit as will flyers advertising optional groups and scheduled structured recreation occupations (see Appendices K and L for a sample flyer and a sample schedule).
The final group of individuals that will be targeted in the marketing campaign for the C.O.C.O.O.N. Project will be community members. Various community members will be solicited to share their expertise with residents as part of the C.O.C.O.O.N. Project. Including outside guest speakers was a successful element of the occupational therapy program in a federal prison described by Platt, Martell and Clements (1977). Guest facilitators with the C.O.C.O.O.N. Project could speak with the “Self Regulation and Community Integration” group about topics such as finding a job, volunteering, women’s rights, operating a small business, preparing for retirement, maintaining health and wellness, or managing bank accounts. They may also lead structured recreation or other group occupations such as movement therapy or music therapy. Involving the community in the C.O.C.O.O.N. Program will be therapeutic for participants, who are learning pro-social behavior and trying to re-connect with members of society not involved in illegal activities. It will also be beneficial for the program itself by fostering support from important community members that could help raise funds, influence decision-makers, and ultimately allow for continuation or expansion of the program. Community members sought out as guest facilitators for the program will be recruited by the occupational therapist over the phone and through face-to-face meetings. Community members will also be solicited for donations to help fund the program. This marketing campaign will be operated by a volunteer committee led by the program developer. The program developer will volunteer her time and recruit former CTF residents who completed the program to serve on the committee. These fundraisers will target the larger community in and around Toledo as well as throughout the globe by maintaining a website and advertising various fundraising occupations. Flyers to
advertise fundraisers will be placed on community bulletin boards in sites around Toledo such as YMCA’s, grocery stores, and churches. Placing flyers on The University of Toledo campus, particularly the Health Science and Human Services campus and law school buildings will be a strategy used by the fundraisers to target individuals who might be especially interested in helping this program. A website listing will be used to attract people visiting Toledo and individuals seeking out entertainment. The website www.dotoledo.org/gtcvb is hosted by a private, non-profit organization called Destination Toledo, Inc. This organization is supported by local businesses and its mission is, “Promoting all there is to do in our area.” They attempt to “get the positive word out regarding the many assets of our community.” Posting an event on the website is free. To do this, the committee must contact Cathy Miller at (419) 321-6404 ext. 5042 or cmiller@doToledo.org (Greater Toledo Convention and Visitors Bureau, 2010). By developing a relationship with this organization and Ms. Miller, the location and availability of fundraising events could be posted on the website once that information is confirmed by the fundraising committee. The opportunity for former residents to participate on the fundraising committee will provide valuable computer, marketing, and networking knowledge and experience as well as another way for them to give back to their community and develop positive roles.

**Participant Recruitment**

The occupational therapist will interview and complete pre-programming evaluations with all new women residents at Toledo’s Correctional Treatment Facility (CTF). The women’s unit at CTF has 26 beds and recently women were given beds in administrative segregation due
to overcrowding. The population on the unit normally fluctuates around 20 residents with resident turnover occurring about every 60-90 days. Almost all women residents will likely be involved in the C.O.C.O.O.N. Project in some capacity so it is estimated that approximately 97 women will participate in the program during its first year (20 residents x (365 days per year/75 day approximate average length of stay for residents)= approximately 97 residents). All medically-able residents will be expected to participate in at least one of two structured recreation occupations each week and may participate in both if they desire, resulting in group sizes likely between 5-18 women. All residents not involved in G.E.D. education will be expected to participate in “Self Regulation and Community Integration” group for the first ten weeks of their stay. Attendance in this group, when led by an occupational therapy student under these parameters, ranged from 11 to 21. These numbers are larger than ideal for occupational therapy groups as suggested by Cole (2005), Remocker and Sherwood (1999), which is why residents with scores below 60 on the ACIS or with identifiable problem areas on the MOHOST will be addressed in smaller groups and as individuals. Most women at CTF, though somewhat lacking in certain social skills, do not have severe communication or interaction deficits so the “Skill Building” group will likely be within the range of 5-9 residents which is more ideal for an occupational therapy group (Cole, 2005; Remocker & Sherwood, 1999).

Due to the importance of education established by Nink and Macdonald (2009), working toward a degree in the education program offered at CTF will be given priority over completing C.O.C.O.O.N. Programming. Women working on their GED will be excused from “Self Regulation and Community Integration” but will be expected to participate in structured
recreation as well as any other groups or occupational therapy services identified by the occupational therapist as potentially beneficial based on the pre-program evaluation. Residents will have the option to refuse programming; however, for those expected to participate, refusal could have implications on the rate at which the resident progresses through the CTF treatment and whether or not she is deemed “successful” by the treatment team at discharge. An unsuccessful discharge can have negative legal implications for women sentenced to complete CTF. All women discharged (successfully or unsuccessfully) from the inpatient portion of the CTF program will be invited to participate in the alumni group held each Saturday at the International Boxing Club of Toledo as long as they remain in recovery, remain free of new legal charges, abstain from all substance abuse and criminal behavior, and comply with all legal obligations including fine payments, parole requirements and conditions, and participation in CTF aftercare programming. Alumni group members will be regularly tracked through offender databases and CTF aftercare staff reports to ensure compliance with these conditions.

Participants in any C.O.C.O.O.N. group may be asked to leave if their behavior becomes disruptive. If a participant becomes disruptive in a group more than once, she will be asked to leave the group permanently and the occupational therapist may choose to work individually with the participant if necessary. If a participant in the Alumni group engages in intentionally disrespectful, pro-criminal, or potentially dangerous behavior she will be permanently banned from the group.

Each participant will be described in terms of age, criminal charges, DSM-IV diagnoses, and recidivism risk category according to an assessment completed independent of the
C.O.C.O.O.N. Project by CTF staff during intake. Most women residents at CTF are categorized as high or moderately high risk for recidivism. Common DSM-IV diagnoses other than substance abuse disorders include post-traumatic stress disorder, anxiety disorders, bipolar disorder, and major depression. The age of the residents can range from 18 to older adulthood. Several current residents are grandmothers, although others are in their teens or early twenties. Most women have been sentenced for parole violations, drug charges, or drug-related crimes such as theft or assault committed while under the influence of some substance. Background information will be documented so that, in long-term analyses, it can be determined which, if any, factors are associated with particularly successful outcomes in the C.O.C.O.O.N. Project. This will inform future participant recruitment and help identify strengths and weaknesses of the program.

**Budgeting and Staffing**

The estimated financial expenses associated with the C.R.A.N.E. Program are summarized in the following budget. Staffing for this program will consist of one occupational therapist working 40 hours per week (see Appendices M and N for the job description and an advertisement for this position). The individual hired must be nationally registered and have at least five years of experience as a practicing occupational therapist. An occupational therapist is needed to perform assessments, design and modify experiences that will be meaningful and therapeutic for participants, and encourage behaviors consistent with Kielhofner’s (2002) concept of “occupational adaptation,” the creation of competence and a positive identity. Experience will be a priority because the occupational therapist will be working autonomously with a difficult population. A master or doctoral degree will not be necessary. Someone with
experience in adult mental health or forensic occupational therapy will be sought. He or she must demonstrate exceptional interpersonal skills, confidence, patience, sound judgment, discernment, openness, and flexibility in order to operate this program. A genuine concern and compassion for the client population will also be necessary. An appropriate salary was determined by calculating 50/52 of the 75th percentile salary earned by full-time occupational therapists working in the Toledo area as of July 2011 according to the website www.salary.com. This number was calculated because the occupational therapist will not be working for the first two-weeks of the first program year. Benefits were determined by multiplying the total salary by ¼ and rounding to the nearest dollar. This relatively high level salary was chosen due to the difficulty of the position, and the cost of any travel expenses incurred by the occupational therapist in the course of recruiting guest facilitators and taking fieldtrips with the alumni group will be absorbed by the occupational therapist as part of the contract. Additionally, the occupational therapist will be expected to securely store some supplies at her home or in her vehicle and transport them to CTF as needed because storage space limited at this site.

**Staff Costs**

<table>
<thead>
<tr>
<th>Employee Position</th>
<th>Hours per week</th>
<th>Weeks during year 1</th>
<th>Salary</th>
<th>Benefits</th>
<th>Total Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupational Therapist</td>
<td>40</td>
<td>50</td>
<td>$74,561</td>
<td>$18,640</td>
<td>$93,201</td>
</tr>
<tr>
<td>Total Projected Staffing Costs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$93,201</td>
</tr>
</tbody>
</table>

*Salary estimated from www.salary.com*
# Items for Therapeutic and Documentation Purposes

<table>
<thead>
<tr>
<th>Item</th>
<th>Rationale</th>
<th>Cost</th>
<th>Quantity</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment of Interaction and Communication Skills, Version 4.0</td>
<td>Necessary for pre and post programming assessments</td>
<td>$35.00</td>
<td>1</td>
<td>$35.00</td>
</tr>
<tr>
<td>The Model of Human Occupation Screening Tool, Version 2.0</td>
<td>Necessary for pre and post programming assessments</td>
<td>$38.50</td>
<td>1</td>
<td>$38.50</td>
</tr>
<tr>
<td>Action Speaks Louder: Handbook of Structured Group Techniques, 6th Edition</td>
<td>Necessary for planning “Skill Building” group interventions</td>
<td>$64.73</td>
<td>1</td>
<td>$64.73</td>
</tr>
<tr>
<td>C-THRU 18” plastic grid rulers</td>
<td>Necessary for occupations that require participants to work with precision, mathematics, and careful planning. These will be counted and monitored by the occupational therapist at all times</td>
<td>$6.97</td>
<td>8</td>
<td>$55.76</td>
</tr>
<tr>
<td>Prism, black, double-tipped, art markers</td>
<td>Necessary for drawing occupations, such as a project residents recently completed in which each designed a 2” x 2” black and white square then all the squares were combined to form one picture</td>
<td>$1.99</td>
<td>12</td>
<td>$23.88</td>
</tr>
<tr>
<td>Prang 24-pack colored pencils</td>
<td>Necessary for drawing or other decorative occupations</td>
<td>$3.64</td>
<td>12</td>
<td>$43.68</td>
</tr>
<tr>
<td>X-ACTO Pencil sharpener</td>
<td>Necessary for sharpening pencils. Safe design (blades housed deep in plastic unit). For occupational therapist’s use only. May break or wear out in the course of programming</td>
<td>$1.70</td>
<td>2</td>
<td>$3.40</td>
</tr>
<tr>
<td>Item</td>
<td>Description</td>
<td>Quantity</td>
<td>Price</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>----------</td>
<td>--------</td>
<td></td>
</tr>
<tr>
<td>Poster-board, 100 pack, assorted colors</td>
<td>Necessary for various creative occupations and for matting especially meaningful arts and crafts projects</td>
<td>1</td>
<td>$38.99</td>
<td></td>
</tr>
<tr>
<td>Crayola construction paper, assorted colors, 40-count</td>
<td>Necessary for creative or decorative occupations such as card-making</td>
<td>5</td>
<td>$13.45</td>
<td></td>
</tr>
<tr>
<td>YES Paste all-purpose, non-toxic glue, 32 oz jar</td>
<td>Necessary for collage-making, decoupage, other arts and crafts projects.</td>
<td>2</td>
<td>$38.84</td>
<td></td>
</tr>
<tr>
<td>Best Value safety scissors</td>
<td>Necessary for decoupage, collage-making, and other arts and crafts occupations. To be supervised and accounted for by occupational therapist</td>
<td>12</td>
<td>$7.08</td>
<td></td>
</tr>
<tr>
<td>Office Max 500-count multipurpose 8 1/2” x 11” paper</td>
<td>Necessary for creative occupations involving drawing, collage-making, or planning among other possibilities</td>
<td>1</td>
<td>$6.99</td>
<td></td>
</tr>
<tr>
<td>1st Class (Forever) U.S. Postage Stamps, pane of 20</td>
<td>Necessary for occupations in which residents are asked to reach out to community members via mail while at CTF.</td>
<td>10</td>
<td>$88</td>
<td></td>
</tr>
<tr>
<td>Ascend #10 business envelopes, 45-count</td>
<td>Necessary for occupations in which residents are asked to reach out to community members via mail while at CTF.</td>
<td>5</td>
<td>$21.45</td>
<td></td>
</tr>
<tr>
<td>Item Description</td>
<td>Description</td>
<td>Price</td>
<td>Quantity</td>
<td>Total</td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>---------</td>
<td>----------</td>
<td>---------</td>
</tr>
<tr>
<td>Theraband 2 pack of heavy latex free exercise bands</td>
<td>Necessary for structured recreation groups as well as sensory integration and physical skill/conditioning interventions. To be supervised and accounted for by occupational therapist</td>
<td>$17.27</td>
<td>7</td>
<td>$120.89</td>
</tr>
<tr>
<td>Theraband 3 pack of light latex free exercise bands</td>
<td>Necessary for structured recreation groups as well as sensory integration and physical skill/conditioning interventions. To be supervised and accounted for by occupational therapist</td>
<td>$15.04</td>
<td>2</td>
<td>$30.08</td>
</tr>
<tr>
<td>Valeo foam exercise mat</td>
<td>Necessary for structured recreation groups as well as sensory integration and physical skill/conditioning interventions. To be supervised and accounted for by occupational therapist</td>
<td>$19.25</td>
<td>15</td>
<td>$288.75</td>
</tr>
<tr>
<td>TKO 75 cm anti-burst fitness ball</td>
<td>Necessary for structured recreation groups as well as sensory integration and physical skill/conditioning interventions. To be supervised and accounted for by occupational therapist</td>
<td>$16.39</td>
<td>2</td>
<td>$32.78</td>
</tr>
<tr>
<td>TKO 65 cm anti-burst fitness ball</td>
<td>Necessary for structured recreation groups as well as sensory integration and physical skill/conditioning interventions. To be supervised and accounted for by occupational therapist</td>
<td>$16.39</td>
<td>6</td>
<td>$98.34</td>
</tr>
<tr>
<td>TKO 55 cm anti-burst fitness ball</td>
<td>Necessary for structured recreation groups as well as sensory integration and physical skill/conditioning interventions. To be supervised and accounted for by occupational therapist</td>
<td>$13.62</td>
<td>6</td>
<td>$81.72</td>
</tr>
<tr>
<td>TKO “Faster Blaster” air pump</td>
<td>Necessary for inflating balance balls prior to structured recreation groups as well as sensory integration and physical skill/conditioning interventions. Balance balls will likely need to be transported to and from area of use while deflated and residents may inflate them as part of occupation</td>
<td>$4.99</td>
<td>3</td>
<td>$14.97</td>
</tr>
<tr>
<td>Item</td>
<td>Description</td>
<td>Price</td>
<td>Quantity</td>
<td>Total</td>
</tr>
<tr>
<td>---------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------</td>
<td>----------</td>
<td>-----------</td>
</tr>
<tr>
<td>Great Papers! 100-count certificate paper</td>
<td>Necessary for certificates of completion for “Self Regulation and Community Integration Group”</td>
<td>$7.99</td>
<td>1</td>
<td>$7.99</td>
</tr>
<tr>
<td>Insignia 5MP high definition digital camcorder</td>
<td>Necessary for recording occupations as a means of feedback for participants in “Skill Building” Group Also may be used for recording fundraising events and posting these and other fun videos to market the project on the project’s website (with consent). The primary use will be providing residents with feedback and the camcorder will be kept with the occupational therapist during the majority of the year so this is not considered a marketing expense</td>
<td>$129.99</td>
<td>1</td>
<td>$129.99</td>
</tr>
<tr>
<td>STOREX Duratech 3” D-ring binder</td>
<td>Necessary for organizing and storing sign-in sheets not yet filed electronically, as well as other materials in hard copy such as resident assignments</td>
<td>$8.99</td>
<td>1</td>
<td>$8.99</td>
</tr>
<tr>
<td>HP Pavilion g6-1b60us notebook PC</td>
<td>Necessary for keeping all therapist’s records, allowing the therapist to access internet resources for intervention ideas, and allowing the therapist to create handouts</td>
<td>$499.99</td>
<td>1</td>
<td>$499.99</td>
</tr>
<tr>
<td>Verbatim USB 4 GB back-up thumb drive</td>
<td>Necessary for backing up all files on a weekly basis. To be kept in locked drawer in CTF offices when not in use</td>
<td>$9.99</td>
<td>1</td>
<td>$9.99</td>
</tr>
</tbody>
</table>
Utility cart, 350 lb capacity

Necessary for transporting program materials from storage in office area to the residential unit, visitation area, recreation gym, or other CTF area for programming

$69.90 1 $69.90

Total projected cost of items for therapy and documentation $1,884.02


Items for Marketing Purposes

<table>
<thead>
<tr>
<th>Item</th>
<th>Rationale</th>
<th>Cost</th>
<th>Quantity</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presentation Poster</td>
<td>To be used and re-used when giving presentations to facility administrators and other important shareholders</td>
<td>$39.99</td>
<td>1</td>
<td>$39.99</td>
</tr>
<tr>
<td>5-page informational booklets</td>
<td>To be distributed to facility administrators and other important shareholders</td>
<td>$1.00</td>
<td>50</td>
<td>$50.00</td>
</tr>
<tr>
<td>Website Hosting</td>
<td>Domain, disk space, bandwidth, SSL and IP, building tools and templates, and technical support for website to market program and fundraise in the community</td>
<td>$10.36 per month</td>
<td>12</td>
<td>$124.32</td>
</tr>
<tr>
<td>Website Payments</td>
<td>To accept donations for program using website</td>
<td>Free</td>
<td></td>
<td>$0</td>
</tr>
</tbody>
</table>

Total projected cost of items for marketing $214.31


In Kind Support

The Correctional Treatment Facility will provide the following as in-kind support to the C.O.C.O.O.N. Project according to Director Bud Hite (via e-mail July 23, 2011) secure closet for storage of supplies and computer; printing and copying services for participant hand-outs,
resident brochures, and community flyers; office supplies such as pens, pencils, tape, staplers, and paper clips; internet access; telephone access; access to the visitation area and its tables and chairs during programming hours; and indirect costs for facility amenities and administration including security, electricity, heat, and air conditioning. Support staff will be available on the residential unit and during recreation time. The International Boxing Club will provide the following as in-kind support to the C.O.C.O.O.N. Project: use of their facility for 2 hours each week including access to a working kitchen, computer lab, and boxing gym, as well as internet access, and coverage of indirect costs for the facility (confirmed via e-mail correspondence with executive director Harry Cummins, July, 28, 2011).

**Total Program Costs**

<table>
<thead>
<tr>
<th>Expense Category</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Projected Staff Costs</td>
<td>$93,201</td>
</tr>
<tr>
<td>Items for Therapeutic and Documentation Purposes</td>
<td>$1,884.02</td>
</tr>
<tr>
<td>Items for Marketing Purposes</td>
<td>$214.31</td>
</tr>
<tr>
<td>In-Kind Support (Indirect Costs as well as Additional Supplies, and Equipment)</td>
<td>$0</td>
</tr>
<tr>
<td>Total Program Cost</td>
<td>$95,299.33</td>
</tr>
</tbody>
</table>

**Funding**

During its first year, the C.O.C.O.O.N. Project will seek grant funding to cover the estimated budget of $95,299.33. Funding agencies were identified based on their areas of interest and ability to cover the program’s budget. Three grant funding agencies were identified as potential sources to provide initial funding for the C.O.C.O.O.N. Project.

The first potential source of funding for this program is The Jacob and Valeria Langeloth
Foundation. This private foundation contributed $264,614 over 2 years for a program designed by Philadelphia University’s Occupational Therapy Department (2007). Philadelphia University’s program was created to prepare women inmates with mental illness for the task of managing their healthcare needs upon release. This program is similar but will help higher functioning women inmates (many of whom have mental illness) to develop necessary skills and practice the positive roles and behaviors expected of them by society. “Correctional Health Care” is currently the only funding priority listed on the foundation’s website (n.d.). The website goes on to state:

Justice-involved people experience disproportionately higher rates of infectious and chronic diseases, substance abuse, mental illness, and trauma than the general population. As such, jails and prisons represent one of the largest target populations for public health services in America, and are important sites for improving the overall health and well-being of communities (para. 2).

This program will use a correctional facility to target the at-risk population described by the foundation. It will seek to improve the mental health of participants, thereby discouraging substance abuse. It will also seek to improve the health and well-being of the communities participants will return to by preparing participants to be successful, contributing members of those communities. The foundation also states on its website that it will favor proposals attempting to support “health and well-being” through various means including: “creative applied research that addresses a major gap in knowledge;” outreach to individuals, communities and populations that are beyond the reach of effective health care;” “efforts to improve patients'
understanding of their paths to recovery;” and “collaboration among health care providers and other organizations.” Through evaluation, my program will address a gap in knowledge regarding the effectiveness of occupational therapy in correctional settings. The program targets a population that has been considered hopeless by some (Lipton, Martinson & Wilks, 1975) and underserved by others (Tripp, Holbrook, Walen & Walsh, 2007) indicating it is “beyond the reach of effective health care.” By providing feedback to participants in the form of assessments, videorecorded occupations, and group feedback solicitation during occupational therapy interventions, and by encouraging self-discovery, knowledge, and communication, the C.O.C.O.O.N. Project will aim to improve participants’ understanding of their paths to recovery. Additionally, the program will involve collaboration between health care providers and other organizations by bringing The University of Toledo’s Occupational Therapy Program together with Toledo’s Correctional Treatment Facility, Toledo’s International Boxing Club organization, and the Ohio Department of Rehabilitation and Corrections.

The second potential funding source for this program is the Residential Substance Abuse Treatment Program (RSAT) operated by the Ohio Department of Public Safety’s Office of Criminal Justice Services’ Grants Administration. This administration supports law enforcement, prevention, and intervention initiatives during their start-up and first years of implementation. The RSAT grant was established to fund residential or jail-based substance abuse treatment. The proposed occupational therapy program would focus on substance abuse problems by helping residents to learn about and practice new behaviors and occupational patterns that will prepare them for sober living and discourage substance abuse. The RSAT requirement that funded
programs “develop cognitive, behavioral, vocational and other skills necessary to solve a substance abuse or related problem” is highly consistent with the goal of the proposed C.O.C.O.O.N. Project, which addresses “motivation” cognitively, “habits” behaviorally, and “skills” vocationally. The C.O.C.O.O.N. Project at CTF also meets the other requirements of the grant in that it will be 12 months long, occur in a residential correctional facility with residents in the program apart from the general correctional population on the Women’s Unit at CTF, indirectly, and at times directly, focus on the substance abuse problems of residents, and CTF already uses urinalysis and other proven, reliable forms of testing in addition to the measures that make up the evaluation of the C.O.C.O.O.N. Project.

The third potential funding source for the C.O.C.O.O.N. Project is The Fund for Nonviolence’s Justice with Dignity Program. This program “supports organizations and networks that seek to reduce U.S. society’s dependence on incarceration” (Fund for Nonviolence, n.d.). The web page dedicated to this program also states “We seek partners who are working to change our punitive system into one that heals the long-term effects of current degrading practices and promotes healthy, safe communities for all of its members” (para. 3). In 2009 this program funded the A New Way of Life Reentry Project which describes itself as “a non-profit organization in South Central Los Angeles with a core mission to help women and girls break the cycle of entrapment in the criminal justice system and lead healthy and satisfying lives” and “builds leadership of formerly incarcerated women” (2011). The Justice with Dignity Program is especially interested in work that engages the affected population in its leadership. The C.O.C.O.O.N. Project will fulfill this expectation by recruiting CTF Alumni as the fundraising
committee in charge of the very substantial task of maintaining the funds necessary to keep the Project active within CTF.

**Self-Sufficiency Plan**

The Self-Sufficiency of the C.O.C.O.O.N. Project will be the responsibility of the women it serves. The grant writer will initially chair a fundraising committee consisting of CTF Alumni recruited from the C.O.C.O.O.N. Project, as well as other local volunteers. Over time, it is expected that CTF Alumni who participated in the C.O.C.O.O.N. Project will take over leadership of the committee. To learn more about fundraising, women on the committee will be encouraged to register and get involved with “Chicks for Charity” a Toledo, Ohio organization of philanthropic women and girls who host events (Chicks for Charity, n.d.). From 2011-2012 this group will be raising money for the International Boxing Club where the Project’s alumni group will meet. Women in the alumni group may gain valuable experience and contacts by associating with this other powerful group of women.

Following the initial year of the C.O.C.O.O.N. Project, it is assumed that the administration and staff at CTF and other key stakeholders will recognize the benefits of the program and support the fundraising committee’s efforts to maintain it. Fundraising efforts will also solicit contacts within the criminal justice system including attorneys and judges, faculty and administration at The University of Toledo, and other local, prominent businesspeople and civic leaders. Ideas for initial, low-cost fundraising efforts may include a “Jail-and-Bail” format used by the Canadian Cancer Society or a “Night in Jail” event that once served as a fundraiser for the Adam’s County Homeless Shelter in Pennsylvania as well as a training exercise for local prison
staff when guests donated a fee to briefly experience prison life without committing a crime (Fundraising Ideas & Products Center, 2011).

Ideally, with consistent outcomes measures indicating the usefulness of the C.O.C.O.O.N. Project and research from similar programs supporting the effectiveness of occupational therapy interventions in reducing recidivism amongst offenders, the government may choose to fund the continuance of the C.O.C.O.O.N. Project as means of cutting costs and the volunteers on the fundraising committee can direct their efforts toward other worthy causes. Washington D.C.’s Center for Economic and Policy Research reported that the average cost of keeping a nonviolent offender in jail or prison was about $25,500-$26,000 in 2009. By reducing the amount of time spent by participants in jail or prison by a total of less than 4 years among the 97 women involved, the Project will be cost-effective. Additionally, means-tested welfare assistance costs the government an average of $7,700 for each poor and low income individual in the U.S. (Rector, 2011). Many women at CTF depend on such assistance when not incarcerated. If the C.O.C.O.O.N. Project can promote improved or newfound success in paid employment among its participants, further government money could be saved.

**Program Evaluation**

Evaluation of the C.O.C.O.O.N. Project will be an ongoing pursuit aimed at refining strategies used and weighing the benefits and costs of continuing or expanding the program. Evaluation data will be taken from the occupational therapist’s records of resident and alumni participation in groups and individual interventions including the completion of “homework” assignments, the occupational therapists records from pre-programming and post-programming
interviews and assessments, CTF records, and the Northwest Ohio Regional Information System. Formative evaluations will involve continuous dialogue between the occupational therapist and the participants and case workers. Case workers will be briefly consulted prior to each day of programming and will be queried as to their perception of the program’s impact with specific participants. Participant feedback will be welcome throughout programming, informally during interventions, anonymously via a “Comments and Suggestions” drop-box, and formally during post-programming interviews. When not facilitating or documenting programming, the occupational therapist will be responsible for soliciting feedback from relevant staff at CTF, including during regular staff meetings and occasional staff training seminars. One interim, overall program evaluation will be completed during a weeklong summer or holiday break about 6 months after the onset of programming and will examine the effectiveness of the program in meeting its first eight objectives.

The summative evaluation will be focused on the success or failure of the program in accomplishing its nine objectives. The methods for this evaluation are as follows:

1. Residents will complete a higher percentage of assigned “homework” tasks after participating in the program for at least 4 weeks compared with the first 4 weeks the resident was participating in programming.

   ○ The occupational therapist will document all C.O.C.O.O.N. Project groups, including the completion of homework tasks (see Appendix O for the group documentation format). During mid-year and summative evaluations, each participant will be analyzed (see Appendix P for the individual participant
documentation format). A full analysis of this information will be conducted every 6 months (see Appendix Q for the evaluation format).

2. Residents will participate in a higher percentage of optional C.O.C.O.O.N. Project groups after participating in the program for at least 4 weeks compared to the percentage of optional groups they participated in during the first 4 weeks after being admitted to CTF.
   - The occupational therapist will document all C.O.C.O.O.N. Project groups, including the names of participants in attendance and whether attendance was optional or required (see Appendix O). During mid-year and summative evaluations, each participant will be analyzed and analysis of this and other objectives will be conducted (See Appendices P and Q).

3. At the conclusion of inpatient programming, 80% of participants interviewed will identify one occupation they performed in the program that they found “enjoyable or satisfying.”
   - Participants will be asked “Can you think of anything you did in any of the C.O.C.O.O.N. Project groups that you found enjoyable or satisfying” and the answer recorded and documented by the occupational therapist during a post-programming interview. This interview will be completed with each participant less than one-week before she is released from CTF. The occupational therapist will check-in regularly with the case managers on the unit who make decisions regarding discharge in order to know when to interview a participant. Case managers must complete applications and their own evaluations with residents
and receive input and approval from other staff members prior to a discharge. This process generally takes about two weeks before the resident is discharged. Some residents may leave CTF suddenly for various reasons. If a participant permanently leaves the facility before the occupational therapist has an opportunity to complete the post-programming interview she will not be included in the evaluation of this objective.

4. By the end of inpatient programming, 80% of participants interviewed will identify one aspect of the C.O.C.O.O.N. Project that was “helpful or valuable in maintaining recovery.”

   ○ Participants will be asked “Can you think of anything you did or learned how to do in any of the C.O.C.O.O.N. Project groups that you think will be helpful in maintaining your recovery” and the answer recorded and documented by the occupational therapist during a post-programming interview. See the evaluation of objective 3 for more information regarding the post-programming interview.

5. At the conclusion of inpatient programming, 60% of relevant participants (participants scoring 60 points or below on the pre-test then subsequently post-tested) will receive a post-test score of at least 5 points higher, compared with a pre-test score, on the Assessment of Communication and Interaction Skills (ACIS) (Forsyth, Salamy, Simon, & Kielhofner, 1998).

   ○ The occupational therapist will assess participants using the ACIS following the pre-programming interview and record the score in the digital files (see Appendix
Information for assessing participants with the ACIS may be obtained through observation and consultation as well as during the interview. If a participant scores higher than a 60 in the pre-programming assessment, she will not be reassessed or included in the analysis. If a participant engages in skill building groups she may be reassessed at any time during her stay at CTF and these scores will also be recorded. Once a participant scores at least 5 points higher than on her initial assessment she will be counted toward the completion of this objective. For participants who scored at 60 points or below and were not subsequently reassessed as scoring at least 5 points higher, the occupational therapist will complete a final ACIS following the post-programming interview to determine whether or not the participant improved by at least 5 points. If a participant permanently leaves CTF prior to completing a post-programming interview, the occupational therapist may choose to complete a post-programming ACIS assessment based on observation and consultation or the participant will be analyzed as having failed to improve on the ACIS.

6. At the conclusion of inpatient programming, 60% of participants will show improvement on at least 3 items on the MOHOST (Version 2.0) (Parkinson, Forsyth & Kielhofner, 2006), excluding the 4 environmental items, when compared with pre-test scores.

   • The occupational therapist will assess participants using the MOHOST (version 2.0) following the pre-programming and post-programming interviews and record the item scores (see Appendix P). A modified version of the OCAIRS
questionnaire for forensic settings will be used in both interviews (see Appendix F). Information for assessing participants with the MOHOST may be obtained through observation and consultation as well as the interview process. If a participant permanently leaves CTF prior to completing a post-programming interview, the occupational therapist may choose to complete a post-programming MOHOST assessment based on observation and consultation or the participant will be analyzed as having failed to improve on the MOHOST.

7. During the pre and post-programming interview process, 60% of participants will be able to identify a greater number of healthy or productive roles they occupy during the post-programming interview compared with the pre-programming interview.

○ This will be determined based on answers to OCAIRS questions referring to roles during the pre-programming and post-programming interviews. Participants who do not complete a post-programming interview will not be included in the analysis of this objective.

8. At least 25% of program participants will attend at least one optional CTF alumni group meeting in the first 3 months after being discharged from CTF.

○ Alumni groups will be documented by the occupational therapist in the same manner as inpatient groups (see Appendix O). Data for individuals will be recorded (see Appendix P) and analyzed (see Appendix Q).
9. For the first 12 months following initial release from CTF into the community, 70% of program graduates for whom data is available will avoid future criminal charges as evidenced by the Northwest Ohio Records Inventory.

○ Participants planning to stay in the state of Ohio and sentenced to remain on parole supervision for the year following their release from CTF into the community will be analyzed using the Northwest Ohio Records Inventory to determine if they have been charged with any offenses in the 12 months following their release from CTF. A case manager with access to the Northwest Ohio Records Inventory will look up each participant on the first anniversary of her release date. By definition, this objective cannot be evaluated until the program has run for over 12 months. It will be first assessed 18 months after the onset of programming.

Letters of Support

Several individuals involved in offender rehabilitation and/or the profession of occupational therapy will be solicited to provide letters of support for the C.O.C.O.O.N. Program. The primary letter of support was provided by Colleen Hartford, BIS, a case manager on the Women’s Unit of CTF. Ms. Hartford was selected to provide a letter of support due to her experience working with women at the sponsoring agency for the past 10 years. Ms. Hartford was highly influential in the creation of the Women’s Unit at CTF, after identifying a need for specific treatment with this population, separate from men at the facility. She currently works as a case manager, leading educational groups and coordinating the care of many residents. She has
been a strong supporter for the inclusion of occupational therapy for the women at her facility. Her extensive work with the target population allows her to recognize their needs, and her dedication to helping these women makes her a powerful advocate.

Other individuals working at CTF will also be asked to pledge their support for the program. Bud Hite, the director of the facility, can attest to the administration’s approval of the proposed program, the current lack of occupational therapy services at the facility, and the in-kind support that will be provided. Another letter of support could be provided by Dawn Leiss, LSW, the second of the two case workers on the Women’s Unit. Like Ms. Hartford, Ms. Leiss is knowledgeable and passionate regarding the target population, but in addition, she is somewhat familiar with the profession of occupational therapy and its potential application at CTF. Women residents at CTF may also be solicited to express their interest in the proposed program.

Outside of CTF, there are a number of other individuals who could provide letters of support (see Appendix R for contact information). Harry Cummins, executive director of Toledo’s International Boxing Club, who has pledged his support through offering the use of his club’s facility to the program, can attest to the power of group involvement and occupational participation in regulating behavior and improving self-esteem. Lois Ventura, PhD, of The University of Toledo Criminal Justice Program, could assist in describing the need for this program in terms of substance abuse and recidivism rates in the Toledo area and the state of Ohio. Dr. Ventura could also testify to the financial burden of incarcerating individuals. Similarly, Penny Ryder, LSW, of the American Friend’s Service Committee Criminal Justice Program, and prisoneradvocacy.org could discuss mental healthcare needs of prisoners that are
commonly neglected. Sandra Whisner, M.A., OTR, could provide an experienced occupational therapist’s perspective on the proposed program, having helped create and document a similar, successful program with male inmates at a forensic psychiatric facility in Texas (Stelter and Whisner, 2007). Sue McNulty, MA, OTR/L, is another experienced occupational therapist who could provide support for the proposed program based on her experience providing mental health, substance abuse, and life skills services to low-income women and families at the Mariposa Women and Family Center in California. Dianne Shuford, MS, OTR/L an occupational therapist, psychologist, and University of Toledo alumnus currently working in forensic occupational therapy at Summit Behavioral Healthcare in Cincinnati, Ohio has verbally expressed support for the proposed program.
References


In Forsyth, K., Salamy, M., Simon, S., Kielhofner, G. (1998). A user’s manual for the assessment of communication and interaction skills (ACIS) (version 4.0). Model of Human Occupation Clearinghouse, Department of Occupational Therapy, College of Applied Health Sciences, University of Illinois of Chicago, and UIC Board of Trustees.


Lipton, D., Martinson, R., & Wilks, J. (1975). *The effectiveness of correctional treatment: A


Ohio Department of Public Safety. (n.d.) ODPS Office of Criminal Justice service grants. From, http://ocjs.ohio.gov/grants.stm#tog

Ohio Department of Rehabilitation and Correction. (2011). Table of organization. Retrieved


of Psychiatry Law, 30, 502-509.


Appendix A

Organizational Chart for Toledo Ohio’s Correctional Treatment Facility
Appendix B

Select Portions of the Organizational Chart from

the Ohio Department of Rehabilitation and Corrections (2011)
Appendix C

Report of Resident and Staff Needs Assessment Survey Results

Anonymous Resident Survey Results:

Survey participants: 20

1.) Would you be willing to work with an occupational therapist?: No-3, Maybe-2, Yes-15

2.) Prior to entering CTF what did you do for work? (residents may have multiple answers): Seeking employment-30%, Caring for family/home-40%, Employed full time-25%, Employed part time-10%, Enrolled in education/training-25%, Mandatory community service-0%, Volunteering in an organization- 5%, Other-20% (prison, “kitchen for the poor,” doing hair, and on disability)

3.) After leaving CTF what do you plan to do? (residents may have multiple answers): Further education-80%, Employment-85%, Mandatory community service-20%, Parenting/home care-65%, Volunteer work-25%, Other-5% (attend meetings).

4.) How many children will you be caring for: average = 1.45, range 0-9, At least 1 child-60%

Questions 5-11 are scored as follows:
5-Excellent
4-Good
3-Okay
2-Needs improvement
1-Poor
0-Refusal to engage in occupation/behavior addressed

5.) When you try to explain something, how well do people understand you?:
Average = 4.1; Range = 3-5

6.) How well do you get along with others most of the time?:
Average = 4.075; Range = 3-5

7.) How well do you listen and follow directions?:
Average = 4.1; Range = 2-5

8.) When trying to give others directions, how do they usually respond?:
Average = 3.675; Range = 1-5
9.) How well can you focus on what you are trying to do?:  
Average = 3.8; Range = 1-5

10.) When asked to do a job, how would someone describe your work?:  
Average = 4.6; Range = 4-5

11.) Describe your ability to have fun or relax without using or doing anything illegal:  
Average = 4.474 (one resident did not respond to this item) Range = 2-5

Areas of greatest need:
1. Giving directions (assertiveness/communication/leadership)  
2. Ability to focus on a task  
3. Ability to get along with others

Residents were asked to “Rank these CTF programs in order of their importance to you: (1 = most important/helpful; 15 = least important/helpful)” residents were verbally instructed to assign a rank of 15 to any and all programs they do not participate in and answers of “n/a” or otherwise indicating the resident does not participate were scored as 15. Many residents failed to assign a rank or make any notation regarding some programs and this was treated as missing data. Most residents did not strictly adhere to a ranking system and assigned the same number to multiple programs- this was considered acceptable.

lower numbers indicate greater importance of the program:

Anger management: Average = 5.77; Range = 1-12  
Chemical Dependency: Average = 2.7; Range = 1-10  
Epictetus Club: Average = 3.94; Range = 1-9  
GED Education: Average = 7.5; Range = 1-15  
***Many residents are not enrolled in GED education but among those who are enrolled there was an Average = 1.3 and Range = 1-3  
Grief and Loss: Average = 7.9; Range = 1-15 *Some residents are not involved in this program  
Healthy Living: Average = 6.84; Range = 1-15 *Some residents have not yet attended this program  
Life Collage: Average = 6.22; Range = 1-13  
Meditation: Average = 7.05; Range 1-15  
Relationship Building: Average = 5.28; Range = 1-14  
Self Efficacy: Average = 4.47; Range = 1-12  
Thinking for a Change: Average = 2.56; Range = 1-8  
TREM: Average = 7.06; Range = 1-15 *Some residents are not involved in this program  
Twelve-Step Book Study: Average = 4.94; Range 1-15
Word of the Day: Average = 5.31; Range = 1-15
YWCA Female Specific Issues: Average = 8.94; Range = 1-15 *Some residents have not yet attended this program

Most important programs (excluding those not attended by all):
1. Thinking for a Change
2. Chemical Dependency
3. Epictetus Club
4. Self Efficacy

13.) Residents were asked “What would you like to learn more about?” and instructed in writing to “Number top choices (1 = most interest and 9 = least interest).” Similar to #12 residents frequently used the same rank for multiple options and some residents did not respond to all options. This was considered acceptable and a lack of response was treated as missing data.

Lower numbers indicate greater interest:

How to help others/give back/improve my community: Average = 3.28; Range = 1-9
How to deal with stress: Average = 2.72; Range = 1-7
How to organize my time (outside CTF): Average = 2.94; Range = 1-8
My goals, strengths, and areas for improvement: Average = 2.17; Range = 1-6
How to improve my thinking and learning abilities: Average = 2.61; Range = 1-7
How to work together with others: Average = 4.61; Range 1-9
How to improve/maintain my physical health: Average = 4.05; Range 1-9
How to plan for life after CTF: Average = 2.16; Range 1-9
Fun things to do during my free time (outside CTF): Average = 3.11; Range = 1-9

Areas residents were most interested in learning more about:
1. How to plan life after CTF
2. My goals, strengths, and areas for improvement
3. How to improve my thinking and learning abilities

14.) On a scale from 0-10 how do you feel about your ability to change your life in a good way (10 = No doubt I can change my life for the better, 0 = I cannot change my life).

Average = 8.84
Dispersion: 10:15 residents, 9:1 resident, 8:1 resident, 1:1 resident, 0:1 resident (1 resident did not respond to this item)

15.) On a scale from 0-10, how do you feel about your ability to improve the way you think, feel, and act in the future (0 = impossible, 10 = confident):
Average = 8.74
Dispersion: 10:13 residents, 9:3 residents, 8:1 resident, 1:1 resident, 0:1 resident (1 resident did not respond to this item)

16.) On a scale from 0-10 how likely are you to stay sober after leaving CTF? (0 = impossible, 10 = confident):
Average = 8.37
Dispersion: 10:13 residents, 9:1 resident, 8:1 resident, 6:1 resident, 5:1 resident, 1:1 resident, 0:1 resident (1 resident did not respond to this item)

17.) Would you prefer to work with an occupational therapist as an individual or in a group?:
Individual: 75%
Group: 5%
Both: 5%
No response: 15%

What is most important to you in life: (Some residents gave multiple answers):
Children and/or being a good mom: 50%
Sobriety/recovery: 35%
Other family: 15%
Other answers: “Change,” “Being proud of myself,” “My girlfriend,” “My health,” “My freedom,” and “Stay happy”

What do you like best about yourself: (Some residents gave multiple answers):
“My personality” (in general): 20%
Children/being a mom: 15%
Sense of humor: 10%
Caring: 10%
Positive: 10%
Other answers: “My abilities,” “Everything,” “Being humble,” “My ability to learn more,” “Adaptable,” “That I’m outgoing,” “That I’m a good person,” “I’m who I am,” “I’m dedicated/loyal,” “Good health,” “Determination,” “I don’t know yet,” “Nothing anymore”

Summary:
Residents answers to items 2 and 3 regarding primary occupations indicated that women plan to be more active in various demanding occupations (such as “employment,” “further education,” “volunteer work,” and “Mandatory community service”) than they were previously. This is likely due to a newfound dedication to sobriety that will create more available time and energy to focus on these pursuits.

Residents generally gave themselves positive assessments in the areas their case managers identified as problematic, reflected in the high scores on items 5-11. Answers to items 14-16 indicate that the women are confident in their ability to change themselves and their circumstances for the better, indicating a strong sense of personal causation. They were also very confident in their ability to maintain sobriety. Values identified most often included children, sobriety/recovery, and other family members. Answers to item 13 indicated that most women were interested in most of the options presented because rather than rank the options they frequently gave low numbers (often 1) to all of the items.

Unfortunately, these responses do not coincide well with 1. the recidivism of several recently released residents 2. observed work and behavior of residents within CTF, and 3. staff and case manager’s verbal accounts as well as written behavior reports. This may reflect a deficit of insight, which has also been identified by staff as an area of need, it may be an accurate reflection of their abilities when clean, sober, and in a more calm environment, or it may be a defensive response to questions perceived as intrusive, patronizing, or insulting.

My interpretation of the inconsistency between residents’ responses on this questionnaire and their behavior within and outside of CTF is that this in itself is the greatest need identified in this survey. It may be that the women at CTF do believe in their abilities and are motivated to engage in socially acceptable, balanced occupational lives, to a certain extent. However, weaknesses in areas such as habits, environments, and some performance capacities, are exposed occasionally within CTF and often when residents are released. These weaknesses quickly undermine the volition and performance capacities that can be bolstered in the limited amount of programming time residents receive at CTF.

Most residents were willing to work with an occupational therapist and most preferred working on an individual basis. The wide range of responses to items regarding program preferences and areas of interest also suggested that individual work might be more beneficial for this diverse group. Furthermore, the residents were relatively uninterested in learning to work together with others. This may reflect the fact that most CTF programming is done in a group format and the women live together in tight quarters with few opportunities to avoid one another. On the other hand, the ability to work cooperatively in a group format is important, despite residents’ reluctance, and may help resident’s achieve their self-identified goals. Therefore, it may be beneficial to offer some combination of group and individual treatment.
Anonymous Staff Survey Results:

A total of 10 staff members returned surveys, they were compensated with free candy.

Staff were asked to rank the following resident issues identified through literature review, observation, and discussion with women’s unit case managers with 1 = most troublesome to the residents themselves, and 11 = least troublesome to the residents themselves. Like the residents, the staff generally assigned numbers without consideration for ranking the various issues (meaning that certain numbers were used more than once and others were not used on individual surveys). This was considered acceptable. The results are as follows with low numbers indicating the issue is more troublesome:

- Innattention/inability to focus: Average: 4.6; Range: 1-11
- Inaccurate self-assessment: Average: 6.6; Range: 2-11
- Poor communication/interaction skills: Average: 5.7; Range: 3-11
- Lack of organization: Average: 7.2; Range: 3-11
- Inability to complete assigned tasks: Average: 6.7; Range: 2-11
- Impulsivity: Average: 3.6; Range: 1-8
- Poor quality of work on assigned tasks: Average: 7.4; Range: 3-11
- Poor problem solving: Average: 5.1; Range: 1-10
- Poor ability to cope with stress: Average: 4.4; Range: 1-10
- Low self-esteem: Average: 5.4; Range: 1-9
- Poor recreation skills (unable to relax/enjoy pro-social activities): Average: 7.4; Range: 1-11

Most troublesome issues:
1.) Impulsivity
2.) Poor ability to cope with stress
3.) Inattention/Inability to focus

Least troublesome issues:
1.-2.) Poor recreation skills/Poor quality of work on assigned tasks
3.) Lack of organization

Staff were asked to “Assess the following potential interventions using this 0-3 point scale:

0 = potentially harmful
1 = would not work/redundant with other programming at CTF
2 = could be beneficial for some residents
3 = I would like to see this offered at CTF”
One staff member added a “4 = Already being done” and these answers were scored as a 1 for “redundant with other programming at CTF.”

The interventions were scored as follows with higher scores indicating greater potential benefit:

Helping residents explore their beliefs, values, strengths, and weaknesses to establish priorities, develop goals and structure future plans: Average: 2.2; Range: 1-3
Helping residents engage in community service projects: Average: 2.3; Range: 0-3
Helping residents explore healthy recreation opportunities: Average: 2.3 Range: 2-3
Challenging residents to practice social and cognitive skills while engaging in hands-on tasks such as art/craft projects: Average: 1.8; Range: 1-3
Teaching residents self-regulation strategies (to increase or decrease alertness/arousal): Average: 2.2; Range: 1-3
Teaching residents organization strategies including time and money management: Average: 2.5; Range: 1-3

Teaching residents organization strategies including time and money management received the highest average score for any proposed intervention, but it is noteworthy that all respondents believed helping residents explore healthy recreation opportunities could at least be beneficial for some residents. Challenging residents to practice social and cognitive skills while engaging in hands-on tasks such as art/craft projects received the lowest average score but one staff member responded that he or she would like to see this offered at CTF and most responded that it could be beneficial for some residents.

Staff were asked to circle one of four potential responses to the question “How well do you understand what occupational therapy is?”

“No idea” - chosen by 1 respondent
“Not sure” - chosen by 2 respondents
“Some understanding” - chosen by 6 respondents
“Very well”- chosen by 1 respondent

When asked “Would you be open to including an occupational therapist on staff at CTF” 1 staff member circled “no,” 5 circled “maybe” and 4 circled “yes”

Summary:

Overall there was very little agreement among staff regarding which resident issues create the most problems for the residents, as evidenced by wide ranging scores for each issue. Those identified as most troublesome (impulsivity, poor ability to cope with stress, inattention/ inability
to focus) correspond with symptoms of AD/HD. The potential interventions also received conflicting responses with at least a few staff members considering almost all the interventions to be redundant with current programming, unfeasible, unhelpful, while each potential intervention also received at least 1 response indicating a staff member would like to see the intervention offered at CTF. The only intervention receiving unanimous approval as having some potential benefit for some residents was helping them explore healthy recreation opportunities. The potential intervention receiving the highest ratings as something staff members would like to see offered was teaching residents organization strategies including time and money management. Only one response indicated that any of the potential interventions might be harmful and this was helping residents engage in community service projects. However, most staff responded positively to this intervention idea, likely making the assumption that appropriate precautions would be taken to ensure safety of the residents and the community. Most staff indicated little interest in using art or craft projects to help resident practice social and cognitive skills. It may be that this intervention would be less meaningful on men’s units where arts and crafts are not a part of their culturally accepted occupational repertoire. Most respondents in this survey believe they have at least some understanding of what occupational therapy is (a brief explanation of occupational therapy was provided along with the survey materials), and 9 of the 10 respondents were not opposed to including an occupational therapist on staff at CTF. The lack of openness to including an occupational therapist on staff at CTF may have been due to budgetary considerations which have been an issue at the facility as of late with one expected lay-off to occur within the next year.
Appendix D

Paraphrased Key Informant Interviews Transcribed
from the Handwritten Notes of the Interviewer

Interview with “Coach Harry” Cummins Executive Director of The International Boxing
Club of Toledo Ohio- April 26, 2011

1. What inspired you to start a youth boxing organization in Toledo? Cummins played on a little league baseball team and his coach emphasized that if the children learn one thing through playing on his team it would be that they should give back to the community. Now he is passing this lesson on to the children he coaches.

2. How long have you lived in Toledo? Cummins has lived in Toledo his entire life.

3. What do you see as some of the obstacles to success for children in this particular community (the Toledo area) that make programs such as yours important? Cummins notes that often children’s families put them down and say things like “you can’t do that, you’re from the hood.” As a result he tries to “de-program” that attitude by teaching the children that only unsuccessful people think that way and they are “champions.”

4. What are some of the strengths you see in the young people you are working with? Cummins states that once the children start believing in themselves they can use the negative things in their lives and turn them into positives. He says that having “tough lifestyle” or growing up with a single mother working two jobs can serve as motivation. The fact that these children “never had things handed to them” can become a positive attribute with the right attitude. He
says he uses stories of professional athletes who had difficult experiences in early life to help inspire the members.

5. **What are some of the biggest challenges you face in dealing with your members?** Cummins lists families, gangs, and drugs as his biggest challenges. He states that about 75% of members’ parents do not care about education. He related a story in which one of his current members is planning to attend OSU to study architecture and recently won a prestigious award for a project in that area. However, his parents are not supportive of his desire to pursue architecture but would rather he become a professional boxer. He also notes that many members have friends in gangs but he encourages these children to “be uncommon” and stand out from their peers by staying away from trouble. He notes that there has only been “one incident” of gang-related crime involving one of his members.

6. **Since beginning the learning center, have you noticed improvement in member’s report cards?** Cummins states that the education center began because he wanted to take members out of school to compete in boxing events in different areas but would not do so if they were failing any classes. He found that 75% of his members were failing in school so he began the learning center. This caused some members to quit but for those who stayed, 16 made it to universities and 2 are graduating with a higher degree this year. He states that new members tend to have bad grades at first but the more experienced members are good role models and “the hardest part is just opening the book” so once they get started it tends to get easier.

7. **How do you assess the effectiveness of your program? Do you use any formal measurements?** Cummins reports that he does do assessments but does not inform the members they are being
tested. He uses a 4 point measure of study skills and writing skills as well as the grade card system. He notes that grades themselves are not sufficient for most funding agencies and this is understandable because grading is poorly standardized amongst grade-levels, schools, and teachers, but he does like to look for improvement in grades from the same teacher from one marking period to the next.

8. *When did you begin getting the club get involved in community service and what have you observed about those experiences?* Gloves with love began in 2007, and Cummins believes it has been a big asset to the club. He states that members feel really good about helping others and it is a big boost to their self-esteem. This is another area where he uses examples of professional athletes who give back to the community to inspire the members and he uses these experiences as evidence that they are “champions” too.

9. *Your program seems to be very well-rounded, can you describe the different benefits you have seen in the young people you work with in terms of physical, mental, and emotional health?* Cummins points out that his program is valuable in helping address anger issues and stress. He says that when children are hitting heavy bags they are not fighting on the streets, in fact, they tend to be tired after exercising which discourages them from getting into trouble. He tends to observe that children seem to release a lot of tension in the first 2 weeks they begin the program and become noticeably more calm. He also shared that often the club will break out into group sessions to talk and develop relationships. The family atmosphere of the club is very beneficial.
10. What types of precautions do you take to insure the safety of your members during training and competition? Cummins states that boxing is “pretty safe” and not all children spar. He states that a majority of the kids train without sparring and no child is forced into the ring in order to stay in the club which makes his program very different from other gyms. He says that he faces a lot of criticism from community service and funding organizations for using boxing but it is an essential element to his program because if he opened a “learning center” no one would be interested. Boxing is the “hook” that allows him to attract a full supply of members (including a waiting list).

11. How many members do you currently have? Are you training any young women? Cummins has found that 30 is a good number of members for the program and that is how many he currently has accepted. He has had larger numbers in the past but found that he was providing more of a free babysitting service than anything else. He now has firmer requirements for commitment including a 3-strike disciplinary policy and with only 30 members he finds that he can work with everyone. He states that about 75% of members throughout the years have been male but he does train young women including a past junior national champion who later joined the military.

12. Do you stay in contact with any of the young people you trained in the past? Do you have any success stories you would like to share? Cummins states that members visit or call him often because IBC is like a family and membership is lifelong. He is amazed that some of the young people he worked with in the beginning now bring their own children to visit him and he is really honored and pleased that adult members sometimes call to ask for advice. Aside
from those members graduating from college, he is also proud of members who have gone on to serve in the military.

13. Has this always been a free service for the community? Yes.

14. I’ve seen from your website that you accept donations and seek grants but often have difficulty with funding; where are most of your funds coming from at this time? Cummins states that he and his club do a lot of fundraising. They received computers through a grant from the Stranahan Foundation under the condition that the members build the computers themselves. Some members became so skilled at putting together the computers they were able to demonstrate to Foundation representatives the ability to assemble a working computer in only 30 minutes. They also receive funds from the Toledo Community Foundation. Although the boxing element deters some funders, Cummins states that often people come in and see that program and how boxing is a way to improve grades and are impressed.

Cummins states that he is very proud of his members. He believes that children need more good male role models and guidance. In addition to the educational center, computer room, boxing rings and gym, the IBC has a new vocational center where members are learning to use tools and building a small model house with a foundation, stairs, and walls. Eventually they will install basic plumbing and electrical systems. There is also a small store that sells IBC merchandise and is operated by the members. Cummins also discussed taking his members to the correctional facility which he said is a very good experience for them because when they return they talk about being determined to avoid staying out of prison. Cummins was willing to have me as a volunteer on Thursday afternoons to help members with reading skills. He states that many of his
members struggle with reading which is a cornerstone of education in general. Over the summer, he has his members involved in book groups and he assesses their reading skills before and after.

**Interview with Sari Adelson, Coordinator of Membership and Special Projects, Prison Creative Arts Project (PCAP) - May 25th, 2011**

1. *Approximately how many volunteers are involved in your project?*

   In the fall and winter, about 50 people, in the summer, about 20-30.

2. *How is the project funded?*

   The University of Michigan supports the project and the staff are housed in the Academic Unit of the College of Literature Science and the Arts. The Kreske Foundation recently provided funds for two new staff positions. There is also a donation base provided by art patrons and other grants from organizations such as the Rockefeller Center and the National Endowment for the Arts are sometimes provided.

3. *What have been some of the biggest challenges you have faced working with this population?*

   Because PCAP is not part of the department of corrections they sometimes face challenges from the MDOC. The Director of the MDOC, Patricia Caruso is supportive and has spoken favorably about PCAP but the wardens and staff at specific facilities are not always supportive. It is also challenging to find enough money to pay staff.

4. *What have been some of your most rewarding experiences?*

   Seeing people come home, especially if they become a part of the program. Some people with come back and talk about PCAP which is rewarding because sometimes it is hard to know if the work is paying off. It is great to have people verbalize that what we did really helped.
5. About how many inmates participated in the project last year?

It is hard to say because PCAP works with incarcerated adults, children in secure settings, and at urban high schools, as well as in the community. At most, eight people participate in a workshop and staff and volunteers work in pairs to run the workshops. The number is probably close to 100-200 people per year.

6. What are the main goals or objectives of PCAP?

The mission is to collaborate with the population we work with to strengthen communities through art and to remind people in their worst moments that they are human.

7. Do you have any specific measures to determine the success of the project?

PCAP does some documentation but success is not really viewed in terms of science. There is a lot of anecdotal research about what the program has meant to those it serves.

8. What sort of feedback have you received from inmates and volunteers?

Some artists have said that the program has saved their lives, especially those who have long or indeterminate sentences. They often say projects give them purpose and sharing their stories makes a big difference in their ability to make it through their sentence. The staff members that get immersed in plays and workshops see changes in the artists’ attitudes they see how they are giving someone a sense of self, a reason to respect themselves, and a sense of skill.

9. Have you worked with both men and women in prisons, and if so, can you describe any differences between the two groups that you have noticed?

During the annual exhibition staff travels to each prison and meets the artists. There is an edge with the men, some gender stereotypes and norms. Also, the men are very careful about
boundaries. The men and boys are cautious around women, they are taught chivalry. It is a very old-fashioned, sort of inappropriate way of respecting women. The women have a lot of trust issues at first and do not understand why people are spending time with them, but once the workshop gets going it is like meeting with girlfriends for a couple hours twice a week. It is really powerful working with them, there is a lot of power in the women’s stories.

Interview with Dianne Shuford, MS, OTR/L, Forensic Occupational Therapist at Summit Behavioral Healthcare in Cincinatti OH, by phone- July 23, 2011

1. Dr. Thomas told me you are forensic occupational therapist in Cincinatti, but I do not know anything else about where you work or what you do. Can you tell me a little about your job?

There used to be seven state psychiatric hospitals but now there are only five. Ours is a very old facility started in the 19th century. There are big log books from back then when they called it an insane asylum. They had mostly civil cases until about 10-15 years ago. Now 85% of cases are forensic where clients have outstanding charges and need to be restored to competency so they can stand trial or they could be not guilty by reason of insanity in which case the court either releases them or sends them to a psychiatric facility. When it was all civil it was a gigantic facility and the patients did everything. Its name changed to Summit Behavioral Healthcare.

There are 10 units with medium security. We do not have a lot of people with medical needs. We aren’t set up for medical care. I do groups with the occupational therapy department. We have the biggest presence of occupational therapists because most facilities have more activity therapists but our CEO is very pro-occupational therapy. There used to be 16 OT’s at one point. Before that CNA’s and therapeutic workers were called “activity therapists” and they practically
ran the place which led to some abuses. They would take clients off the grounds just to do their yard work.

Now we have 5 OT’s and about 7-8 COTA’s. Right now we are trying to move toward more informed care at state hospitals. Trauma is not acknowledged in prisons and jails. Women need to address trauma and need treatment that helps them understand that their behavior now was a tone point the only option but they should try to develop more consistent ways of coping. Most of my groups I do with psychology. I have a master’s degree in psychology. I do a yoga group, trauma group, and DBT skills group. I work with people with severe and persistant mental illness. If a person is refusing to answer questions or not aware of the process or incompetent to stand trial they are sent to us for about 60 days for a low level charge and up to a year for something like a murder charge. If they become competent they go. If not they offer classes in legal system competency.

2. Do you work with individuals, groups, or both?

I can always do one-on-one work. If someone is on my caseload I’m expected to meet with them and chart that weekly. If they are not on my caseload, I do groups for people who are not allowed off the unit.

All the occupational therapists wear spiders, those are buttons to press in an emergency. Our new hospital is a lot nicer than the old hospital. There was no natural light and public bathrooms but now there are no more than two patients in a room. There is one civil unit for people who have not been charged with anything but are a threat to themselves or others and there is a big push to just churn people out. People on that unit are usually out in 3 weeks. People
with severe and pervasive mental illness need wraparound services. On the forensic unit the court dictates how long people stay.

3. What types of assessments or evaluation formats do you use?

We used to have paper assessments and we developed our own. Now all the state psychiatric facilities are using the same one and it is electronic. There is one for forensic and one for civil cases. They are just for occupational therapists.

4. What types of professionals do you work with and how do you share information with one another or work together as a team?

There are 6-7 people on a team. There is the charge nurse, the psychiatrist, and the social worker who signs everything for the payer, then the rest of us are considered consultants. There is a counselor, occupational therapist, and psychologists.

5. Do you use any specific theories or models of practice in your work?

I do a lot of DBT. I have a lot of training in DBT and don’t use a lot of OT models. My roommate at work, we share an office, she is a new grad and is very keen on thinking in terms of OT theories and figuring out what she’s doing and how it fits.

6. What are some of the strengths you see in your clients?

These people’s lives are just shattered, especially by schizophrenia. Many are intelligent and striving to find a way of living with enormous disabilities. One man is 28 years old and has severe felony charges. He was in “Outward Bound,” a gifted program then his illness hit. His mother has mental illness and his dad had a stroke. He said “When I get discharged I won’t be able to get a job,” but they continue to get up in the morning. They try to get through each day
and find a way to express themselves and make a connection with people. Some really desire to make a connection. Therapeutic workers are often rude and disrespectful. Some people in our department can work with a wide range of people. All the OT’s are very respectful to residents. Therapeutic workers often believe they won’t do but really they can’t do. Residents put up with a lot and they behave well when given respect.

7. What have been some of your most successful interventions or strategies?

DBT is very successful. Really listening carefully. It is not always easy to do but you need to try to see the world through their eyes, understand what they see, and treat them with respect. Active listening.

Art groups are sometimes very helpful. One young man who is very coordinated but does not talk was very interested in investigating the properties of balls. He started juggling tennis balls so I started taking him off the unit to juggle with some juggling balls I bought for him. He was doing really well and we had a medical student who made a connection with him because he could juggle too. You can’t always connect through words, that’s the challenge for me. Anything that involves body movements.

Sometimes they don’t make sense and they don’t do well in DBT which requires organization. One woman who killed her son 16-18 years ago, now when she starts getting clear she wants to stop taking her medication. The psychologist is really good at gleaning some kernel that allows her to make a connection. “Yes Yvonne, that’s right” then moves on. Always try to begin and end on a positive note. I begin by asking what’s something positive that happened to you. Sometimes they have trouble grounding themselves and they are often very global and
negative. They may be trying to maintain a connection with family when sometimes the family has checked out or is part of the problem. I feel like I can find more positive things. Their lives are so shredded but they just keep trying in spite of the odds that are so great. Some are just so paranoid and can’t work with attorneys. I hear some of the things they believe and I know it would be very frightening, there are some delusions people have that would be like hell. Some hear voices that are insulting or annoying and they would be very vulnerable in prison.

**Brenda A. Martin, OTR/L the occupational therapy supervisor for the Southeast Louisiana Hospital - Youth Services in Mandeville Louisiana e-mailed this response to a post on OT Connections- June 20th, 2011:**

Jennifer,

I saw your post on OT Connections and would also like to answer some of your questions.

At my facility we use sensory interventions with all of our psych. populations (we do not have a separate substance abuse unit). Our biggest intervention is the use of our sensory rooms as an early intervention for distress. In terms of teaching for relapse prevention, for the youth I work with, I formulate plans to accompany them home and into their receiving school. These include both strategies the youth have found useful here as well as suggestions for environmental adaptations to meet their needs.

In terms of being part of an inter-disciplinary team, I find it useful to remind my colleagues on a daily basis of the role occupational therapy plays and to provide them with evidence that sensory interventions are effective. It is also important to remember that other disciplines do not share occupational therapy's knowledge of sensory processing, so on-going education is vital. At our
facility occupational therapy provides every new employee with a total of 3 hours of in-servicing regarding sensory processing.

Good luck on your project.

**Interview with Colleen Hartford, BIS, Case Manager on the Women’s Unit at the**

**Correctional Treatment Facility (CTF) in Toledo, OH - June 14th, 2011**

1. **What are some of the strengths you see in your residents?**

They are very relationship oriented. They really care about their families. Most are very intelligent. Unfortunately they use that intelligence in bad ways.

2. **What are some of the areas that residents generally need to work on?**

Building healthy relationships, being honest, and being assertive.

3. **What are the most common drugs of choice for residents in this unit? Does the drug of choice seem to significantly alter the recovery process?**

They usually use them all. Women tend to use pain pills and heroine especially. The only noticeable difference is that people who have used a lot of meth tend to have comprehension problems. It really does seem to burn holes in their brains.

4. **What can you tell me about the statistics for CTF and the women’s unit specifically in reducing reoffending?**

Rumor has it that the recidivism rate for the state of Ohio is about 60% and for CTF it is about 40%. One thing I have noticed that is interesting is that the majority of men at CTF seem to be African American while most of the women are White.
5. About how many residents arrive with co-occurring mental health diagnoses (in addition to substance use disorders) and what are the most common diagnoses? How do these diagnoses influence the recovery process?

It can be up to 90% sometimes. Usually it is between 50%-90%. It tends to be high for women. The most common diagnoses are PTSD and bipolar disorder. Not many have schizophrenia but occasionally we see that too. Everyone has OCD because that is part of the addiction, they are compulsive. Its hard to say what comes first though, the addiction or the mental illness, it is really a chicken or egg kind of thing. You have to treat them at the same time, the mental illness and the addiction, they need equal treatment.

6. About how many residents enter your unit with undiagnosed mental health or personality disorders, and about how many receive treatment for these conditions?

All of them. We do as much treatment as possible here at CTF depending on the severity. We (the case managers) try to deal with what we can, but with something more severe residents are sent to Bill or Sandy (counselors) and go to special classes to deal with their issues like Trauma Recovery Empowerment and Grief and Loss. Sometimes we send people out of house to Unison or places like that. We make sure people are hooked up with service providers for after they leave.

7. What do you see as the most important behavioral patterns, habits, skills, or environmental factors for residents to address when it comes to maintaining sobriety and avoiding future criminal activity?
They need to continue seeking professional help and social assistance. They need to get involved in sober groups like church and AA, continue with their positive affirmations, practice asking for help with the little things, and try to integrate slowly back into the community.

8. What do you see as some of the strengths of the programming here at CTF?

Number one: it is very holistic. There is a balance between very specific cognitive-based based programming and creative thinking. We expect self-discipline and continue to motivate residents to be self-disciplined.

9. Can you think of any areas that are not adequately addressed with the current programming?

We need more housing, childcare, aftercare, and transportation for when they leave so they aren’t so overwhelmed. They need to work on the ability to schedule so they don’t get overwhelmed by trying to swallow the whole elephant all at once instead of taking small bites.

10. What type of skills do you think health care professionals need in order to work in a setting such as CTF?

Thick skin, the ability to meet people where they are, humility-apologize, model. Meet them where they are then start pushing them. You need to be good with people, discerning but not judgmental. They (the residents) respond more to positives, they are used to negatives and they can go further than they think they can with encouragement.

11. Can you describe your understanding of occupational therapy?

Teaching life skills to help people advance in everyday situations; teaching new skills.

12. If money were not an issue, do you think it would be helpful to have a full-time or part-time occupational therapist on staff at CTF?
Absolutely. An OT adds to the holistic nature of the program and gives residents opportunities to explore areas within themselves and teaches them to work well with others.

13. What type of role would you like to see an occupational therapist take on in this unit or at this facility as a whole?

This is like my last answer. Run groups in exploring new areas of expression and opening themselves up to new ideas.

Interview with Dawn Leiss, LSW, Case Manager on the Women’s Unit at the Correctional Treatment Facility (CTF) in Toledo, OH - July 7th, 2011

1. What are some of the strengths you see in your residents?

They are survivors... resilient... they have life experience.

2. What are some of the areas that residents generally need to work on?

Honesty, adhering to rules, thinking errors.

3. What are the most common drugs of choice for residents in this unit? Does the drug of choice seem to significantly alter the recovery process?

Alcohol, marijuana, heroine and opiates. Women who use marijuana have a lot of denial. Women who use heroine or opiates are usually in treatment more than once, that addiction really gets a hold of them emotionally and physically.

4. What can you tell me about the statistics for CTF and the women’s unit specifically in reducing reoffending?

In the past 60 days, 8 women were re-sentenced or re-booked so 8 out of 26 have been here more than once right now.
5. About how many residents arrive with co-occurring mental health diagnoses (in addition to substance use disorders) and what are the most common diagnoses? How do these diagnoses influence the recovery process?

Over 80% or between 90-80%. There is a lot of depression, bipolar disorder, and anxiety. It is hard to tell if the diagnoses are accurate though. Some substance abuse experts would rather see people be completely sober before they are diagnosed. It greatly effects recovery. If they are not taking their medication, people cannot work a program of recovery. Mental health diagnoses and drug drug use recovery really go hand in hand. It creates a hard situation because we try to make it so they have less to do when they are released. When they get hooked up with a mental health service they are expected to go to appointments and groups for that but at the same time they have to do CTF aftercare and go to meetings and it is a lot, especially if you don’t have a license, or you have a job or children to take care of. We try to get as much treatment for them as possible while they are in-house at CTF so they will not have as much when they get out.

6. About how many residents enter your unit with undiagnosed mental health or personality disorders, and about how many receive treatment for these conditions?

I don’t know. Most have been previously linked or diagnosed. There is probably a small percentile but it is hard to tell what is substance related versus a true mental illness.

7. What do you see as the most important behavioral patterns, habits, skills, or environmental factors for residents to address when it comes to maintaining sobriety and avoiding future criminal activity?
Habits.... people, places, and things. Justification, rationalization, excuses, blaming, not taking responsibility for themselves.

8. What do you see as some of the strengths of the programming here at CTF?

The variety of programming offered.

9. Can you think of any areas that are not adequately addressed with the current programming?

There is not enough time to address all areas that need work.

10. What type of skills do you think health care professionals need in order to work in a setting such as CTF?

They need to understand drug and alcohol addiction, the legal system, and criminogenic behaviors.

11. Can you describe your understanding of occupational therapy?

I’ve been involved with my son. You want to get optimal performance.

12. If money were not an issue, do you think it would be helpful to have a full-time or part-time occupational therapist on staff at CTF?

Yes, lots of the residents have issues post-drug use or post accidents and it would be good to have someone who could treat them in house because sometimes they need to be seen 2-3 times per week for physical rehabilitation. Even for AD/HD issues, the understanding from an OT perspective would be good.

13. What type of role would you like to see an occupational therapist take on in this unit or at this facility as a whole?
No more recreation time as we know it. Creating a more structured environment for recreation. Also, teaching residents how to calm and focus their brain. OT could even help with trauma or grief and loss with stress balls and stuff like that, even swings.

**Interview with Sandra Cox, MSW, LCDC, Chemical Dependency Counselor who leads “Relationship Building” (including parenting) and “Trauma Recovery and Empowerment” groups with women at CTF - July 19th, 2011**

1. **What are some of the strengths you see in your residents?**
   
   Resiliency, survival skills.

2. **What are some of the areas that residents generally need to work on?**
   
   Relationships, encompassing family, friends, and romantic relationships; self efficacy; and past abuse issues.

3. **What are the most common drugs of choice for residents in this unit? Does the drug of choice seem to significantly alter the recovery process?**
   
   It has changed. It used to be crack but now there is more oxycodone, percocet. A lot depends on the environment and how accessible it is to them.

4. **What can you tell me about the statistics for CTF and the women’s unit specifically in reducing reoffending?**
   
   I don’t have those numbers. Sean was our statistics man and he’s gone now.

5. **About how many residents arrive with co-occurring mental health diagnoses (in addition to substance use disorders) and what are the most common diagnoses? How do these diagnoses influence the recovery process?**
A lot of bipolar. It varies. Maybe 50%. How it affects them has a lot to do with the medications they are on. A lot of them get off their medication and self-medicate then it takes a while to get back in balance. A lot of clinicians misdiagnose the effects or behavior that comes from addiction as bipolar and think it is necessary to medicate them. A lot of education needs to take place. A lot just depends on the environment.

6. About how many residents enter your unit with undiagnosed mental health or personality disorders, and about how many receive treatment for these conditions?

A lot of women come in diagnosed but a lot of personality disorders are missing, probably about 25-40%. A lot of women have been abused in one way or another that is why we see a lot of personality disorders.

7. What do you see as the most important behavioral patterns, habits, skills, or environmental factors for residents to address when it comes to maintaining sobriety and avoiding future criminal activity?

Environment is everything. What they go back to and what they have as a support system. If the family situation is such that criminal activity is the norm it will be hard for them.

8. What do you see as some of the strengths of the programming here at CTF?

It addresses a lot of trauma, grief and loss, and cognitive behavioral issues. It’s a holistic program.

9. Can you think of any areas that are not adequately addressed with the current programming?

For the women, gender-specific training. The male staff can be a problem, especially male authoritarian behavior. Also, there are not enough residential facilities for when they leave.
10. What type of skills do you think health care professionals need in order to work in a setting such as CTF?

Motivational interviewing; good listening skills; knowledge of what is out there for them, outside of CTF; and good forensic skills or they will take advantage of you.

11. Can you describe your understanding of occupational therapy?

Therapy to help individuals resume their life to the best of their ability considering whatever their issue is.

12. If money were not an issue, do you think it would be helpful to have a full-time or part-time occupational therapist on staff at CTF?

Yeah, given the fact that their environment when they leave is so crucial to their recovery.

13. What type of role would you like to see an occupational therapist take on in this unit or at this facility as a whole?

Work with them as far as how to better structure their at home environment to make it conducive to recovery and just listen. They always need people to just listen to them.

14. Is there anything else you would like to add?

Trauma needs to be addressed more, especially individually with men who won’t share in group. Also, we see a lot of AD/HD and impulse control issues, especially with the men.

Interview with Danielle Kidd, CTF Corrections Officer, frequently works first shift on the women’s unit during the week- July 19th, 2011

1. What are some of the strengths you see in your residents?
Their ability to adjust to the environment, adapting, coping, sharing experiences. It is funny how they’ll maintain their sanity. The transformation from the unhealthy look when they first get in to after a while you can see a gleam in their eyes.

2. *What are some of the areas that residents generally need to work on?*

   Anger, abuse, making amends, and education.

3. *What do you see as the most important behavioral patterns, habits, skills, or environmental factors for residents to address when it comes to maintaining sobriety and avoiding future criminal activity?*

   Being honest with yourself that you need help and that you can’t handle it all yourself. Some think that saying you are having a bad day and you want to use is a weakness. Their reaction to things, they need to stop and think before they act.

4. *What do you see as some of the strengths of the programming here at CTF?*

   Overall it is a good program. It addresses all kinds of people, not just drug addicts but dealers, gamblers. It is sometimes the person with the worst attitude at day one that will end up loving the program. I love watching the transition because I see them when they are first brought in.

5. *Can you think of any areas that are not adequately addressed with the current programming?*

   Sometimes people are overloaded. There is not as much one-on-one time as there should be. There is a lot of guessing on the residents’ part. They think too much. I tell them to just keep communicating. Communication is huge. When there is no communication their fear and anxiety goes up. Communication is important to settle people down and solve problems.
6. What type of skills do you think health care professionals need in order to work in a setting such as CTF?

   People skills, effective communication skills, time management, and be fair and consistent in all you do, no taking favorites, every is the same.

7. Can you describe your understanding of occupational therapy?

   Preparing them how to do a job interview. Skills and preparation to handle a job.

8. If money were not an issue, do you think it would be helpful to have a full-time or part-time occupational therapist on staff at CTF?

   Part-time maybe, full-time no.

9. What type of role would you like to see an occupational therapist take on in this unit or at this facility as a whole?

   Resume building, links to organizations that hire felons. There is a man that comes with a trailer sometimes and the residents go out and talk to him. He is hiring for construction jobs.
Appendix E

Integrated Care Pathway for Occupational Therapy Intervention in the C.O.C.O.O.N. Project

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<th>Resident Name: ___________________________</th>
<th>Intake Date: _______</th>
<th>Discharge Date: _______</th>
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<td><strong>Task</strong></td>
<td><strong>Date Completed</strong></td>
<td><strong>Reason not Completed</strong></td>
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<tr>
<td>Initial consultation with Case Manager(s)</td>
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<td>Pre-programming interview</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-programming MOHOST assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-programming ACIS assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resident demonstrates basic understanding of C.O.C.O.O.N. Project’s role in CTF program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resident demonstrates understanding of groups she is expected to participate in</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resident demonstrates understanding of groups she is invited to voluntarily participate in</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discussion with resident regarding occupational goals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goals established and recorded with resident</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-programming interview</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post programming MOHOST Assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post programming ACIS Assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resident provided with Alumni group schedule and information</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix F

Interview Questions Modified from OCAIRS Questionnaire for Forensic Settings (Parkinson, Forsyth & Kielhofner, 2006)

Pattern of Occupation

1.) Describe a typical weekday before you came to CTF?

2.) Describe a typical weekend day before you came to CTF?

3.) Does your daily schedule let you do the things you need and want to do?

4.) Has your daily routine changed over the past six months?

5.) Are you satisfied with the routine you had in place before coming to CTF?

6.) What do you do? What are your major responsibilities?

7.) Do you belong to any groups (like an AA home group or PTA)?

8.) Think of those last two questions in terms of roles you fulfill. What would you describe as your roles?

9.) For each role: How important is it?

   Do you enjoy it?

10.) How well are you able to _____ ? (for each role mentioned)

10.) What else do you do?

Skills

1.) Are you able to do the things you want or need to do?

   What limits your ability to do things?

2.) Are you able to concentrate, problem solve, and make decisions to get things done?
3.) Do you have the physical ability to accomplish what you need and want to do?

4.) Are you able to overcome these limitation and barriers?

5.) Do you prefer to work alone or with others?

6.) How well do you work with others?

7.) Do you have any physical complaints that limit you during the day

**Environment**

1.) Where did you live before coming to CTF?

2.) Where do you plan to go after leaving?

3.) Are there things to do or places to go in those areas that interest you now that you are no longer using?

4.) Are there any barriers that prevented you from getting things done or any barriers that might prevent you from getting things done in your new environment?

5.) Does anything prevent you from participating in activities you would like to be involved in or going places you would like to go?

6.) Are there resources available to help you overcome barriers to getting things done?

7.) Do you spend a lot of time alone when you are outside of CTF?

8.) Who are the most important people in your life right now?

9.) How about when you leave CTF?

10.) Does what they expect from you match what you would like to do?

11.) Would you describe your work/school/community setting as supportive

12.) Do the people or situations in your life place limits on you?
13.) If you need help/support, can you count on family/friends/community?

14.) How well are you at forming close relationships?

**Motivation for Occupation:**

1.) What things in your life do you think you do well or are proud of?

2.) What are some things that have been difficult for you? How did you handle it?

3.) What is the biggest challenge you are currently facing?

4.) How successful do you think you will be over the next six months?

5.) Is your major role as ________ something you enjoy

  What about it satisfies or interests you?

6.) What do you like to do with your time outside of those major roles?

7.) Do you have any other interests or hobbies?

  How often do you _______?

  Are you satisfied with the amount of time you are able to spend ______?

8.) What do you value most in life; what is most important to you?

9.) What other things or ideals do you value (are important to you)

10.) What kinds of things do you do to live up to your values or fit with the way you think you should live?

11.) Is there anything about your life that you feel goes against your values?

12.) Do you ever set goals for yourself or make plans for the future (not as part of an assignment)

13.) Have you followed through on any of your goals?

14.) What goals do you have for you time at CTF?
15.) What goals do you have for the first week you leave CTF?

16.) What goals do you have for the first month after you leave CTF?

17.) What are you doing to accomplish those?

18.) Do you have any long-term goals?

19.) How will you accomplish those?

20.) Do you normally achieve your goals?

Are your goals or whatever you set out to do usually hard or easy.

21.) Would you like to return to your old way of life including abusing drugs/alcohol and/or doing things that are illegal

   What was good and what was bad about that lifestyle

**Readiness for Change:**

1.) Tell me about a time when you experienced a big change in your life?

2.) What did you do?

   a. Did that make it better or worse

3.) How do you react when someone criticizes or challenges you?

   How does it make you feel?
Appendix G

Outline of Self Regulation and Community Integration Group

<table>
<thead>
<tr>
<th>Content</th>
<th>Potential Occupations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self Awareness</strong></td>
<td>Discussion</td>
</tr>
<tr>
<td><strong>Roles</strong></td>
<td>Worksheets/writing assignments</td>
</tr>
<tr>
<td><strong>Responsibilities</strong></td>
<td>Goal writing</td>
</tr>
<tr>
<td><strong>Capacities</strong></td>
<td>Personal Mission Statement</td>
</tr>
<tr>
<td><strong>Strengths/abilities</strong></td>
<td>Talent show</td>
</tr>
<tr>
<td><strong>Limitations/weakness</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Methods to address limitations/weakness</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Values</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Personal values</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Societal values</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Importance of harmony between personal and societal values</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Like a family: don’t have to agree, just get along</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Goals</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Short term</strong></td>
<td></td>
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<tr>
<td><strong>Long term</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Self Acceptance**

Environmental barriers to self-acceptance

- Gender issues
  - Sexism
  - Body issues
  - Abuse

Cultural issues

- Criminal record
- Racism
- Classism
- Stigma of mental illness/addiction

Tools to promote self-acceptance

- Higher power reflection
- Positive thought journal
- Affirmations

**Community Exploration**

Identifying areas of interest

Viewing/creating artwork with positive messages about womanhood and/or body acceptance

Decorating a garbage can with the hurtful things others have said

Inviting a guest speaker who has overcome any of these issues and/or reflecting on written accounts from similar role models

Occupations expressing a survivor vs. victim stance (artwork; writing poetry or thank-you notes to people who have been hurtful)
Recreational activities
   Affordable options
   Relaxation
   Previously enjoyed activities
   Individual and social
Volunteer activities
   Reinforcing values
Group activities
   Shared values/interests
      AA, NA, CA, GA, etc.
      Other self-help/support groups
      Spiritual/religious groups
      Volunteer or recreation activities
Identifying and addressing limitations and barriers
   Social anxiety
      Coping strategies
   Impression management
      AD/HD traits
      Education
      Coping strategies
Helpful habits
   Dressing to impress
   First impression social skills

Community Involvement
   Healthy relationships
      Boundaries
      Reciprocation
      Effective communication
      Assertiveness
   Historical and philosophical ideas about the individual’s role in the community
      Role models who have had a positive influence on the world
   Considering one’s own values regarding community
   Building a better community
      Civics- understanding role as citizen
      Completing (a) community service project(s)

Discussion
   Interest inventory
   Provide resources (groups and volunteer organizations)
   Try-out recreational activities of interest (yoga, dancing, origami, found-object sculptures, board games, etc)

Discussion/Education
   Playing “Catch phrase”
   Role playing
   Writing letters to government officials
   Completing oral report on personal hero including at least one way the resident can follow in her hero’s footsteps
   Brainstorming, choosing, and completing community service project(s) Examples: making cards for hospitalized individuals, building pinatas for children’s/family charities, writing notes/cards to deployed military personnel, etc.
   (residents should be able to have some choice so the project(s) will have meaning to them)
Appendix H

Sample Materials from Self and Community Group

Mission Statement:
Many businesses and other organizations have “Mission Statements.” Mission statements explain the who, what, why, and how of the organization (why they exist, who they serve, what they do for those people, and how they do it).

People can also have mission statements. A personal mission statement answers these questions:
1.) What do I want from life? (NOT things you want to have, what you want to become)
2.) What do I value?
3.) What do I do well?
4.) What do I want to accomplish during my lifetime?

To create a personal mission statement, you will need to think hard about your identity, your hopes, and what is most important to you. If you do a good job, the mission statement can help remind you of your purpose and dreams. It can even be used when making decisions and planning your schedule.

To get started with writing your mission statement, answer the questions below on a separate sheet of paper:
1.) Roles can be a part of the mission statement, how would you like to be described in the three roles you identified as most important?

2.) Think about someone who is important in your life that you admire. Write out a list of at least 3 qualities you like best about this person. Which of these qualities will you need to have in order to create the future you want for yourself (circle them)?

3.) In 1-2 sentence(s), what do you believe about your higher power?

4.) What are some of your skills that could help others or make the world a better place (list at least 3)?

Now write a rough draft of your mission statement on the same paper. The questions you just answered will help give you some ideas but the mission statement must answer the 4 questions on the top of the page. Spend a few days thinking about it. Make changes if you need to. It is important that this statement is right for YOU, it should be one of a kind (because you are one of a kind) and it should inspire you. In our next session you will have a chance to write-out your mission statement using arts and crafts supplies. Even after we do this, it is okay to change the statement but it is NOT okay to throw it out and forget about it, you can use it for other activities we will do like goal writing.
Writing for a Cause

Brainstorm on a separate sheet of paper or on the back of this worksheet.

1.) Think of a public issue that you feel strongly about. Use newspapers and magazines if you cannot think of anything or to learn more about your issue. These are just some examples: funding for AIDS (or any other disease) research, funding/support for places like CTF, public housing, minimum wage, access to affordable healthcare, expungement laws, smoking bans, casinos in Ohio, etc. It should be something that you care about and our government has some control over.

2.) Decide if your issue is a local, state, or national issue. It could be more than one (for example: healthcare decisions are made at the state and national level; education decisions are made at all levels). Ask others for help if you cannot decide.

3.) Based on your decision, choose a government official from the list below:

**State Level:**
Governor John Kasich  
Riffe Center, 30th Floor  
77 South High Street  
Columbus, Oh 43215-6117

State Representative from District 48  
Mike Ashford  
77 S. High St  
11th Floor  
Columbus, OH 43215-6111

State Representative from District 47  
Teresa Fedor  
77 S. High St  
10th Floor  
Columbus, OH 43215-6111

State Senator from District 11  
Edna Brown  
Senate Building  
1 Capitol Square, 2nd Floor  
Columbus, OH 43215

**National Level:**
Senator Sherrod Brown  
United States Senate  
713 Hart Senate Office Building  
Washington DC 20510

Senator Rob Portman  
United States Senate  
338 Russell Senate Office Building  
Washington DC 20510

9th District Representative  
Marcy Kaptur  
United States House of Representatives  
2186 Rayburn House Office Building  
Washington, D.C. 20515-3509

**Local Level:**
Mayor Michael P. Bell  
One Government Center  
640 Jackson  
Suite 2200  
Toledo, Ohio 43604

Toledo City Council  
One Government Center  
640 Jackson  
Suite 2120
4.) Use the formal letter format below to write a letter to the official you selected. You may want to start with a rough draft and have someone proofread the letter for you.

Your Street Address  
Your City, State Zip code

Month Date, Year

The Honorable Name of Official  
Title of Official (for example: Legislator, U.S. Senate)  
Street address you are sending to  
City, State Zip code you are sending to

Dear Representative/Mayor/Governor/Senator Name of Official:

In the first paragraph introduce yourself as an interested constituent (a fancy word that means you are one of the people this official represents) and introduce your issue.

In the body, explain why the issue is important and support your opinion. You can use facts from the news, newspapers, and magazines, as well as experiences from your life. Use as few words as you can to express yourself without wasting the reader’s time.

In the last paragraph, re-state the purpose of the letter. Ask the official to do what they can to support your cause. Thank the official for his or her time and attention.

Sincerely,

Your signature

Your name printed

5.) Address an envelope but DO NOT ENCLOSE THE LETTER until a case manager or student has read it. If the letter is well written, we will help you to mail it. Use the address you expect to have after leaving CTF as the return address.

6.) To contact officials after you leave CTF visit: http://www.usa.gov/Contact/Elected.shtml
# Appendix I

Sample Weekly Schedule for C.O.C.O.O.N. Project’s Occupational Therapist

<table>
<thead>
<tr>
<th></th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30 AM</td>
<td>Consult/Document/Plan</td>
<td>Consult/Document/Plan</td>
<td>Consult/Document/Plan</td>
</tr>
<tr>
<td>9:30 AM</td>
<td>Individual/Sm. Group</td>
<td>Pre/Post Interview</td>
<td>Individual/Sm. Group</td>
</tr>
<tr>
<td>10:30 AM</td>
<td>Skill Building</td>
<td>Self/Community</td>
<td>Skill Building</td>
</tr>
<tr>
<td>11:30 AM</td>
<td><strong>Lunch Break</strong></td>
<td><strong>Lunch Break</strong></td>
<td><strong>Lunch Break</strong></td>
</tr>
<tr>
<td>12:30 PM</td>
<td>Document/Plan</td>
<td>Document/Plan</td>
<td>Document/Plan</td>
</tr>
<tr>
<td>1:30 PM</td>
<td>Structured Recreation</td>
<td>Individual/Sm. Group</td>
<td>Structured Recreation</td>
</tr>
<tr>
<td>2:30 PM</td>
<td>Individual/Sm. Group</td>
<td>Individual/Sm. Group</td>
<td>Pre/Post Interview</td>
</tr>
<tr>
<td>3:30 PM</td>
<td>Pre/Post Interview</td>
<td>Individual/Sm. Group</td>
<td>Individual/Sm. Group</td>
</tr>
<tr>
<td>4:30 PM</td>
<td>Document/Plan</td>
<td>Document/Plan</td>
<td>Document/Plan</td>
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<table>
<thead>
<tr>
<th></th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
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</thead>
<tbody>
<tr>
<td>8:30 AM</td>
<td>Consult/Document/Plan</td>
<td>Consult/Document/Plan</td>
<td></td>
</tr>
<tr>
<td>9:30 AM</td>
<td>Pre/Post Interview</td>
<td>Individual/Sm. Group</td>
<td></td>
</tr>
<tr>
<td>10:30 AM</td>
<td>Self/Community</td>
<td>Individual/Sm. Group</td>
<td></td>
</tr>
<tr>
<td>11:30 AM</td>
<td><strong>Lunch Break</strong></td>
<td>Document/Plan</td>
<td></td>
</tr>
<tr>
<td>12:30 PM</td>
<td>Document/Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1:30 PM</td>
<td>Team Meeting</td>
<td></td>
<td>Prepare for Alumni</td>
</tr>
<tr>
<td>2:30 PM</td>
<td>Individual/Sm. Group</td>
<td></td>
<td>Alumni Group</td>
</tr>
<tr>
<td>3:30 PM</td>
<td>Individual/Sm. Group</td>
<td></td>
<td>Alumni Group</td>
</tr>
<tr>
<td>4:30 PM</td>
<td>Document/Plan</td>
<td></td>
<td>Document/Plan</td>
</tr>
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</table>
Appendix J

Example Brochure for C.O.C.O.O.N Project Participants

### The C.O.C.O.O.N Project

**Changing Ourselves by Celebrating Our Occupational Nature**

Occupational Therapy at CTF

### What to Expect

During your time at CTF you will have a “Self Regulation and Community Integration” group twice a week unless you are in GED classes. In this group you will think about who you are and how you can be an active member of your community. You will also have recreation time activities twice a week. You are expected to join the activity at least once per week but are always welcome. You may also be called into smaller groups to work on your skills or goals with the OT. After you leave CTF you can come to alumni group meetings at a nearby location in Toledo.

### What is an Occupational Therapist?

An occupational therapist or “OT” is a healthcare professional who helps all kinds of people do the things they want and need to do in order to be happy and healthy. OT’s work in schools, hospitals, nursing homes, clinics, worksites, and many other places. An OT might help an older adult learn to get dressed after hip surgery or help a child who has trouble using her hands to feed herself or hold a pencil. OT’s work with the people they see to solve problems through exercises, practice, or changing things in the environment.

### Why should I work with an OT?

OTs work with all kinds of people, not just older people or children or people who are sick or have disabilities. Most people can find some area of their life that they could improve (even OT’s) and an OT will work as your partner. It is up to YOU to decide what you will do with your life outside of CTF but if you want to make some changes, an OT might be able to help you prepare.

### What could I learn with the help of an OT?

- Fun things to do in my free time
- Ways to relax and fight stress
- Ways to stay alert and focus
- Ways to schedule my time, budget my money, and plan before I try to do things
- Ways to understand, accept and express who I am
- Methods to set and achieve goals

### What is the C.O.C.O.O.N. Project’s Goal?

To promote the motivation, habits, and skills necessary for women residents to engage in rich and fulfilling occupational lives.
Appendix K

Sample Flyer to be Posted on the Women’s Unit at CTF

The C.O.C.O.O.N Project
Changing Ourselves by Celebrating Our Occupational Nature
Occupational Therapy at CTF

CTF now offers the services of a licensed and registered Occupational Therapist to its women residents

“Life opens up opportunities to you and you either take them or you stay afraid of taking them” - Jim Carrey

- Assessment and Feedback
- Self Regulation and Community Integration Group
- Organized Recreation Activities
- Small Group and One-on-One Work (for residents with special goals who might benefit)
- Off-Site Alumni Group
### C.O.C.O.O.N Activities

**Week of January 2nd, 2012**

<table>
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<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wed.</th>
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<th>Friday</th>
<th>Sat.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recreation</td>
<td>Self/ Community:</td>
<td>Recreation</td>
<td>Self/ Community:</td>
<td>Small Group and</td>
<td>Alumni Group</td>
</tr>
<tr>
<td>Activity:</td>
<td>Crab</td>
<td>Activity: Yoga</td>
<td>Community: Recovery</td>
<td>Individual Sessions</td>
<td>discharged residents only</td>
</tr>
<tr>
<td>Crab</td>
<td>Goal Setting</td>
<td>(sign up for mat)</td>
<td>Path HW due</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soccer</td>
<td>HW due</td>
<td></td>
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</table>

**Week of January 9th, 2012**

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<th>Thurs.</th>
<th>Friday</th>
<th>Sat.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recreation</td>
<td>Self/ Community:</td>
<td>Recreation</td>
<td>Self/ Community:</td>
<td>Small Group and</td>
<td>Alumni Group</td>
</tr>
<tr>
<td>Activity:</td>
<td>Low-impact</td>
<td>Activity: Silly</td>
<td>Community: Women’s</td>
<td>Individual Sessions</td>
<td>discharged residents only</td>
</tr>
<tr>
<td>Low-impact</td>
<td>Aerobics</td>
<td>Relays</td>
<td>Issues</td>
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</tr>
<tr>
<td>Aerobics</td>
<td>Appreciation</td>
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<tr>
<td></td>
<td>Letter/Poem</td>
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</table>
Appendix M

Job Description for Occupational Therapist to Facilitate C.O.C.O.O.N. Program

Occupational therapist will operate grant-funded program with women residents in Toledo’s Correctional Treatment Facility (CTF). The therapist will work 40 hours per week including 36 hours at CTF and 4 hours on Saturdays at the International Boxing Club (IBC) facility. Duties include consulting with case managers and other staff at CTF, conducting standardized assessments from the Model of Human Occupation (MOHO) (Kielhofner, 2002), collaboratively writing goals with participants, planning and facilitating group and individual interventions based on MOHO and an outlined program development plan, developing assignments for residents to complete in their free time, maintaining records to be used in program evaluation, recruiting community members to work with residents, delivering in-service presentations to CTF staff, and organizing, storing, and transporting program materials. Groups will include an active recreational group, occupation-based social skills group, a group focused on self-regulation strategies and successful community integration, and a group for former CTF residents at the IBC facility. Individual sessions and small groups will be scheduled at the therapist’s discretion to address specific participants’ goals. Therapist must be nationally registered and licensed in the state of Ohio with a bachelor’s, master’s, or doctoral degree from an accredited occupational therapy program. He or she must also have at least 5 years of experience as a practicing occupational therapist. Experience in the fields of mental health and/or substance abuse is preferred.
Appendix N

Advertisement Seeking Applicants for Occupational Therapist to Facilitate C.O.C.O.O.N. Project

Seeking Occupational Therapist to Lead Innovative Program Serving Women Residents of Toledo, Ohio’s Correctional Treatment Facility

Full-time position for confident, self-directed OTR/L ready to help justice-involved women discover new occupational possibilities

Potential Candidates Must Have:
- National registration and licensure in the state of Ohio (OTR/L)
- A bachelor’s, master’s, or doctoral degree from an accredited occupational therapy program
- At least 5 years of professional experience*
- Good communication skills
- A strong desire to help others

*Experience in mental health and/or substance abuse treatment is preferred

If interested, please call:
(734) 255-4414

Or send your resume to
The C.O.C.O.O.N. Project
1100 Jefferson Ave
Toledo, OH 43604
Appendix O

Documentation Format for C.O.C.O.O.N. Project Groups

**Date:** 1/1/2012  
**Group:** Self Regulation and Community Integration  
**Session Number:** 22  
**Topic:** Identifying Roles and Responsibilities  
**Attendance:** 12

<table>
<thead>
<tr>
<th>Homework Assigned/Completed</th>
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<td>11</td>
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<tr>
<td>12</td>
</tr>
</tbody>
</table>

**General Notes:** Overall good participation. Majority of group were able to identify roles and responsibilities they value and those that are negative. Worksheet assigned for homework.  
**Plan:** Go over homework and move on to mission statements in next session. Try active warmup occupation prior to seated work.
Appendix P

Documentation Format for Individual C.O.C.O.O.N. Project Participants

Name: Jane D.
Intake: 1/1/2012
Discharge: 4/1/2012

Pre-Programming ACIS: 67
Post-Programming ACIS: N/A

<table>
<thead>
<tr>
<th></th>
<th>Motivation</th>
<th>Pattern</th>
<th>Com./Int.</th>
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Pre-Programming Roles: mother
Post-Programming Roles: mother, poet, friend, woman in recovery

Resident’s Goals:
1.) Plan a routine for life at home that will help with recovery - Accomplished
2.) Discover a new hobby to do at home - Accomplished

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Enjoyable/Satisfying Occupation: Writing poems
Valuable/Helpful Occupation: Making a time pie
Alumni Group Attendance: None as of 6/1/2012 (has until 7/1/2012 to be evaluated)
### Documentation Format for Evaluation of C.O.C.O.O.N. Project

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HW1a: Homework tasks assigned in first four weeks  
HW1c: Homework tasks completed in first four weeks  
HW2a: Homework tasks assigned from after four weeks until discharge  
HW2c: Homework tasks completed from after four weeks until discharge  
OG1o: Optional groups offered in first four weeks  
OG1a: Optional groups attended in first four weeks  
OG2o: Optional groups offered from after four weeks until discharge  
OG2a: Optional groups attended from after four weeks until discharge  
Ob: Objective (1= participant met objective, 0= participant failed to meet objective, blank= N/A)
Appendix R:

Potential Sources for Letters of Support

**CTF Women’s Unit Case Manager**
Colleen Hartford, BIS
1100 Jefferson Avenue
Toledo, OH 43604-5838
(419) 213-6200

**CTF Women’s Unit Case Manager**
Dawn Leiss, LSW
1100 Jefferson Avenue
Toledo, OH 43604-5838
(419) 213-6200

**CTF Director**
Bud Hite
1100 Jefferson Avenue
Toledo, OH 43604-5838
(419) 213-6200

**CTF Resident**
*Not currently identified*
1100 Jefferson Avenue
Toledo, OH 43604-5838

**The International Boxing Club of Toledo Executive Director**
Harry E. Cummins III
1717 Adams St.
Toledo, OH 43604
(419) 450-8435

**The University of Toledo Criminal Justice Program Associate Professor**
Lois Ventura, PhD
HH 3004
Mail Stop 119
2801 W. Bancroft St.
Toledo, OH 43606-3390
(419) 530-2660
American Friends Service Committee Criminal Justice Department Co-director
Penny Ryder, MSW
1414 Hill Street
Ann Arbor, MI 48104
(734) 761-8283

Mariposa Women and Family Center, Occupational Therapy Director
Sue McNulty, MA, OTR/L
812 West Town & Country Road
Orange, CA 92868-4172
(714) 547-6494

Opportunities Promoting Self-responsibility (OPS) Program Co-creator
Sandra Whisner, MA, OTR
Texas Tech University School of Allied Health Sciences
3601 4th Street, MS 6294
Lubbock TX, 79430
(806) 743-3220

Forensic Occupational Therapist
Dianne Shuford, MS, OTR/L
Summit Behavioral Healthcare
1101 Summit Rd
Cincinnati, OH 45237
(513) 948-3347
Capstone Mentored Studies Annotated Bibliography

Jennifer Lambarth

Faculty Mentor: Beth Ann Hatkevich, PhD, OTR/L

Site Mentor: Colleen Hartford, BIS

Department of Rehabilitation Sciences

Occupational Therapy Doctoral Program

The University of Toledo

August 2011
Sources Related to Ethical Considerations


Abstract: No abstract available for this source.

Summary and Significance:

This document serves as the guide set forth by the national professional organization to direct conduct when ethical issues arise. “Ethical action” is defined as:

A manifestation of moral character and mindful reflection, a commitment to benefit others, to virtuous practice of artistry and science, to genuinely good behaviors, and to noble acts of courage (p. 1)

The ethical principles defined in this document are based on the core values of the profession: altruism, equality, freedom, justice, dignity, truth, and prudence. The first principle is “Beneficence,” concern for the well-being and safety of service recipients through actions such as defending their rights and removing harm. The second value is “Nonmaleficence,” intentionally refraining from actions that could cause harm such as exploiting a service recipient. This value also mandates that occupational therapists address all personal problems and limitations that could cause harm. The third value is “Autonomy and confidentiality,” which involves respecting the rights of service recipients to privacy, self-determination, and the refusal
of services. The only exception to confidentiality and the right to privacy comes when a therapist or staff member believes an individual is in serious danger (specific laws and regulations requiring disclosure to appropriate authorities without consent in certain situations vary). The fourth value is “Social justice,” which involves helping to ensure the common good, including educating others on the value of occupational therapy services. The fifth value is “Procedural justice” which requires occupational therapists to comply with institutional rules, local, state, federal, and international laws, as well as AOTA documents applicable to the profession. Knowledge of the AOTA Code of Ethics and an ability to appropriately handle ethical issues also fall under this value. The sixth value is “Veracity,” which refers to the provision of “comprehensive, accurate, and objective information” when representing the profession. This includes maintaining accurate and timely documentation as well as refraining from academic misconduct. The seventh value is “Fidelity,” which involves treating colleagues and other professionals with “respect, fairness, discretion, and integrity.” This includes proper use of conflict resolution strategies and attempting to resolve all ethical violations within the organization before seeking outside involvement.

This is a document that all occupational practitioners and students are required to read and the exercise of reviewing it was very beneficial to me because of the ethical dilemmas I face at my site. The most relevant values to my project include autonomy and confidentiality and procedural justice. At CTF there is a conflict between autonomy and confidentiality and procedural justice because facility policy requires residents to attend all available daytime programming, including my groups. Procedural justice also conflicts with beneficence at times
because my ability to best serve residents is compromised by facility regulations limiting what can be brought onto the unit and who can be taken off of the unit. Nonmaleficence can conflict with beneficence as well because it is important that interventions be interesting and challenging to the residents but it is imperative that interventions are physically and emotionally safe for the staff and residents. Further investigation into ethical dilemmas similar to those faced at CTF has yielded very few other resources.


*Abstract:*

Objectives- To identify ethical dilemmas experienced by occupational and physical therapists working in the UK National Health Service (NHS). To compare ethical contexts, themes and principles across the two groups.

Design- A structured questionnaire was circulated to the managers of occupational and physical therapy services in England and Wales.

Subjects- The questionnaires were given to 238 occupational and 249 physical therapists who conformed to the set criteria.

Results- Ethical dilemmas experienced during the previous six months were reported by 118 occupational and 107 physical therapists. The two groups were similar in age, grade, and years of experience. Fifty of the occupational therapy dilemmas occurred in mental health settings but no equivalent setting emerged for physical therapy. Different ethical themes emerged between the
two groups, with the most common in occupational therapy being difficult/dangerous behaviour in patients and unprofessional staff behaviour, and for physical therapists resource limitations and treatment effectiveness. No differences were found in the ethical principles used.

Conclusion- the ethical dilemmas reported by the therapists were primarily concerned with health care ethics, rather than the more dramatic ethics reported in much of the biomedical ethics literature. Differences were found between the two professional groups when ethical contexts and themes were compared but not when ethical principles were compared. This suggests that educators and researchers need to be aware of work settings and the interdisciplinary nature of employment as well as ethical principles help by individual therapists.

Summary and Significance:

This study attempted to present a more realistic picture of the ethical dilemmas physical and occupational therapists deal with on a day to day basis. The author cited a lack of research into the dilemmas faced by OT’s and PT’s compared with nurses or physicians, as well as a tendency for literature to focus on dramatic ethical dilemmas not necessarily relevant to most practitioners as the impetus for this study. A four-page questionnaire was sent to 238 occupational therapy service managers who were instructed to pass it along to a staff member who spend the majority of his or her time treating patients. A total of 118 occupational therapists filled out the survey appropriately, sharing biographical information, as well as a report on an ethical dilemma that occurred in the past six months, along with a ranking of ethical principles related to the incident. Analysis included a description of the respondent, content analysis of the dilemma, and collation of data related to ethical principles. Agreement between two raters was reached in all content
analysis. For occupational therapists, 48% of dilemmas occurred in community settings and 31% occurred in an acute hospital settings. Clinical specialties where dilemmas occurred most frequently were mental health (50%), neurology (17%), and learning disabilities (16%). The most common theme was difficult or dangerous behavior in patients, which accounted for 26% of dilemmas. An example of an occupational therapist providing physical restraints for a family raising a child who exhibits violent and destructive behavior. Other examples included patients sleeping with one another, patients masturbating in public, patients with mental health issues that cannot be released because of the danger they present to society, and people with neurological disorders who insist on driving motor vehicles. The second most common theme was unprofessional/incompetent staff, which accounted for 20% of dilemmas. This included situations in which staff were gossiping about patients or treating less popular patients unfairly. Other popular themes included lack of respect for vulnerable patients, difficult or risky decisions about patient discharge, and unfair allocation/lack of resources. Principles used in dealing with these ethical dilemmas were ranked as follows: 1.) Justice (patient), 2.) Rights (patient), 3.) Doing harm/not preventing harm, 4.) Rights (staff), 5.) Autonomy, 6.) Justice (staff). In concluding, the author pointed out that ethical decision making for occupational and physical therapists often involved several participants over long time periods with no obvious start or finish and repeated episodes. These real, day-to-day dilemmas are more complex than the dramatic stories usually documented in the literature relating to end-of-life issues or genetic engineering and the author points out, “The needs of workers in mental health settings for more information on other issues is poorly addressed.”
I agree that there is not a lot of information available on the practical ethics of occupational therapy in a mental health setting. This article illuminated the fact that my Capstone project, which focuses on mental health in a community-based setting with difficult/dangerous individuals, could lead to a number of ethical dilemmas. I was attracted to this article because the study was conducted in the UK where occupational therapists work more commonly in mental health and even forensic settings. Although AOTA ethical principles were not discussed, the principles used in the study could be easily translated to represent “Justice,” “Autonomy and confidentiality,” “Non-malificence,” and “Fidelity.” The ethical dilemmas common to occupational therapists in this study relate to some of the issues I have faced at CTF. Regarding the dangerous or difficult behavior of service recipients, our unit has had to deal with inappropriate sexual relationships between residents. My site mentor was careful to explain to residents that while their sexual behavior and sexual preferences are within their rights while in the privacy of their homes it is not appropriate for them to engage in sexual behavior while living in a crowded non-private facility. As an occupational therapy student, I have to be cognizant of the potential for dangerous behavior when planning occupations. Relating to unprofessional staff, I have come to accept the “venting” of many staff members working with a very frustrating and difficult population. However, there have been times when staff behavior has made me feel uncomfortable. For instance, staff members identified the last name of a resident who was caught engaging in a sexual act with his pregnant girlfriend while off the facility grounds on a medical pass to all CTF staff as well as parole officers and staff from another facility while attending an off-site training seminar. Unfair allocation, lack of resources, and difficult decisions regarding
discharge has become a major issue at CTF because bed space is limited and phase progression can be accelerated or delayed as a result. Recently my site mentor, the rest of the treatment team and I considered the release of a resident who received minimal treatment because the bed was needed and no other appropriate candidates could be found. This individual was considered a detriment to the treatment environment for other residents and seemed to be gaining little from programming due to the severity of her symptoms. However, we also had to consider her safety and whether or not it was fair to release her simply because she was so difficult to treat. This article helped me to see how many of the situations I find difficult at CTF are ethical dilemmas that relate to the AOTA principles of “Autonomy and confidentiality,” “Fidelity,” and “Non-maleficence,” and are similar to the issues confronting many occupational therapists working in community-based settings and in the area of mental health.


Abstract: No abstract available for this source

Summary and Significance:

This web page featured a blog post about an ethical dilemma in which a Level I fieldwork student was treating a prisoner for an ulnar nerve injury and he stated that his goal was to make a fist again so he could fight. The student was very upset by this and found it difficult to treat the man knowing that he intended to recover his function only to hurt others. Responses to the post
were empathic but offered a lot of good advise. One responder had worked extensively with people in the correctional system and had grown up in a violent neighborhood. This person pointed out that anger is easier to express than fear and that the man probably had a lot of negative feelings about himself that would only worsen if professionals were judgmental towards him. This poster and many others pointed out that the man probably needed to fight in his environment to protect himself from other aggressors and he may have been expressing this goal in order to get a reaction out of the OT student. The student was advised to treat the man knowing that he would also be using his hand to eat, dress, and perform other necessary, nonviolent tasks. She was also encouraged to attempt to listen to him openly and empathetically as his statement may have been a cry for help. One poster pointed out the importance of setting limits with the man and asking him for a positive goal instead.

I have not faced this specific ethical dilemma in working with women offenders who are generally more positive about changing their lives. However, in past psychiatric settings I have experienced clients who say things most likely intended to shock me or other students and staff members so I know the importance of taking such statements as signs of illness and not an indication that the client is necessarily dangerous or evil. I do sometimes question the willingness and ability of women at CTF to change their behavior after they have left the facility based on statistics and experience with relapse and recidivism, so I try to be cautious that the information or skills I promote cannot be used for nefarious purposes. For instance, I have to be careful when leading discussions that we do not get into the specifics of committing or covering up crimes so that techniques are not transmitted. This is a dilemma similar to the one in this blog.
because it might benefit women to speak freely about their past indiscretions or learn about the experiences of others (and sometimes I almost want to use past criminal acts to show the women how creative and intelligent they can be- criminal activity can be quite a problem solving exercise) but it also puts the women and the community at risk if they are learning to become better criminals. I can also see that sometimes the difficult behavior of service recipients at CTF does lead to staff burn-out and cynicism that might detract from the care provided so I know I will need to very aware of my own attitudes in relation to the quality of service I am providing.

Sources Used for Developing Interventions


Abstract: No abstract available for this resource

Summary and Significance:

This web document provided a ideas for stimulating discussion about financial management as well as suggestions for finding employment with a criminal record. The questions provided to stimulate discussion were fairly simple, and focused on definitions of financial concepts such as sources of income, necessities and luxuries, fixed and variable expenses, and savings. Next, budgeting scenarios are presented with corresponding questions. Finally, information about job
opportunities is offered including information about the Federal Bonding Program and the U.S. Department of Justice’s Center for Employment Opportunities. The author also included a statistic from a large survey indicating that a majority of companies are willing to hire ex-offenders.

I printed a copy of the questions to use in a group that will focus on financial planning but I will probably not use all of them. I modified the budgeting scenarios to be slightly more relevant to the population at CTF and plan to assign one situation each to groups of about 3-4 residents who will then share their situation and answers with the large group. I looked into the programs referred to that help “high-risk” workers find jobs and included that information as well as some of the advice on job-seeking behavior in a handout with several other resources.


Abstract:
How do you go from a having great idea to writing a story that people will love to read? Character and conflict, plot and dialogue, setting and scenes, write and revise ... It's easier than you think if you understand the elements of a story.

Summary and Significance:
This webpage walks children through the process of writing a story using examples from familiar stories (like Shrek and Harry Potter) as examples. The site breaks down the writing process into the following steps: 1.) ideas, 2.) sketch the “basics,” 3.) fill in details: character and conflict, 4.) plan the plot, 5.) plan the scenes, 6.) write, and 7.) revise. I do not plan to go through each of
these steps in my assignment, but I did take many of the tips from this website to create a hand-out for a story writing assignment for residents at CTF. This site had a lot of helpful advice about creating a setting, writing a “get the story going” event, creating different types of conflict, building the plot based on a chain of cause and effect, and wrapping up the story by handing out punishments and rewards to characters as warranted. These last two elements of a story are pro-social life lessons (the decisions and actions of characters have consequences) as well as elements of good storytelling. This website also offered a worksheet that I might provide to residents who have difficulty trying to come up with a story.


Abstract: No abstract available for this source.

Summary and Significance:
This web page was designed to teach children the basics of writing a story. Hale encourages writers to develop a main character, setting, problem and resolution by asking questions like “what does your character look like?” and “when does your story take place?” He also provides suggestions such as advising writers to “Let your artistic side go... Only let your inner editor work on the story after your inner artist is finished.” I used some of the suggestions from this webpage to create a hand-out as part of a story writing assignment I prepared for women residents at CTF. The writing assignment is designed to allow residents to practice the social skill of storytelling (providing sufficient detail, staying on topic, clearly communicating ideas, etc.).


*Abstract:*

There is no abstract available for this source

*Summary and Significance:*

This webpage was designed as a suggested assignment for secondary educators to provide to students to assist in writing goals in such a way that the students are more likely to achieve them. Suggestions include: making the goals realistic, stating them in positive terms, making sure they depend on the goal-writer’s actions and not circumstances outside of their control, breaking larger goals into “sub-goals,” establishing criteria and time tables to evaluate success, and physically writing out the goals. I plan to use this webpage to create a similar assignment for the residents at CTF. I will credit the source on the assignment and alter the content to be more consistent with the Model of Human Occupation and the discussions/assignments the residents have already created but this will not require many changes as the source is easily understandable and consistent with the principles of motivation and behavior used in my program so far.

Abstract: Within the pages of this book, Lisa Lewis explains, in an easy and readable manner, a complex yet intriguing intervention strategy for helping children and adults with autism. Drawing upon her own success with removing gluten and casein from her son’s diet, she answers the many questions parents and professionals might have about choosing a dietary intervention. Why choose a special diet? Are there tests to help me decide? Is there research to support this type of intervention? Will my child starve? What do I cook? Plus she provides over 150 good-tasting recipes to get started on the diet...everything from spaghetti and meatballs to holiday treats and sweets to edible clay!

Summary and Significance:

I scanned through most of this book with the exception of chapter two “About Special Diets” which I read in its entirety to decide if such diets might be helpful for women at CTF. Chapter two begins by presenting some of the first known dietary treatments for diseases, the “Ketogenic diet,” which has been shown to be effective in the treatment of childhood seizure disorders, and the use of cabbage juice (or consumption of other cruciferous vegetables) for the treatment of recurrent respiratory papillomatosis (RRP). Dietary interventions for AD/HD are more controversial, but also more intriguing given the prevalence of these disorders. Dietary intervention for AD/HD is more relevant to my project because some women at CTF carry this diagnosis and many others experience symptoms consistent with the syndrome. According to Dr. Ben Feingold, late pediatric allergist and author of Why Your Child is Hyperactive, food dyes, artificial flavorings and certain preservatives. In certain children with a genetic predisposition, these chemicals are able to escape from the digestive tract before they are broken down which
allows them to interfere with neurotransmitters and brain function. Additionally, Dr. Feingold hypothesized that for some children, food allergies exist that can reduce neurotransmitter levels leading to changes in behavior. Two studies published in 1994 supported this theory. One study found that the removal of wheat, dairy, corn, soy, citrus, eggs, chocolate, artificial colors, and preservatives from the diets of hyperactive children led to decreased hyperactivity while the reintroduction of those foods led to a return to their behavioral baseline. The other study, published in the Journal of Pediatrics, studied the effect of food colors and additives on behavior, and also supported dietary interventions. The “heart” of the dietary intervention described in this text, however, is more closely related to the dietary restrictions necessary for individuals with Celiac Disease. This diet excludes the protein gluten, found in plants from the grass family including wheat, oats, barley, rye, and triticale, and the protein casein, found in dairy products. It is believed that these proteins, when not properly broken down, may function as opioids. This is not harmful if the proteins follow the typical digestive path and are excreted in the urine, but if they are able to escape from the gut they can act on the central nervous system contributing to some of the maladaptive behaviors seen in children with pervasive developmental disorders. Supporting this theory, many children with autism are also diagnosed with celiac disease. In addition to leaky membranes, scientists have also found a link between learning disorders and phenol sulfur transferase (PST) deficiency. PST is important in breaking down substances that would otherwise build up to toxic levels including the neurotransmitters serotonin, dopamine, and noradrenaline. In order to treat this deficiency, diets are recommended that decrease food components requiring PST detoxification so that more PST is available to break down those
substances like neurotransmitters that are produced by the body. The final contributing factor to the neurotoxin exposure highlighted in the chapter is the overuse of antibiotics. The author argues that excessive antibiotic use creates a vicious cycle of poor health in children. When a broad-spectrum antibiotic is used to treat an upper respiratory or ear infection, it also kills the good bacteria that aids in digestion and fights off parasites and fungi. Fungal infections resulting from antibiotic use can contribute to a leaky gut, however, doctors rarely prescribe anti-fungal agents along with antibiotics because many do not understand the potential harm, illustrated by NIH studies, of digestive system yeast infections. Temporary diets free of sugar and fermented foods along with anti-fungal may be helpful when antibiotic use contributes to gastrointestinal leakage.

I will briefly present an introduction to this information and resources where residents can find out more about GF/CF or other special diets during a group discussion of nutrition. Such a specialized diet might be helpful for a few residents or for their children, particularly those who struggled with difficult behavior before adolescence. However, for most women whose difficulty began during or after adolescence/trauma/drug abuse, I would doubt that these particular diets, specifically the GF/CF would be beneficial because, if anything, people tend to exhibit decreased natural levels of opiates and dopamine following prolonged drug use and perhaps even preceding drug use in cases where drugs are used for self-medication. Instead, I will rely mainly on other sources specific to people in recovery from substance use disorders. I will mention the possible link between additives and preservatives and AD/HD because avoiding convenience foods filled with chemicals is probably a good idea for people who have physically stressed their bodies (one
woman profiled in the Ford novel about recovery opened her own health food restaurant out of her desire to heal her body), but I would probably not advocate for the GF/CF diet with this population without conclusive evidence (such as the protein urinalysis described in this book) that a problem exists because it is too difficult and costly for individuals who are often very mentally, emotionally, and financially stressed.


Abstract:

This document has been prepared by Many Hands Sustainability Center (MHSC) as part of its Nutritional Education and Job-Training Program, a program that offers former prisoners recovering from drug and alcohol addiction an opportunity to develop job skills, learn about all aspects of organic farming, and become educated about proper nutrition and healthier lifestyle choices.

Summary and Significance:

This document featured a great deal of research and practical guidance related to nutrition for people recovering from substance use disorders. It explains how addictions can alter brain chemistry and other biological functions, creating imbalances in the body that sometimes lead to physical discomfort but seemingly more often lead to fatigue and mental or emotional disruptions such as poor memory and concentration, irritability, and depression. Some nutrition-related disorders that commonly afflict individuals with substance use disorders that are
described in the document include: hypoglycemia, adrenal fatigue, allergies/sensitivities, leaky gut, yeast/candida problems, and nutritional deficiencies. Individuals in recovery are encouraged to eat foods rich in vitamins, minerals, high quality protein, and complex carbohydrate, consume high quality fats in moderation, and avoid highly refined/processed foods, foods high in sugar and low in nutrients, and caffeine. They are also encouraged to eat regularly, at least three meals a day, including breakfast. Unfortunately, as the document points out, this runs counter to the prevailing tendency of addicts, even those in recovery, to eat addictive “junk foods” that lead to poor physiological regulation and put them on a roller coaster of biochemical highs and lows experienced emotionally as well as physically.

This source was used to create an educational hand-out which will be read aloud and discussed in group as a precursor to an occupation in which residents will use grocery store fliers to plan and illustrate a nutritious meal they could make after leaving CTF. I would have preferred actually making a meal or at least a simple snack but this would have required administrative approval and been severely limited by regulations regarding what can be brought onto the unit. Facilitating a group on nutrition has been suggested or endorsed by three CTF staff members who work with the women residents, as well as my faculty mentor who is aware of the influence nutrition can have on behavior. This article supported the observations of these individuals, as well as my own experience and the accounts of residents who have described their diets during drug use with such statements as, “I lived off of king-sized peanut butter Twix bars and giant Slurpees because it was cheap and I didn’t feel like eating anyway” and who purchase and consume loads of highly-processed, sugary foods and coffee from the commissary. This topic
pertains to occupational therapy because, as this document confirms, nutrition can have a big impact on one’s ability to successfully perform occupations and fulfill role obligations by influencing one’s energy level, emotional stability, and mental efficiency. Furthermore, cooking, gardening, and eating regular, healthy meals are all important occupations that the women at CTF will hopefully value when given education (and ideally opportunities).


Abstract: No abstract.

Summary and Significance:

This web page featured an outline that described the value of creating a personal mission statement, how to craft personal a mission statement, and how to use a personal mission statement to establish discreet, measurable goals.

I found this website very useful in structuring a mission-writing occupation for CTF residents. It also prompted me to emphasize incorporating the mission statements in a goal-writing occupation as a follow-up. This will reinforce the importance and utility of the mission statements while supplementing them with more concrete objectives. Because it was written for an audience of adults who may have learned to read later in life, the content was not overly complex for CTF residents. As stated on the webpage:

Goals serve us by organizing our actions and by giving them meaning. When we sense that our actions bring meaningful results, we have greater incentive to perform those
actions. Our mission provides the purpose for our goals and actions, and goals that are backed by a sense of mission tend to be both more satisfying and more motivating.

I included the website on the hand-out I will be giving to explain the assignment so residents can have it as a resource in the future if they are interested in learning more about leadership/professional development.


Abstract:

Bestselling author and financial expert Suze Orman inspires women to take charge of their money... and their lives. Suze Orman: Women and Money shares surprising insights into the complicated relationship women have with their money. Suze knows that emotional awareness goes hand-in-hand with financial knowledge and helps women remove the blocks that prevent them from making more out of the money they have. In this uplifting television special, Suze describes the “Eight Qualities of a Wealthy Woman” and offers her signature mix of insight, empathy, and humor. She emphasizes that what’s at stake is much bigger that money - it’s about every woman’s sense of who she is and what she deserves. And it all begins with each woman’s decision to save herself.

Summary and Significance:

In this lecture, Orman relates her personal rags to riches story and provides advice to empower all women to improve their relationship with money. She claims that because women tend to care
mostly about their relationships they need to learn to have a better relationship with their money by nurturing themselves and their personal financial security as much as they nurture others. She lists some traps women tend to fall into such as allowing their husbands to get them into debt, avoiding asking their bosses for a raise, not filing important documents, and giving money to children out of guilt. The first thing she advises women to do is believe they can be financially successful and imagine what that success will look like. Later she shares her vision of success with her “eight qualities of a wealthy woman.” These qualities build on one another such that each quality depends on the preceding qualities. The first is harmony, defined as consistency among one’s thought’s feelings, words, and actions. The second is balance, which Orman describes as an equilibrium that gives women the confidence they need to make decisions. The third is courage, which is the emotional energy that quiets fear which would otherwise prevent action. Paradoxically it is by taking action that one develops courage. The fourth is true generosity which does not refer to the tendency of women to give themselves away, but rather the kind of giving that benefits both the recipient and the woman herself. The fifth is happiness, the result of the first four steps that will prevent women from spending money on things they do not need. The sixth is cleanliness, which is how a woman displays respect for her what she has earned and for herself. The seventh is beauty which comes from one’s inner strength and confidence that is created when a woman knows her worth and power. The eighth and final quality is wisdom, which allows women to make good decisions from that place of confidence. Orman sets the audience out on the first step of developing these qualities by making them stand up and say their name. She points out how hard it is for women to take credit for anything and
sometimes women even struggle to decide on what their name should be (“Do I use my married name, my divorced name, my maiden name”) but in order to “own their power and control their destiny” Orman emphasizes the importance of understanding one’s own identity. Other advice Orman provides include avoiding shame and blame, avoiding becoming attached to material possessions, asking questions about financial matters when one is unsure, and never “putting yourself on sale” meaning never give of yourself for less than you are worth.

Although I was hoping for more practical financial advise to share with the women at CTF, such as how to avoid excessive spending or the accumulation of debt, it occurred to me that most of the financial advice in this lecture applied to women with greater financial means than the average CTF resident. The advise that was provided in the lecture might be of some value to the women at CTF who sometimes fail to value themselves and are in great need of most of the qualities Orman discussed. However, this type of motivational speech is pretty typical of the programming they already receive very regularly. If the women at CTF could avoid shame and blame, believe in themselves, and acquire qualities such as harmony and courage, it would help them a great deal. Unfortunately, this lecture provides very little advise about how to do that. The one exercise Orman used, having the women stand up and say their names with confidence inspired me in developing an occupation to do with the residents in which they will practice poise, confidence, and interview skills during an “inner beauty pageant.” I may also use some of her advise, along with other more relevant sources of financial information for people with limited incomes, for a money management discussion and exercise I am planning to engage residents in.

Abstract: No abstract available for this source.

Summary and Significance:

This brief online article provided an argument for the importance of creating a budget as well as a lot of general information about to begin the process. Ramsay explains that creating a budget is simply spending money “with intention” or a plan that is drawn up before that money becomes available. He warns readers that it may take 3-4 months before a workable budget is hammered out but it is worth the effort because many people find they have more money available to them after they go through this process. I plan to share the tips and advice from this webpage during a group I am planning on budgeting and financial management.


Abstract:

Action Speaks Louder provides the therapist with a collection of over 50 tried and tested structured group techniques for use in helping people with communication difficulties. Now in its sixth edition the book is well known to all those professions involved in helping clients with problems of this kind. The exercises have been especially designed to encourage active participation and a careful step-by-step approach is detailed for each one to make practical
implementation easier. Key features for this edition include: inclusion of exercises for children as well as adults; more emphasis on non-verbal exercises than in previous editions; similar types of exercises grouped together for easy reference; clear and easy-to-use layout of previous editions retained. Although originally written for use by occupational therapists Action Speaks Louder has proved to be an invaluable resource for anyone involved in interpersonal skills training, where the emphasis is on helping people with communication difficulties to help themselves.

**Summary and Significance:**

I perused the main portion of this text for ideas for occupations to do with the women at CTF and found a couple that might be appropriate. I also read the first chapter, titled “Some basic concepts” to learn general principles that could improve my ability to lead groups. In that chapter, the authors pointed out that non-verbal skills, including rhythm, use of time, interpersonal distance/touch, gestures/posture, facial expression, paralinguistics (voice, tone and pitch), and objectics (style of dress) are often more meaningful in interactions than verbal skills themselves. This is important information I hope to share with the women I work with when discussing social skills. The authors then delved into facilitating successful therapeutic groups. In planning the group they advise keeping a consistent location and time, considering the use of space and possible distractions in the environment, and determining a session focus based on the goals of participants. The optimal group size was said to be 8-10 including staff. Exercises chosen should address the deficits of group members while also capitalizing on strengths and taking into account their group cohesion and ability to concentrate. The exercises presented in this book were described using Model of Human Occupation (MOHO) and Model of Lifestyle
Performance terminology. Both models were described briefly in the first chapter. In order to be consistent with MOHO, the authors point out that exercises must be meaningful and productive, which is something I must be mindful of because I am using this model for my program development plan. The authors explain the presentation process as consisting of orientation, introductions if new members are present, a clear statement of the purpose and procedure of the occupation, restatement of important points, and confirmation of understanding by the participants. The leader must know the directions for the occupation well and present them confidently to encourage meaning and purpose in the participants. The leader should also cede as much leadership and decision-making as possible to the group, participate as a model when appropriate, and be prepared to move on if the group loses interest. The leader also has an important responsibility to engage the group in discussion following the occupation. In this discussion the leader can encourage participants to put their feelings into words and relate what they learned back into their daily lives. The leader may also wish to share some personal experiences or attempt to equalize the discussion if some participants are monopolizing the group while others are less forward. In closing, the authors advise therapists to reform the group, summarize the theme and key points, close on a positive note, and remind participants of the time, date, location, and topic for the next group. Following a group, the authors suggest assessing the participation, group mood, and effectiveness of the exercises used. A MOHO-based “Baseline Assessment Form” was offered as an example format that followed a SOAP (subjective, objective, assessment, plan) outline. They also suggest keeping written records of the date, number of participants, number of staff, major goal/focus, mood of the group, exercises
used, and a good-bad rating scale of each exercise with an explanation for every group session that is facilitated.

I thought this text was very helpful for providing a simple structure to follow in leading groups. Although I had a great deal of experience leading groups during my Level II fieldwork and in MOPS II, I have never come across such a simple and straightforward explanation of how to structure a group occupation. I thought the format they laid out would work with almost any model of practice but it was helpful that they referred to MOHO specifically at times so I can easily tie this in with my program development plan. Many of the occupations featured in the book would be too simple for most of the women at CTF but the suggestion for group size led me to consider breaking up the group in my program development plan into different levels or areas of need. In that case, most of the occupations would be appropriate for at least the lower level group. The emphasis on communication skills in the text would be appropriate for my program because promoting positive interactions is a main objective of my program and I plan to use the Assessment of Communication and Interaction Skills as an outcome measure. Some occupations I might try with the entire group include: “Storytelling,” “Charades,” “Compliments,” “Gifts,” “Perceptions,” “Pass the Ball,” and “Support Systems.”

**Sources Supporting use of the Model of Human Occupation**

Abstract: No abstract available for this source

Summary and Significance:

This manual provided the information and forms necessary for me to administer the ACIS assessment. This assessment examines social skills in physical, informational, and relational domains. In the physical domain, the individual is assessed based on physical contact, gaze, gesturing, maneuvering, body orientation, and posture. In the informational domain, the individual is assessed based on his or her ability to articulate, express feelings, ask questions, initiate interaction, display affect, modulate his or her voice, share information, make himself or herself understood, and sustain speech. In the relational domain the individual is assessed based on collaboration, conforming to social norms, focusing, establishing rapport, and accommodating others’ reactions and requests. The rater must take into account the context, social group, and other relevant influences and then determine how effective the individual’s behavior was in various interaction. A score of 4 for a skill indicates that it supported social action, 3 indicates that the individual’s skill was “questionable” but did not disrupt the occupation, 2 indicates that ineffective performance in the skill did impact the occupation, while a score of 1 indicates a deficit that caused the occupation to “break down.” The rater may record that a skill was “not assessed” if it was not required by the situation. Observation can occur during an open occupation such as a break, a parallel task such as eating a meal, a cooperative group task such as a game or discussion group, or a one-on-one discussion. Observation usually takes about 15-45 minutes followed by 5-20 minutes of rating time. Administrators are encouraged to record ratings as soon as possible following observation. It is noted that the administrator must use his or her
own social skills to interpret the situation and make appropriate ratings. The manual also includes an explanation of the creation of the instrument using Rasch analysis and summaries of reliability and validity studies conducted as of 1996.

I will use this assessment as part of my Capstone project. I will administer the assessment to selected CTF residents as part of the needs assessment process and may incorporate the assessment as part of the overall evaluation in my program development plan. The assessment is part of the model of human occupation which I am using to guide my project, and it examines performance skills that I have observed some residents struggle with.


Abstract:

Occupational therapists encounter individuals who are victims of domestic violence in many different settings. The role of the occupational therapist with each client depends on that client’s specific needs, the treatment setting, and the skills and beliefs of the therapist. This article presents a theoretical argument for why the occupational therapist should choose to be involved in the treatment of domestic violence. The Model of Human Occupation provides a framework for understanding functional issues related to domestic violence. Methods of assessment and treatment are presented using this model. A continuum of levels of involvement including referrals for resources or treatment, direct and indirect treatment and program consultation is
offered. Each level is illustrated with case vignettes demonstrating the therapist’s role. Issues related to the challenge of working in domestic violence and reasons that women may refuse intervention are also discussed.

Summary and Significance:
This article discussed the ways in which occupational therapists can address the issue of domestic violence with clients. The authors point out that women with disabilities deal with domestic violence more often than non-disabled women, likely because disability makes one more vulnerable to be abused and less able to escape the situation, but also because the disability may be a result of the abuse. Occupational therapists are practically, ethically, and in many cases legally, obligated to respond to any disclosure of abuse by clients. That response may be undertaken by an individual occupational therapist or through the work of an entire treatment team. It may take any of five forms: 1.) following a legal requirement to report the abuse, 2.) initiating a referral to outside resources or services, 3.) offering direct treatment, 4.) providing indirect services, 5.) and utilizing program consultation. Therapists are directed to their respective state domestic violence acts and occupational therapy practice acts for information on reporting laws which vary from an obligation to report any suspicion of abuse to an obligation to report only abuse carried out with a deadly weapon. Referrals may be made for emergency housing, legal advice or assistance, domestic violence counseling, medical care, services for children, support groups, special agencies, and emergency hotline numbers. The authors suggest that such information is made available in women’s restrooms and not given to a woman in hard copies if she if taking such material might put her in greater danger. Direct treatment can be
offered by occupational therapists working for domestic abuse agencies as well as those working in more traditional health care settings if the functional necessity of such interventions is documented. The authors used the model of human occupation (MOHO) to conceptualize assessment and intervention for women facing domestic violence. They discussed MOHO assessments including the Occupational Performance History Interview II, the Occupational Self-Assessment, the Assessment of Motor and Process Skills, and the Assessment of Communication and interaction skills, as potentially useful with this population. They also suggested promoting skills for successful role performance, skills for independent living, environmental adaptations, exploration of new roles, education, and prevocational and vocational training as possible methods for addressing the needs of women dealing with domestic violence. They identified these needs based on work with women in transitional housing who had difficulty with budgeting, parenting, home management, stress management, anger management, and other instrumental activities of daily living. Indirect services are provided when occupational therapists train other staff to address these needs and consultative services occur when occupational therapists are utilized in the planning or alteration of domestic violence programs. The authors make suggestions for occupational therapists not familiar with domestic violence issues such as avoiding the word “abuse” in screening and assessment, and addressing the issue immediately following an episode of battering when a woman is most vulnerable and intervention is more likely to succeed.

This article is relevant to my project because it illustrates how MOHO can be used with a population that shares significant overlap with the women at CTF. The overlap and similarities
between the women at CTF and women in domestic abuse programs is highlighted by the fact that my site mentor was hired to establish the women’s program at CTF based on her work with battered women at the YWCA. Many of the women residents at CTF have experienced domestic violence as children and/or adults and deal with some of these issues in a special group facilitated by a licensed counselor ("Trauma Recovery and Empowerment"). Based on accounts from my site mentor, in the past, CTF has housed a woman who killed her husband in self defense, and another woman who was re-admitted to CTF during aftercare when it was apparent that her home environment was unsafe. The needs identified in this article are similar to the needs identified for women at CTF including stress management and independent living skills and the interventions suggested are similar to those I plan to use in my program development plan which is also based on MOHO. I may consider adding some vocational training as an element of my program, if possible, for select women at CTF with an identified need for job skills to promote financial independence that will facilitate termination of unhealthy relationships.


Abstract:
Since the introduction of community care, the care of mentally ill people has transferred from hospitals to community settings and has thus resulted in an increase in the number of people with special housing needs. This development, coupled with the high incidence mental health
problems in the homeless population generally, is problematic for community-based mental health workers because the needs of these people are complex and the demand on services becomes greater. The emerging role of the occupational therapist in this field of care is considered and the model of human occupation is proposed as a useful theoretical framework to conceptualise the complex needs of this client group.

Summary and Significance:

This article introduced the problems faced by homeless, mentally ill individuals, and illustrated, through a case study, how some of these issues could be addressed using the model of human occupation (MOHO). “Caring for People” a British government “white paper” introduced in 1989 was said to usher in the shift from caring for people with mental illness in hospitals to the community. Although this was a positive move for many people, securing housing for some individuals became a major challenge. However, the authors also point out that many homeless people have never been institutionalized but represent a younger generation of people with mental illness or socioeconomic hardship. For some people, mental illness may not have precipitated homelessness but may have been triggered by the stress of having no place to live. Although rehabilitation services for the homeless are limited, the authors assert that occupational therapists working in mental health are more and more likely to be referred homeless clients. People without homes often present with interdependent health, social, and occupational needs, having likely suffered a great deal of loss in their lives. The model of human occupation conceptualizes these needs in terms of the person, made up of volition, habituation, and performance subsystems, and occupational behavior, the activity people engage in during much
of their time awake which may be playful, restful, or serious and productive. The person is seen as “adaptive” by being in dynamic interaction with the environment and any disruption to this system may result in dysfunctional occupational behavior. Homelessness disrupts the person in all three subsystems. The authors observe that volitionally, homeless people tend to blame others and feel externally controlled. They often do not believe their actions can influence their lives and may therefore neglect to seek out those services that are available to them. In the subsystem of habituation, the homeless tend to have difficulty structuring their time and often lack any type of worker role. A worker role is important in expressing one’s effectiveness and avoiding social isolation so structured community-based vocational rehabilitation schemes are proposed by the authors as a means of providing purposeful work and socialization for homeless people. In the performance subsystem process, and communication/interaction skills can be variously impaired by mental illness, particularly schizophrenia and depression which can make it difficult for individuals to problem solve and make plans. Motor skills may be impaired by homelessness which can lead to skin and foot ailments, chest disease, and poor nutrition. These problems were illustrated in the case study of “Jane” a 32-year old woman who had been unsuccessful in housing programs operated by social or voluntary agencies until being admitted to a small residential facility for people with mental illness, operated by an occupational therapist. Jane was obese and had frequent gynecological issues. A mild learning disability, anxiety, and depression made it difficult for her to establish productive routines and successfully engage in the roles she identified as valuable to her, taking care of her home and others. Instead, she engaged in rigid inflexible routines and tried to care for her brother who she was having an incestuous
relationship. She had few interests, but did identify a love for animals. Staff at the residential facility refused to accommodate her rigid routine and she chose to abandon it in favor of receiving their assistance and attention. Staff also helped her to adopt a kitten from a local shelter that she would use her extra money to feed, instead of giving the money to her brother who then stopped visiting. Newsletters from the animal shelter that provided the kitten were used to help Jane improve her very limited reading skills. To address her obesity and anxiety regarding travel in the community, Jane was encouraged to go on nature walks with other residents where she might see wild animals. Jane also became more productive by engaging in craft time and then using the crafts to decorate her room and sell for extra income. After one failed attempt at independent living, Jane was successful in moving out of the facility into her own apartment with 15 hours of support to help her care for her home and continue making progress in pursuing her interests and succeeding in her roles.

This article was helpful because it illustrated the use of MOHO in a population similar to offenders with significant overlap. Some women leaving CTF have no safe home to return to and are sent to transitional housing or a homeless shelter. Additionally, the population at CTF is similar to the homeless population described in this article because the residents often lack employment or stable routines, have mental health diagnoses, have experienced a great deal of loss in their lives, have experienced trauma such as child abuse (as “Jane” from the case study did), and/or often had poor nutrition or self-care while out in the community abusing substances. I thought the case study in this article was a good example of how MOHO can be used not only to define issues but to address them through meaningful occupation. I provided the women at
CTF a short list of local animal shelters because a case manager on the unit taught them that they are allowed to visit these shelters and play with the animals which made many residents very excited. How to pursue leisure interests and succeed in valued roles are both important aspects of the programming I have run so far at CTF and will be central to my program development plan just as they were central in Jane’s rehabilitation.


Abstract:

No abstract available for this resource

Summary and Significance:

This chapter provides an outline of the model of human occupation authored by its primary theoretist, Dr. Kielhofner. He explains that the model is unique due to its combined focus on the motivation for occupation, the pattern for occupation, the subjective dimension of performance, and the influence of environment on occupation. He also states that this model can be used with any person having difficulty with occupational life at any point in the lifespan. The model conceptualizes the person as consisting of three elements: 1. volition, 2. habituation, and 3. performance capacity. Volition is further broken down into values, interests, and personal causation, while habituation can be broken down into habits and roles. The environment can be broken down into the physical and social environment. In the model of human occupation, values, interests, personal causation, roles, habits, performance capacity and the physical and
social environment are constantly linked as a transforming whole that guides one’s thoughts feelings and actions. A core belief of the model is that all humans require constant maintenance and reorganization that is also dependent upon occupation. The term adaptation is used in this model to describe competence within one’s environment over time along with the establishment of a positive identity. Another belief of the model of human occupation is that only clients can accomplish their own change through the process of occupation and for occupation to be therapeutic, it must be real and meaningful to the individual. Potential positive changes that can be addressed with this model include: increased understanding of one’s strengths and weaknesses, increased acceptance of limitations and pride in abilities, acquisition of new habit patterns, development of values supporting positive choices, increased awareness of responsibilities associated with success in various roles, and increased participation in things of interest.

This chapter is a very useful review of the model of practice I am using to guide my program development plan. The potential changes listed could serve as a starting point when I am writing goals and objectives. The emphasis on real and meaningful occupation as the therapeutic method is important for me to remember. As is the emphasis on the individual’s sense of identity and motivation which are major sources of difficulty in the population I am working with.

Abstract:
This paper discusses the current context of the UK mental health service system and the resulting need for program change within acute-care inpatient hospitals. The primary focus is to illustrate through practice example what can be done to support the delivery of client treatment packages by using the concepts described by the Model of Human Occupation (MOHO). The paper concentrates on explaining how MOHO has helped to guide program redesign and develop an Occupational Therapy Care Pathway to support occupation-focused user services. The example given is of a hospital service in Gloucestershire, England, which provides inpatient care for people experiencing acute mental illness.

Summary and Significance:
This paper describes a restructuring of mental health services designed to address the need for improved service despite declining resources. After closing one of two acute care psychiatric hospitals in their county, the Gloucestershire Partnership NHS Foundation Trust was established in Gloucestershire, England to redesign services in their remaining hospital using an “evidence-based framework in line with standards set by client campaign groups.” The model of human occupation (MOHO) was chosen as the “ideal” model to guide this process because of a focus on the client’s experience and a substantial research base. The redesign consisted of three main fronts: 1.) an evaluation and reorganization of the hospital environment to center on clients’ occupational needs, 2.) consideration, recognition, respect, and treatment when necessary for clients’ personal causation, values, and interests, and 3.) creation of an occupational therapy care pathway to guide occupational therapy practice. The environmental reorganization involved the
efficient use of MOHO assessments to identify appropriate occupations for clients,
interdisciplinary contribution to providing occupations for each client, an occupation-based
service led by occupational therapy and implemented by many disciplines to provide occupation
throughout the day and week, the availability of information about therapeutic opportunities to
support choices for participation, and partnership with local organizations and community
resources to provide even more opportunities for clients. The focus on MOHO motivational
constructs was accomplished through flexible occupational therapy programs that respond to
client needs and interests, a range of occupational challenges in a variety of locations, including
the community, to meet the needs of clients with a range of abilities and interests, structured
feedback from clients exploring the perceived relevance following an occupational therapy
session with adjustments made accordingly, and new staff roles of “activity worker” and “media
expert” to support engagement in occupations of interest. The occupational care pathway was
modified from a forensic psychiatry pathway described by Duncan and Moody (2003) consisted
of a description of the occupational therapy treatment episode process including initial
information gathering, developing rapport, assessment, agreement of treatment goals,
development of treatment plan, identification of appropriate and available intervention options,
repeating of initial assessment/outcome assessment, creation of a discharge plan, and reports.
“Decision points” along the pathway allow the the experience to be tailored to the specific client
including the choice for further assessment if necessary, the collaborative determination of the
level of support needed from a registered occupational therapist, and the range and focus of
intervention options such as skill development, sensory processing, vocational rehabilitation, re-
motivation, adapting routines, and exploring leisure. An example of leisure exploration was provided. After an initial session in which the occupational therapist facilitates a discussion regarding the benefits of leisure, the therapist arranges “taster sessions” of the leisure occupations client’s expressed interest in. Often other disciplines are involved in these sessions, including a member of the nursing staff who led group in learning to line dance because this was an interest the staff member shared with a client.

This article demonstrates the ability of MOHO to guide a very successful redesign of psychiatric services. It was noted in the article that “The hospital environment shifted from a containment environment to one that facilitated engagement in daily life despite illness. These outcomes have been communicated and celebrated at a national level (Janner, 2006)” (p. 41). Most correctional facilities could also be described as “containment environments” that could be transformed through similar programs, led by occupational therapists and engaging all staff members, into environments that facilitate engagement in daily life despite incarceration and often illness. I appreciated the involvement of the interdisciplinary team in implementing this occupation-based program and hope to encourage similar collaborative effort in my program development plan. The emphasis on exploring leisure and other occupational interests is something I also hope to incorporate in my program. The pathway described in this article was based on a treatment pathway originally created for a forensic setting and I hope to locate that article to see if it could contribute to my program development plan or guide my current practicum work at CTF.

**Abstract:**

This paper reviews the psychodynamic basis of borderline personality disorder with special reference to work difficulties. The model of human occupation is reviewed, and its use as a theoretical framework for a formulation of borderline occupational functioning is proposed. A hypothetical model is conceptualized and expected deficits in the volitional, habituation, and performance subsystems described. The primary occupational dysfunction of the borderline patient is shown to occur at the level of exploratory behavior, or play, and to manifest itself in the inability to perform autonomous adult roles. A treatment approach derived from this formulation is delineated, emphasizing the need for a context of exploration and curiosity. A specific treatment program is described and the therapeutic change process is illustrated through clinical case examples.

**Summary and Significance:**

This article was based on the author’s work at a Manhattan day treatment program for individuals with borderline personality disorder. The program was described as a psychodynamically oriented therapeutic community that clients participated in for 6-18 months. It was designed to address problems that originated from a failure in the parent-child relationship during the rapprochement subphase of the separation-individuation stage of development occurring in toddlerhood. If a toddler’s insistent but fragile urge towards independence is not supported in this stage, it is theorized that the syndrome of borderline personality results in
which the individual continues to rely on splitting as a primary defense mechanism throughout life. This persistent splitting can lead to an inability to neutralize aggressive feelings which in turn leads to destructive acts of rage. It also leads to a number of other deficits in work behavior including inconsistency, a pattern of intense involvement followed by pre-mature termination often at the brink of success, troubled relationships with supervisors and co-workers, lack of satisfaction derived from work, avoidance, procrastination, and unrealistically high expectations for perfection. The author states that individuals with borderline personalities often have grandiose fantasies about ideal careers and may be quite talented in their areas of interest such as art, music, dance, and theatre. However, when it comes to realistic task completion, they generally despise doing work and derive little satisfaction from their skills. To address these issues the author formulated a “Model of Borderline Occupational Functioning” based on the model of human occupation (Kielhofner, 1980), and the work of Kernberg (1975). This model presumes that the primary dysfunction in borderline personality occurs at the level of exploratory behavior or play. Due to problems during the rapprochement subphase, individuals with borderline personalities do not develop autonomy. As they reach adolescence, a time at which role achievement becomes one’s primary purpose and cues guiding performance lessen, volition and habituation deficits lead to impulsive and erratic behavior. To address this, Salzen suggests using clear, consistent functional demands within a given timeframe in order to create a benign cycle of success in work behaviors while simultaneously encouraging exploration, acceptance, and curiosity about the doing process. The occupational therapist in this context should hold functional expectations but also encourage the client in his or her struggle with meeting or failing
to meet these expectations, appreciating genuineness and modeling self-exploration and experimentation with new strategies.

This article was helpful in establishing the role of the occupational therapist in the treatment of borderline personality disorder and providing well-theorized guidance for group intervention. It also establishes the utility of the model of human occupation with this population. Some of the women at CTF have borderline personality disorder, and many of the women residents exhibit behavior consistent with borderline traits including appraisal of themselves and others based largely on affective state, difficulty controlling aggressive feelings, and a need for immediate gratification. Although the psychodynamic theory this article draws heavily upon is somewhat out of date, the intervention guidance proposed directly addresses the problems observed in people with borderline personality disorder without much consideration for the potential origin of the disorder in a dysfunctional toddlerhood. The idea that a deficit in play may contribute to borderline personality, though rooted in psychodynamic theory, I can find validation for in my personal experience. I have tried in the past to do playful occupations with the women at CTF such as putting on a talent show but the women were described as “lost” by one of the case managers, who added structure to the occupation by suggesting residents display what they have learned at CTF. Based on this article, I will likely try more playful occupations in the future. After reading this article I decided to give the residents an assignment in which they must design an invention and then present it, as though they are giving a business proposal, to their peers. This will help them work on assertive communication with the presentation, and hopefully elicit some cognitive exploration as they develop ideas for their inventions.
Abstract:

This article will provide current, relevant information on human immuno-deficiency virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) in the correctional setting. Issues pertinent to the correctional setting, such as HIV testing and confidentiality, transmission of the HIV virus in the correctional setting, and HIV-related education will be explored. An occupational therapy program, outlining two separate programs for (1) those who are HIV positive and those who are diagnosed with AIDS and (2) those at risk for contracting the virus, will be discussed.

Summary and Significance:

Much of this article focused on the issue of HIV/AIDS in correctional settings at a time (1990) when the disease was fairly new to public consciousness. The author explained that individuals in the correctional system are at high risk of contracting the disease while in the community and even while incarcerated due to IV drug use, risky sexual behaviors, sharing razors, and amateur tattoos. As a result of this high risk, she notes that inmate education regarding HIV/AIDS is required in most prison settings and there is lively debate among officials regarding mandatory testing and possibly even segregation of inmates. The author also discusses the psychosocial implications of an HIV/AIDS diagnosis which she contends are similar for inmates and civilians but more difficult for those incarcerated due to isolation from potential support systems. Issues include coping with physical, psychosocial, and cognitive declines; experiencing the interruption
of life roles; and addressing the myriad of emotions such as guilt, fear, and anger, that may surface in dealing with the disease. In the second portion of the article, the author describes occupational therapy interventions carried out in a correctional setting for those with HIV/AIDS and those at risk. Intervention for those with the disease is described through the case study of “L” a 40-year-old woman in denial of her HIV positive status. Prior to intervention, L’s main roles involved prostitution and heroin use and her goals consisted of returning to that lifestyle. L was described as loud, intrusive, and overly sexual in social situations. Her self-care was inadequate and she lacked any positive leisure or productivity skills. While admitted to a psychiatric facility from jail, L participated in cognitive retraining, social skills, and leisure interest groups. She also worked with the occupational therapist and other staff to establish healthier daily habits related to diet, hygiene, and self-care, and was educated about the importance of staying drug-free and living a healthier life due to her compromised immune system. Following intervention, L was deemed competent to stand trial and better prepared to return to jail. The program for individuals at risk for HIV/AIDS was delivered by an occupational therapist and infection control nurse to groups of 8-10 residents for 2 hours per week. During the group, residents view a slide show of basic information, participate in a discussion, then watch a video documenting the lives of three people with AIDS in a correctional facility. Finally, participants break into two groups to play a game in which each group thinks of questions and answers related to the material they learned in order to quiz the other group.

This was one of very few published articles describing an occupational therapy program in a correctional setting. The initial portion of the article describing HIV/AIDS was largely...
unhelpful as most of that information is outdated. However, the portion of the article describing occupational therapy with offenders was valuable because it establishes the use of occupational therapy in US corrections. The case study presented a more traditional role for the occupational therapist and was more in line with the Model of Human Occupation by addressing roles, routines, and the areas of leisure, self-care, and productivity. The HIV/AIDS prevention program featured the occupational therapist in more of an educator role. The idea of incorporating a game to reinforce learning in that group was something I may incorporate in the future if I want to present a lot of information during a group in the future. I was disappointed with the use of the video in this group, however, because it was stated that this “solemn realistic view of the illness” was an aspect of the program directly addressing motivation, a key element in the Model of Human Occupation, but in my opinion this form of motivation is very misguided. The idea of “volition” in the Model of Human Occupation focuses on the positive aspects of motivation such as empowering individuals with feelings of self-efficacy, engaging individual’s interests, and appealing to their internal values, not on using scare tactics which are generally ineffective. I do appreciate Schindler’s other points regarding education such as her insistence that passive forms of education such as pamphlets must always be accompanied by active discussion, including a forum for inmates to voice questions and concerns. She also makes the point that content presented to inmates must be factual and expressed in clear and simple terms, advise I will keep in mind whenever I provide education to individuals in a correctional environment. Overall, this article sets a precedent for occupational therapy programs established in US correctional facilities using the Model of Human Occupation.

Abstract: No abstract available for this source.

Summary and Significance:
This manual provided the information and materials necessary for me to evaluate individuals using the MOHOST instrument. The manual begins with a brief review of the model of human occupation which is the theoretical basis for this assessment and my program development plan. It is explained that the purpose of the assessment is to inform practitioners about the effectiveness of the service they provide and to steer them toward improvement. This is consistent with my purpose for the instrument as part of the evaluation process for my proposed program.

The assessment consists of 24 items in six different sections. In the volition/motivation for occupation section, the individual is assessed on his or her appraisal of ability, expectation of success, interests, choices. In the habituation/pattern for occupation section, the individual is assessed on his or her routine, adaptability, roles, and responsibility. In the communication and interaction skills section the individual is assessed on his or her non-verbal skills, conversation, vocal expression, and relationships. In the process skills section, the individual is assessed on his or her knowledge, timing, organization, and problem solving. In the motor skills section, the
individual is assessed on his or her posture and mobility, coordination, strength and effort, and energy. In the environment section the individual is assessed on the physical space, physical resources, social groups, and occupational demands, that make up his or her environment. Each item is scored on a 4-point scale similar to the ACIS using the acronym “FAIR” with 4/F meaning performance in that specific area facilitates occupational participation, a 3/A indicates it allows occupation participation, a 2/I indicates it inhibits occupational participation, and a 1/R indicates that it restricts occupational participation. Information for determining ratings is gathered through informal and formal observation in a variety of settings, discussion with clients or caregivers, case notes, and the completion of other formal assessments. Writing up the assessment is said to take about 10-20 minutes if the therapist is experienced in its use but this should be done following at least a week of client observation. An addition to the MOHOST assessment are OCAIRS questions that can be used to guide occupational interviewing. These questions can be used in place of or to support data gathering for the MOHOST if clients are capable of being interviewed. OCAIRS questions are available in three different forms for mental health, forensic, and physical/older adult mental health settings. It is recommended that practitioners rephrase the questions to most effectively communicate with their clients. The manual is also helpful in providing descriptions for each score on each item and several lengthy case studies illustrating how the MOHOST can be applied to a variety of clients.

I plan to administer this assessment with a few of the residents at CTF as part of my needs assessment process and include it in the evaluation portion of my program development. I have re-phrased questions from the mental health and forensic OCAIRS interviews provided to
construct an interview that will be more relevant to women at CTF while still eliciting the information necessary to assess the items on the MOHOST. I plan to go through the assessment with the individuals assessed at an appropriate time after they complete the interview so that the experience is as therapeutic as possible for the women who participate.


**Abstract:**

The implementation of evidence-based change in practice settings is complex and far-reaching, but only limited research has been undertaken in this area. This participatory action research study investigated the implementation of the Model of Human Occupation (MOHO) across a mental health occupational therapy service.

**Method:** The study involved preparatory workshops and 12 months of team-based, monthly group reflective supervision sessions, facilitated by a colleague from academia, with follow-up contact for a further 12 months.

**Findings:** The main findings emphasise the importance of developing a critical learning space, or “community of practice,” and identify that barriers to theory implementation can be overcome by collective effort with a shared dialectic. The successful development of a community of practice
required the careful consideration of a number of interconnected influences, including those of self, peer, and facilitator, and contextual and theoretical relationships.

**Conclusion:** The study concluded that the community of practice was central in supporting the effective implementation of MOHO and its associated assessment tools. A key output of the study is a Participatory Change Process, which illustrates the key steps undertaken and interrelated factors affecting theory uptake. The process requires further testing, but has potential to guide theory implementation in other settings.

**Summary and Significance:**

This study was inspired by a “Study Day” conducted in 2003 by an occupational therapy service manager who wished to increase the evidence base and theoretical knowledge of occupational therapists working across a mental health trust by introducing concepts and assessments from the MOHO. This was received positively by the occupational therapists in the trust so the supervisor, in conjunction with researchers and academics set out to examine and support the process of implementing MOHO throughout the service. The research aspect of the project aimed to determine how barrier to theory integration can be removed, identify the role of educators and researchers in facilitating practice development, and assess the impact of using MOHO on therapists’ perceptions of their role and work. To study the process, Participatory Action Research (PAR) was used. In this model, research is conducted with participants rather than on them, encouraging them to be co-researchers rather than subjects. Data was gathered during monthly, recorded, group reflection sessions. The change process occurred over 2 years and the group was followed for an additional year afterward. Individual therapists also had opportunities
to speak with the facilitator one-on-one. The group sessions were devoted to the obstacles preventing use of MOHO, re-examining practice from a MOHO perspective, and discussing and testing MOHO assessment tools, most notably the OCAIRS. From the reflective observations of the meetings and the reflexive commentary of the facilitator, researchers identified a “Participatory Change Process” consisting of disjuncture, change factors, engagement, significant moments/cumulative change, and transitions. In disjuncture, therapists experienced difficulty with the new learning involved and barriers to implementation of the model. Barriers were both personal, as some therapists felt creatively stifled by the implementation of a model of practice, as well as environmental such as time constraints. Change factors identified included self-efficacy and personal agency beliefs, peer relationships, facilitator influences, contextual circumstances, and therapists’ relationships with MOHO, which allowed individuals to overcome obstacles and solve problems related to the change. During engagement, therapists began learning through their work as they used MOHO concepts and tools. Rather than relying on meetings for their education, the therapists were able to critically explore and examine their practice independently as “active learners.” Significant moments/cumulative change occurred as the occupational therapists recognized the limitations to their previous ways of practicing and discovered a new appreciation for their professional role and identity as well as the importance of occupation-based practice. Finally, in the transition stage, therapists had constructed a new way of practicing that improved their self-respect as well as the respect of their interdisciplinary teammates and service users in such a way that implementing MOHO became a self-reinforcing process.
The significance of this article was not what I had expected. I assumed the article would support the use of MOHO in mental health settings and to some degree it did this by indicating that the model was eventually well received by therapists, interdisciplinary colleagues, and service users and helped to define the role of occupational therapists in these settings. However, the main focus of the article was not the model of practice itself, but how a group of therapists were able to successfully change their ways of practicing. Although the authors admit that their model of change requires further validation, it might be useful in informing the type of change people in recovery from substance use and other mental health disorders must make in their lives.

Although helpful to many professionals, the model of change put forth by Prochaska and DiClemente has a very broad focus. This model, which was elaborated by occupational therapy researchers, is more consistent with the values of that specific profession. In my limited experience in researching and working with people who have substance use disorders, I think the concepts of disjuncture, change factors, engagement, significant moments/cumulative change, and transitions could be very relevant to the type of change that takes place in their lives as they learn new ways of living. Some similarities include the importance of a supportive community in facilitating change, which corresponds to the success of 12-step groups, the redefinition of roles that garner more respect from others as well as one’s self providing reinforcement, and the importance of practicing new principles and critically examining whether one’s actions are consistent with those principles rather than simply learning about them in the classroom. Some other principles of change included in this article that might be applicable to change in the lives of people with substance abuse and/or behavioral issues include empowering participants in the
decision-making, not imposing change or learning too fast on an individual without consideration for the obstacles or issues he or she is facing, and allowing participants in the change process to make the new model “their own,” by not only accommodating themselves to the model but also molding the new model around their individual styles. I think this article is valuable in putting forth an occupation-based model for the change process and I will keep its principles in mind during my practicum and program development work.

Sources Related to Population Needs and Obstacles

Abstract: No abstract available for this source.

Summary and Significance:
Healthy People 2020 is a set of goals and objectives with ten year targets designed with the help of a variety of individuals and organizations to guide efforts in health promotion and disease prevention. The stated vision for this project is “A society in which all people live long, healthy lives” and overarching goals involve people living longer lives free from preventable health problems, eliminating health disparities, creating environments that support health, and promoting quality of life throughout lifespan development. General health status, health-related quality of life, determinants of health, and disparities serve as the foundation health measures indicating progress toward those goals. Numerous objectives, grouped into 42 topics, measure health indicators ranging from the proportion of persons with health insurance to the
concentration of mono-n-butyl phthalate in urine samples. Healthy People 2020 is similar to Healthy People 2010 developed in 2000 but has an expanded focus to emphasize health-enhancing social and physical environments including early education in health promotion and disease prevention rather than mainly addressing individual behavior. The emphasis on lifespan development and health promotion from early-middle childhood all the way to older adulthood is another new feature. In response to events such as the September 11th terrorist attacks and several devastating natural disasters and pandemic scares since 2000, disaster preparedness is addressed in Healthy People 2020. Other new topics focus on LGBT health, genomics, sleep health, healthcare-associated infections, and blood disorders/blood safety. Technological advancements over the past 10 years also influenced the newer version of Healthy People which is being disseminated primarily through a website maintained to allow users to explore evidence-based resources for implementing interventions. The document also encourages advancements in health information technology and communication.

The objectives most relevant to my proposed program fall under the topics of substance abuse and injury and violence prevention. Under substance abuse, my program will address objectives SA 13.3 reducing the proportion of adults reporting use of any illicit drug during the past 30 days, SA 19 reducing the past-year non-medical use of prescription drugs, and SA 20, reducing the number of deaths attributable to alcohol, among others, by promoting a sober lifestyle among CTF residents, approximately 90%-95% of whom have substance use disorders. Under the topic of injury and violence prevention my program will address objectives IVP 39 reducing violence by current or former intimate partners, IVP 33 reducing physical assaults, and
IVP 37-38 reducing child maltreatment injuries and deaths, by promoting positive relationship skills and coping strategies to regulate emotional arousal among CTF residents, some of whom have committed violent offenses and many of whom have been involved in abusive relationships. My program will also address the topics of physical activity and mental health and mental disorders. Specifically, by promoting leisure skills and introducing leisure occupations, including physical leisure occupations, to women with notable deficits in this area, the program will address the physical activity objective PA 1 reducing the proportion of adults who engage in no leisure time physical activity. Because about 50%-90% of the women at CTF have a serious mental illness such as PTSD, bipolar disorder, or occasionally schizophrenia, in addition to substance use disorders, the program will address the mental health and mental disorders objective MHMD 8 increasing the proportion of persons with serious mental illness who are employed by encouraging pre-vocational skills such as organization, self-appraisal and understanding of personal strengths, weaknesses, interests, and values, time management, and communication and interaction skills.


Abstract:

Many clients treated by occupational therapists in psychiatric settings are survivors of sexual abuse. The diagnosis of post-traumatic stress disorder (PTSD) and multiple personality disorder (MPD) most accurately reflect the experience of these clients, yet misdiagnosis is common. An
overview of these diagnoses is presented. Psychotherapeutic principles are reviewed and a dual approach to occupational therapy is suggested. Within this dual approach, the model of human occupation (Kielhofner and Burke, 1980) is useful in addressing a client’s present daily living concerns. Object relations theory guides an occupational therapy focus on recall and emotional recovery from past abuse experiences. A case study illustrating a dual approach to occupational therapy is presented.

**Summary and Significance:**

This article discussed an occupational therapy approach that can help individuals who have experienced sexual abuse. The article points out that childhood sexual abuse is increasingly recognized as a common and debilitating experience shared by as many as 1-in-3 or 1-in-4 girls under the age of 18 as well as 1-in-6 boys. Adult rape is also alarmingly frequent, occurring approximately every 6 minutes in the United States. After experiencing sexual abuse, an individual will generally pass through “post-traumatic phases” including 1.) the acute crisis phase, 2.) the avoidance phase, 3.) the reemergence phase, and 4.) the resolution phase. The acute crisis phase and reemergence phase have the most potential to disrupt occupational functioning and lead to hospitalization. However, most individuals do not initially present to health care professionals primarily due to abuse or post-traumatic stress disorder, rather they are admitted to treatment with diagnoses such as depression, adjustment disorder, borderline personality disorder, psychotic disorders, psychosexual dysfunction, dissociative disorders, eating disorders, suicidal tendencies, and substance use disorders. Post-traumatic stress disorder, multiple personality and other dissociative disorders, and borderline personality disorder were
each discussed in the article due to their relatively strong relationship with sexual abuse. For occupational therapists dealing with individuals who have survived sexual abuse, the article suggests a dual approach in which recall and emotional recovery from past abuse is facilitated in addition to a strong focus on the reality of current daily life. If the therapist has a limited amount of time with a client, it is suggested that the focus remain on “here and now” functioning. Interventions might include expressive therapy, group work, relaxation training, and systematic desensitization to threatening stimuli. The Model of Human Occupation was used to structure intervention focused on functioning in day-to-day life including the promotion of empowerment, choice, and self-esteem to enhance one’s sense of personal causation, the exploration and expression of values and interests, an emphasis on balance among roles and activities, exploration of enjoyable leisure pursuits, addressing cognitive distortions, and improving communication skills as necessary. For specific interventions, an occupational therapist may try engaging clients in movement therapy, self defense training, physical challenges, assertiveness training, role play and identification/testing of cognitive distortions. In cases when an individual, whether encouraged by the occupational therapist or unintentionally, begins experiencing “catharsis” or relives a traumatic experience during a therapy session, the article advises therapists to remain calm and be welcoming of strong expressions of emotion such as tears and shaking. Touch should be used only with caution, but the author states that it may be helpful to perform a reorienting occupation at the end of sessions such as asking individuals what they are looking forward to in the near future. A case study follows the general discussion in this article and focuses on a young woman, “Alice,” who experienced ritual abuse as a child. During her
final year in college she became unable to finish her degree when the lectures on sexual abuse that were part of her women’s study curriculum caused her to “crack-up.” Although “fine” most of the time, the Alice began demonstrating alternate personality states that were severely self-destructive, repressed, or regressed. As a result she spent three years in a psychiatric hospital under strict supervision to ensure her safety. The occupational therapist served as a liaison between the treatment team on the unit and the rehabilitation therapists (recreation therapists, vocation specialists, and expressive therapists) who saw very different sides of Alice. In rehabilitation therapy she was usually “fine,” highly motivated, and successful, but while on the ward, her other personality states initiated dangerous behaviors. As she became too unstable to attend rehabilitation therapy, the occupational therapist began working with her directly and they developed a strong relationship. When her insurance ran out, the occupational therapist and others advocated for her release back into the community rather than placement in a state institution. The occupational therapist was very influential in her outpatient care, helping her to find employment, return to school, and enjoy leisure time with friends.

This article was helpful in validating the use of the Model of Human Occupation and many of the intervention strategies that will be part of my program with individuals who have been sexually abused. This is important because of the link between sexual abuse and substance use disorders. Many of the women at CTF participate in a trauma recovery group and some residents have shared the fact that they were sexually abused as children, making this article very relevant. I do not plan to directly address past experiences in the program due to time constraints, overlap with the trauma group, and my lack of training in this area. However, the interventions in
this article based on the Model of Human Occupation are consistent with or could be added to the interventions I plan to use in my program. Furthermore, this article helped to prepare me for potential cases in which an occupational therapy session might unintentionally lead an individual to re-experience emotions related to past trauma. Thanks to this article, I will be better prepared to deal with such a situation and I will also be less nervous or upset knowing that such experiences, though difficult, may be beneficial. This article also establishes an important role for occupational therapy in an area dominated by counseling or talk therapy professionals (pp. 12 and 22), which can help me make my case for the inclusion of occupational therapy at CTF, where a history of abuse affects many residents.


Abstract:
Life on the Outside is a riveting account of one woman’s struggle to win her freedom and change her life; it is also an extraordinary feat of reporting, one that makes vivid the real-life effects of the rough justice meted out to the poorest of the poor. The book tells the story of Elaine Bartlett, who spent sixteen years in prison for a single sale of cocaine- a consequence of New York State’s controversial Rockefeller drug laws. It opens on the morning Elaine is set free from the women’s prison in Bedford Hills, New York, after winning clemency from the governor. At age forty-two, having spent most of her adult life behind bars, she has no money, no job, and no real home. What she does have is a large and troubled family, including four children, who live in a decrepit
housing project on the Lower East side of Manhattan. “I left one prison to come home to another,” Elaine says. In the months following her release, she strives to adjust to “life on the outside”: conforming to parole’s rules, hunting for a job and a new apartment, and reclaiming her role as head of the household, all while campaigning for the repeal of the merciless sentencing laws that led to her long prison term.

In recent years the United States has imprisoned more than two million people—many for nonviolent crimes—while making few preparations for their eventual release. Now those people are returning to our communities in record numbers, coming home as unprepared for life on the outside as society is for them.

Jennifer Gonnerman is one of the most talented journalists of her generation. With Life on the Outside she at once calls attention to a mounting national crisis and claims a place alongside the masters of narrative nonfiction writing, all by telling one woman’s story—a story of struggle and survival, guilt, and forgiveness, loneliness and enduring love.

Summary and Significance:

This book evolved from a journalist’s interview with Elaine Bartlett, a woman who was imprisoned for over 16 years on her first offense for selling cocaine that she agreed to transport in order to make a quick $2,500. The man who hired her to transport the drugs was actually a corrupt police informant who “helped” police officers in upstate New York meet their unofficial arrest quotas as part of the “war on drugs.” In return, he and his friends were given lighter sentences on the occasions in which they were caught selling and trafficking drugs. The long sentence Ms. Bartlett received was a consequence of the controversial New York State
Rockefeller Drug Laws which mandate at least 15 years to life in prison for anyone convicted of selling 2 ounces of cocaine. One interview turned into many, as Elaine proved to be more than willing to share her experiences. After she was released, the journalist spent hundreds of hours with Ms. Bartlett from her release in 1999 until the completion of the book in 2003. Additionally, the author/journalist interviewed friends, family, and others involved in Elaine’s life to provide further insight into the melodrama. The fact that Elaine had served time in prison was not unusual in her family. Two of her six siblings had been imprisoned, another had been arrested but given parole, a third battled drug addiction and HIV, a fourth died of AIDS-related illness, and the fifth, arguably the most stable member of the family, was murdered for no apparent reason. After her release she spent many weekends visiting her brother, son, and co-defendant husband who had gone along with her while she was carrying the cocaine to keep her safe. Although they began the trip as friends, the couple married in the courtroom just before sentencing and Elaine’s husband remained devoted to her despite spending even more time in prison than her. Elaine grew less interested in her husband as her sentence went on and found that after her release, despite romantic visits, she could not forgive him for marrying another woman who visited him in jail. Elaine’s children essentially grew up without their parents. Elaine went to prison when her youngest was an infant and her oldest was 11. They lived in a crowded housing project apartment on the Lower East Side of New York City with their Grandmother and various aunts, uncles, and cousins. Her oldest child was a star basketball player who devoted his adult life to mentoring inner city youth through basketball programs. Her second child, Jamel, became a drug dealer and drifted in and out of prison. His mother and older brother were very upset by this, but his other family only half-heartedly discouraged his efforts because he was helping to
supplement their welfare-based income. Her youngest daughter dropped out of high school shortly after Elaine returned from prison and largely ignored Elaine, choosing to live with friends instead. Eventually she confessed to Elaine that a strong fear of her mother returning to prison was the reason she kept her distance. Her third child was suffering from depression after recently giving birth. Without any support from the baby’s father and forced to drop-out of high school, she spent most of her time in the dirty apartment watching soap operas at the time her mother returned. Elaine’s mother had passed away a few years before she was released and since that time, the family and their apartment had fallen apart. It took very little time for the initial high of Elaine’s release to fade into a daily struggle to find and maintain employment, housing, and relationships. At first, Elaine receives a significant amount of attention and money from friends and relatives sympathetic to her plight but when the dust settles and the money runs out, Elaine is constantly unsatisfied with her crowded living arrangement that offers no more privacy than she received in prison, and her desperate financial situation which is arguably more stressful than prison life. She eventually finds work at an inpatient substance abuse rehabilitation center for men which is at times rewarding but at other times represents yet another challenge for her to deal with. She also must handle personal and family crises including the death of her sister, her older daughter’s unwillingness to leave the apartment, her younger daughter’s unwillingness to live in the apartment, attend school, or accept Elaine’s attempts at creating relationship, and her younger son’s legal trouble and dangerous lifestyle. Her dream is to save enough money to move her family out of the subsidized housing that she and her son are not legally allowed to live in (although the probation office looks the other way, they face the constant threat of the housing authority evicting the entire family). Unfortunately, Elaine is unable to save any money at all
because family members and friends, most of whom do not work, constantly badger her for spare cash. At one point, someone with access to her checkbook, drains her entire account (later her sister is pleads guilty of stealing money from a company using check fraud and receives probation). Nothing on the outside seems to be going as Elaine had imagined, but she does find purpose in speaking at protests and rallies against the Rockefeller drug laws that kept in her prison for so long. Along with the encouragement of other activists, Elaine receives the support of a prison volunteer who helped her successfully apply for clemency from the governor while Elaine reciprocated by helping the volunteer cope with an HIV diagnosis. Elaine’s family relationships also begin to improve towards the end of the book as her older daughter’s depression seems to lift and their old apartment is vacated in favor of separate living situations.

Although her sentence was arguably extraordinary considering the circumstances of her crime, from what I have read and observed, her struggles after leaving prison were fairly common. She had to seek out assistance from an agency that specialized in finding employment for the formerly incarcerated and despite this, numerous certificates and diplomas she earned while in prison, including her associate’s degree, and glowing reviews from her case manager at the agency, it took several months for her to find a position that paid $18,000 per year. Throughout her struggle, Elaine demonstrated some of the traits that are addressed at CTF including unhealthy boundaries with her family demonstrated by her inability to say “no” when others asked her for money, inadequate social skills demonstrated by her inability to live with others without fighting that sometimes led to violence and Elaine storming out to live in a shelter, and resentment toward authority and a sense of entitlement demonstrated by her behavior
at work including failure to come in on time, obey the dress code, or respectfully speak with her boss, which led to her eventually firing. Elaine would have been a good candidate for residency at CTF rather than the 16 year prison sentence she received. She had a tendency toward criminal thinking as well as a difficult environmental situation that led her to take the $2,500 offer that led to her sentence. At CTF she would have been able to earn her GED while also working to improve her social skills and assertiveness and address her anger management issues to improve her relationships. With the help of an occupational therapist she also could have improved her organizational and work skills to better manage her time and finances without becoming overwhelmed and understand the expectations of employment. Just as her lengthy prison sentence inspired Elaine’s role as an activist, the occupational therapy at CTF would also encourage activism and other meaningful community service roles.


Abstract:

This paper is a discussion of the experience of adult attention deficit hyperactivity disorder (ADHD). While much is known about the diagnosis and treatment of childhood ADHD, therapists may be less familiar with the clinical signs of adult ADHD and fail to detect and address such deficits in patients. Adult ADHD often affects all occupational domains—work/school, family life, social relationships, and self-organization—often without the person’s awareness of the condition. When people with ADHD do not receive a formal diagnosis until
adulthood, deficits in the above occupational domains may be severe. The first half of this paper describes (a) clinical presentation; (b) classification; prevalence, adult course, and comorbid conditions; (c) biologic factors; and (d) pharmacologic treatment. The latter half discusses occupational therapy intervention and describes a case study involving a college student.

Summary and Significance:
This was a very informative paper that described ADHD very thoroughly, explaining relevant neurobiological, neuroanatomical, genetic, and pharmacological findings, as well as behavioral and psychosocial aspects of the disorder. The former category may be useful for educating individuals with ADHD in an effort to combat shame, defensiveness, and low self-esteem while promoting insight and understanding toward one’s difficulties. The authors also explain those difficulties, often tying them directly to the biologic research, in terms of occupational functioning. They point out that often adults who were not necessarily diagnosed with ADHD as children have a great deal of occupational dysfunction that has accrued over their lifetimes including educational and vocational failure, interpersonal conflict, and low self-esteem. The most useful aspect of the article is the suggestions for occupational therapy intervention that address these issues. The authors break down the role of occupational therapy into five domains: helping the individual monitor and regulate sensory stimulation to avoid over/underload; helping the individual organize their physical environment; helping the individual optimize time management; helping the individual improve social awareness and interaction, and helping the individual manage stress. Each domain consists of about 2-6 specific interventions to be completed in a step-wise fashion. For example, to improve social awareness and interaction,
occupational therapists are encouraged to first help clients become aware of their inappropriate social behavior (which may be difficult due resistance from clients to confront their deficiencies and a tendency to blame others instead). Then occupational therapists are encouraged to use role play to practice appropriate social behavior in a variety of settings. Finally, occupational therapists can encourage clients to practice the use of social norms in real-life situations. The biggest downside to this article was the lack of empirical evidence to substantiate the methods/techniques presented. A case study was included at the end of the article but consisted of “the compiled experience of several students” written as one story of a fictional occupational therapy student. As such, no objective assessments were reported and the case study seemed to simply represent a summary of how all of the suggested interventions work in an ideal situation in which everyone surrounding the student is extremely accommodating and the student herself is extremely motivated. Many of the women residents as well as my site mentor at CTF struggle with adult ADHD or symptoms similar to those of adult ADHD. The extensive information available in this article could help me develop several sessions of an ADHD group in which women could receive education regarding how the condition affects their occupational lives and the five domains of occupational therapy intervention could be addressed. Group occupations could include making sample planners and daily schedules, brainstorming organization ideas, drawing real or imaginary room floor plans, relaxation exercises, and identifying events requiring schedule flexibility and events that do not need to be addressed immediately. Social skills role playing is already a large part of the CTF curriculum.

Abstract: No abstract available for this source

Summary and Significance:

This brief article contained basic information regarding AD/HD, as well as information on the link between AD/HD and substance abuse and other risky behaviors. According to this article, 50% of adults with AD/HD have a full substance use disorder while 20% of adults with a substance use disorder have AD/HD. Harris identifies this as an “emerging area of practice.” The article also states that adults with AD/HD are less health conscious, more likely to divorce, less likely to enroll in or complete college, more likely to be involved in an automobile accident, and more likely to engage in risky sexual practices. They are also at risk for major depression disorder (16-31%), antisocial behavior problems (7-8%), neurotic symptoms (79% in boys with AD/HD followed into adulthood). In advocating for a multimodal approach to treatment (including occupational therapy) Harris points out that medicated adults with AD/HD have only small differences in work performance compared to their non-medicated counterparts. The article debunks popular myths such as “AD/HD is just an excuse for bad behavior,” it is caused by poor parenting, children will outgrow it, and only hyperactive individuals have it. It also points out that, although it is polygenetic, AD/HD is just as heritable as physical height.

This article was somewhat redundant with others I have read about adult AD/HD. However, it did point out that education brings about more change that other psychosocial interventions such as cognitive behavioral therapy, social skills training, and life skills coaching, which will help me in planning how to address AD/HD in my program. I may include some of
the information from this article in my educational material, especially the statistics about automobile accidents and the study comparing medicated and unmedicated workers. I may also visit and/or share some of the websites suggested in this article, particularly the site devoted specifically to women and girls with the disorder (www.addvance.com). This article is unique among the AD/HD literature I have read because it specifically advocated for the role of occupational therapy in working with these adults.


*Abstract:*

This article, based on a presentation given at the First National Personality Disorder Congress, provides a brief descriptive overview of the occupation-based intervention group programme, the Journey day service, with contributions from a former group member, Rachel, of her experience of participating in and completing the programme.

*Summary and Significance:*

I thought this was a very useful article because many of the women at CTF have Axis II diagnoses. The authors define personality disorders and the problems typically associated with them with an emphasis on occupational therapy. They state that many people with personality disorders have “Conative problems” defined as difficulty directing one’s self and establishing meaningful life goals. Their program attempted to address some of the most troubling aspects of
personality disorders through engagement in focused, goal-directed activity that 1.) facilitates improved control/regulation of thoughts and feelings, and 2.) transcends the typical goal of avoiding negative affect by seeking positive outcomes. Closed groups consisting of 10 members, 1 user consultant and 3 staff met for a total of 6 months. During the first 12 weeks they met weekly for consistent, structured, 4-hour sessions focused on education regarding occupation, engaging in occupations, reflecting, and creating individual occupational action plans. During the second 12 weeks, the group met once per month while members worked on fulfilling their occupational action plans and reflecting on the experiences. The article described one group member’s experience facing a “death-defying” physical challenge and overcoming her fear in order to succeed. In doing so she developed a passion for rock climbing and discovered that this occupation allowed her to enjoy “me time” and feel more at ease with family life. At the end of the program this group member demonstrated slight improvements in her personal sense of competence, the amount she valued occupation, and some aspects of quality of life, but at the 6 month follow-up large improvements were seen in all measures, likely because by that time she had obtained funding to engage in rock climbing on a regular basis. I was disappointed that the authors did not present evidence from more than a single group member. However, it was nice to read about an occupational therapy program for this particular population because of the similarities with the population at CTF. Additionally, the authors of this study used the Model of Human Occupation in addition to the Functional Group Model in creating their program, which is the model I am using for my program. Unfortunately, there was not a great deal of description
regarding how the specific concepts of MOHO related to the goals or methods of the group aside from the use of the Occupational Self-Assessment as one of the outcome measures.


*Abstract:*

When Marya Hornbacher published her first book, *Wasted: A memoir of Anorexia and Bulimia*, she did not yet have the piece of shattering knowledge that would finally make sense of the chaos of her life. At age twenty-four, Hornbacher was diagnosed with Type I rapid-cycle bipolar, the most severe form of bipolar disorder.

In *Madness*, in her trademark wry and utterly self-revealing voice, Hornbacher tells her new story. Through scenes of astonishing visceral and emotional power, she takes us inside her on desperate attempts to counteract violently careening mood swings by self-starvation, substance abuse, numbing sex, and self-mutilation. How Hornbacher fights her way up from a madness that all but destroys her, and what it is like to live in a difficult and sometimes beautiful life and marriage- where bipolar always beckons- is at the center of this brave and heart-stopping memoir.

*Madness* delivers the revelation that Hornbacher is not alone: millions of people in America today are struggling with a variety of disorders that may disguise their bipolar disease. An Hornbacher’s fiercely self-aware portrait of her own bipolar as early as age four will powerfully change, too, the current debate on whether bipolar in children actually exists.
Ten years after Kay Redfield Jamison’s *An Unquiet Mind*, this storm of a memoir will revolutionize our understanding of bipolar disorder.

**Summary and Significance:**

In this memoir, Hornbacher tells the story of her turbulent life colored by a mental illness she seems to experience as early as the age of four. As a child she was plagued by racing thoughts and fears that caused her to stay awake all night and led her classmates to call her “crazy.” By early adolescence she discovered the wonder of alcohol and developed an eating disorder, both of which served to calm her mind and make her feel more “normal.” Unfortunately, both of these coping mechanisms led to serious health consequences. Despite treatment for her anorexia, her weight continued to decline until she was hospitalized very near death, at which point she made a decision to do what was necessary to survive, including gaining about 60 pounds. This story is chronicled in her first novel. As part of her treatment for the eating disorder, Hornbacher was assumed to be depressed and given Prozac, a medication that would further destabilize her true illness. As a student, writer, and professor, she fit in with the hard-drinking, eccentric literary crowd and married an old friend from her teenage years. Her explosive temper quickly ended that marriage and her unscrupulous spending left her nearly broke. It was during this time that she was first diagnosed as bi-polar, but she did not take this diagnosis seriously, was careless with her medication, and continued her with her unhealthy habits of consuming large quantities of alcohol and caffeine and neglecting sleep. Even her first psychotic break and hospital stay were not enough to convince her that she should give up alcohol for good. After a couple of disastrous relationships, including a road trip nearly ending in murder-suicide by her psychotic
boyfriend du jour, and a cutting incident that turns into a vague but dangerous suicide attempt by Hornbacher herself, she eventually begins to recognize that her alcoholism combined with her bipolar disorder have made her life completely unmanageable. Although she knows it will not make her entirely well, she decides she must first give up drinking before she can address her other disease. At an AA meeting she meets her future second-husband and cares for him during a period of severe depression. For a short time after he recovers, her life approximates her ideal of normality until a job writing for a magazine leads Hornbacher to take on too much work and neglect her sleep and nutrition. This begins a several year odyssey in and out of the psychiatric ward in which Hornbacher is completely unable to function through her misfiring brain and medication side effects. During these years, her second-husband, family, and friends provide a great deal of support. Hornbacher eventually resorts to electro-convulsive therapy and finds a combination of medications that provide her with enough stability and energy to return to work in her home office. Her newfound health puts a strain on her marriage when roles must be rearranged with Hornbacher no longer the patient and her husband no longer the caretaker. During a separation, Hornbacher briefly returns to her eating disorder for comfort but is able to recover. Her husband returns to his depression and calls Hornbacher in desperation leading to reconciliation between the couple. The book concludes with Hornbacher describing the battles she wages to maintain her admittedly tenuous grasp on sanity including keeping a “mood journal,” dealing with medications and their side-effects, and trying to find coverage for her astronomically high medical bills.
This book provided a great deal of insight into what life is like for someone with bipolar disorder, type I. Based on this book there is a huge role for occupational therapy in helping people with this disorder by helping individuals plan healthy, balanced schedules, manage medications, cope with stress and anxiety, and identify early warning signs of an acute episode. Hornbacher describes occupational therapy in the psychiatric ward as

Where people bend over the paint-stained table and struggle with their med-unsteadied hands to thread dull needles with which they will make yet more leather coin purses, or paint sheet after sheet of thin paper watery black, or scribble enormous, angry explosions with red and orange pencils and crayons, the force of their scribbling tearing the pages. When time is up the occupational therapist will ask us to rate on a scale of one to ten the degree to which this alternative activity helped distract us from our current situation, and to rate how we feel now as compared to how we felt when we came in the room (pp. 182-183)

This is the only mention of occupational therapy in the book and it helps to illustrate that, although Hornbacher had to accept a number of lifestyle changes, occupational therapy was misappropriated as a distraction to the acutely ill rather than assisting more stable individuals to help them maintain a healthy balance in life while outside of the hospital.

Hornbacher points out in a section titled “Bipolar facts” that the odds of a person with bipolar I struggling with a substance abuse disorder at some point in their lives are about 60 percent and the rate of alcoholism in bipolar women is seven times that of the general population. Consistent with this, there are women currently at CTF with a diagnosis of bipolar,
and this is a condition identified by case managers as something they frequently deal with.

Hornbacher also has a section of “Useful Websites” that serve as a resource for some of these women. I would not recommend the book to most individuals with bipolar disorder because it discusses alcohol use and manic episodes in such a way that impulsive individuals may miss the greater message (Hornbacher’s first novel about anorexia has similarly been criticized as “triggering” for some people with eating disorders). However, I may provide portions of it as a resource.


Abstract:

Two time Oscar-nominee Winona Ryder stars in the fascinating true story of a young woman’s life altering stay at a famous psychiatric hospital in the turbulent late 1960’s. Questionably diagnosed with Borderline Personality Disorder, Susanna (Winona Ryder) rebels against the head nurse (Whoopi Goldberg) and top psychiatrist (Vanessa Redgrave), choosing instead to befriend the resident “loonies” ... a group of troubled women including the irresistibly charismatic sociopath Lisa (Angelina Jolie). But Susanna quickly learns if she wants her freedom, she’ll have to face the person who terrifies her most of all, herself.

Summary and Significance:

This film was based on the book by Susanna Kaysen chronicling her 18-month stay at McLean Hospital where she was diagnosed with Borderline Personality Disorder. Although the book was
based on real-life, the movie was, in my opinion, loosely based on the book. In the film, Kaysen befriends a woman named Lisa with Antisocial Personality Disorder (previously referred to as sociopathy). The two women escape the hospital together until Lisa launches a sadistic verbal attack against a former patient they are staying with. This leads the former patient to kill herself. When Lisa fails to exhibit any emotional reaction to this, Kaysen recognizes how ill her friend is and calls the authorities. Both women are brought back to the hospital, with Lisa dragged in against her will and subjected to further electro-convulsive therapy. Upon returning, Kaysen reconciles with the staff she had initially distrusted and works toward her release. At the end of the movie, she leaves the hospital with a part-time job in place at a bookstore and a plan to become a writer.

I chose to watch this movie because of its focus on women with personality disorders but was disappointed with its over-the-top characterizations. Although the book was enlightening and I would recommend it to anyone working in mental health, the movie was less realistic and thereby less valuable for professional or educational purposes. Although the book attempted to humanize the mentally ill and make a statement about how subtle the distinction between “crazy” and “sane” truly is, the film mainly focused on the entertainment value of mental illness. As a result, this film will not contribute significantly to my work.


Abstract:
The Handbook of Women, Stress, and Trauma is a compilation of the most up-to-date research, theory, and practice in the intersection of women’s studies, traumatology, counseling, and therapy, providing the first comprehensive look at the stressors that affect women’s lives. The book is divided into three sections, the first of which examines women’s experiences of stress and trauma using a lifespan developmental framework spanning from childhood through old age. The second section focuses on the range of violence and abuse of women, and includes cutting-edge research on the long-term health and neuropsychiatric effects of stress and trauma. A final section presents careful examinations of stress and trauma in the lives of women of color, women with disabilities, and lesbian women, three populations that are often overlooked. This unique volume is an invaluable resource for students and practitioners of all levels, and represents a new standard of knowledge to promote further research in the field.

Summary and Significance:

This book cited countless studies in its thorough discussion of how negative experiences impact women of all ages and races. Several themes could be found throughout the book including: 1. the fact that women are disproportionately victimized; 2. the fact that women react to stress differently than men (“tend and befriend” versus “fight or flight”); 3. the fact that trauma and stress, particularly if it is prolonged or occurs in childhood, can have a multitude of physiological and neurological consequences, and 4. the fact that women who have experienced trauma or stress are at an increased risk for engaging in unhealthy behaviors. Some other interesting topics included in the book were the discussion of stress and trauma related to childbearing, the birth process, and miscarriages, the stress and trauma, as well as coping mechanisms, specific to
minority populations including the disabled and lesbians, and the difficulties associated with intimate partner violence.

This book was very relevant to the population I am working with at CTF. I have already many accounts of personal stress and trauma from the women residents there including grief over a miscarriage, difficulty ending an abusive relationship, and being sexually abused by one’s father among many others. Several groups at CTF address issues related to stress and trauma including, “Trauma Recovery Empowerment,” “Grief and Loss,” “Life Collage,” and “Self-Efficacy” because the need in this area is so apparent. Things I have learned in this book have aided in my understanding of the women’s behavior including the links between stress and trauma and drug abuse, risky sexual behavior, chronic pain syndromes, eating disorders, self-mutilation, anxiety, insomnia, social dysfunction, AD/HD, and even memory deficits. Recently a woman on the unit was very distressed because she becomes severely ill each month during her period and while the other staff was insistent that nothing was wrong with her, I recalled from this book that there is a link between intimate partner violence and premenstrual dysphoric disorder. I have also been able to engage in an informed discussion with the counselor who leads the “Trauma Recover Empowerment” group regarding the effects of trauma.


*Abstract:*
Borderline personality disorders are characterized by unstable affect, mood, behaviour, object relations and self image. Clients can almost always appear to be in a state of crisis. Treatment approach with these clients can be a challenge. Their behaviour can be highly unpredictable, and their achievements are often below the level of their abilities. Occupational therapists need to be aware and be able to deal with clients that easily refuse help and can deny their problems, using several defence mechanisms like splitting and projective identification that can be highly disruptive on a team and can ultimately provoke the staff to turn against the person.

In this article the author describes the occupational therapy intervention in a case of an individual with a diagnosis of borderline personality disorder and comorbid minor depression. It includes the assessment methods, approaches and interventions, evaluation and outcomes; it is set in the community.

Summary and Significance:

This article featured a case-study in which “Maria” a 45 year-old Spanish woman received occupational therapy support twice per week over the course of a year while residing in the community with her husband and son. Maria had a history of hospitalizations for an eating disorder and was currently unemployed with few social contacts. She had difficulty with basic self-care and home management tasks, bathing and changing clothes infrequently and relying on her mother for most chores. She was aggressive towards her son and husband and displayed poor self control, low self-esteem, and very limited tolerance for frustration. Following completion of the Canadian Occupational Performance Measure (COPM) along with other assessments, Maria and the occupational therapist worked on establishing routines and checklists for personal care.
and home management and practicing coping strategies. The therapist relied on a client-centered, cognitive behavioral, directive approach in working with Maria and encouraged her to participate in occupations she could accomplish in order to boost her self-esteem and motivation. By the end of the year, Maria was performing remarkably better in all of her COPM goal areas and her relationships with her husband and son were greatly improved. Despite spending most of her time in bed prior to the intervention, by the end of the year she expressed an interest in seeking employment outside of the home.

This article was relevant to my project because many of the women at CTF display similar behavior to Maria. Maria was physically abused as a child, did not complete her high school education, and prior to the intervention, she was disorganized, impulsive, unmotivated, and though very poorly of herself, this profile is similar to many of the women at CTF. This article is a promising step toward establishing the effectiveness of occupational therapy for women with personality disorders and could be cited as an argument for including occupational therapy in correctional settings due to the high proportion of individuals with personality disorders housed there. The article also provided practical guidance for working with women similar to Maria such as using clear, objective communication with simple instructions; achieving a therapeutic alliance based on an empathic, available, trustful attitude; promoting assertiveness, understanding, and acceptance of anger and fears of relationships; using relaxation techniques to address impulse control; and using modeling, reinforcement, role play, and feedback to support effective behavior.

Abstract:

In a violent city where murder is the norm, basketball is the only truth. Omar McGee gathers testimony from the street in an attempt to make sense of the world he himself struggled against as a child. McGee chronicles the rich legacy of great ball players that have come out of Flint, Michigan, against the gridlock of poverty, drugs, and crime that General Motors left behind.

The film highlights the careers of Flint natives Morris Peterson (New Orleans Hornets), Jason Richardson (Phoenix Suns), Mateen Cleaves (Denver Nuggets), Chucky Atkins (Oklahoma City Thunder), as well as Tracy McGrady (Houston Rockets) and Glen Rice (formerly of the Los Angeles Lakers) who have achieved the dream of making it to the pros.

Summary and Significance:

More than documenting the game of basketball and the stars that play it, this film focused on the bleak environment left behind as General Motors moved its manufacturing plants to Mexico. After decades of plentiful unskilled work, the people of Flint were largely uneducated and unprepared for the loss of their jobs. Many became involved in the drug trade as the rise of crack cocaine coincided with the downfall of manufacturing. The film follows one dealer who took on the family business, cooking crack in his kitchen, where he also kept a gun in his silverware drawer and a closed-circuit television monitoring the front of his modest home in his cupboard. As his rock hardened, he candidly explained how crack put pimps out of business because women would become so addicted they no longer cared about protection and would charge only $5 for their services. By the time of production, this young man had been arrested. Other
characters in the film included “homies” barbecuing on the sidewalk and discussing why children idolized “the dope man” and the drug-dealing lifestyle. Not only does the dope man have the jewelry and the car and the cash they explain, but even small time “homies” like themselves will throw in money to buy a kid in the neighborhood a coat if his family cannot afford one. Unfortunately, the generosity of the people of Flint does not extend much further than these charitable neighbors and the support of the high school basketball teams. The high school basketball courts are shiny and new, with large seating capacities and security guards to ensure the players’ safety. Elsewhere pictures in the schools show rusted tiles and crusted drinking fountains. In one school, there is no library. Residents point to corrupt administrators who drive fancy cars while their schools fall to pieces. Basketball players from Flint high schools are not held to the same academic standards as most high school athletes, with programs requiring only a 1.8 GPA. Players from Flint are also notable for their flamboyance and trash-talking on the court; “big egos” as one resident phrased it. This attitude was the downfall of one very talented player who tried to enter the NBA after high school and despite being drafted, failed to adapt to the expectations of the professional league and fizzled out. A different Flint player profiled in the film was encouraged to enter the draft after high school but chose a free college education instead and was very successful. Another exception to the “big ego” tradition of Flint was a professional player whose parents had been educators. He was also very successful in his basketball career. The film ends with scenes from a Flint “Pro-Am” game in which famous basketball players return to their hometown and are greeted as heros by the children and drug
dealers alike. This is interspersed with words from a slam poet condemning the town for its reliance on basketball and drug dealing as the source of all possible role models.

This film illustrated the type of environment that produces criminal behavior. Although perhaps not as extreme as Flint, Toledo faces similar problems of unemployment, violence, and drug abuse, and has a similar history of lost manufacturing jobs in a globalizing, high-tech economy. The man who was arrested for dealing drugs and the men hanging out on the street emphasized that even though they sell drugs, they are also trying to do good things for their community. This is the type of criminal thinking that has destroyed their community. At CTF thinking such as “I have no other choice” or “I am just taking care of my family” is a major issue that is addressed through cognitive-behavioral programming. The “big egos” and “cockiness” displayed by Flint basketball players as a reflection of their culture, is another issue that is addressed at CTF during cognitive retraining and social skills practice, although this is more common among men than women. The discussion of crack was highly relevant to my work at CTF where women sometimes admit to cheating on their boyfriends. I once observed an experienced case manager confront a resident when she wrote about this situation asking, “were you cheating on your boyfriend or were trying to score dope?” To this she acknowledged the latter statement to be true. This film made me think about the place of women in an culture like Flint, because other than a couple woman who were interviewed about the environment, the only mention of women was the discussion of prostitutes. If the message in a place like Flint is that the only way out of poverty is through basketball or the violent, male-dominated world of drug

Abstract:

Autumn’s eyes is a compelling documentary about a 3-year-old girl who tries to navigate through the harsh reality of severe poverty, her teenage mother’s incarceration and looming foster care. Charming, obedient, and unable to fully comprehend the severity of her environment, Autumn is shielded from her own reality. Caught between the innocence of childhood and the growing necessity to be an adult, she represents hope to a family of women caught in the cyclical web of abuse, incarceration and poverty. Autumn’s Eyes captures this impressionable time in a child’s life, and asks the greater question: is there truly hope for a child growing up in these circumstances? Through the perspective of a little girl, Autumn’s Eyes explores this perilous state of hope.

Summary and Significance:

This was a very heart-wrenching documentary of a family fighting very hard to survive for the sake of children (including 3-year-old Autumn) who do their best to hang on for the ride. After Autumn’s mother is imprisoned for a charge she vehemently denies (but which Autumn’s grandmother explains as a drunken indiscretion), Autumn is cared for by her morbidly obese grandmother. At age 40, this woman has numerous children of her own including a 12-year-old
and 14-year-old, and serious health issues related to her poorly controlled diabetes. When she is hospitalized, the family is thrown into crisis once again as the electricity is turned off at their apartment and the children are temporarily taken in by the state. Perhaps the saddest moment in the film came when the Autumn’s 14-year-old uncle contacted a more distant relative to ask for a job selling drugs to help support his family. Autumn’s grandmother tearfully explains that she never wanted this and never told him to do it, but she never told him not to do it. Autumn’s grandmother is released from the hospital after a short time and regains custody of the children but continues to voice frustration over her condition and considers gastric bypass surgery. Her feelings about her weight are made clear early in the film when she warns her 12-year-old daughter to stop eating so much or she will become “400 pounds” and start having sex with any man she can find because she will hate herself so much. In another moment of revealing candor, Autumn’s grandmother advises the 3-year-old to only marry a man who can please her sexually, otherwise, she will go out and cheat and her husband will kill her. Of course, Autumn already knew what she wanted in a man: “lots of money.” Eventually Autumn’s 19-year-old mother returns from jail to await her final sentencing and Autumn is thrilled to spend time with her. As her mother’s court date approaches Autumn becomes anxious knowing her mother might be taken away again. She throws a tantrum when she is not allowed to accompany her mother on a job interview and worries that her mother will be late for her court appearance. Meanwhile, the entire family is evicted and must move to a different apartment. The film ends on a positive note with Autumn’s mother receiving a sentence of time served and 3 years probation. To wrap things
up, Autumn is interviewed by the voice of a young man, presumably her uncle, saying that she wants to become a doctor when she grows up.

This film documented many of the most relevant issues for the population I am working with. At CTF, young children are probably the greatest source of joy and pain for the women residents. Many, if not most, of the women at CTF are mothers. They are generally distressed about the time they are loosing with their children. Compounding this, many mothers worry about the adequacy of the care their children are receiving and/or the threat of their children being put in “the system.” One of the happiest moments in the film occurred when Autumn proudly recited the Pledge of Allegiance that she had learned in school. Autumn’s mother was thrilled that her daughter had learned this by the age of 3, saying, “I didn’t learn that until 3rd grade.” The hope that Autumn was special enough to break free from their family’s bleak existence was apparent. Similarly, at CTF, pictures of young children are common treasures that motivate the women residents. Financial and health issues are also common in the residents and their families and this film did a nice job directly linking such issues with crime itself when Autumn’s uncle turns to drug dealing during a crisis. Overall, the film illustrated the circumstances that lead to criminal behavior, demonstrating the funnel that can drain even well-meaning individuals into hospitals, institutions, and early graves. This would be a good film to show anyone working or considering working in corrections or with people who are impoverished or at-risk. I would not consider this a good film to show the women at CTF because the message more appropriate for outsiders like myself, whereas they are already acutely aware of their circumstances.

Abstract:
From baboon troops on the plains of Africa, to neuroscience labs at Stanford University, scientists are revealing just how lethal stress can be. Research reveals that the impact of stress can be found deep within us, shrinking our brains, adding fat to our bellies, even unraveling our chromosomes.

Yet understanding how stress works can help us figure out ways to combat it and how to live a life free of the tyranny of this contemporary plague. In Stress: Portrait of a Killer, scientific discoveries in the field and in the lab prove that stress is not a state of mind, but something measurable and dangerous.

Summary and Significance:
This documentary focused mainly on the research of Professor Robert Sapolsky who has been studying baboon communities in Africa for the past twenty years. By measuring blood levels of two chemicals linked to the stress response (glucocorticoids and epinephrine) he has found that baboons low in the social hierarchy seem to have more stress. He observes that baboon communities, like human societies can be mean and vindictive. An alpha male will bully a lower ranking male who in turn will act out aggressively against a female who will then take out her anger on a juvenile baboon. He hypothesizes that this is why the lower ranking the baboons have higher amounts of stress hormones whereas the higher ranking baboons who are in control of
most situations have lower amounts of stress hormones. To extend this to humans, the example of a highly stressed low-ranking government official and a high-ranking government official was presented. The low-ranking official complained that his superiors were generally unfair and punitive. He frequently missed work due to illness. On the other hand, the higher-ranking official was able to establish a manageable work schedule for herself and seemed to enjoy her work. She stated that she was generally in very good health. The link between stress and health was further established with a discussion of body fat distribution differences, a tendency toward ulcers, which was the first recognized stress-related illness, and arteriograms showing increased atherosclerosis in the blood vessels of people with higher levels of stress hormones compared to those with lower levels. It was explained that part of the stress response is to shut down functions not essential to escaping danger such as the immune system. Although ulcers are actually caused by a bacteria, that bacteria is present in a large proportion of people but only becomes troublesome with chronic immune suppression. The neurological impact of stress was also featured in this documentary which showed that certain parts of the brain “light up,” indicating greater dopamine activity, less in people with high levels of stress hormones. Dopamine, the narrator points out, is an important neurotransmitter in the experience of pleasure as well as the ability to learn. Another study, in which rats were subjected to a life of stress and then their brain cells were then examined, showed that neurons were more poorly developed in the stressed rats than in the control rats whose brain cells had far more branches indicating connections with other brain cells in a well developed brain. Hope for living a less stressful life was provided by a special community of Sapolsky’s baboons that found contaminated food and lost about half of
their males to the disease. The males that died were mainly the more dominant and aggressive. As a result, less time was spent in acts of aggression or dominance and the baboons spent more time grooming one another. As expected, baboons in this community had lower levels of stress hormones but more surprisingly, the culture of nonviolence continued even as new male baboons entered the community because their aggression was not tolerated and they quickly learned to interact cooperatively or left.

This video was relevant in that it further demonstrated the negative effects of stress, which helps to explain a great deal of the behavior seen in residents at CTF, who have often had very stressful lives. It also argues toward the position that people who have a low socio-economic status are under a greater amount of stress than those with more status and perhaps subjecting them to even greater levels of stress during incarceration for substance-use related crimes is counterproductive. Some leaders or privileged individuals may believe that they must deal with more stress than the typical CTF resident who has limited finances and education, because they tend to have “more responsibility.” However, because they are in more dominant positions they have more control over their circumstances and are able to act out their frustration on subordinates such as employees, financial dependents, and even politically marginalized populations such as criminal offenders and public assistance recipients, with little fear of retaliation. On the other hand, more vulnerable individuals who do not have the resources to make it to the top, are under more stress because they have less control over a number of things such as where they live, what they wear, and what they eat. Additionally, they must deal with more negative encounters with authority as well as violence in their homes and communities.
because they are not in a position to prevent this. If people who are at a lower socioeconomic status, as this documentary would suggest, truly are under more stress, it indicates that the cycle of poverty, violence, crime, and substance abuse may in fact be caused, at least in part, by the nature of our society, not the moral defects of the less fortunate, because this documentary also suggests that being under stress can be a major neurobiological disadvantage. I think this video is an important lesson for our society. Although it is sometimes hard at the top, it is almost always harder at the bottom. However, the documentary pointed out some ways people can experience less stress in their lives and that was probably the most helpful aspect of it. I plan to share the story of the cooperative baboon community with the women at CTF as part of their “Self and Community” curriculum because in the community of residents, there are constant complaints of “bullying” and harassment that go on between the women. I think the story of how baboons learned to get along by not tolerating aggression could be inspiring. (I will be sure to explain that although death was the impetus for this condition, killing the aggressive members of the community would be counterproductive). The video also pointed out that changing one’s values can be helpful in reducing stress. For example, if someone has a low-ranking position at work but is captain of his softball team, perhaps it will be useful for him to make softball a bigger part of his internal identity than his less satisfying job. This is a strategy I have observed at CTF and will promote in positive ways among the residents. Many of the women residents value being a mother more than anything else, perhaps because in this role they are the authority, whereas they have less control at work or in their adult relationships. Although it is important for them to find more than one empowering role and take on more control in other situations, there are healthy
aspects of focusing on the areas of life they have control over. I think would also be helpful for the women to understand the baboon stress hierarchy so they are discouraged from being a part of the chain of aggression. It might help them to stop tolerating abusive behavior among people they might view as superior (such as partners, older relatives, or men in general) while also prompting them to consider their own behavior towards those they might view as inferior (such as children, partners, animals, and disabled or elderly individuals). This film also pointed out that doing good for others is one of the best ways to combat stress which supports the service aspect of my proposed program and will help me pitch the idea of helping others in order to help oneself to the residents who are less interested in serving.


*Abstract:*

In the last decade, the number of kids doing time in adult prisons has tripled, even though the juvenile justice system was originally established to keep them out of the adult system.

From award-winning documentary filmmaker Leslie Neale (Road to Return) comes Juvies - stark insight into the personal stories of twelve kids being prosecuted and incarcerated as adults.

For two years, Neale taught a video production class at Los Angeles Central Juvenile Hall to juveniles who were being tried as adults. Following the kids into adult prison, Juvies exposes a justice system that has become a dehumanizing vending machine of injustice.
Narrated by actor Mark Wahlberg, himself a former juvenile offender, Juvies gets inside the lives of these kids who face a life of incarceration haunted by mistakes and missed opportunities. They display courage in the midst of despair, hope in an ocean of loss.

Summary and Significance:

This film captures the stories of handful of young people caught up in the politics of getting “tough on crime” and losing their innocence. Interviews with passerby's on the street indicate that many people are in favor of sending juvenile offenders to adult prison. “If you do the crime, you pay the time” they reason. The media has helped to fuel this attitude with high profile cases of extremely violent young people. However, the statistics indicate that juvenile crime has been declining in recent years and even those same individuals that applauded adult punishment for juvenile offenders thought that a young person driving a car from which gunshots were fired should serve perhaps a year or two in prison since he had not been armed when his friends spontaneously opened fire on a group of rivals verbally harassing them. Instead, this young man, Duc, who is heavily featured in the film was sentenced to 8 years to life in an adult prison. Another teenager who had been roughhousing with a group of people in a drug house was sentenced to 25 years to life in a women’s prison after the situation became violent and another young woman was killed. These two young people are soft-spoken, enjoy reading, writing, and studying, and seem to light up in shots where they are learning about video production. As they are followed into adult prison, they are clearly uncomfortable, but show remarkable resilience. Duc came from a home in which he was physically abused as part of his Asian family’s child rearing “traditions.” He received good grades and had never been in trouble
before the incident with his friends in the car. In prison he is determined to take advantage of 
every learning opportunity he is given and tries to channel his negative feelings in his writing.
Unfortunately, this film points out that opportunities for individuals to improve themselves while 
incarcerated are diminishing as part of the anti-coddle attitude that, “prison should be 
punishment, not a chance to go to college.” However, in the absence of pro-social occupations,
prisoners point out that male prison is dominated by violence while women’s prison is dominated 
by homosexual relationships between otherwise heterosexual women and both are infiltrated by 
drugs. One person interviewed actually began doing drugs for the first time in order to deal with 
his incarceration. The severity of Duc’s sentence, and the sentences of many of the others
juveniles featured in the film reflected legislature aimed to crackdown on gang violence through 
“sentence enhancement.” However, it is pointed out that for young people growing up in poor
urban neighborhoods, it is almost impossible to avoid relationships with gang members and very 
easy for prosecutors to establish gang connections in young people who are not heavily involved 
or even affiliated with a specific gang. The film also pointed out that if Duc were to complete his
life sentence it would cost taxpayers an excess of $1 million to incarcerate a young man with 
tremendous potential.

I doubt this film was representative of most young people facing criminal charges
because their stories seemed fairly extraordinary. However, the fact that some incarcerated
individuals have tremendous potential to become productive citizens if they are not hindered by
broken system and counterproductive public beliefs, is realistic and supportive of my program.
This film pointed out that most Western nations consider the U.S.’s justice system “barbaric,”
which is consistent with the relative paucity of occupational therapy mental health services compared with nations such as the U.K. This film also illustrated the value of providing occupations for inmates, some of whom desperately long for an escape from prison culture. It also illustrated that incarceration may be sufficient in and of itself to necessitate rehabilitation for people, especially young people, forced to live in these unhealthy environments.


*Abstract:*

How can we all live happier, more fulfilling lives? This Emotional Life explores ways we can improve our social relationships, learn to cope with problems like depression and anxiety, and become more positive and resilient individuals.

Host Daniel Gilbert, Harvard psychologist and best-selling author of *Stumbling on Happiness*, talks with experts about the latest scientific understanding of our emotions and how we can find support for the issues we all face. Each episode weaves together scientific perspectives with the compelling personal stories of ordinary people, complemented by insight from celebrities like Chevy Chase, Larry David, Alanis Morissette, John Leguizamo, Katie Couric, and Richard Gere, among many others.

*Summary and Significance:*
I was disappointed with this documentary for not revealing the secret to finding ourselves... and happiness but it did give some useful guidance. In fact, I think this series would be great for CTF residents to watch on a day when staff shortages make it difficult to provide programming. The series examines the lives of ordinary and extraordinary people to discuss the diverse ways in which we deal with a variety of emotions. Some of the most relevant stories included: a woman who grew up in an abusive family then struggled with a tendency toward impulsive acts of aggression that embarrassed, alienated, and endangered her; a privileged man who became addicted to drugs but was able to get clean by going to 12-step meetings; a veteran who was able to overcome his PTSD through intense exposure therapy contrasted with another veteran who refused to seek counseling as his anger began to harm his family; prisoners of war in isolated cells who used a “tap code” to communicate with one another over years of captivity; a juvenile offender who met a wealthy surgeon while delivering furniture and after being taken under this man’s wing went on to become a successful surgeon himself; monks who showed more activity in the part of the brain thought to correspond with positive emotions (the left prefrontal cortex) after years of training in meditation, which similar brain imaging techniques revealed is a very active mental process; and an adolescent boy who had extreme difficulty in social relationships after spending the first two years of his life in a crowded Russian orphanage before being adopted by a loving couple who worked with a psychiatrist to help him establish healthy attachments and understand boundaries. Most of these stories were very inspirational and provided a message that many CTF residents need, that in order to experience positive emotions, people must directly deal with and address their negative emotions, not by passively ruminating...
in them but by actively overcoming or combating them. Most of the people who were able to
show resilience and happiness made a choice to go to meetings or therapy, to doggedly pursue an
admired mentor, or to spend countless hours of captivity drawing mental house designs or
tapping French lessons rather than giving in to feelings of helplessness, discomfort, or anxiety.

Another message in the documentary that was noteworthy was the importance of healthy
relationships and social support. This is something the women residents at CTF seem to
understand very well. However, their ability to establish healthy and stable relationships and
social support is questionable. This series gave a nod to the role of occupation in solving
relationship problems by pointing out that cooperatively engaging in novel challenges is an
effective way to improve relationships. For example, a researcher demonstrated that married
couples rated their mates more favorably after they had completed an obstacle course tethered to
one another. In fact, occupation was presented as a positive coping mechanism in many portions
of the film. Physical exercise was shown as a way to deal with anger, meditation was applauded
for its emotional benefits, and sexual intimacy was discussed as an important aspect of marital
bonding and associated happiness for one couple. I would love to show this video series at CTF,
but because it is so long I will probably just try to incorporate the stories into relevant
discussions or show selected clips or stories.

Waite, R. (2010). Women with ADHD: It is an explanation not the excuse du jour. Perspectives
in Psychiatric Care, 46, 182-196.

Abstract:
Keywords: ADHD; gender; multimodal treatment; recovery; review; women

PURPOSE. To call attention to attention deficit hyperactivity disorder (ADHD) as a psychiatric disorder that can limit women's potential and overall well-being.

CONCLUSION. ADHD, a legitimate neurobiological disorder that is often hidden, ignored, or misdiagnosed among women, causes them to struggle in silence. Proper interventions for women with ADHD that provide significant attention to context mitigate challenges across psychological, academic, occupational, and social domains. This should amend the diagnosis du jour concept, thereby supporting mechanisms to improve early intervention and positive outcomes.

PRACTICE IMPLICATIONS. Primary care practitioners play a central role in recognition, intervention, and recovery of women with ADHD.

Summary and Significance:

This article provided an in-depth examination of AD/HD in general, as well as how it affects adult women specifically. AD/HD is defined as an ongoing pattern of inattention, hyperactivity, and/or impulsivity that is more severe and frequent when compared to individuals at a similar level of development. When inattentive, hyperactive, or impulsive behavior is not consistent over time, it is more likely attributable to an affective disorder. There are numerous etiological factors that can contribute to the symptom configuration known as AD/HD such as intrauterine nicotine exposure, hypoxia at birth, or inflammatory brain disease but twins studies indicate that about 80% of variance is genetic, including a gene that has been identified in relation to the neurotransmitter dopamine. It is estimated that about 9 million adults in the United States are
affected by AD/HD and as a result miss more workdays and accrue twice the medical expenses of other adults. Women are often not diagnosed until adulthood, if they are ever diagnosed at all. Women diagnosed in adulthood are more likely to experience depression, stress, anxiety, decreased self-esteem, eating disorders, alcohol and other substance use disorders, and sleep disorders. They are also more likely to exhibit decreased interpersonal sensitivity, impaired processing skills, poor planning and organization, and greater emotional reactivity. Regardless of age at diagnosis, women with AD/HD are less able to be consistent parents, less able to manage jobs and/or households, more likely to go through a divorce and more likely to become single parents. The chronic stress related to these and other issues related to AD/HD can result in physical manifestations such as fibromyalgia and chronic fatigue syndrome. To address these issues the author suggests “supporting self-determination,” empowering women with AD/HD to see themselves beyond their disorder, and instilling hope consistent with the recovery model of mental health. Training in time management, organization, communication, task breakdown, decision-making, self-monitoring, and self-control skills are recommended, as are pharmaceutical interventions including non-stimulant Atomoxetine, and Guanfacine which the author notes is effective for those who may abuse stimulants.

This article was used to develop an educational discussion, a hand-out summarizing coping strategies, and a worksheet exercise for the residents in the women’s unit at CTF. Symptoms consistent with AD/HD have been identified by the case managers on this unit as some of the biggest issues the residents face. The author of this article identified “intoxication” as a potential cause of “secondary” AD/HD along with head trauma, birth complications, and
other previously mentioned, non-genetic etiologies. Two women participating in the discussion identified themselves as having been diagnosed with AD/HD while an additional two shared that they were currently raising children with this diagnosis. The women expressed interest in learning more about diagnosis and non-addictive pharmaceutical treatment, and shared their experiences including difficulty in school, medication side effects, and strategies they have used for dealing with the symptoms.

Sources Related to General Substance Abuse and Offender Rehabilitation


Abstract:
It is not what you think! The threat of drugs isn’t some guy in the back alley... it’s the local convenience store, your own medicine cabinet, or your child’s best friend. Drugs are no longer something you have to smoke, or shoot, or snort... they’re candy-flavored pills. DRUGS ARE EVERYWHERE and they’re hidden in plain sight! Join five-time National Motocross Champion, Travis Pastrana, as we take a candid look at today’s drugs and listen to conversations with real experts, and even former drug dealers. They want you to learn from their experiences and mistakes while offering their first-hand insight to this epidemic. You’ll be shocked! Discover what you can do to protect your family.

Summary and Significance:
This video sought to educate parents and teens about the danger of the “new face of drugs” referring to the fact that many mood-altering substances are now available in pill form. This makes them especially dangerous because our society views taking pills as a common, health-
promoting ritual and views “bad drugs” as those that are smoked, injected, or snorted. Some dangerous substances are readily available such as legal over-the-counter or common prescription drugs. Other illicit substances, such as ecstasy, are manufactured in large quantities with popular logos, including cartoon characters, and even various flavors. To make matters worse, pills marketed as ecstasy often contain significant amounts of methamphetamine an even more dangerous and addictive drug. The video includes interviews with teens and adults who have been affected by the new face of drugs who talk about how innocently their problems began. One young woman took a pill given to her by a friend without knowing it contained an illicit, powerful, mood-altering substance, a young man began with “just herbal” drugs such as marijuana and mushrooms, then “just legal” drugs including oxycontin. This video stresses that such perceptions lead teens down a dangerous path because even “herbal” and “legal” drugs can be deadly and very addictive. One teen shared the story of her brother being put on life support as a result of intentionally tripping on cold pills. Another teen shared the story of her own near-death experience that occurred after unintentionally drinking a large amount of GHB in a friend’s soft-drink. At the end of her story she noted her drug-using friends’ reaction to this harrowing experience was to say, “Wow, that sucks... want a pill?” The video concludes with five “STEPS” for parent to protect their families. Parents are encouraged to 1.) Say something positive daily, 2.) Take note and learn something new weekly, 3.) Educate your family through a fun activity monthly, 4.) Plan one-on-one time with each of your children each season, and 5.) Set aside work and celebrate your family on vacation once a year.
Although this video featured a lot of content that would make even the most respectful
teen roll his or her eyes or suppress laughter, there was some valuable content as well. For
example, one woman I recently interviewed at CTF was hospitalized as a young teen after
tripping on cold pills, something I had never heard of before the interview or watching this film.
I thought the video made a very valuable point when an expert explained that using ecstasy
makes people happy, gregarious, and empathetic, all the things they are constantly told they
should be but can only seem to achieve when abusing a dangerous substance. I think this may
contribute to a great deal of drug use seen in the women at CTF who are under pressure to
constantly be good friends, daughters, mothers, and partners under difficult circumstances. A lot
of the other information shared in the video was very relevant to the drug use discussed by
women at CTF. At one point, a case manager asked women to raise their hands and observed that
about half of the women residents at that time began using drugs when they were prescribed
narcotic pain killers from a doctor for a legitimate condition indicating that drug use can and
does begin very innocently in some people. Also, before viewing this video I was surprised with
the number of people I have come in contact with who took drugs without having any idea what
exactly they were consuming because a friend was giving them out. The STEPS given at the end
of the video might even be useful to share with CTF residents, many of whom are mothers,
because they are simple, achievable ways to effectively parent whether you are concerned with
drug abuse or not. Even the parts of the video I found to be weaknesses in its presentation were
educational for me because I think I am at risk of making the same mistakes. The host of the
video was the mother of a famous motocross athlete and he was also featured in the film.
Although the video emphasized that fact that almost all young people are at risk for using drugs, the host and her son seemed to be delivering a contrasting message that he would never consider doing drugs because it would ruin his fun-filled, adventurous life. I appreciate the message that life without drugs is very fun, and this is a message I have tried to convey. However, this film showed me how poorly that message can come across when it seems as though you are saying “It is very unreasonable to try drugs because life is great without them” rather than “But for the grace of God I have avoided or escaped drug addiction, come to find peace with a higher power, and am learning to appreciate the wide range of emotions and experiences I can and must deal with in my sober life.” The former statement is oversimplified if not entirely false and sends the message that using drugs is something only screw-ups will try.


Abstract:

Treatment and rehabilitation of mentally disordered offenders has traditionally been a function of high security hospitals, but is increasingly based in community settings. Evidence for the effectiveness of psychological interventions remains scarce, and for secure hospitals, is limited to demonstrations of short-term effects using a conventional range of behavioural and cognitive-behavioural procedures. Some findings support the use of directive community programmes in meeting the needs of public safety and improved reintegration of the individual. Long-term
services are required, and more complex psychological contributions are needed to meet the multiple needs of this client group.

Summary and Significance:

This paper reviews the research on “what works” in preparing mentally disordered offenders to avoid future criminal charges. The author states that structured programs based on the personality and social psychology related to criminal behaviors may see an average of 40% lower recidivism when completed in community settings and 30% lower recidivism in institutional settings. However, the author also asserts that the conclusions of Quinsey, who in 1988 reported that treatment programs for mentally disordered offenders are most notable for their non-existence, poor execution, lack of evaluation, absence of conceptual sophistication, and inadequate description, continue to accurately portray the literature. The article defines “mentally disordered offender” as one who has been legally recognized for a disorder severe enough to justify interventions beyond those typical of the usual criminal justice system. Under England and Wales’s Mental Health Act of 1983 this includes individuals with “mental illness, arrested or incomplete development of mind, psychopathic disorder or any other disorder or disability of the mind.” Mental illness typically refers only to severe disorders such as schizophrenia or affective psychosis, while psychopathy refers to individuals who exhibit any personality disorder and have committed severe violent or sexual offenses. The comorbidity of severe mental disorders, substance abuse, and antisocial personality disorder is fairly common among these offenders. Additionally the article reports that a 1998 study found that among prisoners in England and Wales, men and women respectively demonstrated rates of 7% and 14% for psychosis, 40% and
63% for neurotic disorders, and 64% and 50% for personality disorders, with only 10% of prisoners free of symptoms and co-morbidity common. As far as “What works” with this population, the article reports that community-oriented services based on shorter stays within secure facilities in or around urban areas where general psychiatry, prison, probation, and social services are more easily accessible are becoming more popular in corrections systems. It is also recognized that the subjective distress of the offender is a significant antecedent to recidivism. Negative affect, the author explains, is associated with interpersonal conflict, substance abuse and financial difficulties, most of which are self-generated by the offender due to poor coping skills. Based on this, it is thought that treatment for the offender should target common problems including motivation, and social skills, along with other dysfunctional traits associated with personality disorders. Unfortunately, in offender rehabilitation, the professional must act as both a helper and an agent of social control, considering both treatment and security. This brings in an ethical dilemma as clinicians must determine if the ultimate goal is to reduce the risk to society or improve the mental health of the offender. The author argues that often security is given greater emphasis over treatment which is unfortunate because as he argues, treating the problems of the offender will generally reduce the problems caused by them. This does not mean that offender rehabilitation should overlook an individuals criminal behavior. The author points out that addressing “criminogenic needs” of offenders by modifying thoughts, values, or behaviors that facilitate criminal activity will reduce the likelihood of reoffending. Another method found to be effective in reducing recidivism is a “seamless” transition from institution to independent living in the community. This is most effectively accomplished through community follow-up
including intensive case management. There has also been some success reported with restructuring secure environments using therapeutic community or token economy approaches. The author concluded by restating the limitations of the current literature regarding treatment of mentally disordered offenders and emphasizing the need for individualized assessment and treatment, psychological care that goes beyond skills training, and continuous support consistent with a chronic disability approach recognizing that ongoing support and maintenance are necessary.

The suggestions in this article were very consistent with the current treatment approach at CTF and gave me some ideas as to what I could add with an occupational therapy program. CTF reflects the advice in this article as a community-based correctional facility located in downtown Toledo. Outside psychiatric services are available to residents who frequently receive treatment from outside providers while on a “med pass.” Parole officers, 12-step groups, and even local religious organizations are able to visit residents providing important links to the community while they are still in the secure environment. After leaving the secure environment, most former residents remain in an aftercare program in which they participate in programming each day, attend 12-step meetings, receive “curfew calls” and are subject to drug screening. “Decent and humane principles” and offender-focused versus offense-focused treatment as encouraged in this article are generally practiced at CTF. The article was in agreement with my site mentor, however, that more aftercare would be beneficial for the CTF program. The article also supports the types of interventions I would like to include in my program by pointing out the importance of teaching skills to allow offenders to be more effective, and addressing problem
areas that lead to distress such as financial management. The citation for the statistic that only 10% of prisoners in England and Wales are free of mental illness is one I plan to use in my literature review establishing the need for more available programming in correctional facilities and is a statistic I recognize as being used on the British Occupational Therapy Association’s Mental Health webpage. I may also use this article to support a proposed aftercare component of my program such as a voluntary alumni group in which former residents can meet to engage in organized recreation occupations led by the occupational therapist.

Although the article was written with psychology professionals in mind with a focus on more severely disordered offenders than are typical of the CTF population, I think that the broad principles it discussed could easily be generalized to include my site and program, particularly the ethical principles. As one example, in discussing evaluation, Blackburn states that “Reduced recidivism is a necessary but not sufficient criterion for the effectiveness of intervention” (p.302) because of our ethical obligation to the offender as a client who may be left institutionalized or in another form of distress without engaging in criminal activity and I will keep this in mind when developing the evaluation for my program. Ethically speaking, Blackburn explains that the offender, institution, and society all represent our clients when working in offender rehabilitation and they must all be considered when planning my program and engaging in interventions at CTF.

Abstract:

Addicted and Mentally Ill: Stories of Courage, Hope, and Empowerment presents vignettes about people with mental illness and addiction whose situations are representative of what goes on in a dual-diagnosis in-patient setting. This nonclinical, easy-to-read resource addresses the misunderstandings and prejudices surrounding dual diagnosis, the necessity for appropriate treatment and follow-up care, twelve-step principles and practices, medication, and the involvement of family in treatment. Presenting unique insights into the lives and thoughts of dually diagnosed people, this book shows how co-occurring mental illness and addiction can be treated with the minimum amount of blame, shame, or poor decision making.

Summary and Significance

This short book discussed some of the issues people with co-occurring mental illness along with addiction face in life and recovery. It was written by a Certified Alcohol and Drug Counselor who shares her knowledge along with “vignettes” about patients she has worked with in a 21-day rehabilitation program for people with “dual diagnosis.” Bucciarelli writes about individuals with dual diagnosis from a very patient and understanding perspective. Although she advises professionals and family members to use “tough love” as necessary and push individuals to do for themselves even in the face of resistance, she also calls for improved treatment and support of what she considers a very misunderstood population. She recognizes that individuals with substance abuse issues can be manipulative, disproportionately angry, and very difficult to work with, but points out “People are not their disease. People may have a disease, but more often the disease has them.” p. 81. The vignettes she shares also communicate both an understanding of
the severity of dysfunction her clients exhibit as well as a respect and even affection for the clients themselves. Some main points from the book include the importance of allowing even severely ill individuals a sense of dignity and as much independence as possible, including independence from misguided family support; the importance of less tangible qualities such as hope and spirituality in recovery; the importance of being firm and consistent; and finally, the fact that in her line of work, failure is common, and success is almost never certain.

This book provided a lot of insight into what it is like for individuals early in recovery from a substance use disorder. Bucciarelli explained that often when people lose their main coping mechanism they feel very vulnerable. After being numb for a long time feelings come rushing back and are often hard to process. As a result, it is often anger that is the first recognizable emotion to surface and this anger must be felt and expressed as part of recovery. This is an interesting point because the women I work with often express a lot of anger, which is often attributed more to “criminal thinking” and aggressive tendencies rather than a first step to recovery. Bucciarelli also wrote about the role of personality disorders in some of her client’s illnesses. She asserts that the desire to “get over” or manipulate others is not an attempt to make life better through extra privileges, but is actually an inappropriate way to cope with feelings of powerlessness. As such, it is important for staff to be firm and not provide the favor these clients are seeking so that they can learn to better connect with their environment. This was an important perspective for me to consider. I often thought the case workers at my site were being petty and inconsistent by refusing to address some resident requests, yet giving favors and attention to those who did not regularly seek it. However, this book helped me see that by being firm with
residents constantly seeking gratification, the staff was helping those residents learn more
effective ways of getting their needs met in the long term. My favorite quote from the book was
Bucciarelli’s description of a holistic, psychosocial program she worked for at the beginning of
her career. “Our purpose” she states “was to give these individuals a chance to achieve
something no matter how small, that could restore their pride in themselves.” She goes on to
explain, “Some of this was accomplished through establishing a recovery-based newspaper,
creating a consumer-run kitchen that made lunches for other consumers and staff, and providing
opportunities for art projects and even video making” (p. xi).

Many of the clients featured in the vignettes in this book had more severe mental
illnesses than the women I am working with and some did not engage in criminal behavior.
However, some of the patients were very similar to the women at CTF. Most of the clients in this
book and most of the women at CTF share a common history of significant childhood trauma.
Most of the clients in this book and many of the women at CTF used mood altering, addictive
chemicals as a means of self-medication to “feel normal.” I think the insights and stories in this
book will help me better relate to the women at my site and improve my therapeutic use of self
by encouraging me to push the women outside of their comfort zone toward personal
empowerment. Hopefully by helping less and being firm yet respectful and compassionate as
Buciarelli demonstrated in this book, I will see an increased sense of self-efficacy in some of the
women I work with. However, I will also try to accept the fact that not every woman I see is
ready for recovery and relapse for some may be inevitable no matter how great a program I
produce or how much effort I put in.

Abstract:

In editing this anthology, we have sought to honor the words, the artists, and our common humanity. We are guided by the belief that every individual has the capacity to create transformative and liberating art, and to find one’s true self in the process.

Summary and Significance:

This compilation of poetry, short stories, and one novel excerpt, was very inspiring to me and I might choose to share portions of this book with CTF residents or staff to inspire them as well. Working in a correctional facility, even a progressive CBCF such as CTF only a couple days per week, can be frustrating and sometimes contribute to a negative attitude toward offenders. This anthology is a display of prisoners at their best. It showcases sensitivity, insight, remorse, creativity, love, pain, heartbreak, and hope, eloquently presented by the least likely of authors, many of whom may never be released. The quality of writing in this anthology was exceptional, especially considering the poor communication skills I have observed amongst residents at CTF, many of whom rarely share or exhibit any depth of emotion. Following the work, each author provided a short statement regarding their life and/or inspiration. This was almost as interesting as the pieces themselves and supported my belief that such expression would not have been possible without the help of dedicated volunteers from the Prison Creative Arts Program (PCAP)
that provide workshops for Michigan prisoners. Teaching prisoners to tap into their creative energy produced some very remarkable results published in this anthology. The thoughtfulness that went into the work they produced, and the statements made by the prisoners in this anthology helped remind me that even hardened prisoners can be capable of incredible talent and growth. I would love to use this work to support the value of non-traditional corrective rehabilitation techniques, however, it is not to be used without permission of the individual authors. Instead I will share it with people at CTF in the hope that they will be similarly inspired.


Abstract: (For entire book)

This volume presents current treatment approaches for offenders with mental disorders in a variety of settings. After reviewing administrative and legal issues in the provision of care, the volume addresses therapeutic work with inpatients, outpatients, and incarcerated persons. Separate chapters now cover special issues in the treatment of sexual offenders, offenders with mental retardation, and juvenile offenders. Throughout, the approaches featured are interdisciplinary and eclectic, incorporating biological and psychological perspectives.

Summary and Significance:

This chapter served as an overview of the issues faced by correctional treatment program directors ranging from public perception to staff recruitment. The authors describe such
programs as providing screening, evaluation, psychiatric treatment, rehabilitation, housing, custody, consultation, case management, and/or special treatments for offenders with mental disorders in forensic hospitals, civil psychiatric hospitals, outpatient or community mental health clinics, jails/lock-ups, prisons, centers for persons with developmental disabilities. They provide examples of programs that were established in New York by the Bureau of Forensic Sciences of the State Office of Mental Health including a suicide prevention program that trained officers to identify high risk inmates and follow procedures for their management in jails and lock-ups, a program that taught police officers to recognize and deal with mental illness and emotional crises they encounter in the community, and diversion programs designed to avoid inappropriate incarceration of people with mental illness using alternative mental health models such as intensive case management. The authors also describe a well-recognized theme in offender rehabilitation, they call the “dual mandate” imposed by politicians, courts, and the press to keep the “criminally insane” away from the community. Unfortunately, this desire places a heavy financial burden on the government while also making it harder for offenders to eventually return to the community after long periods of potentially detrimental institutionalization. Determining whether an offender is or is not safe to be released has proven to be nearly impossible for clinicians who usual only observe the individual in a highly structured, unnatural environment. A wrong decision can lead to a firestorm of negative press and even wrongful death lawsuits if an offender becomes violent after being released from a secure setting, but the deinstitutionalization movement for people with mental illness has shed light on the inhumanity of permanently restricting the freedom of people with mental illness and the ability of many such
individuals to lead successful lives in the community. The suggestions for release provided in this chapter include the establishment of a progressive movement through less structured, more independent settings rather than an abrupt release from a secure hospital or prison. They suggest that release decision-making be made using a rigorous, explicit, multidisciplinary process that may even rely on outside opinion so that in cases where public safety is compromised it will not be the result of carelessness on the part of the organization. Items to consider during this process include: the severity of risk, the likelihood of risk, changes observed in the individual, and conditions of the proposed release such as employment, housing, and relationships. To orchestrate successful release, the authors advise discharge planning, outpatient monitoring, and periodic re-evaluation. As mentally disordered offenders are receiving inpatient treatment, they provide recommendations for staff to avoid violence such as exploring the individual’s history of violence, identifying and avoiding risky situations, engaging offenders in skill acquisition, including concrete life management skills, and teaching crisis resolution techniques. The recommended level of staffing for a 24-bed maximum security adult psychiatric unit consisted of 38.5 full time staff members including 4 “activity therapists” (recreational, rehabilitation, and or occupational therapists). The authors provide little advice as to how one obtains funds to create adequate programs but list factors influencing funding including concerns about public safety, fear of litigation, advocacy by forensic administrators, and non-government agencies such as NAMI and the National Mental Health Association.

This resource will be useful for developing my written program development plan. It advocates for the inclusion of 10 hours a day 7 day per week “activity therapy” involving 4 full
time staff members for every 24-bed maximum security psychiatric hospital, which I could argue
would be best administered or managed by an occupational therapist. It provided advice as to
what to emphasize in trying to obtain funding and support. Mainly I will emphasize the ability of
my program to promote public safety and financial responsibility through proven intervention
strategies that will support the offender’s successful participation in the community because
public safety and cost effectiveness appeal to everyone regardless of political affiliations. The
authors summarize the battle mental health advocates wage on behalf of mentally disordered
offenders “against a long history of inadequate resources and punitive political philosophy to
press for improved treatment, better living conditions for patients, enhanced security (both
perimeter and internal), and community support systems for forensic patients. They do so in the
belief that balance between treatment and security, between support and scrutiny, and between
the dignity of each individual patient and the public’s right to be safe is the best way to make
communities safer” p.8. This chapter also pointed out the shortfalls of making important clinical
decisions based on an artificial, highly structured environment. The authors establish a need by
stating, “The ability of clinicians to make accurate, long-term predictions about the
dangerousness of individuals upon release has been repeatedly criticized and it, at best,
unproven” p. 2. Here is another important benefit of the inclusion of an occupational therapist,
who can establish more naturalistic challenges that will allow for improved evaluation of
offenders by the entire team, while also adding different evaluation methods and perspectives to
the process.

Abstract:
Healing and Hope is a window into the world of addiction, as seen through the eyes of six women who were brave enough to face their personal demons, do battle— and win. Their stories are a poignant and profoundly moving testament to courage, compassion, and above all, the will to survive.

Summary and Significance:
This book featured the stories of six very diverse women attending a Betty Ford Clinic reunion weekend. Betty Ford herself provides commentary on the stories and how they relate to major themes in addiction recovery. Each woman had a great deal of emotional pain in her life as well as a family history of alcoholism or mental illness. However, their specific paths to rock bottom, through treatment, and into recovery were very different. “Paula” grew up with an abusive mother and alcoholic father. She married a devoted and loving man but began taking pills to help her deal with the stress of being a mother as well as to keep her weight down and her energy up. After a ski accident left her with severe and chronic back pain she became addicted to pain pills and, with the help of her doctor, would order hundreds of them each month. With the support of her husband and two daughters, she was able to get clean at the Betty Ford Center and became a model of successful recovery. Unfortunately, her chronic pain became very debilitating and she began using pain pills again at the advice of another doctor. This led to another downward spiral into compulsive use and another very humbling stay at the Betty Ford Center. “Jaqueline” also
had an alcoholic father and was a constant “people pleaser,” causing the staff at the Betty Ford Center to be very wary of her chances for recovery. She entered treatment after an intervention staged by her family and became resentful when she returned home from the Center and life went on as usual with no one showering her with praise. She began using again almost immediately after her discharge but denied it to family, friends, and treatment providers. Eventually she was arrested for DUI and forced to return to inpatient treatment by her employer. This time she was put into a long term treatment program and was able to learn how to be more assertive. “Beatrice” was a black woman who grew up in Alabama while segregation, though illegal, was common practice. She gave birth to a child out of wedlock and became very resentful when the child’s father married another woman and denied his parental responsibilities. She too had difficulty expressing her feelings initially in treatment, but was able to overcome this with time, leading to self acceptance and recovery. “Claire” was a musician whose mother died when she was a teenager. Soon after, one of her brothers lost a leg serving in World War II and her other brother returned from the war with a drinking problem that would eventually take his life. She married twice, both men being alcoholics, but her second husband joined AA and was in recovery when he died from colon cancer. After his death, Claire’s drinking escalated. After her daughters helped her realize how out of control her behavior had become, she reached out to her late husband’s friends from AA who referred her to the Betty Ford Center where she was able to begin her recovery. Later she became aware that both of her daughters had substance abuse issues but both were also able to stop using with the support of Claire and AA. “Harriet” had a very negative relationship with her volatile mother and was sexually abused by her grandfather.
The only member of her family who supported her was a step-brother she did not know as a child. He was willing to finance her stay at the Betty Ford Clinic, including extended care that helped her to get her life back in order after her alcoholism nearly killed her. During treatment, her mother and sisters went into her apartment and threw away all of her belongings. Despite never reconciling with her mother, Harriet was able to accept her difficult family situation.

“Laurette” was raised by her loving grandparents following her mother’s suicide, but they were unable to keep her from joining a gang. Laurette was the only woman in the book who spent time in jail. She had a great deal of difficulty accepting herself as a lesbian and was not open about this initially in treatment. She was a talented chef but her drug abuse was getting her in trouble at work so her employers sent her to the Betty Ford Clinic. Despite nearly being kicked out due to her angry and insubordinate behavior and her lack of belief in any higher power besides the group itself, Laurette was able to stay in recovery after leaving the Center and went continued her successful cooking career. At one point she served as the Ford family chef, then she went on to run a holistic vegan restaurant out of a desire to restore her physical health after the damage of her drug abuse.

Because the Betty Ford Center is a voluntary program requiring some type of payment for services, most of the women in this book were fairly different from the women I have met at CTF. The women in this book often had jobs, homes, and families to return to, whereas many women at CTF are not so fortunate. However, a few women at CTF do come from higher social classes, and all of the women in the book faced some type of trauma or hardship. Laurette’s story in particular might appeal to the women at CTF, an illustrates that someone with a criminal
record in recovery for severe drug addiction can become very successful. Laurette’s success came from pursuing her both her passion for cooking and improved physical wellness. It is my hope to instill this type of purpose in as many women as possible. Ford makes an argument for gender-specific programming that is very relevant to my women only program by stating, “So often female patients are reluctant to share their failures, fears and anger, their flights of fancy, their shame and guilt, their abuse experiences openly in front of men.” She goes on to point out, “Men patients often exploited the women’s eagerness to please.” and “Getting sober is tough, tough work. What you don’t need is to be sidetracked by preening for- or being chased by-members of the opposite sex” (p.8). Ford also relates an anecdote indicating the potential value of occupational therapy for this population. Harriet was concerned that her alcohol abuse had decreased her cognitive and fine motor skills. To address this concern, the staff allowed her to do volunteer work in the office, stuffing envelopes and putting together small bathroom care packages for the patients. Over time her skills improved and she was overheard happily humming to herself. Ford and the treatment team came to the conclusion that “doing something useful for others” had facilitated her physical and mental recovery.


Abstract:
Imagine not drinking a bottle of wine before making a pass; not oving in like a starving cat when someone is at a bar; not apologising for something you don’t remember doing. Once upon a time,
Tania Glyde couldn’t imagine living any other way, and to the outside world she seemed fine - despite the constant hangover from drinks and the bottle of vodka stashed in her handbag.

At the end of her 23 year love affair, Tania Glyde remembers her inner white wine witch and questions our powerful sense of entitlement to drink until we fall over: Cleaning Up describes why women drink, how to stop and what life after alcohol is really like.

**Summary and Significance:**
This memoir recounts the story of an English woman from a dysfunctional middle class family who, for years, used drugs and alcohol to escape her feelings of inadequacy, until a suicide attempt helped her realize both how intolerable her life of cycling between intoxication and hangover had become, as well as how strong she could be. Ms. Glyde grew up with an emotionally abusive, likely mentally ill mother and a father who passively accepted the behavior of his wife. In school she found it difficult to fit in but when she reached puberty and began drinking, thing became somewhat easier for her socially. After becoming sexually active at a young age as teenage boys from a nearby boarding school began frequenting her bedroom window, she gained a reputation that made life difficult for her once again. College was no better as she failed to live up to academic and social standards while her only strength appeared to be her ability to party and tolerate huge quantities of alcohol. From college her life descended through a number of jobs she performed poorly in due to perpetual hangovers and various other physical ailments. By surrounding herself with friends who had problems similar to her own, if not more severe, she simultaneously buffered her denial and made life more dramatic and difficult for herself. Her relationships with men included drawn out roller-coaster romances with
a heroine-addicted musician and an egocentric, wealthy, and not-quite-divorced businessman. All the while, Glyde was compelled to seek out treatment for the depression and feelings of inadequacy that haunted her but was usually turned away through the catch-22 of the British National Health Service that reasoned if one was well enough to seek help for his or her problems, he or she not ill enough to need treatment. Eventually she was put on an antidepressant, though she never seemed to find an adequate therapist she could afford. Her turnaround comes after several botched suicide attempts stemming from a breakup with the businessman she was seeing. In her very compromised state she is unable to properly slice her wrists and attempts at overdosing lead to days spent passed out on the floor of her apartment but nothing more. After waking up alive, Glyde finds a newfound motivation to get sober and slowly tapers off her alcohol consumption in what she describes as “A slow and bloody rebirth” (p. 163). Shortly thereafter she begins a successful career as a sex columnist. During her recovery she tries out 12-step meetings but finds internet forums more helpful. Although she abandons many of the people she previously partied with when she realizes how unrewarding those relationships are while she is sober, she continues to spend time at clubs and bars with friends and even takes a few accidental sips from wrong glasses (glasses containing alcohol) but finds this disgusting and is not tempted to relapse. Her greatest challenge in recovery described in this book comes when her father passes away and her mother calls her several days later to let her know. Despite this, Glyde remains sober.

This book was significant in that it described one of the many possible paths through addiction to recovery for a female addict. It discussed co-occurring mental illness in Glyde’s
struggle with depression and the importance of treating both the addictive behaviors and the underlying negative emotions. It also discussed unhealthy relationships with men and unhealthy friendships that can make it harder to realize one has a problem and to subsequently recover. Glyde’s bravery and strong motivation following her suicide attempts is inspiring. She reasons that if she can survive earnestly trying to kill herself at least twice, she is capable of recovering. This might be a good argument to use with some of the women at CTF who have been described by themselves and others as “survivors” of many thing. This book illustrates that the survivor label can be a powerful one. This book also offers numerous practical insights and advice stated in the very blunt manner only a recovering addict could muster with any credibility. Despite her distaste for 12-step meetings, Glyde’s book is almost a meeting in written form. Some of what shares, such as the fact that people with depression simply cannot use alcohol, when it comes to social drinking and drug use, misery loves company, and we as a society have a lot of strange notions about acceptable and even desirable behavior would be valuable for the women at CTF if they know it is coming from someone who can relate to their situation. Her eleven excuses for alcoholism, and “eight people-friendly excuses for not drinking” might also be worth sharing or pulling from in discussions with CTF residents. Some portions of the book were less applicable to the women at CTF because of the focus on UK-specific issues such as an ethnic heritage that celebrates drinking, a more rigid class structure, and a different healthcare system, but many of the other issues Glyde described are fairly universal such as the shame of a bad reputation and the desire to belong with a group of people.
Abstract:

This paper describes borderline phenomenon as it relates to occupational therapy treatment groups. The author discusses the genesis of the syndrome from the separation-individuation phase, its relation to adult functioning, subsequent treatment design, and recommended therapeutic interventions. A case illustration will highlight these elements.

Summary and Significance:

This article summarizes the prevailing theory behind the origin of borderline personality along with guidance for practitioners working with people affected by borderline personality. The developmental theory of borderline personality explains that a person with this syndrome has not developed past the separation-individuation stage of development and therefore has not achieved the developmental milestones of internalized integration of opposing feeling states nor fully developed self identity. As a result, people with borderline personalities maintain splitting as a defense mechanism, project their feelings about themselves onto their environment, and lack the ability to sublimate their emotions. Additionally, they cannot experience intrinsic pleasure from activities but seek only narcissistic rewards making the completion of almost all tasks more difficult. To address these problems, the author suggests assisting the client to recognize the unconscious feelings provoked by an activity, then help him or her to maintain these feelings by confronting defenses. Finally, the therapist is urged to redirect the client toward using the activity as an outlet for feelings and resolution of the inner conflict. The author emphasizes a “marriage
of discussion and doing,” stating that “dysfunctional patterns are improved through the act of doing” and cannot be remedied simply by discussing how difficult or emotional the activity is without following it through to completion. A newspaper group was provided as an example of a work adjustment group for individuals with borderline personality disorder because it required participants to make decisions, accept the decisions made by the group, place expectations on one another, execute individual tasks and provide client-to-client feedback. The therapist may wish to give some clients supervisory roles or allow the group to elect supervisors but is cautioned to oversee the client supervisors to ensure no abuse of power takes place. Recreation groups, particularly those using creative or expressive media are also discussed as important outlets for individuals struggling with intangible unconscious issues. Because art encourages projection, such occupations can become self-reflective and lead to insightful discussions. Recreation groups are also useful in that they challenge individuals to choose tasks without the input of others, hopefully encouraging the differentiation of self and formation of a personal identity. The article concludes with a brief discussion of countertransference and the importance of remaining objective. Because individuals with borderline personalities can evoke strong feelings in those who work with them, it is important for therapists to focus on group functioning and rely on professional team members to avoid allowing personal feelings to interfere with professional duties.

This article provided a great deal of background knowledge on borderline personalities as well as practical guidelines that can help me in developing my project and working with the women at CTF. The residents I work with at CTF frequently display borderline personality traits
and a few residents may be diagnosed with borderline personality disorder. I was inspired by some of the ideas in this article such as building a puppet, which was the project highlighted in the case study, and creating a newspaper group with all the different roles and responsibilities this would entail. The emphasis on creative activities was encouraging because this is an area I would like to pursue more in my project but I have been discouraged by the lack of enthusiasm amongst CTF residents when it comes to doing creative assignments. However, in this article I was encouraged to help residents confront the negative feelings they may have about doing certain tasks and then try to motivate them to overcome these feelings and complete the task. The quote from page 29 “dysfunctional patterns are improved through the act of doing” nicely summarizes my argument for an occupation-based group at CTF that will allow residents to practice the new skills they learn and discuss.


Abstract:

The feature-length documentary film ADDICTION is the centerpiece of the Addiction project. Bringing together the nation's leading experts with award-winning filmmakers, it consists of nine separate segments, including: "Saturday Night in a Dallas ER," by Jon Alpert; "A Mother's Desperation," by Susan Froemke and Albert Maysles; "The Science of Relapse," by Eugene Jarecki and Susan Froemke; "The Adolescent Addict," by Kate Davis and David Heilbroner; "Brain Imaging," by Liz Garbus and Rory Kennedy; "Opiate Addiction: A New Medication," by D.A. Pennebaker and Chris Hegedus; "Topiramate: A Clinical Trial for Alcoholism," by Alan and
Addiction, the documentary, along with the supplementary series, featured interviews with some of the experts in the field of treating people with addictions and understanding why people are unable to stop using despite what Dr. Volkow describes as “catastrophic consequences.” The interviews punctuate real-life stories of people struggling with addictions including a young couple addicted to opiates going through replacement therapy, a steamfitter’s union dealing with epidemic levels of alcoholism within their ranks, a man addicted to amphetamines in such denial that he believes doctors are altering his brain scans to make it appear he is damaging his nervous system, and a teenager who has been going to school high each day since he was in sixth grade. Some themes that ran through the documentary and series included: the devastating effects of addiction on one’s physiology, family, and society, the power of triggering stimuli, the difficulty of financing recovery, the ambivalence associated with recovery, the genetic and environmental factors related to addiction, the importance of treating co-occurring disorders as the addiction is being treated, the value of a multimodal approach to treatment, including medication, the empirical evidence currently available to guide treatment approaches, the commonality of relapse, and the hope for advancements in treatment and eventual recovery for most addicts. The text following each segment of the series states “With continuing advances in medical and behavioral treatments, addiction will soon be commonly accepted as a manageable chronic
disease. Science has shown that the brain has a remarkable ability to recover from addiction.”

The people involved in this documentary advocate that addiction is not a moral failure but rather a chronic disease for which it is the individual’s responsibility to manage. In one segment, they illustrate the positive aspects of drug courts, which divert individuals with drug-related offenses from the criminal justice system.

This video series provided a lot of review information I have already learned about the science of addiction, but also provided some new information I found helpful. I learned more about the changes in the brain associated with long-term drug abuse including a lot about post-acute withdrawal syndrome which will help me when working with people in recovery. Although the ability of the brain to recover when a person remains abstinent was stressed, this documentary explained that this process is long and difficult. A person in recovery might experience anhedonia for six months to a year after they stop using due to changes in their dopaminergic system. I also learned that people respond to “triggers,” stimuli that are associate with drug use, on a subconscious level. Even if pictures are shown too fast to be consciously recognized, the brain will respond in such a way that the person could experience a strong physical craving. This information will be important to know when relating to people in recovery who might have difficulty experiencing leisure as pleasurable or may not understand the danger of returning to old using environments. Actually showing portions of the video or similar videos about brain imaging studies might be worthwhile. This video also provided support for the interventions used with women at CTF. The experts clearly stated that non-confrontational methods have proven to be more effective than older more abrasive forms of treatment. Despite
this, they point out that involuntary forms of treatment such as CTF, have equivalent success rates to voluntary programs. I plan to share this piece of information with residents so they might better appreciate the value of CTF and view it as a valid path to recovery. Experts in the documentary speak in favor of motivational interviewing and cognitive behavioral treatment. Kathleen Brady, MD, PhD, even spoke about the importance of “a meaningful life” for people in recovery that might include enjoyable employment, going to school, and/or involvement with non-using friends and family. Other experts also talked about how friends and family can help an addict by providing positive “alternative activities.” As an example, one grandmother bought her grandson a drum set and although it gives her headaches, she was thrilled when he played his drums for hours instead of going to the bar after a bad day. This points toward the role of occupational therapy in the treatment of addictions, although the profession was never specifically mentioned.


Abstract:

American Meth is a cross-country journey that focuses on several facets of the methamphetamine epidemic. From the oil fields of Wyoming and New Mexico to the homeless in Portland and the teens of Montana, filmmaker Justin Hunt spins a blue-collar tale of tragedy and triumph. Actor Val Kilmer lends his voicing talents as your narrator while exploring both the damage being done and the community efforts to reclaim America. The movie culminates with the introduction of James and Holy, a pair of meth addicts and the parents of four children, who
let Justin into their lives. American Meth does two things: It informs of the devastation that this
drug is imposing on our country, and it encourages Americans that it is possible to rescue our
friends, our neighbors, our families, one person at a time.

Summary and Significance:
This film shed light on the issue of methamphetamine (meth) use in the US by traveling to
various areas of the country where men and women are becoming addicted and officials are
trying to fight back. The film introduces the history of meth which was first synthesized as a “a
medicine in need of a disease” then marketed as a treatment for asthma, allergies, fatigue, and
excess weight before it was made illegal. It also introduces some of the materials used to produce
meth including cat litter, drain cleaner, and a chemical used to keep gasoline in cars from
freezing. More powerfully, it introduces some of the individuals trying to recover from meth
addiction who carry pictures of their children as they engage in treatment, teenagers who use
meth because “there is nothing else to do out here” in rural areas, oil companies who have a
difficult time finding enough employees willing and able to stay drug free, and government
agencies and officials working to stop meth use by showing the public disturbing images along
with providing standard education and law enforcement. The film concludes with the story of
James and Holly who struggle to keep their family together by giving up meth and trying to start
over in a new state. After having their water shut off and their four children nearly taken out of
their custody, the couple decide they need to change their lives. Their children, ranging in age
from 2 to 8 take care of themselves as Holly and James spend their time lying in bed, fighting
with one another, and trying to scrape up enough money to put gas in their truck. Eventually the
couple pack up all their belongings in a truck and trailer and take their children with them back to Illinois where they will live with James’ parents.

This video was useful in illustrating why some people begin using illegal substances and the type of lifestyle some addicts maintain. The story of James and Holly was probably the most relevant aspect of the video because it showed some of the challenges of getting clean and the humanity of those affected by addiction. Despite their frequent parental failures, highlighted in scenes where the eight-year-old decided he was not going to go school and the two-year-old dragged a gallon of milk out of the refrigerator and pulled a bag of popcorn out of the garbage to eat for breakfast, both James and Holly were easy to care about. Holly discussed how her mother used her in prostitution to fund her own addictions and was the one who introduced drugs to Holly, while James was visibly ashamed with how his life had deteriorated as a result of his addiction and desperately wanted better for his children. Despite their obvious misery, the pair obviously love their children. In one scene, Holly decorates the tree outside their trailer with Christmas lights well after Christmas was over because her son likes them, while in another scene James playfully rides small bicycles along with the children. Although it may be somewhat unrealistic, post-script reveals that James, Holly, and the other recovering addicts featured in the film all remain sober for the months following the end of filming. This makes the film encouraging as well as enlightening. Although meth specifically is not a major issue for most women at CTF, one resident I have interviewed mentioned using it, so the basic information about the effects of the drug and slang associated with it could be helpful. The story of James and Holly was useful because it showed the occupational malfunction that can result from any type
of addiction. The video also supported a consistent theme in recovery I have observed in practice and some other resources, that children are often the biggest motivating factor in recovery.


Abstract:
A rare and intimate look into the lives of mentally ill offenders struggling to make it on the outside. This year alone, hundreds of thousands of prisoners with serious mental illnesses will be released into communities across America. Within 18 months, nearly two-thirds will be rearrested.

Summary and Significance:
This was an approximately 55 minute documentary following several prisoners with chronic mental illness as they are released from jail. It takes place mainly in Ohio. All the subjects are black men isolated from family support. They cycle amongst shelters, group homes, homelessness, and prison. Outside of prison, they often stop taking medication. This causes them to relapse, lose touch with reality, and engage in destructive behaviors, break-ins, robberies and assaults. Often they do well under supervision, but all progress is lost once they stop taking medication. Psychiatric treatment available in the community is either poor or non-existent. Often the men lose their medications or do not get them re-filled. They seem to lack the organizational skills necessary to adhere to their complex medical regimens (some must take 3 doses per day). There exist few state psychiatric institutions, and even the severely mentally ill
can only stay for short periods to become stabilized on medications. Instead, prisons serve as the “new asylum.” Experts argue for a middle ground between widespread institutionalization and the current community mental health system described as a “huge social failure.” Because the film takes place in Ohio I may be able to meet with some experts and program directors featured including Jonathan Lee of Bridgeview Manor and Scott Schnyders of Refuge of Hope. One prisoner mentioned heading to St. Paul’s in Toledo, which is located near CTF. I gained some interesting insights about the issues this population faces. Disorganization is a huge problem in terms of both cognition and practical matters (unable to establish/maintain routines). Small set-backs can have major consequences, such as when one man was unable to obtain public housing, which led him to destabilization, substance abuse, and removal from his shelter. Most women at CTF are not as severely disabled as the men in this video but they do share some common difficulties such as the challenge of regaining benefits after leaving prison and the tendency to relapse when faced with set-backs.


Abstract:
In recent years, one response to drug abuse problems has been to provide treatment in prison and probation settings. Results are promising, although the need for improving mandated treatment has been expressed. The Cognitive Enhancements for Treatment of Probationers (CETOP)
project is investigating cognitive enhancements in a modified therapeutic community (TC) setting. One enhancement is node-link mapping, a visual graphing strategy. Map "nodes" contain ideas, actions, and feelings; these are connected by links that illustrate meaningful relationships.

Current findings indicate increases in group participation, ratings of session depth, and positive ratings of coresidents, counselors, and security staff. The present study extends this research by comparing mapping-enhanced counseling to standard counseling on self efficacy and motivation for basic psychosocial skills (e.g., emotional control). Probationers (n = 381) in it 16-week residential program were assigned randomly to conditions in 12 TCs (n = 30-35). Motivation and self-efficacy were assessed by two self-report questionnaires, one midway and one at the end of treatment. A five-factor solution was produced from each questionnaire. With community as the unit of analysis, means of enhanced counseling were higher in all cases. Wircoxen tests indicated four significant differences at midterm for mapping on motivation and self-efficacy of communication and emotional control (p <.05). At the end of treatment, mapping was higher for motivation of cognition and emotional control and self-efficacy was higher for communication.

Discussing Bandura's model, these findings provide evidence that maps may enhance psychosocial skills, which have been associated with maintaining recovery (25, 37).

Summary and Significance:

The authors of this study established the benefits of both “modified therapeutic communities” (TC’s) and Node-link mapping. The therapeutic communities in their study consisted of 16-35 residents sentenced as a part of probation related to substance abuse. Communities are formed monthly and all residents in a community live together and attend
programming together along with 2 counselors for 16 weeks. This phase if followed by 12 weeks of aftercare. Programs addressed life skills, GED training, substance abuse, and other psychosocial concerns. In taking the TC approach a step further, the experimental group in this study used node-link mapping during treatment groups while the control group received standard TC programming. Node-link mapping is a way of displaying feelings, events, and behavior patterns spatially using ovals and various lines to represent ideas and relationships in hierarchies, cycles, chains, or free form. Use of node-link maps has been found to be especially effective for individuals with limited education, attention deficits, and addiction issues by providing a visual focus and common language. In this study, residents in the experimental group demonstrated a greater sense of self-efficacy in communication an greater motivation in the area of emotional control at the end of 16 weeks. The authors note that no difference in motivation or self-efficacy was noticed in other areas of life management such as being a good role model or finding a job. They suggest that node-link maps directly related to these skills could be employed but from an occupational therapy perspective, node-link mapping could be complimented with occupational therapy which, based on this article, was not present in the TC’s. Node-link maps could be a useful tool for occupational therapists working in correctional environments because it allows us to present information visually as well as verbally; however, from an occupational therapy perspective, additional modes for education and the communication of ideas including hands-on doing could be used in conjunction with node-link mapping. I have seen one worksheet at my site that uses relationship mapping, which is similar to node-linking mapping in that it represents complex ideas visually instead of verbally; however, it is a little simpler because it focuses
exclusively on relationships (not behaviors patterns or events). I might want to use node link mapping during discussion of habits and habituation because node link maps can illustrate cycles of behaviors and consequences.


*Abstract:*

There is a critical need for the development of effective substance abuse and dependence treatment programs in prisons and jails. One aspect of treatment provision within this population that has received insufficient research attention is the inclusion of health promotion or wellness programs, including exercise and other health-related lifestyle modification training. Little is known about either the physiological or psychological consequences of such lifestyle modification programs among prisoners with substance use disorders. This study reports the effectiveness of an experimental wellness program included as part of a residential treatment unit in a federal correctional institute in the United States. A sample of 43 female offenders with a history of polysubstance abuse or dependence, who had volunteered to be part of a residential drug treatment program, were evaluated. Changes in health status and perceived psychological well-being between entry into the program and exit after maintaining participation for a minimum of 9 months were assessed. Pretest-posttest comparisons on a variety of physiological parameters indicated that significant improvements had occurred in the physical fitness of the
Thematic analysis of qualitative self-reports by inmates exiting the program suggested that participants had also experienced significant enhancements in a number of areas pertaining to psychological well-being, including self-esteem, health awareness and concerns, healthy lifestyle adoption, and relapse prevention skills. These results suggest that including health promotion training in drug treatment programs for incarcerated offenders may have beneficial results.

Summary and Significance:

In this study 43 women with a history of polysubstance abuse or dependence were enrolled in a 9 month residential drug treatment program that included a physical health and fitness component in addition to the counseling typically offered in drug treatment programs. Participants were required to attend 2 formal exercise sessions per week and were encouraged to exercise in their free time. Exercise sessions consisted of peer-led aerobic dance classes, instructor-led classes, and individualized programs the women created following education. Participants were given written reports of their pre and post-intervention scores on several assessments of health and physical fitness to improve motivation and demonstrate the benefits of their work. Overall significant differences were found between pre and post measurements in muscle strength, diastolic blood pressure, and aerobic capacity and in a focus group women stated that exercise gave them an alternative way to cope with stress, helped them realize the physical toll of an unhealthy lifestyle, and helped them develop self-discipline. The authors concluded that physical health may be as important as emotional health in relapse prevention. Although this may be a
stretch, there are certainly benefits shown to addressing physical health in substance abuse treatment.

This study focused on a very similar population to the women I am targeting in my program, with the main differences being a longer course of residential treatment and the lack of criminal charges. Although not conducted by occupational therapists, I thought this study was very relevant to occupational therapy’s potential role with women who abuse substances. There was an emphasis on ensuring the women were able to exercise independent from the instructor, and that they were able to see that their actions were having an impact on their health thereby empowering them to continue with these healthy habits. I also appreciated the study’s recommendation for maintaining balance in health education by pointing out that physical health is not the only aspect of wellness. A six dimension model of wellness including: physical, occupational, spiritual, intellectual, emotional, and social dimensions was discussed. I plan to look into this model and possibly use it in my program development.


Abstract: There is no abstract available for this source.

Summary and Significance:

This text discussed the twelve-step principles and philosophy in great depth including the history and organizational structure of Alcoholics Anonymous, along with chapters dedicated to all of the steps. The book emphasized the importance of spirituality, humility, giving back (amends), honesty, and community to maintaining sobriety. Although some professionals are critical of 12-
step programs, the author of this book supports Alcoholics Anonymous and other similar programs, explaining that they have consistently been shown to work and have grown tremendously in popularity throughout the world. He advises clinicians to refer appropriate clients by having a list of AA member contacts and a knowledge of local meetings.

I was superficially familiar with the twelve steps before reading this book because they are written colorfully on a resident-made sign at CTF and are discussed occasionally during the programming I have observed. Twelve-step work is an important part of CTF programming during residency and “aftercare” but due to my schedule I do not often observe these groups. After reading this book I feel that I can carry on an intelligent discussion with long-time members of twelve-step groups and other substance abuse professionals about the underlying values inherent in the steps that contribute to their success. I am also better equipped to reinforce these values in my discussions and work with the residents themselves, who have varying levels of familiarity with the steps. One quote from this book struck me as an important reminder to be careful during my interventions so that I do not spend excessive amounts of time “educating,” “Can clinicians teach someone the importance of humility if they maintain a hierarchical stance, with the professional as “expert in the art of living” and the client somehow lacking” (p. 108). This quote reminded me that instead of standing in front of the women attempting to teach a litany of scientific facts and occupational therapy knowledge about life, I should attempt to guide a shared discussion that will lead the women to discover their own, more meaningful, truths about wellness.

Abstract:

Now, for the first time on DVD, audiences can revisit SCARED STRAIGHT! and see the lasting effects of the teenagers and convicts’ encounter in Scared Straight! 20 Years Later, hosted by Danny Glover. The day documented in SCARED STRAIGHT was unforgettable— the question is, did it work?

Summary and Significance:

This documentary featured footage from a 1978 encounter between a small class of juvenile offenders and an even smaller group known as the “Lifers” of Rahway State Penitentiary. Later, it followed-up with the juveniles and Lifers 20 years after the initial meeting. In 1978 the students are given a brief tour of the prison and then taken into a back room where they sit on folding chairs before a group of imposing men standing in front of a graphic mural. The men show off their identification cards to validate their status as inmates then proceed to yell, threaten, and insult the young people. The students learn about prison life from a man who lost his eye while serving time for murder and kidnapping. They are forced to remove their shoes as the prisoners illustrate how it feels to have one’s personal belongings taken. They are each assigned numbers and one student is even assigned as a sex slave to various prisoners, holding onto their belt loops and sold for a cigarette, when he admits he is scared. Becoming the property of tougher prisoners, the Lifer’s explain, is how one obtains protection. Although this seems traumatizing and counterproductive given the non-confrontational methodology favored in recent literature, only one of the juveniles from the original documentary was in prison 20 years later.
Two other students continued to have problems with the law after the 1978 intervention, but they eventually changed their behavior after experiencing prison for themselves. Most of the young people admitted that the encounter really did change their lives for the better. Generally, they all had families and jobs, some were military veterans and many were involved with religious organizations or other community service. The Lifers did not fair quite so well. Two died from AIDS-related illness and another had a fatal heart attack. One was in prison on a new charge after being released and his son was also in prison, following in his father’s footsteps by participating with the Lifer’s himself. The Lifer’s group of the 1990’s was more progressive and scenes showed the Lifer’s not only yelling at young people but also encouraging and reassuring them in discussions typical of any mentor. Some Lifers from the original film did overcome their moniker and make a life for themselves outside of prison. The man who lost his eye was released in 1990 and said during a reunion in 1998, “If I commit a crime now you might as well hang me because I cannot go back to prison.” He also told the students of his 1978 class, whom he reunited with, that he had a lot of anger when he was speaking with them, but he really did want to help and he was very happy to see they were doing well. It was obvious his demeanor had changed a lot over 20 years and the students were able to laugh with him as they reminisced about their experience.

I admit I was somewhat surprised that the original Scared Straight experience seemed to be so effective. Current literature on offender rehabilitation indicates that punitive measures and scare tactics are not effective. However, there are some major differences between the juveniles in Scared Straight and the typical adult offenders of today. Primarily, the juveniles in 1978 did
not speak much of drugs or alcohol as motivation for their crime. Mainly, they seemed to enjoy the criminal activity itself, which they are very proud of. They also appeared to be of average intelligence and unhindered by mental illness. All of them were able to behave appropriately throughout their visit to Rahway. Most of the women at CTF, in contrast, speak little of their criminal activity and do not exhibit pride in it. They have difficulty sitting still, tend to speak to little or too often, and would likely scream back, run away, or burst into tears if confronted in a similar manner to Scared Straight! However, I think this film was enlightening in showing how confrontation can be effective in certain conditions. I thought the exercise in which the young people were forced to take off their shoes in order to teach them empathy for their victims was a good idea. Learning empathy is one of the main cognitive behavioral goals at CTF. I also thought it was telling that those individuals who did continue with criminal activity or who were in prison 20 years later, stated that drugs and alcohol were the biggest influence on their behavior. Another important aspect of this film was the therapeutic benefit to the prisoners, who found a great deal of meaning and purpose in their encounters with young people. The fact that, despite their harsh methods, their desire to keep the juveniles out of adult prison and away from the lifestyle they led was very sincere. Their concern for the well being of the young people was obvious, and it was clear they were not just angry at the them for hurting others, they were angry at them for hurting themselves. I think that contributed greatly to the effectiveness of their message. The fact that they were themselves offenders, that they had been in the same place as the juveniles at one time, and were willing to admit that their knowledge came from making the wrong choices was probably another reason their group was effective. Based on this film, I will
try to remember that not all messages must be positive, as long as those tougher messages come from a sincere concern for the well-being of the recipient and with great humility from the messenger.


*Abstract:*
What had happened to my beautiful boy? To our family? What did I do wrong? Those are the wrenching questions that haunted every moment of David Sheff’s harrowing journey through his son Nic’s addiction to drugs and tentative steps toward recovery. *Beautiful Boy* is a fiercely candid memoir that brings immediacy to the emotional rollercoaster of loving a child who seems beyond help.

Before Nic Sheff became addicted to crystal meth he was a charming boy, joyous and funny, a varsity athlete and honor student adored by his two younger siblings. After meth, he was a trembling wraith who lied repeatedly, stole money from his eight-year-old brother, and lived on the streets. David Sheff traces the first subtle warning signs: the denial, the three A.M. phone calls (is it Nic? the police? the hospital?), the rehabs. His preoccupation with Nic became an addiction in itself, and the obsessive worry and stress took a tremendous toll. But as a journalist, he instinctively researched every avenue of treatment that might save his son and refused to give up on Nic.
Beautiful Boy grew out of an article in the New York Times Magazine that drew an overwhelming response from readers grateful that Sheff had finally given voice to the devastating experience they shared. As the psychologist Mary Pipher, author of Reviving Ophelia said in praise of Beautiful Boy, “When one of us tells the truth, he makes it easier for all of us to open our hearts to our pain and that of others.”

Summary and Significance:

In this heart-wrenching memoir Sheff not only documents his son’s drug use, lies, crimes, and relapses, he also discusses the boy turned young man who was and is athletic, caring, creative, talented, intelligent, and loving... when he was sober. The metaphor of a rollercoaster nicely sums up the years years of Nic’s life after his father first found marijuana in his backpack when he was in junior high. After punishment and several lengthy discussions, Nic’s father thinks the issue is resolved until Nic is caught purchasing marijuana at his high school. With the help of a mentor teacher who convinces Nic to join the swim and water polo teams he coaches, Nic again seems to be headed down the right path until he travels alone to study in Paris in the summer before his senior year of high school. After the trip, which his father later learns he spent drinking heavily, he becomes sick with a stomach ulcer and loses interest in school and sports. He makes it through his senior year of high school with what his father tries to rationalize as a severe case of “senioritis” but during a graduation party he tries crystal meth for the first time and is instantly hooked. This begins a period of destructive cycling in which Nic begins running away from home, stealing things, and lying to convince everyone he is okay. A failed attempt at college leads to a stint in rehab, something Nic will do anything to avoid but when he crawls
back home in withdrawal with nothing left it is the only option his father will allow aside from living on the street. After this first 28-day stint Nic decides to try college again and seems to be doing well after his first year but runs off with his father’s car shortly after returning home for the summer, later revealing he had been using the entire year. This becomes a recurring pattern, in which Nic goes to rehab and does well for a time before relapsing. The rehab stays get longer, as do the periods of sobriety, leaving his father with some hope. This is a very cautious optimism. The way in which Nic’s struggles are experienced by his family is the main focus of the memoir, written by his father. His father, mother, step-mother, and two half-siblings are stuck on the rollercoaster along with Nic although throughout the novel they slowly learn how best to deal with loving an addict. For Nic’s father, this means detaching himself from his son and learning to accept the “C’s” of Al-Anon, he did not cause it, he cannot control it, and he cannot cure it. Despite trying to protect his younger children to the best of his ability, they are inevitably exposed to Nic’s problems as he breaks into the house, steals from his brother’s piggy bank, and is arrested on their driveway. They are also exposed to the anxiety Nic’s unpredictable behavior elicits in their father. Despite this, they seem to learn from Nic’s mistakes and speak openly with their family, therapist, and even peers about drug use. By the epilogue, Nic is tenuously sober and his father has come to “accept and even appreciate that he is living his life his way” (p. 315).

This book provided valuable insights into the destruction of addiction in the addict’s life and his or her family. It served as a reminder that some people who abuse drugs or alcohol were at one time innocent children, with a great deal to offer the world and may still be full of
potential. The author does his research on addiction, particularly methamphetamine addiction, and points out that while this drug can reek havoc on the user’s brain, the brain can also recover with prolonged periods of abstinence (1-2 years or more). Despite some guarded optimism, the book is realistic in portraying the chronic nature of addiction and the fact that many rehab programs are “only slightly better than useless when it comes to the treatment of meth addicts” (p.120). The author describes a form of cognitive behavioral therapy that may be relevant to my program. He explains that when an addict lapses into incidental drug use, he or she can be trained to stop the process at a “choice point” and try an alternative activity rather than respond to the “priming” mechanism that can lead to a more serious relapse. The book also provides a weary parent’s perspective on art therapy, which initially elicits rage in a man who as “been through too much to be sitting on the floor finger painting,” but eventually brings him to tears at what is revealed through the creations of he, his son, and his ex-wife. Other occupations featured in this book include drawing a “path to recovery” in which steps are written onto stones leading from the start to the finish and the stones’ surroundings represent the swamp of challenges the addict must avoid or overcome in order to stay sober. This book also inspired a potential occupation to try with women at CTF by discussing an artist that, because he became overwhelmed with the whole, learned to break down images into a grid of manageable squares. Learning to “not swallow the elephant whole” is a need that my site mentor identified, and breaking down images using a grid is how I was taught to draw in high school art classes so I could teach this method for artwork as a potential leisure occupation with added meaning.

**Abstract:**

Take a fascinating look inside the old Ohio Penitentiary as you follow a group of inmates who meet weekly under the tutelage of a lifer named Zeno in a group called the Epictetus Club. The inmates study the teachings of this Greek philosopher, and with the help of his ancient wisdom they meet the daily challenges of their lives. Learning to think outside the limits of their own literal walls as they struggle to redeem themselves, the club members show us how to think beyond the limits of our self-imposed limitations and comfort zones.

**Summary and Significance:**

In this book the principles of Cognitive-Behavioral Therapy (CBT) as originally elaborated by a student of Epictetus in the Enchiridion are presented by inmates at a maximum security prison in Ohio. It was a good review of CBT principles, and I enjoyed the metaphors and occupations featured that can help teach these principles. The “ABC’s of inner boxing” (Attacking thought, Block the attacking thought, Counterpunch) provide a simple process to help fight against negative thinking. Specific attacking thoughts that are addressed include: “it can’t be done;” “if I ignore the prices I will not have to pay them;” “I am a victim of events;” “I am entitled to have whatever I want;” “he can’t say that to me;” “I will not get caught;” and “I need to worry.” “Counterpunching” involves thinking about where the thought will lead in the long run, looking at problems from multiple angles, being grateful, helping ourselves by helping others, and recognizing that some things are out of our control. I have seen or experienced many of these attacking thoughts and the “counterpunches” offered can be very helpful. I also think the four
walls of F.A.I.L. (Failure, Apathy, Inertia, Lack of vision) the main character claims “imprison” people are very consistent with thought processes I have observed in my fieldwork. The book also includes exercises or occupations that can be done to work on re-structuring thinking, such as drawing a diagram of the costs of criminal behavior. I am glad that this book is assigned to residents in the CTF program. It is easy to read, keeps one’s attention engaged, and teaches strategies and ideas in a way that is easy to understand and remember. It also provides positive role model in the form of an inmate character Zeno who leads the group until the prison is shut down and he is given furlough to continue his work of motivating others while in the community. By allowing Zeno to do the teaching from his prison cell, the book avoids seeming too sanctimonious. Hopefully I can remind the residents of principles from the book as needed and reinforce them in the discussions I lead and assignments I give.


*Abstract:*

In this paper, I argue that every rehabilitation program presupposes conceptions of possible good lives for offenders and, associated with this, an understanding of the necessary internal and external conditions for living such lives. I first clarify the notion of good lives and outline its necessary features. Second, I establish the conclusion that all offender programs presuppose a conception of good lives. In order to make the argument a little more concrete, I demonstrate how a state-of-the-art treatment program for sex offenders and research on the process of
offender change presuppose such a conception and expose the problems evident in the way they engage with this dimension of rehabilitation. Third, I argue that it is necessary for individuals working to rehabilitate offenders to explicitly construct conceptions of good lives for different offenders and to use these conceptions to shape the behavior change process.

Summary and Significance:

In this paper the author argued that “A necessary condition for the reduction of offending is the instillation of ways of living that are more fulfilling and coherent” (p.514). By this he meant that in order for offender rehabilitation to be successful, each individual offender must, with the help of treatment professionals able to realistically appraise that individual’s resources and obstacles, create a realistic and coherent concept of a “good life” in which “primary human goods” are all addressed in some way, with the relative importance of those goods determined based on the individual’s profile and self-narrative. “Primary human goods” consist of physical, psychological, and social needs such as health, positive self-regard, and a sense of relatedness. The concept of a good life may be built around one’s sense of self as a devoted parent with needs related to parenting being the priority and other needs being met around that role, or alternately devoting one’s life to spiritual fulfillment through involvement in community service and religious organizations. The author proposes that the role of the treatment program is to identify and address obstacles that might prevent offenders from obtaining necessary human goods and attempt to teach them how to get primary goods through acceptable means or seek a broader range of primary goods. I thought the author made a good argument about the importance of individualized treatment as compared with a “manual” approach that assumes only one concept
of a good life and a generic set of obstacles to achieving it. I also agree that creating coherent
treatment goals based on the positive concept of a good life may be more effective than a group
of seemingly unrelated goals such as staying clean and sober, attending meetings, finding
employment, improving communication skills, etc. I was very excited to read about research on
the life narratives of desisting offenders compared with persisting offenders because of the
importance of life narratives in the Model of Human Occupation and I plan to find the article
cited. The fact that persisting offenders saw themselves as hopeless victims trying to survive any
way they can while desisting offenders developed narratives of redemption in which earlier
-crimes and circumstances helped shape new and adaptive identities is consistent with material I
have read in a recovery workbook assigned to CTF residents.

**Sources Supporting Occupational Therapy in Offender and Substance Abuse
Rehabilitation**

Berget, B., Skarsaune, I., Ekeberg, O., Braastad, B.O. (2007). Humans with mental disorders
working with farm animals: A behavioral study. *Occupational Therapy in Mental Health*,
23, 101-117.

*Abstract:*

There is a lack of scientific studies using farm animals in animal-assisted therapy (AAT) for
persons with mental disorders. This Norwegian study used video records to study the working
abilities and behaviors of 35 severely ill psychiatric patients in interacting with farm animals
during a three-month intervention. The patients showed higher intensity (difference score: 0.26
+/- 0.05, p < 0.0001) and exactness (difference score: 0.31 +/- 0.06, p < 0.0001) in their work at
the end of the intervention, particularly patients with schizophrenia and personality disorders.
The patients spent most relevant time in physical contact with the animals, feeding, cleaning, and milking cows. Among patients with affective disorders, increased intensity of work correlated significantly with increased generalized self-efficacy (rs = 0.82, p = 0.01) and decreased anxiety (rs = -0.7, p = 0.05). For the patients with schizophrenia and personality disorders no correlation was found between the behavioral parameters and the effect scores of psychiatric instruments.

Occupational therapy with farm animals may be beneficial to some persons with mental disorders.

Summary and Significance:

In the introduction of this article the authors reviewed some of the mental health benefits associated with animal assisted therapy (AAT) including decreased heart-rate, decreased blood pressure, and decreased anxiety and depression observed in the presence of animals. They also discussed the “Green Care” therapy in which caring for animals, plants, gardens, or forests are used to improve coping skills and self-esteem through the establishment of daily routines including physical contact and care for other living beings. In the study, psychiatric patients with various disorders (10 with personality and behavioral disorders, 8 with affective disorders, and 4 with anxiety or stress-related disorders all of which diagnoses are seen at CTF, in addition to several with schizophrenia or schizoaffective disorders) worked as “stockmen” caring for animals under the supervision of a farmer 6 hours per week for 12 weeks. Participants were given a battery of psychological assessments before and after treatment and were videotaped working on the farm once during their first two weeks and once during their last two weeks.

Upon observing the videotapes, researchers rated participants’ exactness and intensity of work
with the animals higher during the later video session indicating improved work skills. They also found participants in the animal work group to score higher on measures of self efficacy and quality of life as compared with a control group.

AAT has been studied in correctional environments with offenders. I have yet to find any scholarly articles related to the use of “Green Care” in correctional rehabilitation although I remember seeing a magazine article in which offenders cared for a golf course and the idea of gardening in a prison yard does not seem far-fetched. I might like to include AAT or a “Green Care” element in my program development plan or in occupational therapy intervention with residents at CTF. Due to security measures this would be difficult, however, residents at CTF are given time outdoors when weather permits so the creation of a small garden may be feasible with clearance from Mr. Hite, the Director of CTF. Visits from therapy animals would also likely require approval from administration but could be very beneficial especially for anxious or depressed residents. Introducing animal care as way to increase meaning and purpose in one’s life following release could help residents stay motivated to maintain sobriety. This article was also helpful by establishing a method and scale for evaluating work as it occurs. I could theoretically use video sampling in a similar way to evaluate the work skills component of my own program.


Abstract: No abstract available for this source.

Summary and Significance:
This brief article described a program initiated by Elizabeth Ciaravino, Ph.D., OTR/L and carried out with the help of her occupational therapy graduate students at the University of Scranton designed to address life skills with people involved in the county’s drug treatment court. The drug treatment court specializes in rehabilitating non-violent offenders who were arrested for substance abuse. While involved in the court, these people progress through a series of phases with mandatory treatment from various providers, weekly court appearances, and random drug testing. The occupational therapy group became a treatment requirement for 8-12 clients during their phase 3 treatment. The group was titled, “Better Living Through Life Skills” and worked with clients on utilizing their non-treatment time effectively. Areas such as time management, budgeting, appropriate attire, and job interview skills were addressed in weekly group meetings and individual meetings as necessary. Subjective data on the program was largely positive and the clients stated that they found the group format in which they could work together as the most useful aspect of the program. As a research project one of Ciaravino’s students will investigate outcomes such as recidivism, place of residence, ability to maintain employment, and engagement in meaningful and healthy occupations. The students involved stated that the experience was rewarding for them, especially as they helped the clients to empower themselves and understand their behavior and choices.

I wish this article was longer because the program described is very similar to the program I am creating for women at CTF. CTF primarily houses people with substance use disorders for the purpose of treatment rather than strictly punishment and this is similar to a drug court. The needs identified for their program were also similar to mine. In my program I plan to address all
the areas described in this article. I only wish more detail had been provided as to specific interventions used. Ciaravino advocates for the role of occupational therapy in this area stating, “Substance abuse is such a prevalent problem. Having worked in that area before, I know that there is so much occupational therapy can offer” (p.10). The article also illustrated how work with this population can be successfully carried out by students as a very rewarding educational experience. Finally, this article indicated that group work with this type of population can be considered “useful.” I am still considering how much of my program will be run in a group versus individual format. I will attempt to contact Ciaravino to find out more about her program and the planned research that was alluded to in this article.


*Abstract:*

In this article we will outline the general position of occupational therapists in the field of addictive behaviours. We will then describe the occupational therapy (OT) service at the Cambridge Drug and Alcohol Service and how the model of Sanderson and Reed (1980) was interpreted, and proceed to discuss how the “model of change” (Prochaska and DiClemente, 1986) was used to promote a more effective integration of the OT component into the multidisciplinary treatment provision.

We will then illustrate how this identified a gap in the service, which led to the development of a specific OT “combination package,” and briefly review the effectiveness of
this package and the pathways of two clients through the service to illustrate the application of T
in the multidisciplinary context using the model of change.

*Summary and Significance:*

This article outlined the work of two occupational therapists functioning as part of the Cambridge Drug and Alcohol Service. The service consisted of a day program, outpatient programming, and community-based programming. Treatment provided included individual and group therapy. The occupational therapists used a model devised by Sanderson and Reed (1980) for much of their program development. This model is client-focused and looks at the individual, made up of qualities, personality, norms, values, attitudes, experiences, contexts, and stage of life, his or her functions, including organic, motor, sensory, cognitive, intrapersonal, and interpersonal, activities of daily living, including self care and domestic care, productivity, and leisure, and the environment, consisting of possibilities and limitations. This model defined the occupational therapists’ “core skills” and role on the team. They sought to assess and address functioning in the activities of daily living with an emphasis on the use of activity. In addition to running groups, the occupational therapists also carried out part of the generic caseload of the organization, including conducting new patient assessments. In order to create a coherent treatment process across all the disciplines working in the service the occupational therapists later tailored their groups to fit within the Model of Change (Prochaska and DiClemente, 1986), which was incorporated by the entire staff and described the process of recovery in terms of four stages: 1. pre-contemplative, 2. contemplative, 3. action, 4. maintenance. An activity-based group was designed for clients in the contemplative stage, while a skills-training group was
developed for clients experiencing success in the action stage and moving into the maintenance stage. An alcohol education and support group was already in place to meet the needs of those clients beginning the action stage. These stages were also used as a means of outcome measurement and the authors noted that clients had a sense of accomplishment in moving from one stage to the next. In the first year of their program 12 clients entered the group and 10 completed it. Eight members had minor relapses, but quickly returned to recovery. Toward the end of the article, the authors noted that they began incorporating the Model of Human Occupation in the second round of their groups and considered it “useful” in their work.

The authors lamented the fact that occupational therapists are not common professionals in the field of drug and alcohol rehabilitation. As a result, they tend to get lost as a tiny minority in large multidisciplinary teams and their role is ill-defined and poorly understood by colleagues. This in turn leads to underuse of occupational therapists as a potentially valuable resource. In order to combat the isolation of being a professional minority in the field, the authors of this article suggest joining groups such as The Association of Occupational Therapy in Mental Health (AOTMH), and a specialist network known as SUBNET, in order to exchange information and experiences. However, the authors emphasize that occupational therapy in this field is most effective when properly integrated within the multidisciplinary team.

This article was very valuable in that it addressed an important concern of mine regarding professional identity in a field where occupational therapy has not been well-established. It provides precedent for an occupational therapist to engage in “common skills” tasks shared by all members of the team such as intake assessments, which I have been learning to perform at CTF.
This article points out that by engaging in these more general tasks, occupational therapists gain a better understanding of substance use disorders and the all areas of treatment. The article is also valuable because of the scarcity of documented occupational therapy programs for this population. The use of the Model of Human Occupation, although mentioned only briefly, will help to validate my use of this model because the authors evaluated it favorably after using it with a similar population of individuals with substance use disorders (unfortunately it was never revealed how many women participated in this program). I plan to look into the AOTMH and SUBNET to see if these organizations are still in existence because they may allow me to get in contact with occupational therapists willing to be interviewed as part of my program development process. The article also provided additional knowledge regarding the Model of Change (Prochaska and DiClemente, 1986), which was discussed in the Couldrick and Alred (2003) text and provides an interesting framework for describing substance abuse disorder recovery.


Abstract:

Prolonged occupational deprivation impacts an offender’s ability to reintegrate successfully into their community. Occupational Therapists can create programs for offenders to aid in preparation
for reintegration, create support networks, develop independently living and vocational skills; in turn these programs can decrease recidivism.

Summary and Significance:

This paper was created by a second-year occupational therapy student and reviewed five different studies related to life skills training and prisoner rehabilitation. Two of these studies showed that animal based programs can be an effective means for decreasing criminal behavior while increasing social skills and self-esteem. Another study showed that an “interactive life skills” training program was more effective than an individual psychotherapy-based approach. Only one article featured the direct involvement of occupational therapists (Eggers et al., 2006). Butz suggests, based on her literature review, that occupational therapists have a unique and beneficial perspective to contribute to the rehabilitation of criminal offenders by helping them adjust to their role as healthy and productive members of society through the creation of support networks and development of independent living and vocational skills. She also advises that occupational therapy programs should include a post-release component in order to fully prepare individuals for independent living in contexts and environments unavailable in a prison setting, and occupational therapists should develop more research on activity based life-skills training programs.

I have already read 3 of the 5 studies reviewed in this article but the two related to AAT were new resources for me to investigate. Based on my perspective from those articles I have also reviewed as well as my experience searching through the available literature, I agree with the author’s conclusions. I may use her opinion to further validate my own in the literature
review for my program. I also sought out more information on AAT including the articles Butz reviewed.


Abstract:
This paper briefly outlines the role of occupational therapy in assessing and treating patients with the tripartite problems of mental disorder, dangerousness and an addictive behaviour. The first unit dedicated to the management of such patients within conditions of high security was opened in Broadmoor Hospital in 1995. It is a 25-bedded male inpatient ward. This article focuses on occupational therapy in this unit, the forensic addictive behaviours unit, but many of the issues discussed apply to patients with an addiction within other forensic psychiatric settings.

Summary and Significance:
This article discussed some of the history an theory of the interplay between addiction and forensic behavior then described the Forensic Addictive Behaviours unit at Broadmoor Hospital in the UK, focusing on the role of the occupational therapists working on the unit. The authors pointed out that while opinions on the issue are mixed, the British Criminal Justice System allows offenders to enter a plea of diminished responsibility when their behavior was affected by a disorder, including a substance use disorder. However, such pleas are most likely to succeed if based on depression or a personality disorder with substance use as an associated issue. Prison surveys show that 1 in 10 men and 1 in 4 women in correctional facilities have an addiction. A
triaxial model was proposed to describe the link between substance abuse and criminal behavior. This model states that substance abuse leads to criminal behavior through psychopharmacological, economic, and systematic axes in which the individual is directly influenced by the reaction of the substance in their system, the individual is compelled to finance use and must resort to crime to do so, and the individual is led to criminal behavior through involvement in the substance using subculture or illicit drug supply industry. Despite a strong link between substance abuse and criminal behavior, the authors lament the general lack of overlap between forensic and addiction services and call for greater awareness and liaison between the two fields. For example, criminal behavior can be an exclusion criteria for some substance abuse programs and staff in forensic services often provide minimal focus on addiction issues. In order to address the special needs population of offenders with both mental disorders and clinically significant addictive behaviors, Broadmoor, the oldest of three high security special hospitals in in the UK, developed the Forensic Addictive Behaviours Unit in 1995. The core of the program is a multimodal therapeutic community created within the secure unit and group therapies are used to compliment this approach. Psychodynamic, alcohol, drug, and sexual education, relapse prevention, social skills, anger management, and occupational therapy groups are all offered. In addition, because the community members have dual diagnoses, they often require individual support, and motivational interviewing is considered an important aspect of the therapy. The occupational therapy intervention consists of a two-tiered approach orchestrated by a pair of occupational therapists working in the unit. In the first tier, task-based activities such as social, creative, domestic, relaxation, and sports activities are used to provide assessment
information and practice of real-life situations. Other assessments used by the occupational therapists include the Coping Responses Inventory, the Social Anxiety and Distress Scale, and the Locus of Control Scale. More advanced occupational therapy groups involve personal development such as self-awareness, coping skills, social skills, volition, and self-esteem. Role play and role development activities are used in these higher level groups. The occupational therapists also contribute to the overall therapeutic community approach by considering the environment through activities such as the creation of murals.

The Addictive Behaviours Unit at Broadmoor as described in this article seems similar to CTF in many ways. Offenders admitted to CTF generally have some type of substance use disorder and about half have some co-occurring mental illness. Treatment in both programs involve a combination of multimodal group therapy and one-on-one interaction with counselors and case managers as necessary. In fact, the use of motivational interviewing was recently encouraged at CTF with a two-day training seminar. The groups in both programs address similar areas including anger management, social skills, and addiction education. One major difference is the inclusion of a comprehensive occupational therapy program at Broadmoor which is currently absent at CTF. Some of the occupational therapy interventions discussed in this article are or will be featured in the program I am creating, and this article will help to support them, however, some of the occupational therapy interventions would not be practical at CTF because of other differences between the two programs. These differences include the longer length of stay at Broadmoor, an average of 8 years compared to about 80-90 days at CTF, as well as the differing size of the facilities and resources available, with Broadmoor
accommodating between 400-500 individuals at any given time and CTF housing a maximum of about 130 residents. As a result of these differences, any occupational therapy program at CTF would not be as extensive as that offered at Broadmoor. Finally, this article described a men’s unit whereas I am working in a women’s unit. However, many of the interventions described in this article would fit nicely into the program I am designing, and this article pointed out that incarcerated women are more likely to have substance use disorders than their male counterparts. Although the authors claimed to be using the Canadian Model of Occupational Performance, they did not mention using the COPM assessment and their strong emphasis on the use of occupation and improvement of volition was consistent with the Model of Human Occupation. This article will be valuable in establishing the potential contribution occupational therapy can make in a multimodal treatment community similar to CTF, as well as providing a literature base for specific intervention ideas to use with this population.


Abstract:
The links between occupational performance, mental health, and offending behaviour are being increasingly recognised and the number of occupational therapists working with mentally disordered offenders is rising. This book is written by forensic occupational therapists, and describes their experience of working within various environments, including secure psychiatric settings, prisons and the community. It also considers practice in specialist clinical areas such as
learning disabilities, women’s services, self-injury, addictive behaviour, sexual offending and personality disorder.

Summary and Significance:

This text represents a compilation of chapters on various topics relevant to the emerging practice of occupational therapy within the forensic hospitals and prisons of the United Kingdom, each written by occupational therapists in the field. Due to the acknowledged paucity of published literature on these topics, the authors draw from personal experience in their various institutions for much of the material presented. Some major themes in the book include: 1. the need for activity to be therapeutic, not simply a means of controlling behavior as it has traditionally been in these settings; 2. the need for occupational therapists to work cooperatively with other staff and as a part of cohesive multidisciplinary teams; 3. the difficulty of negotiating safety and security concerns with concern for the therapeutic relationship and creation of a positive rapport, and 4. The need for increased research and dissemination to establish best-practice principles, and the need for implementing theory-based practice until such research is available.

As the only text available on using occupational therapy to address criminal offenders, this book was extremely relevant to my project. Despite searching OT Connections, I have yet to meet any occupational therapists working in this area so the experiences shared by the authors of this book have been extremely valuable for me in understanding the role of an occupational therapist in a forensic setting. Some of the most relevant chapters for my project and specific population included “Women in secure environments,” “Everyone is an artist” “Forensic addictive behaviours,” “Programme planning,” “Self-injury or relief from overwhelming
emotions,” and “Personality disorder - a role for occupational therapy,” although each of the 20 chapters were valuable in some way. Also contributing to the significance of this resource was the fact that 8 of the 20 chapters referred to the Model of Human Occupation, which seemed to be the preferred model of practice for forensic occupational therapy in the UK at the time this book was written. Some specific ideas in the book that sparked my interest included: 1. a program that provided bicycle safety courses as well as used bicycles for community outings and to loan to newly released individuals in order to facilitate community reintegration; 2. the use of Socratic questioning during cognitive behavioral groups; and 3. allowing women contact with men in a safe, controlled environment to facilitate the acquisition of appropriate social skills in mixed company. The only drawback associated with this text is its focus on the laws and institutions of the UK, which differ from the judicial and correctional systems of the US.


*Abstract:*

The requirements for health care professionals to demonstrate evidence-based practice and to adhere to the clinical governance agenda are of pressing importance. These processes have been enhanced by the use of integrated care pathways (ICPs). ICPs outline and document clearly the key components of an individual’s care within a given service. The lack of ICPs, in both mental health in general and occupational therapy in particular, is noted and discussed. The benefits of
ICPs for occupational therapists are highlighted and an example of such a pathway, within a forensic mental health environment, is discussed.

Summary and Significance:

This article promoted the use of “Integrated Care Pathways” or “ICPs” as a way to ensure the incorporation of evidenced-based practice in routine clinical treatment. The authors point out that evidence-based practice is an “ethical, professional, and political imperative” (p. 473) and ICPs represent a method of implementing and evaluating clinical guidelines providing the best available evidence to direct intervention. ICPs were first developed in the United States as a way to plan and control large projects within specific time frames, for military purposes in World War II and then for healthcare in the 1980’s as health care reform demanded cost effectiveness. In the United Kingdom, they are being developed to ensure that best practice is a part of the everyday clinical routine of NHS professionals. In mental health care, ICPs are generally process oriented, meaning they identify the tasks completed during a patient’s care episode. The example provided in the article was developed by occupational therapists as a profession-specific care pathway implemented at a secure psychiatric facility in Carstairs. This process was encouraged by an ICP facilitator who identified different practices and interpretations of items on the ICP which were hampering its effectiveness. For example, it was initially unclear whether formal or informal assessments were to be used for certain items. A more detailed explanation of when specific assessments would be appropriate was created to alleviate this confusion. Variance analysis is another component of ICPs that was used at Carstairs. Variance analysis reports describe incidents in which a certain item from the ICP is not completed for a specific individual,
including the reason for the variance and any planned action to be taken in the future. These reports document whether clinical developments are truly incorporated and maintained in practice. The article provided the pathway used at Carstairs leading up to a patient’s case review. It included: completing the MOHOST assessment, assessment of life skills, assessment of social skills, liaison with key worker regarding recommendations for pattern of occupation, documentation of all occupational therapy assessments and interventions in the case review report, providing feedback to the patient regarding all occupational therapy assessments and interventions, providing the patient with an opportunity to contribute to the case review report, and attending the case review meeting. Overall, the ICP was considered an effective “change management tool” that helped occupational therapists at Carstairs be “conscientious and explicit” (p.477) in the use of evidence-based practice and the achievement of clinical standards. In the future, they hope to allow patients more control over the ICP by including their input in future versions of the document and providing an overview and explanation of the document to each patient.

This article was interesting to me because I have, in the past, been troubled by the lack of standardization of practice in occupational therapy, particularly in mental health settings. While creativity and flexibility are vital for professionals in this area, I also feel that increased use of evidence-based practice, including ICPs could help provide occupational therapists with more interdisciplinary credibility and confidence in practice which are also important in these settings. In designing my program I would like to include an ICP that outlines the standard of care that is to be delivered to each participant. This will include the intake and discharge assessment process,
interdisciplinary communication, collaborative goal setting with the participant, and other key interventions that will make up programming. This article is also relevant because the care pathway described was used in a secure psychiatric, also described as “forensic” facility and used the MOHOST as the standard assessment. This supports my use of the MOHOST as one of the main assessments for my program.


*Abstract:*

The incarcerated population in U.S jails has more than doubled in the last thirty years while prison populations have quintupled. Over half of those released from incarceration return to correctional systems within one year of release. One of the reasons for these high rates of recidivism is that many inmates lack the community living skills necessary for community reintegration. Successful community reintegration for ex-offenders requires a skill set that occupational therapists have long addressed in their domain of practice. Compared to practitioners in the United Kingdom and Australia, U.S. practitioners have been slow to develop occupational therapy programming in correctional settings. This article describes a community reintegration program for jail inmates built through a collaborative partnership between a university occupational therapy program, community non-profit organizations and a county jail.

*Summary and Significance:*

This article sets a precedent for the establishment of well-documented occupational therapy programming in a U.S. correctional setting using grant money. The introduction references Wilcock and discusses issues of occupational deprivation, imbalance and alienation. The authors also point out that U.S. occupational therapists lag behind countries such as Australia, the U.K., and Canada in providing examples such as their program. The program presented in the article, The Community Reintegration Project, a portion of the Allegheny County Jail Project, began in 1999 through the Department of Occupational Therapy at Duquesne University’s Practice Scholar Program, which focuses on community based practice. As implied by the title, their project supports community reintegration through the promotion of employment, wellness, family/support structures, life skills, and education. The project was funded through Goodwill Industries of Pittsburgh, Wholistic Consulting and Development Inc., and Duquesne’s Occupational Therapy Department. Two occupational therapists from the University worked with Goodwill staff to operate the program by administering occupational assessments, helping with goal setting and action planning, creating a curriculum, and providing follow-up in the community. Outcomes from the first 11 months of the program have been largely positive. This project is not very similar to the program I will propose because the services offered by Duquesne’s occupational therapists and the staff they supervise is similar to the programming already offered at CTF, and is more educational and less occupational. However, the background information and references from the introduction were a good starting point for my literature review. Some of the assessments and outcome measures used (including the Occupational Self-Assessment from MOHO) could be incorporated into my program and the
authors did a nice job quantifying their success so that this article can be used to advocate for more occupational therapy programs in jail settings. The creation of reintegration plans and therapist follow-up in community settings after the participant is released are intriguing ideas and I appreciate the authors’ emphasis on self-responsibility and productive occupational patterns. I plan to contact the authors of this paper to obtain an update on their project and perhaps some advice if they are willing to respond.


Abstract: No abstract available for this source.

Summary and Significance:
This brief article described the creation of a “word garden” through the combined efforts of inmates at the Pender Correctional Day Program, along with the horticulture therapy staff, 2 COTA Level II Fieldwork students, and their academic fieldwork coordinator. The Pender Correctional Day Program is a yearlong program designed for offenders with mental, physical, or social disabilities with low IQ scores that provides basic skills training in math and English. The program also engages offenders in horticulture therapy. The word garden project was an attempt to combine the philosophies of occupational therapy and horticulture therapy in order to promote group experience, performance patterns, introspection, communication, and landscape trade learning. Words such as “Patience,” “Respect,” and “Kindness,” were painted on rocks that acted as “touchstones” and inspired themes for the different sections in the garden. During gardening,
participants were encouraged to reflect on the words and share the thoughts and feelings they evoke. The occupational therapists helped participants explore the symbolism and powerful messages in the words as well as the symbolism of various tasks such as weeding, pruning, raking, and planting. Those involved in the project observed that the physical labor helped the special words take on additional meaning.

This article was valuable for illustrating how occupational therapy can work alongside other disciplines to create meaningful programs for offenders. The Pender Correctional Day Program is similar to CTF in that it is an alternative to punitive incarceration that already offers programs designed to prepare offenders for more productive lives. It differs by focusing on disabled offenders as opposed to those with substance use disorders and other mental illness, but it is reasonable to assume there would be some overlap among their respective populations. This article shows that occupational therapy can make unique contributions to a program that already has a competent treatment team in place. It also demonstrates that higher level students can successfully take on leadership for program development in this field. The idea of using key words or phrases in the creation of creative projects in order to promote reflection, is something I may use in my practicum. I also appreciated the advocacy for enhanced offender treatment provided by this article, particularly the quote, “Prisons can be confining without being punitive, hard without being meaningless, secure without being barren, and productive without being costly” (p.39).

Abstract: No abstract available for this source.

Summary and Significance:
This brief letter in response to an article about screening for substance abuse provided a number of practical tips for interacting with substance abusers. Groves advises practitioners to recognize that many of their clients have been dealing with AD/HD from childhood through adulthood. The letter suggests using two-step commands, stating that presenting two concepts at once is the optimum level of manageable comprehension for these individuals. The letter also suggests using questions such as “What is working/what isn’t working?” and “What did you learn?” to determine a client’s level of understanding consequences. The author points out that people with AD/HD often have difficulty recognizing consequences and may not respond well to advice. Noting that verbal information can be quickly forgotten, the value of providing written information or allowing individuals to take notes is stressed. Practitioners are also reminded that although statements should be kept simple, people with AD/HD who abuse substances may be very intelligent.

My experience with the women at CTF has been consistent with Groves’ insights in this letter. AD/HD symptoms were identified by case managers at CTF as a significant issue for many residents. I plan to use more questioning in future discussions with residents because this has been suggested by this as well as other resources. I also plan to try to simplify future group intervention plans and assignments because I have also noticed a tendency to become confused or lose interest when a task becomes overly complex. However, like Groves, I also appreciate

Abstract:
Everyday occupation is a primary means by which we organize the worlds in which we live. The phenomenological experiences of day-to-day life build meaning and community in our lives; yet everyday occupation is often “seen but unnoticed.” Cultural tendencies and invisible social forces contribute to the obscurity of the everyday and, in severe situations, to occupational deprivation. The purpose of this Slagle lecture is to raise awareness of the complexity and “delicate layerings” of everyday occupation, its theoretical and conceptual underpinnings, the consequences of severe occupational constraints to health and well-being, and the essential relevance of everyday occupation to occupational therapy and occupational science. Everyday occupation related to food is probed in depth to illustrate the richness of day-to-day living. Occupational therapy personnel are encouraged to gain deeper understandings of the importance and meaning of everyday occupation in the lives of clients and the general public, thereby helping people find value in their everyday practices.

Summary and Significance:
This article based on Hasselkus’ distinguished lecture focused on the importance of everyday occupations that are often taken for granted until circumstances prevent or drastically alter their
performance. She notes that in prison “where everyday occupation is severely constrained, the term occupational deprivation applies” (p.635). Additionally, she lists other conditions including poverty, illiteracy, lack of employment opportunity, stigma, homelessness, and violence as circumstances that can prevent individuals from engaging in meaningful occupation. She points out that a man with quadriplegia and a caregiver whose husband had dementia both likened their life situations to prison. An intervention for occupational deprivation created by students working with homeless men in South Africa was described as facilitating “the ability of the men living at the shelter to ‘choose, organize, and perform’ occupations they found useful and meaningful by rediscovering forgotten occupational interests and abilities and by increased awareness of the capacity for renewal through occupation” (p. 636). Hasselkus cites sources I may wish to look into including a text by Watson and Schartz (2004) that describes occupational therapy programs created in South Africa including work with women and children involved in the criminal justice system. She also refers to a video created by inmates of a maximum security prison in Wisconsin chronicling the conditions of their environment and patterns of occupation. Hasselkus also discusses an emerging trend in occupational therapy to broaden our focus from the individual level toward communities and populations including the promotion of our universal human right to engage in meaningful occupation.


*Abstract:* No abstract available for this source,

*Summary and Significance:*
This article described a group developed by an occupational therapist for individuals with substance use disorders receiving treatment at an acute care hospital for other diagnoses including CVA, TBI, SCI, orthopedic trauma, and neurological disorders. Dubbed a “Time Management Group” content was based on helping clients develop insight, coping skills, a proactive as opposed to reactive lifestyle, assertive as opposed to aggressive relational styles, and other healthy habits, patterns, and behaviors related to maintaining sobriety. Clients were referred based on accumulated evidence of substance use disorder and were then assessed regarding cognitive, perceptual, language, and physical abilities that would allow them to participate or necessitate accommodations. Ground rules including the attendance policy, confidentiality, honesty, and lifetime membership in the group for those who wished to return after discharge were established and communicated to all incoming members. Membership was voluntary. Topics for the group were determined based on the needs of the clients and included: how nutrition can assist the process of abstinence; time management; leisure; coping and stress/anger management; socialization skills; and codependency issues. The importance of the group leader providing non-judgmental empathy and validation serving as an advocate for the clients was emphasized.

This article provided some practical guidance in working with individuals with substance use disorders as well as advocacy for the role of the occupational therapist in their treatment. The author stated that it is important to be knowledgeable regarding indicators of drug abuse and common slang terms related to illicit substances. Some indicators I had not considered before included: abscesses, cellulitis, dirty fingernails, nervousness, agitation, and poor skin. Slang
terms defined in the article included: “chipping” (occasional recreational use of a drug), “run” (prolonged habitual use of a drug), “slamming” (IV drug use), and “rig” (syringe). Because this article is over 10 years old, these terms are likely out of date but I will continue to respectfully ask individuals about slang terms I do not understand and make note of them. Based on this article I will also try to be more diligent in establishing and maintaining ground rules in my groups and will incorporate this as an important step in the program I develop. I found the phrase “proactive versus reactive lifestyle” very helpful because this has been an issue I have observed but have not been able to elucidate (in my experience, people with substance use disorders tend to lead very chaotic lives, constantly reacting to various situations rather than organizing their lives into patterns of goal directed behavior which I believe the author communicates succinctly in the above phrase). In concluding, the author makes a strong argument in favor of occupational therapists taking on a greater role in substance use disorder recovery by stating, “Substance use disorder is an all-encompassing disease process affecting all aspects of a person’s life... Occupational therapy can facilitate the integration of work, self-care, and leisure and assist with the transition back to the community to break the cycle of recidivism” p. 39.


Abstract:
Occupational therapy has been integrated into a multidisciplinary consultative clinic that serves a state juvenile correctional system. The areas in which the occupational therapist functions are sensory integration, visual motor training, vocational day care, recreation and crafts, staff training, and student supervision. These services are described as illustrative of the potential use of occupational therapy in a nontraditional setting.

Summary and Significance:
This article described the work done by an occupational therapist hired by an agency providing consultation to the Division of Youth Services of the Commonwealth of Virginia in 1973. The occupational therapist was hired based on research indicating high rates of sensory integrative dysfunction in children at state training schools. The children sent to these schools were all between the ages of 8-18 and had been sent for a variety of reasons including arson, breaking and entering, car theft, and being found “beyond parental control.” The occupational therapist’s role was to determine the incidence of sensory integrative and visual motor problems then begin direct or indirect services to address them. Additionally, the occupational therapist was responsible for orienting institution staffs to occupational therapy services. The article mainly focuses on interventions at the “Bon Air” facilities, housing 150 young men and 50 young women. Some programs conducted in consultation with the occupational therapist included vocational day care training for women ages 15-18 as well as crafts and structured recreational activities for the young people at a variety of ability levels. Sensory integrative screening and therapy was also overseen by the occupational therapist, as was the supervision of occupational therapy and psychology students.
This article focused on a younger population than my project, however, it was still relevant in several ways. Some of the sensory integrative deficits observed in children with behavioral issues seem to carryover into adults with behavior issues based on the accounts of professionals at my site. I would like to look further into the research available on this topic but I was disappointed that the main study mentioned in the article was unpublished and because the article is nearly 40 years old I am afraid this line of research may be difficult to access. The article supports structured recreation for children with behavioral issues stating that, “It is, at least partially, he lack of recreational skills and the inappropriate use of leisure time that has brought many of these children to state care” (p. 539). Some of the ideas for crafts and recreation might be appropriate at CTF including: learning African dances; copper tooling; patchwork; poster design; painting; and “mod podge” (decoupage). I think the most relevant aspect of this article in relationship to my site was the vocational day care training. This program involved 7 young women ages 15-18 who all learned about child rearing in a classroom and during at least 350 hours of practicum working at a day care center. This helped the young women gain important child-rearing skills and knowledge they may not have learned from their mothers, while also promoting “a realistic attitude toward planning their own families” (p.538) by challenging the idea that having children is an easy way to acquire love and attention. At the end of the program, the young women received certificates that could help them find employment as day care workers. Although I could not recreate this program within the structure of CTF some aspects of the program could be incorporated into my work. For example, the article mentions a project in which the women created “low-cost, easily constructed developmental toys.” I would like to look
into some of these toys as projects for my group because women who do not have young
children could still give them away to someone in need.

Occupational Therapy, 32*, 517-524.

*Abstract:*

Presents an historical overview of prison and adult correctional programs. The nature of the
correctional institution, the assumptions about and research on the nature and needs of inmates,
and plans and outcomes of past and present correctional programs are discussed.

*Summary and Significance:*

As stated in the title, this article was an overview of the history, functions, treatment
philosophies, institutional nature, and similarities and differences with psychiatric settings of
correctional institutions. It contains broad background information and suggestions for
practitioners. Penner states that occupational therapy should be provided to inmates on a
voluntary basis but acknowledges that occupational therapists cannot cure criminals. She
establishes a role for occupational therapists, “to provide useful services in innovative,
noncoercive approaches in corrections” (p.523) by promoting coping skills, cooperative group
occupations, and decision-making opportunities. However, Penner cautions that therapists should
not expect to revolutionize the often discouraging world of correctional rehabilitation nor “cure”
inmates. This was the only AJOT article I could find related to prisoner rehabilitation. Penner
did a nice job summarizing literature from outside of occupational therapy and the article was far
ahead of its time in questioning the adequacy of the prison system for deterring crime and calling for the treatment of underlying deficits common in the prison population. A major drawback is that, as an overview, the article is entirely theoretical in nature. Concrete examples or validation for the theories proposed in this article are not provided. In fact, it was unclear whether or not Penner had ever set foot inside a correctional facility or worked with offenders. Her idea of creating occupational therapy programs that are completely voluntary is admirable though probably not feasible. In my opinion, self-motivation is a skill that occupational therapists should address in the course of correctional rehabilitation, not a realistic pre-requisite. On the other hand, coping skills and self-determination, areas Penner emphasizes, are indeed areas in which I have recognized a need.


*Abstract:*

Two senior occupational therapy students at Eastern Michigan University were assigned during consecutive semesters to a Level I fieldwork placement at a Federal correctional institution and were supervised by a faculty member. Each student led a group of men in a life planning and work readjustment program. The program development, implementation, and evaluation of the experience are discussed here.

*Summary and Significance:*
This article describes an occupational therapy program that took place at the Milan Federal Correctional Institution over two semesters as a means of illustrating how occupational therapy can function in non-medical settings. Initially six men who resisted participation in other prison groups were assigned to the weekly meetings led by an occupational therapy faculty member and a selected student from Eastern Michigan University. During the first semester the men were assisted in exploring individual skills and interests in relation to work, leisure and self-care. The men expressed interest in job acquisition skills and were given opportunities to practice filling out job applications and mock interviews which were recorded in order to provide feedback for the men. During the second semester, the program focused on promoting knowledge and skills to facilitate reintegration into the community upon release. This involved informing the members of community resources, practicing money management skills, considering housing options, and discussing debt management. Four of the original six members of the group quit so a new group of 15 men approaching their release were incorporated. The occupational therapists noted that the men became less resistant to expressing themselves and developed more positive attitudes toward society with increasing time in the program. They also pointed out that the occupational therapy students took over increasing responsibility for leading the group over time and the faculty member attended the meetings less frequently.

I thought this was a very interesting article for a number of reasons. The Milan Federal Correctional Institution was one of the inspirations for my project because I drive past it on my way between Toledo and my home. It might be worth trying to locate some of the individuals involved in the project even though it took place over 30 years ago. I was also intrigued by the
fact that undergraduate occupational therapy students were able to lead a group of men convicted of dealing in narcotics, car theft, and armed robbery who were notably uncooperative when it came to prison programming. I found the following quote inspiring:

The student gained leadership skills and effectively handled her own and the group members’ frustrations and disappointments as well as difficult staff relationships. At the semester’s conclusion the student came to believe that the occupational therapist could make a significant contribution in a prison setting.

Although there was some indication, based on the drop-out rate, that the group was not successful and no quantitative evidence that it was, the authors noted that one member was able to set better goals for himself then go on to obtain funding for a college education. In my group I am also encouraging the establishment of positive goals and would consider even one success story of this magnitude to be a positive outcome in a similar population. The use of guest speakers in this program is something I am now considering more seriously for my program because it may have contributed to the inmates’ more positive attitude toward society described in the article. Another good idea for programming found in the article was the creation of a budget based on expected earnings through “reality oriented problem solving.” Although the program in this article dealt with men only, I think those and other program ideas would be just as applicable with women.

Abstract:

This article describes the development of an occupational therapy sheltered workshop program, Opportunities Promoting Self-Responsibility (O.P.S.) for criminal offenders with mental illness. The program promotes the patient’s social participation with regard to community that could perhaps reduce re-incarceration. The most significant of these participatory functions is the ability to fulfill meaningful occupational roles with regard to community and work. The program was created to provide criminal offender patients with therapeutically directed opportunities to develop increased self-responsibility. The definition of role responsibilities, assessment, and treatment approaches are illustrated through case examples of eleven actual workshop participants. The workshop was found to promote patients’ technical skills, performance behavior, social skills, and independent functioning within the occupational role of worker.

Summary and Significance:

This article provides a list of models of practice that have been applied to the forensic setting: the Model of Human Occupation (Lederer, Kielhofner, & Watts, 1985), the Lifestyle Performance Model (Velde & Fidler, 2002), and the Theory of Occupational Adaptation (OA) (Schultz, 1995). The authors applied OA to their “Opportunities Promoting Self-Responsibility (O.P.S) program. O.P.S. was an attempt to promote performance behavior, social and technical skills, and independent functioning, by placing criminal offenders with mental illnesses in the
role of worker in a paper-making, leather-crafting, or ceramics “crew,” using local nursing home residents as customers. The idea of incorporating community interaction with a progression of productive worker roles (trainee, apprentice, and master craftsman) in this program was very inspiring. The occupational therapists I plan to use progression through various roles as well as the community involvement in my programming. Case studies were used to discuss outcomes such as pro-social behavior, problem-solving, internal locus of control, and self-evaluation. The authors also claimed that overall, patients’ statements and behavior indicated increased engagement and satisfaction with themselves and others. They offer advice for others, such as myself, who may want to operate a similar program. They advise therapists to provide challenges and allow patients to struggle for the solution themselves, be flexible, take advantage of every therapeutic opportunity, and encourage patients to use objective information to evaluate their work rather than giving constant praise or affirmation. Standardized assessments or other outcome measures such as recidivism of participants would have strengthened the article, but its main goal seemed to be encouraging and empowering therapists to create of similar programs elsewhere, so it is highly relevant to my project. Although they used a different theoretical framework (OA) our approaches share similar goals and an emphasis on meaningful occupation.


*Abstract:*
This article describes a unique interdisciplinary substance abuse relapse prevention programme conducted by occupational therapy and psychology graduate students under faculty supervision in a northwestern rural United States women's prison. The psychology students taught the inmates the theoretical bases for the programme, trigger identification and coping skills, social support development and assertive communication. The occupational therapy students used activities to help the inmates to identify their values and interests, develop ideas and resources for leisure and jobs, structure and manage their time, practise assertiveness and identify strengths. Although programme effectiveness was not formally measured, it appeared to both the students and the faculty members that the inmates experienced personal growth and that the student therapists gained professional skills in working with another discipline and in leading groups.

Summary and Significance:
This article described a 6-8 week group program for women being incarcerated for up to 120 days as a result of a drug-related offense. The group was led for three weeks by a psychology student, then for one week the occupational therapy and psychology student ran the group together, this was followed by three weeks in which the occupational therapy student led the group, and finally, the two students co-led the last group. A literature review revealed that 70% of women offenders have experienced physical abuse at some point in their lives; women offenders are often introduced to drugs by family members or a male partner; women offenders tend to demonstrate maladaptive thinking patterns such as “black and white” thinking, catastrophic thinking, magical thinking, and a tendency to over-personalize; and understanding a
woman’s life history can uncover strengths that may translate into healthy coping strategies. Related to these concepts, the authors found that the components of an effective treatment program include: instruction on how to be more assertive in maintaining personal rights, training in how to find and maintain employment, problem solving in daily life, recognition of high risk situations that could lead to relapse, relapse prevention techniques, social skills training, and stress management. To create their program, the students and faculty involved in the project used this knowledge along with ideas from the Transtheoretical Model of Change by Prochaska and DiClemente. This model has been cited in other sources and consists of five to six stages: 1. pre-contemplation, 2. contemplation, 3. preparation, 4. action, 5. maintenance, and 6. termination, the last of which may be reached by some people in recovery from substance use disorders only if they no longer face temptation and have achieved total self-efficacy. Using the Model of Change, it is up to the individual, with the nonjudgmental and non-confrontational support of professionals, if and why he or she needs to change. This determination is made by weighing the benefits and hazards of the behavior considered. Motivational interviewing is used to provide support as a part of this model. During group programming, the psychology student begins the group by establishing the rules and asking members to share their history of using drugs and their difficulties with functioning. The psychology student also addresses the basic concepts of lapse, relapse, and relapse prevention based on the Model of Change, the psychological and physiological mechanisms of urges and cravings, coping techniques, and assertive, aggressive, passive, and passive-aggressive communication styles. The occupational therapy student becomes involved at this point by working together with the psychology student to role play the
various communication styles. As the occupational therapy student takes over the group he or she discusses topics such as the importance of healthy leisure, and concepts from the Model of Human Occupation such as volition and habituation. The occupational therapy student also leads the group in various occupations such as completing an interest checklist, brainstorming affordable leisure pursuits, determining personal values, how they influence one's lifestyle, and how they can be discarded during periods of drug use, exploring vocational interests, planning a schedule for after release that incorporates occupational balance, and planning budgets. No formal assessments of the program were conducted due to the difficulty of insuring confidentiality and following-up after release. However, informally, the group received praise from the inmates who felt that it reinforced learning from other classes. While speaking to a rehab counselor after release, many women expressed that the group run by the occupational therapy and psychology students was one of the most life-changing classes they were involved in.

This article described a program developed in part by occupational therapy students and faculty that was delivered to a population very similar to the women at CTF. The women in this program were similar to the women at CTF in that they were serving relatively short sentences for drug-related offenses. The group size was similar, with about 10 women in their groups compared to about 6-26 that are typically involved in CTF groups (including those I have been leading). The group described in this article was led by an occupational therapy student about half the time and another graduate student the other half. The facilities were even similar in that the women were housed in bunks rather than cells. The main difference between the populations
was that the location of the facility in this article was described as “rural Northwest” whereas CTF would be described as “urban Midwest.” The program described in the article is similar to the program I am proposing in that it uses the Model of Human Occupation and the intervention ideas are similar to and/or consistent with topics and occupations I have considered or will, as a result of this article, consider for my program. The Model of Change and Motivational Interviewing have been discussed in many resources I have reviewed so far and will likely be incorporated into my program because they are supported by CTF administration (which recently provided training in Motivational Interviewing for staff). It was reassuring to read that women were not offended, but rather found it helpful, that material covered in the program described was to some extent a review of material from other groups because it is very hard to completely avoid overlap with the other programming at CTF. Fortunately, my site mentor has been supportive of aspects of my program that take a different approach to looking at topics covered in other groups, just as the women in this article were appreciative of the opportunity to continue exploring important issues they had addressed in other programs. The inclusion of psychology students differentiated this program from my own. However, this emphasis on multidisciplinary cooperation and reciprocal input will be a priority in the development of my program. It would have been beneficial for the developers of this program to include some type of formal outcome measure, as the author points out there were no outcome studies published relating to the provision of occupational therapy in a US correctional facility. However, this article provides favorable informal evidence to use in supporting my similar program, as well as numerous citations indicating that occupational therapy programs are under way in some US prisons.

*Abstract:* No abstract available for this resource.

*Summary and Significance:*

This article discussed the role of occupational therapists in treating individuals who present with a substance use disorder. The article was primarily directed toward occupational therapists who encounter individuals with substance use disorders during rehabilitation for another, potentially associated, issue. Wand discusses a few screening tools, including one specifically designed by AA for use with women, that can help identify and define substance use disorders. She acknowledges that recovering persons often resist treatment for this problem or are ambivalent regarding change. When an individual does decide to stop using, the need for a structured treatment environment is well recognized. To facilitate the recovery process, Wand suggests that occupational therapists establish a strong relationship with the client based on understanding and empathy, allow the client time to adjust without strongly confronting denial, promote coping mechanisms as denial fades, explore the client’s goals, allow the client to orchestrate therapy, help the client understand it is his or her responsibility to change, help him or her develop skills for sequencing, organizing, and managing details, and educate the client on the variety of emotional responses that can be expected during treatment and why it is important for his or her health and well-being to stop using. Wand emphasizes the importance of respecting the client’s choices stating, “When the purpose is to facilitate choosing abstinence, it seems counterproductive to remove client choices regarding aspects of treatment” (p.40)
This article was a very valuable resource for providing practical advice for me in working with people in recovery. Some specific suggestions that I plan to implement in my practicum include working toward client-defined goals and encouraging clients to consider how their present behaviors will facilitate achievement of these goals, pointing out discrepancies between behavior and desired outcomes in collaborative problem solving. A group occupation I plan to use at CTF is outlined in this article as Wand suggests therapists help clients design a “toolbox” of coping mechanisms to help relieve stress and drug cravings. This featured some other critical thinking questions that I could use with residents during my practicum such as asking recovering persons why they believe they will be successful, what are some of the advantages of recovery, and what activities drug consumption was preventing them from doing. The article also advocates for the role of the occupational therapist in substance use disorder recovery, stating that cravings and relapse can be related to stress, anhedonia, and dysphoria, which can be mediated through purposeful activity.


Abstract:

Occupational deprivation is a concept which we are in the early stages of conceptualising and defining. However, that does not make it any less real to those who have experienced extended periods of occupational deprivation. This paper outlines an investigation into the occupational world of a group of inmates in one of New Zealand’s largest maximum security prisons. These
inmates were part of a special unit as they were identified as having special needs. The project started in response to a request from the prison to establish an occupational therapy programme in the unit. Through further dialogue it became clear that there were more basic questions that needed to be addressed. What was required was an assessment of the occupational needs of inmates and this was subsequently agreed to and contracted for.

The process of investigation included a time use survey, a review of current levels of occupational engagement of all inmates and an assessment of individual functional skills. Methodological strategies included participant observation, interviewing inmates and staff, reviewing documentation inclusive of policy guidelines, and analysing and interpreting individual assessment data. It was found that rigid policies and practices contributed to an environment in which deprivation from occupation was the norm, and occupational deprivation has historically been used as a form of punishment.

Summary and Significance:

This article describes the work of the author and her colleague, who performed a needs assessment prior to beginning intervention with the a group of prisoners with special needs at a large, notorious, maximum security facility in New Zealand. These adult men were housed in the “assessment block” due to a history of mental illness, borderline intellectual disability, history of self-harm, an inability to cope with mainstream prison life, or threat from other prisoners due to the nature of their offenses. In order to determine occupational needs and ways in which these needs could be met within the organizational context, the two occupational therapists engaged in participation observation, semi-structured interviews with inmates and staff, documentation
review, and assessment of inmates using the AMPS. During participant observation the author was deeply affected by the stark contrast between prison life and her own experiences. She noticed a lack of rituals or activities marking the time of day or differentiating between days of the week. The unit had a strict “no tools” policy for safety reasons which limited potential occupational engagement. The author noted that a computer was present in the recreation room but no software had been purchased for it. The only occupational “bright spot” noted was a fish tank that motivated inmate behavior such that the men would rise at 4:30 AM or trade in cigarettes for opportunities to feed the fish. During semi-structured interviews, staff comments could be summarized by the statement of one employee that “The inmates exhibit the whole range of human deficiencies” (p. 128) these include lack of basic living skills, medication side-effects, ego-centricity, inability to concentrate, low intelligence, lack of trust, lack of insight, and laziness. The level of cooperation and helpfulness of inmates during the interview process was contrary to the negative view presented by staff. Inmates lamented “feeling flat and tired from not doing enough” and they identified sleep as their main occupation. They expressed interest in occupations stating that it would help them focus less on negative thoughts, help them learn new behaviors such as cooperation, trust, and help them keep in touch with the community, and help them become more knowledgeable. They also believed it would be satisfying “bringing a picture in my head to life,” having something to display to others, and having an acceptable means of releasing anger and frustration. Documentation review indicated inconsistency between the ideals expressed in policies, plans, and reports, and the reality of the prison environment. While administrators call for the promotion of dignity, human growth, successful community
reintegration, and occupational opportunities, the author notes that these outcomes are unlikely within the context of prison which lacks the necessary “atmosphere of hope, self-determination, and opportunities to learn new ways of behaving” (p.129). Assessment using the AMPS indicated that all inmates in the unit had significant motor and process skills impairment. To address the needs established during the assessment described, the occupational therapists made recommendations to enhance daily and weekly routines, train staff in a new tool use protocol, and increase access to low risk occupations, in addition to a proposed occupational therapy program. In post script, the author noted that her recommendations had garnered interest but progress was delayed to upcoming privatization of prison systems.

This article is relevant to my project because it describes the initial steps of an occupational therapy program development plan within a prison setting. The setting described in the article was very different from CTF in that there is less obvious occupational deprivation at CTF due to the schedule of self-improvement classes and lower security allowing residents access to writing instruments and other tools (some, such as scissors, requiring observation). However, there is certainly some occupational deprivation present in that residents have little, if any, control over their occupational engagement (including scheduled shower, meal, and bed times) and many occupations, such as discussion groups, are not naturalistic. Women are able to perform laundry and cleaning tasks but must share these responsibilities with other women (with roles given by assignment rather than choice) and perform them at designated times often leading to frustration rather than satisfaction. Similar to the author of this study, I have experienced that staff often express negative attitudes towards the residents. Like the author, I would attribute
these attitudes to continued stressful and/or traumatic staff experiences that have resulted from years of interacting with difficult residents. I can also relate to the author’s sense of awe at the foreignness of life in a correctional facility, as well as her respect for the individuals who endure these limiting environments, and her desire to change them for the better.