NSW GOVERNMENT Health
Justice Health &
Forensic Mental Health Network

The Violence Reduction Program Forensic Mental Health (VRP-FMH)

Facilitator's Manual©
Version 1

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also co-developed he Violence Reduc ion Program-Forensic Men al Heal h (VRP-FMH) version.

Note: The Violence Reduc ion Program (VRP) was designed o reduce violence and an isocial behaviours among violence-prone forensic clien s wi hin bo h criminal jus ice and forensic men al heal h se ings. The program has been used in bo h se ings and has been found o be useful for forensic pa ien s, inclusive of hose wi h men al heal h disorder ha is sufficien ly s abilized o facili a e such rea men par icipa ion. The VRP developers are sensi ive o he impor an differences be ween clien s in hese wo se ings and have endeavoured o use narra ives in he manuals ha are applicable o bo h groups. In mos ins ances, he erm 'par icipan ' is used o describe individuals par icipa ing in he VRP. If and when erms such as *'offen e '* or *'pa ien '* are used, hese are in ended o be generic and should be considered as applicable descrip ors for clien s in all se ings.

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Preface

The Violence Reduc ion Program (VRP) was ini ially developed as a high in ensi y rea men program for offenders wi h a his ory of violence, some of whom also have significan men al heal h concerns. In response o he need for a violence reduc ion program ailored for he Forensic Men al Heal h con ex , and a he reques of he Jus ice Heal h & Forensic Men al Heal h Ne work (JHFMHN) in New Sou h Wales, Aus ralia, adap a ions of he VRP were made o produce he VRP-Forensic Men al Heal h version (VRP-FMH).

In he VRP-FMH, he key principles of he VRP rea men approach, such as he 3-Phase rea men pa hway, he use of he Violence Risk Scale and S age of Change assessmen s, he 24/7 rea men approach, as well as he broad con en of VRP are re ained. Two addi ional sec ions were added o address men al heal h-specific needs.

Addi ional revisions include in egra ing ma erial from he VRP Supplemen ary Manual for Facili a ors in o appropria e places wi hin he VRP-JH Facili a or's Manual for ease of access o he ma erial; he VRP Par icipan 's Workbook was similarly revised. The JHFMHN also sugges ed ha a more guided and session-based forma may offer some advan age over he exis ing VRP organiza ion and be be er sui ed for program delivery in heir services. As a rial projec , he VRP-FMH was re-organized in o 20 sessions in he adap ed Facili a or's Manual as well as he Par icipan 's Workbook. The pros and cons of he exis ing VRP delivery approach and he revised session-based forma will be assessed af er several rial applica ions of he VRP-FMH, i is a work in progress. Wi h he excep ion of he above adap a ions, users of he VRP-FMH will see more similari ies han differences be ween he original and he adap ed VRP.

The adap a ions were comple ed by Sarah Wells and Panayio a Zingirlis and overseen by Dr Vindya Nanayakkara of he JHFMHN in consul a ion wi h he VRP au hors. The VRP-FMH is in ended for use by NSW Forensic Men al Heal h services only under he governance of JHFMHN. Commen s on he VRP-FMH and he VRP are welcomed.

Audrey Gordon and S ephen Wong
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Violence Reduction Program-Forensic Mental Health (VRP-FMH) - Facilitator's Manual

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Program Objectives:
The main objec ives of he VRP is o decrease he frequency and in ensi y of aggressive behaviours, o decrease or elimina e he an isocial beliefs and a i udes ha suppor he use of aggression and violence, and o facili a e he use of appropria e in erpersonal skills ha are effec ive in reducing he risk of fu ure violence.

Theoretical Orientation and Principles of the VRP:
The VRP is designed based on cogni ive behavioural and social learning principles. I also incorpora es a relapse preven ion model and uses an incremen al learning approach. A modified S ages of Change (SOC) Model (Prochaska & DiClemen e, 1986; Prochaska, DeClemen e & Norcross, 1992) is used in he VRP o guide he selec ion of s ra egies, echniques, and he in erim objec ives ha are consis en wi h he responsivi y charac eris ics of VRP par icipan s. In addi ion o having a good overall unders anding of he heore ical principles underpinning he VRP, rea men facili a ors should also be knowledgeable on general group and individual processes of rea men delivery. Prior o delivering he VRP, facili a ors are encouraged o refer o Appendix B, which con ains 'References and Recommended Readings'.

Prior o commencing he VRP, each par icipan should be horoughly assessed using he Violence Risk Scale (VRS, Wong and Gordon, 2000, 2006; see Appendix C for a lis of VRS S a ic and Dynamic Variables) o iden ify criminogenic fac ors ha will serve as rea men   arge s. Addi ional assessmen   ools can be used as required. The VRS uses a modified SOC Model o de ermine he clien 's rea men readiness pre and pos   rea men   o assess rea men changes during and subsequen   o par icipa ion in he VRP. Wi h rea men , posi ive behaviours should become more s able and sus ainable. Progression hrough he s ages of changes has been empirically linked o reduc ions in violen recidivism (Lewis, K., Olver, M., & Wong, S. C. P., 2009).

The VRS assessmen can guide facili a ors in developing rea men plans ha address relevan criminogenic need areas and also in he selec ion of appropria e clinical s ra egies and relevan   rea men goals ha correspond wi h he individual's SOC (VRP-FMH Facili a or's Manual Phase 1).

There are many fac ors ha influence progress hrough he SOC. For example, less mo iva ed clien s who commence he program in Pre Con empla ion or Con empla ion s ages will obviously ake longer o reach he Main enance s age in comparison o a more mo iva ed and advanced par icipan who s ar s he program in he Prepara ion s age. As such, i is expec ed ha no all VRP par icipan s will successfully progress o he Main enance S age wi h one 'dosage' of VRP. I is recognised ha   rea men is an ongoing process wi h he par icipan con inuing o learn, generalize and prac ice skills and s ra egies learned in he VRP well af er he

end of he formal program. Some clien s may need o repea he program if discharged prema urely due o problem behaviours. O hers may par icipa e in addi ional communi y or hospi al based main enance programs or addi ional voca ional or o her ac ivi ies ha can fos er he in ernaliza ion and generaliza ion of wha is acquired in he VRP. Wi hin he VRP concep ualiza ion, he end resul of a successful rea men journey is he even ual achievemen of he Main enance S age of Change. However, like all journeys, no everybody who s ar s he journey ravels o he end bu each s ep is viewed as successful progress in he righ direc ion and should have some posi ive impac on he reduc ion of violence behaviours.

VRP '24 /7 Treatment Principle'

A founda ional premise of he VRP is he no ion ha rea men is 24/7, ha is, rea men and change are ongoing in he individual's daily ac ivi ies wi hin he en ire environmen where he VRP is si ua ed. Ra her han viewing he VRP as an in erven ion ha happens only in a group room or during individual herapy work, he au hors view all aspec s of he par icipan 's environmen as an ex ension of formal rea men ac ivi ies. In shor , al hough clien s may par icipa e in group or individual work o learn abou risk reduc ion rela ed concep s and ac ivi ies, i is he fur her learning and prac ice of skills in heir daily lives, albei of en wi hin a highly con rolled environmen , ha will bring he problems and learning's o life. S aff can also use he oppor uni ies o observe he behaviours of he par icipan s under a varie y of si ua ions o de ermine if changes are s able, generalizable and sus ainable.

Evalua ions of rea men impac should occur over ime and place and no be res ric ed o ime spen in formal rea men in erven ions. Observa ions based only on formal rea men ac ivi ies are highly selec ive as individuals ypically spend much less of heir waking hours par icipa ing in formal rea men based rea men ac ivi ies rela ive o o her hospi al ac ivi ies and rou ines. In day o day living si ua ions, here are more oppor uni ies for he individual o prac ice heir learned skills and for s aff o make observa ions under differen condi ions and challenges. For individuals unwilling or unable o "walk he alk", i is unlikely ha rea men will have been effec ive.

Any employmen oppor uni ies, educa ion, recrea ional ac ivi ies, in erac ions wi h s aff and wi h peers e c., all serve o augmen he learned skills by providing oppor uni ies o prac ice and generalize hem o a varie y of si ua ions and circums ances. To his end, all s aff ha come in con ac wi h he VRP par icipan should have a general awareness of he program in order o suppor he par icipan s' change process. I follows ha he sharing of informa ion regarding he performance of VRP par icipan s be ween all hose who come in o con ac wi h hem is an essen ial componen of he program.

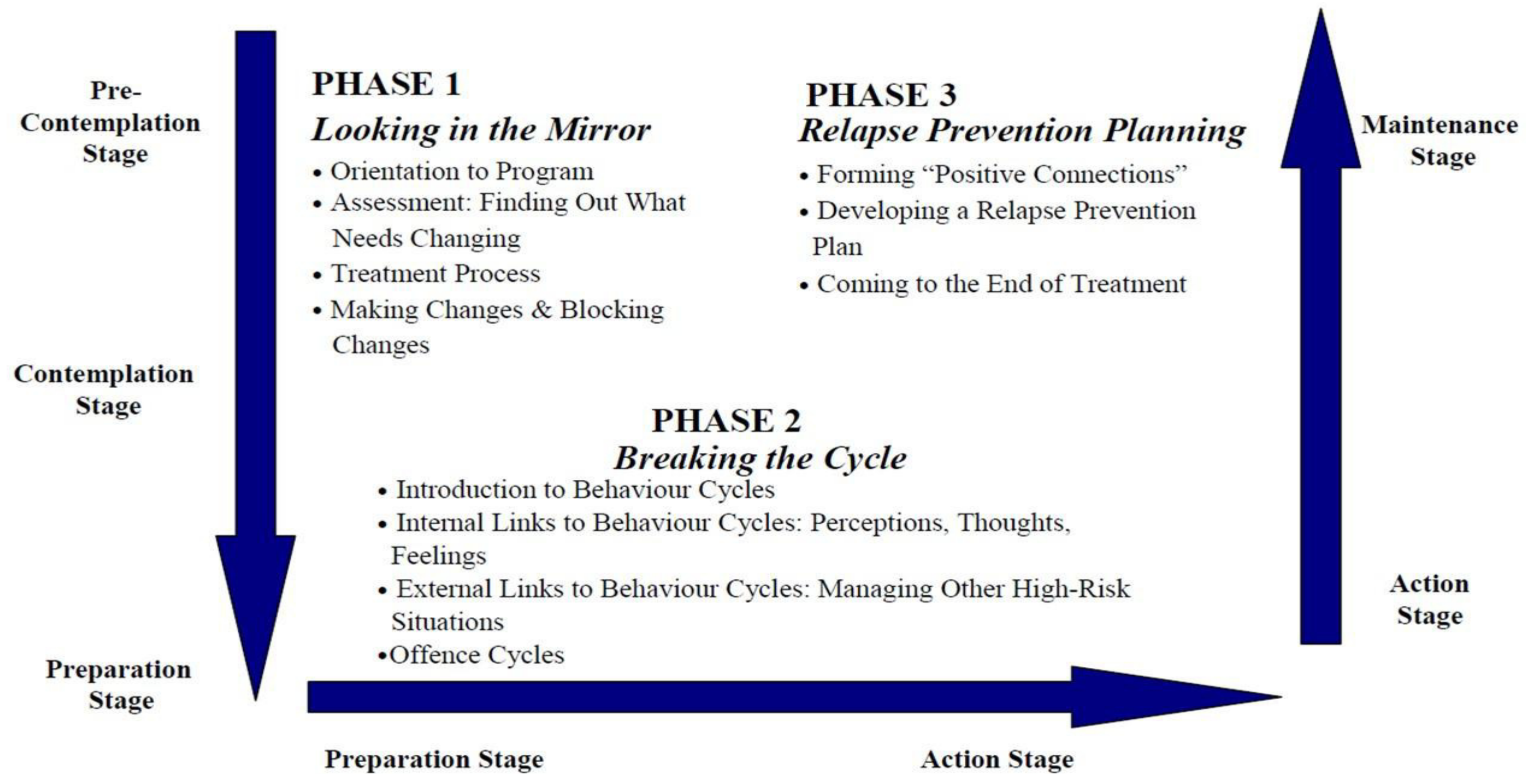
Program Design & Content:
The VRP is delivered based on he Three Phase Trea men Delivery Model (Gordon & Wong, 2000). Figure 1 illus ra es he Model and depic s he rela ionships be ween he general program con en and he S ages of Change wi hin each of he phases. Phase 1 of he VRP, *Looking in he Mi o ,* focuses on enhancing he par icipan 's unders anding of he origins and main enance of aggressive behaviours, he iden ifica ion of rea men arge s, and developing herapeu ic alliance. Phase 2, *B eaking he Cycle*, focuses on he acquisi ion of relevan skills o res ruc ure and change emo ional, cogni ive, and behavioural pa erns, iden ified in Phase 1, ha influence aggression and violence. Phase 3, *Relapse even ion,* emphasizes he developmen of an overall plan and he generaliza ion of skills and s ra egies, learned hroughou he VRP, o a varie y of con ex s and si ua ions o mi iga e he risk of violence. There are behavioural objec ives se for each phase and heir successful a ainmen is required for he progression from one phase o he subsequen phase.

Miles one celebra ions are s rongly encouraged a he end of each Phase and a o her significan poin s hroughou he program, for example, or following he presen a ions of disclosures, offence cycle, or relapse preven ion plans. As much as possible, aking in o accoun hospi al regula ions, par icipan s should be involved in planning he celebra ion (e.g., ype of food, beverage, music, ac ivi ies, who hey wish o be in a endance, e c.). Miles one celebra ions provide valuable oppor uni ies for s aff o congra ula e and reinforce posi ive changes and behaviours and o model appropria e in erpersonal skills and behaviours. In addi ion, such celebra ions serve o s reng hen herapeu ic alliances and enhance mo iva ion.

The con en of he VRP program is designed o address rea men arge s commonly found wi hin a violen offender popula ion. Supplemen ary or al erna ive in erven ions, program ma erial and ac ivi ies ha mee he module objec ives can be used o enhance he par icipan 's unders anding and in ernaliza ion of program con en . A Glossary of Terms is included (see Appendix A) which provides a brief descrip ion of some key erms.

To fur her maximize rea men efficacy, if ime permi s, program deliverers are encouraged o incorpora e o her effec ive in erven ions ha hey may be curren ly delivering as an addi ional means o mee VRP module/program objec ives. For example, Dialec ical Behavioural Therapy sessions would fi well wi h he VRP *In e nal Links o Behavio Cycles: Feelings* module and Schema Therapy would correspond well wi h *In e nal Links o Behavio Cycles: Tho gh s an A i es*). O her ypes of skills based in erven ions/programs (e.g., subs ance abuse, domes ic violence, e c.) can be incorpora ed in o Phase 2 of he VRP while rea men main enance work would fi well in Phase 3. The general principle is ha any in erven ion ha is incorpora ed in o he VRP should be delivered a he appropria e ime (e.g. Phase 3 ype in erven ions should no be in roduced during Phase 1 and should complemen he corresponding module and phase objec ives).

Figure 1



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