Review of Programs for Young Offenders at St. Lawrence Youth Association

by

Caroline Fleming

A thesis submitted to the School of Community Services
in partial fulfillment of the requirements for
the degree of
Bachelor of Applied Arts in Behavioural Psychology

St. Lawrence College
Kingston, Ontario
Canada.
April 11, 2008
DEDICATION

This thesis is dedicated to the Behavioural Psychology program of St. Lawrence College with hope that it will assist in future research in the area of young offenders.
ABSTRACT

The purpose of this thesis was to determine the most significant areas of services for young offenders at the St. Lawrence Youth Association and to review the treatment programming for these areas in two young offender facilities. Recommendations were made to the agency regarding best practices for treatment. Six areas were reviewed: emotion regulation; self-harm; sexuality; relationships; coping with physical abuse and stress management. The areas to be reviewed were determined by the pattern of staff ratings on the Youth Offender Needs Questionnaire (YONQ). In this survey, facility staff and managers rated the areas of services of importance to their young offenders. Dialectical Behaviour therapy (DBT) was suggested for use in treating emotional regulation and self-harm. It was recommended that the agency continue to use the Girls’ Group modules with specific alterations for the areas of sexuality and relationships. A trauma-focused cognitive-behaviour program and treatments addressing post-traumatic stress disorder was recommended for use in the area of coping with physical abuse. Finally, cognitive-behaviour therapy (CBT) was recommended for stress management. Limitations of this study include a low response rate of the YONQ (50%) and short timeframe for research on treatment programs. Strengths of the thesis include providing the agency with a review effective treatment programs for its residents and benefiting young offenders by offering appropriate treatment for their specific need areas.
ACKNOWLEDGEMENTS

I would like to express gratitude to Martha McCann, Valerie Souliere, Gary Bernfeld, Marie-Line Jobin, as well as and Rob Rowe and the staff at the St. Lawrence Youth Association and its facilities, for their encouragement and assistance during the writing of this thesis. Were it not for their support, this thesis would not have been possible. Many thanks.
LIST OF TABLES

Table 1 ................................................................................................................................. Chosen Need Areas 3
TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEDICATION</td>
<td>ii</td>
</tr>
<tr>
<td>ABSTRACT</td>
<td>iii</td>
</tr>
<tr>
<td>ACKNOWLEDGMENTS</td>
<td>iv</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>v</td>
</tr>
</tbody>
</table>

CHAPTER

I. INTRODUCTION ........................................................................................................ 1

II. METHOD

Participants ................................................................. 2
Materials .......................................................................... 2
Procedure ......................................................................... 2
Preliminary Results ....................................................... 3

III. LITERATURE REVIEW AND RESULTS

Emotion Regulation ......................................................... 4
Self-Harm ......................................................................... 6
Sexuality ......................................................................... 8
Relationships .................................................................... 10
Coping with Physical Abuse .......................................... 11
Stress Management ........................................................ 13

IV. DISCUSSION

Strengths and Limitations ............................................... 15
Multilevel Challenges to Service Implementation ............. 16
Contribution to the Behavioural Psychology Field ............ 16
Future Research ............................................................ 16

REFERENCES ....................................................................... 18

APPENDICES

Appendix A: Young Offender Needs Questionnaire (YONQ) ......... 21
Appendix B: Current Programs Implemented At Sundance ........... 22
Appendix C: Current Programs Implemented At Achievement St. Lawrence .... 24
Appendix D: Youth Offender Needs Questionnaire Results .......... 27
Appendix E: Key Concepts in the Recommended Treatments ......... 28
Appendix F: Summary of Recommendations Made to Agency ........ 29
Appendix G: Summary of Stress Inoculation Treatment Phases ....... 31
CHAPTER I - INTRODUCTION

While many types of young offenders with different needs pass through custody and detention facilities, the programming for these offenders remains the same. Treatment programs at these facilities are utilized for long periods of time without being re-evaluated to see if they are meeting the various needs of young offenders. While the agency is using the programs they are familiar with, current research and findings may prove these treatment programs to not be as effective as recently developed programs. New approaches to treatment that are more promising in meeting the many needs of young offenders may have been found since the introduction of the programs and methods used at some facilities.

It is important for facilities treating young offenders to be familiar with the research literature on best practices. This way, if the current programs that are being run at a young offender facility prove not to be as effective as more recently developed programs, the facility can update their treatment in the best interest of the youth that they are targeting.

Gender differences must also be kept in mind when reviewing treatment programs since male and female young offenders struggle with the same issues, but present them in a different manner. For example, a male may express anger by physically assaulting others, whereas a female may express anger through the cutting behaviours seen in self-injury. Male and female young offenders differ not only in their expression of their issues, but in developmental experiences, aetiology and thus presents differences in treatment implications (Aalsma & Lapsley, 2001). Male and female youth offenders may have similar needs (treatment for conduct disorder, depression, aggression, etc.) but the way in which these needs are addressed differs. As cited in Mullis et al. (2004), Acoca (1999) states that programs “ought to comprehensively address the specific needs of girls, recognize the risk factors most likely to impact girls, and capitalize on the protective factors most likely to build the resiliency of girls” (p. 9).

At the request of the St. Lawrence Youth Association (SLYA), a review of the various treatment programs the agency used in its facilities was conducted to ensure the programs were effective and identical. The St. Lawrence Youth Association had two facilities for young offenders: Sundance (all female) and Achievement St. Lawrence (ASL; both male and female). Literature reviews were conducted to determine the efficacy of the treatment programs used at both facilities and to search for more beneficial programs to address the various needs of youth offenders. Recommendations were made to the agency regarding improving current programs or adding new ones to better treat the needs of young offenders as well as the cost benefits of doing so.

The purpose of this thesis was to review group treatment programs utilized at SLYA and to make recommendations for improving the quality of the treatment young offenders receive while at the facilities by keeping up to date with best practices that have been shown to be effective in recent research.
CHAPTER II - METHOD

Participants
Participants for this thesis include the facilities Sundance and Achievement St. Lawrence of the St. Lawrence Youth Association. It aims at providing the agency with effective programming that can be used to treat young offenders for long- or short-term stays. The thesis is also designed for the young offenders at the facilities who can benefit from having an effective treatment program that address their needs while taking into account their length of stay. The Sundance facility houses only female residents, whereas Achievement St. Lawrence holds both male and female residents. Based on a review of 2007 files, approximately 60% of the residents at Achievement St. Lawrence were female and 40% were male. Age ranged from 12-17 at both facilities.

Materials
The Young Offender Needs Questionnaire (YONQ) was developed in order to determine which female young offender need areas are most important to address in terms of treatment programming (see Appendix A). A 30-item list consisting of areas relevant to young offenders was compiled. The person filling out the questionnaire is asked to choose 12 areas they feel are most crucial to address and then rate these 12 areas in order of the importance (with “1” being the most important and “12” being the least). Ten copies of the YONQ were given out – one to the manager and three to the frontline staff of each facility, one to the clinical director and another to the community programs manager.

Procedure
In order to complete this thesis, the following steps were taken:
1. Review current programming in both St. Lawrence Youth Association Facilities (see Appendices B and C)
2. Create a list of issues and disorders addressed by current programming at the association (ex. substance use and abuse)
3. Develop questionnaire to be answered by frontline staff and managers at the facilities to determine key need areas
4. Operationally define “best practices” to create criteria for judging efficiency of a program
5. Review literature on subjects relevant to the needs of male and female youth offenders to be examined further
6. Review literature on clinical needs of adolescent females (non-criminogenic needs; those not pertaining to criminal activity)
7. Based on the preliminary literature review and results of the questionnaire, need areas are chosen for further examination
8. Brief the manager and director of treatment services on need areas chosen, to ensure that they agree with these as important areas to be reviewed
9. Conduct a literature search on current programming to find if programs have demonstrated validity
10. Perform another literature search on additional programs that may be more effective for the issues and disorders identified as important
11. Analyze and assess data gathered in order to provide recommendations (including cost benefits) for improvements to existing programs and additional programming for each need identified by the literature review and questionnaires

12. Submit draft to manager for feedback and modify recommendations based on his suggestions

13. Submit final report to manager

**Preliminary Results**

Eighteen copies of the YONQ were distributed to frontline staff and managers of both facilities. Nine were received resulting in a 50% response rate. The importance of the need areas were scored by recording the number of times it was chosen to be an important need area and then finding the mean score for each need area by adding the rankings together and dividing it by the number of times chosen.

The following are the top 12 need areas deemed to be most important; (1) cognitive distortions, (2) substance use and abuse, (3) emotion regulation, (4) anger management, (5) self-harm, (6) sexual abuse, (7) stress management, (8) conduct problems, (9) eating disorders/body image, (10) coping with abuse (physical), (11) relationships, and (12) sexuality. ‘Cognitive distortions’ was the top need area and was chosen 7 times with a mean ranking of 3.4. ‘Personal hygiene’ and ‘grief and loss’ were not selected at all. For more results see Appendix D.

Based on the results of the YONQ, the need areas listed below were chosen to be reviewed further. This author chose to examine 6 of the 12 areas while a colleague will focus on the other 6 areas (see Table 1).

Table 1

**Chosen Need Areas**

<table>
<thead>
<tr>
<th>This Author</th>
<th>Colleague</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotion Regulation (3)</td>
<td>Cognitive Distortions (1)</td>
</tr>
<tr>
<td>Self-Harm (5)</td>
<td>Substance Use and Abuse (2)</td>
</tr>
<tr>
<td>Stress Management (7)</td>
<td>Anger Management (4)</td>
</tr>
<tr>
<td>Coping with Physical Abuse (10)</td>
<td>Sexual Abuse (6)</td>
</tr>
<tr>
<td>Relationships (11)</td>
<td>Conduct Problems (8)</td>
</tr>
<tr>
<td>Sexuality (12)</td>
<td>Eating Disorders/Body Image (9)</td>
</tr>
</tbody>
</table>
CHAPTER III - LITERATURE REVIEW AND RESULTS

Emotion Regulation

Definition. Emotion regulation enables one to recognize, monitor, evaluate, and modify the way they react to various stimuli and situations (Phillips & Power, 2007). It involves being able to recognize an emotional reaction, monitor the behaviour displayed during the reaction, evaluating the positive and negative outcomes of the behaviour and modify the behaviour to produce more adaptive solutions. If one cannot properly recognize and express emotions in a prosocial and adaptive way, this leads to emotion dysregulation which affects the individual’s ability to function appropriately (Kostiuk & Fouts, 2002). Poor emotion regulation may result in an inability to make accurate evaluations and to make decisions regarding appropriate behaviours in various settings (Kostiuk & Fouts).

Emotional experiences tend to be intensified at the onset of adolescence (Silk, Steinberg, & Morris, 2003). If the adolescent does not learn to identify emotions (frustration, anger, disappointment, sadness, etc.), he/she may develop maladaptive ways to express these emotions. Maladaptive coping mechanisms can include violence towards self or others and avoidance of issues by refusing to talk, dropping out of school, running away from home or engaging in substance abuse. These methods of coping have been found in many adolescents with conduct problems, especially females (Mullis, Cornille, Mullis, & Huber, 2004).

Link to Conduct Disorder. When adolescents learn to express their emotions in criminal ways (most commonly assault), they enter into the justice system as young offenders. Studies have shown that at least 20% of young offenders have emotional problems (Otto et al., 1992; Loeber & Farrington, 1998; Stewart & Trupin, 2000, as cited in Trupin, Stewart, Beach, & Boesky, 2002). Studies with male young offenders have shown a connection between emotion dysregulation and antisocial behaviour (Trupin et al., 2002).

In a study by Kostiuk and Fouts (2002), four adolescent girls with conduct disorder from a residential treatment program were interviewed to determine their understanding of their emotions and ways to express them. It was found that all four girls could not describe the behaviours or feelings of calmness and therefore could not describe how to achieve a feeling of calmness. The lack of understanding of the emotion itself is said to contribute to the girls’ inability to calm themselves during negative times. Overall the four girls had difficulty identifying internal feelings of emotions and techniques to decrease/increase negative and positive emotions.

Link to Mental Health. Problems regulating emotions is a component of emotional disorders and mental illnesses (Moses & Barlow, 2006). It can be seen in affective disorders such as bipolar disorder, major depression, dysthymia, cyclothymia, behavioural, emotional, and substance use disorders (Trupin et al., 2002). Emotion dysregulation has also been seen in eating disorders (Safer, Telch, & Agras, 2000). According to Gross (1999, as cited in Phillips & Power, 2007), poor emotion regulation is shown in over half of the DSM-IV Axis I disorders and in all of the Axis II disorders.

Because lack of emotion regulation is a component of many different disorders and mental illnesses, many young offenders would benefit from having specialized treatment to aid them in identifying, monitoring, evaluating, and modifying their emotions. Treatment that
enhances emotion regulation would not be geared towards one particular group of young offenders, but all young offenders who suffer from personality, mood, behaviour and emotional disorders, substance abuse, and other mental illnesses such as depression and eating disorders.

**Missing Elements in Agency Programming.** Currently there are no treatment programs at either the Sundance or Achievement St. Lawrence facilities that address a broad variety of emotions. One can argue that issues with regulating certain emotions can be addressed in programs specifically for that emotion. For example, a young offender who has difficulty expressing anger appropriately and does so through physical aggression may be treated with an anger management treatment program. This tactic may benefit the individual in terms of dealing with their anger but it does not touch on other emotions. An important part of emotion regulation is being able to distinguish the difference between various emotions and find the right coping technique for each emotion.

Another limitation with treating single emotions versus multiple emotions is that more treatment programs would be needed to treat different emotions. For example, a young offender may attend one treatment program for issues with anger, another for issues with sadness and another for issues with binge-eating. This can be time consuming and costly in an attempt to acquire all the programs needed for each area. Instead, a treatment program for emotion dysregulation would touch on all these areas and provide young offenders with techniques of recognizing and coping with not just one, but all of their emotions.

**Dialectical Behaviour Therapy.** Dialectical Behaviour Therapy (DBT) is a type of cognitive behaviour therapy originally developed by Marsha Linehan to treat borderline personality symptoms. Linehan’s (1993) *Skills Training Manual for Treating Borderline Personality Disorder* is divided into four modules: Mindfulness, Interpersonal Effectiveness, Emotion Regulation and Distress Tolerance (Mahari, 2003). Each section contains worksheets to help the individual achieve the goals of each section.

Mindfulness encourages the individual to differentiate between rational and irrational states of thinking. Interpersonal effectiveness involves using skills to obtain objective, relationship and self-respect effectiveness (Linehan, 1993). Emotion regulation, perhaps the most important section in the manual, helps the individual to identify and label emotions and their purposes, decrease emotional suffering by reducing vulnerability to intense emotions, increase positive emotions and to change the outlook on emotions and the behaviours expressed when possible (Linehan, 1993; Safer, Telch, & Agras, 2000). Finally distress tolerance helps the individual to find prosocial, alternative strategies to cope with emotional situations (Linehan, 1993).

Because emotion regulation is such a large part of DBT, many young offenders with different disorders can benefit from emotion regulation therapy. Although the program was developed for those with borderline personality disorder, it has been adapted to treat other populations such as young offenders. According to Trupin et al. (2002), “The prevalence of emotional dysregulation including symptoms of BPD among incarcerated female juvenile offenders suggests that DBT may be an effective strategy for this population” (p. 122).

In a study by Evershed et al. (2003), DBT was used to treat male forensic patients with an emphasis on anger and violence. The DBT treatment included a weekly group and individual sessions for 18 months. When compared to another group of patients who received treatment as usual (TAU), DBT patients reported greater reduction in seriousness of violence-related
incidents, hostility, cognitive anger, disposition to anger, expression of anger and anger experience (Evershed et al.).

DBT has been adapted for many adolescent populations such as those with eating disorders (Safer et al., 2000) and inpatient and outpatient forensic patients (Trupin et al., 2002). The successful adaptations have shown that DBT is effectively generalisable to populations other than those with BPD (Trupin et al.). This is promising treatment to apply to young offenders who suffer from emotion dysregulation.

**Recommendations.** Based on the empirical support for the use of DBT, it is recommended that it be used in the facilities to improve emotion regulation in young offenders. DBT is best held in group sessions where young offenders can learn and share coping mechanisms with each other. Since patient-therapist relationship is a key component of DBT, it is recommended that someone who has a good relationship with the youth run the program. This could be a staff member or manager of the facility. Linehan’s *Skills Training Manual for Treating Borderline Personality Disorder* is available for purchase online at a low cost and handouts from the manual have been released by Linehan and are available online for no cost. Since DBT is an effective, low-cost, easy to implement treatment program, it is recommended for use at the agency’s facilities to treat emotion dysregulation.

**Self-Harm**

**Definition.** Self-harm has been referred to by many other names. Self-harm may also be called self-injurious behavior (SIB), self-inflicted violence, self-abuse, non-suicidal self-injurious (NSSI) behaviour (Muehlenkamp, 2006), deliberate self-harm, self-injury, self-mutilation (Whitlock, Powers, & Eckenrode, 2006) or, most commonly used by those who self-injure (SI), cutting. People who self-injure can do so in many ways. The most appropriate definition of SIB refers to a variety of behaviours in which an individual purposefully inflicts enough harm to his or her body to cause tissue damage. This can be done by cutting, carving, burning, or scratching the skin, ripping or pulling the skin or hair, bruising, breaking bones (Whitlock et al., 2006) or interfering with wound healing. Those who engage in self-harm usually do so by cutting themselves with razors, knives, scissors or other sharp objects, but methods can also include burning, hitting themselves or extreme head banging, continuous scratching of the skin and interfering with would healing. Common places of injury include arms, legs, thighs and chest and they make efforts to hide their marks or come up with explanations beforehand -- the most common being “the cat scratched me”.

The onset is typically in late childhood to the early teens. In a study by Nock and Prinstein (2004) the mean age of onset was 12.8 years. They noted that SIB can persist anywhere from 10-15 years to decades. Many adults who engage in self-harm report beginning in their early teens. SIB is most common among adolescents and more common in females than males (Whitlock et al., 2006). In the study by Nock and Prinstein (2004), 74.2% of the adolescents who engaged in acts of self-harm were female and 25.8% were male. Rates of self-injurious behaviour are also larger than one would assume. According to Briere and Gil (1998) as cited in Stone and Sias (2003), 4% of the general population and 21% of clinical clients engage in SIB. Referring again to the Nock and Prinstein (2004) study, 82.4% of adolescents in the sample had engaged in at least one act of self-harm during the past year. Bowen and John (2001) reviewed
trends in SIB between 1985-1995 and found a 62.1% increase in males and 42.2% increase in females.

**Missing Elements in Agency Programming.** As with emotion regulation, there are currently no treatment programs at the agency’s custody facilities that address self-harm. This is unfortunate due to the fact that self-harm tends to be a component of many disorders. Self-injurious behavior is not only common on its own, but is co-morbid with borderline personality disorder, eating disorders, posttraumatic stress disorder, depression, anxiety disorders, and a history of abuse or trauma (Whitlock et al., 2006). These disorders are found in many male and female young offenders and therefore many would benefit from a treatment program that addresses SIB.

If self-harm occurs with another disorder, it is unlikely that it would be become a focus of treatment. For example, if a young offender is undergoing treatment for an eating disorder or substance abuse disorder, it is unlikely that the treatment would appropriately address self-harm, even though it is a problem in both cases. Like the example with emotion regulation, the young offender then may have to attend more than one treatment program which can be time consuming and costly.

**Dialectical Behaviour Therapy and Self-harm.** Research has been conducted for various treatments for SIB. According to Muehlenkamp (2006), there is little empirical data offering treatment guidelines for SIB. Wester and Trepal (2005) claim that no one treatment is the most effective for treating SIB. There are treatments, however, that have proven to be beneficial.

Dialectical Behaviour therapy (DBT; Linehan, 1993) is one of the few treatments that focus on self-injurious behaviour and is based on problem solving, skills training, and cognitive-behavioural interventions (Muehlenkamp, 2006). According to Muehlenkamp (2006):

- To reduce SIB, DBT strategies include (a) validation of the client’s experiences; (b) problem-solving techniques, including behavioural analyses of the self-injurious behaviour or suicidal behaviour along with teaching of adaptive coping behaviours; (c) behavioural skills training in mindfulness, emotion regulation, interpersonal effectiveness, and distress tolerance; and (d) contingency management strategies (p. 171).

DBT has been shown to be effective in reducing self-harm in individuals with borderline personality disorder (Muehlenkamp). Randomized clinical trials of DBT have shown to be effective in reducing acts of SIB 6 months after treatment (Koons et al., 2001; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; Linehan et al., 2002; Verheul et al., 2003 as cited in Muehlenkamp, 2006). Shearin and Linehan (1994) found that DBT was more effective than “treatment as usual” in reducing the frequency and severity of SIB across two studies with a total of 44 patients (as cited in Muehlenkamp, 2006). Those treated with DBT have reported improvements in coping beliefs, depressive symptoms, suicide ideation, and impulsiveness (Low, Jones, Duggan, Power, & MacLeod, 2001, as cited in Muehlenkamp, 2006). A review by Comtois and Linehan (2006) found that outpatient and brief psychological treatments were effective for patients following a suicide attempt or other acts of self-injury.

More and more, SIB is being recognized as a coping technique. According to Whitlock et al. (2006), “self-injury is used to alleviate distress temporarily rather than to signal the intention to end one’s life” (p.409). Those who engage in SIB claim that these acts of harm are what enable them to deal with the stress of life and help them go on. If SIB is used as a maladaptive coping mechanism, then it is possible to provide adaptive coping mechanisms. “Alternatives can
be a substitute for SIB because they can provide similar sensations or visual stimuli as the original SIB without tissue damage” (Wester & Trepal, 2005, p.181).

**Recommendations.** Based on the empirical support for the use of DBT, it is recommended that it be used in the facilities to treat self-harm in young offenders. DBT is best held in group sessions where young offenders can learn and share coping mechanisms with each other. Since patient-therapist relationship is a key component of DBT, it is recommended that someone who has a good relationship with the youth run the program. This could be a staff member or manager of the facility. Linehan’s *Skills Training Manual for Treating Borderline Personality Disorder* is available for purchase online at a low cost and handouts from the manual have been released by Linehan and are available online for no cost. Since DBT is an effective, low-cost, easy to implement treatment program, it is recommended for use at the facilities to address self-harm.

**Sexuality**

**Definition.** Not only does sexuality include the performance of sexual acts, but encompasses how one expresses themselves as well (Rye & Meaney, 2007). One can express their sexuality through the clothes they wear, the language they use, the movies they watch and even the books they read. Most definitions do not incorporate a more subjective side of sexuality and tend to focus on the basic, physical aspect (intercourse, masturbation, etc.). While this information is vital in order to make positive, well-informed choices, the emotional side of sexuality cannot be ignored. As cited in Coleman (2002), the World Health Organization (1975) produced this very fitting definition of sexuality: “Sexual health is the integration of the somatic, emotional, intellectual, and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication and love” (p. 3).

Adolescence and early adulthood is a time for exploring and discovering sexuality, both alone and with others (Wallmyr & Welin, 2006). Sexuality as a need area for young offenders pertains to the acceptance of one’s sexual orientation and identity. Knowing and being comfortable with one’s attraction to the same or opposite sex and other aspects of sexuality or romance can play a major role in the definition of a healthy self-esteem and sexuality.

**Link to Self-Esteem.** Research has suggested that the recognition of an attraction to the same sex during early adolescence in girls can predict high self-esteem (Savin-Williams, 1990 & Savin-Williams, 1995 as cited in Swann & Spivey, 2004). Self-disclosure of sexual orientation has also been thought to have a role in high self-esteem (Swann & Spivey, 2004). According to Cass (1979, as cited in Swann and Spivey, 2004):

disclosure and self-esteem have been hypothesized as a bi-directional process in which previous self-esteem and psychological health leads to greater self-acceptance and disclosure, which in turn leads to more social support, greater self-esteem and improved mental health (p. 632).

Another important aspect of sexuality could be called ‘sexual self-respect’. This involves the individual to be able to refuse to be pressured into sexual activities, to use effective contraceptive and protective methods when engaging in sexual activities (to avoid pregnancy and the spread of sexually transmitted diseases/infections) and to have enough value for oneself to not let themselves be used for sex. Simply put, sexual self-respect is enough value for one’s body to protect it from harm and disrespectful usage.
Body image is a factor that influences the way individuals think about their sexuality (Gillen, Lefkowitz, & Shearer, 2006). According to Gillen et al. (2006), adolescents who have a negative view of their bodies are more likely to engage in risky sexual behaviours than those who have a more positive view of their bodies. Gillen et al. hypothesize that this is because any sexual advance is viewed by the adolescent to be positive feedback about their body and so they will engage in risky sexual behaviour by failing to refuse the partner or not using protection (Gillen et al.).

The time for sexual curiosity, discovery and immaturity is during adolescence. Being comfortable with one’s sexuality at an early age will set the stage for a healthy, high self-esteem and is the reason sexuality is important to be addressed for both male and female young offenders. It is also important to present factual information to youth, in order to counteract any false messages about sexuality they receive from the media and pornography (Wallmyr & Welin, 2006).

**Missing Elements in Agency Programming.** There is little programming at the facilities that addresses sexuality. The programming that does however is specifically for girls. These programs are Girls’ Group modules which address sexuality by focusing on attitudes, abstinence, sexually transmitted infections, pregnancy and birth control and decision making. In a copy of a power-point presentation found at one of the facilities prepared for SLYA by Bonnell (date unknown), the purposes of the Girls’ Group are briefly discussed. This is a psycho-educational program that provides information on various issues that address the needs of girls in ways that promote group discussion and thought. No other information could be found on these Girls’ Group modules.

**Recommendations.** As stated by Haglund (2006), “Sexuality education may teach early adolescents how to value and respect themselves and others and to confidently make choices based on their values” (p. 373). There is no doubt that running sexuality programs in young offender institutions to address issues such as sexual orientation and values would be beneficial to males and female adolescents.

While the Girls’ Group modules do address important issues pertaining to sexuality for girls, this program is only designed for girls. According to Gillen et al. (2006), programs addressing sexuality should be gender specific. The Girls’ Group modules for sexuality do address appropriate issues in terms of sexuality such as decision-making, birth control and sexually transmitted infections/diseases. Because of this, it is recommended that the Girl’s Group modules continued to be used for females and be adapted for males (Guy’s Group) so that they address the same issues in a masculine way. It is also recommended that the module on homophobia (which is not listed under healthy sexuality) be incorporated in the sexuality sessions to promote discussion, awareness and acceptance of not only one’s own orientation but others’ as well.

To ensure that the information in the Girl’s Group module on sexuality is helpful, the following are some characteristics McKeon (2006) of Advocates for Youth lists for effective sex education programs (p. 2):

- Information is age- and culturally appropriate and presented in a safe environment
- Program is developed with the help of members of the community and young people
- Help the youth to identify their individual, family and community values
- Help the youth to develop skills in communication, refusal and negotiation
- Make sure all information about contraception and abstinence is medically correct
- Make sure goals for preventing sexually transmitted diseases and pregnancy are clear
- Focus on health behaviours related to these goals
- Address risks and protective factors with ways to change risk factors and promote protective factors
- Use all activities of program as designed

It is recommended that this list be used as a checklist to make sure the program is being delivered properly and in a way that will benefit the youth.

**Relationships**

*Definition.* Relationships are especially important in an adolescent’s life because they provide a solid bond of trust between the youth and the peer, parent, teacher, counsellor or other person. In the confusing time of adolescence it is crucial that males and females both have peers they can trust as well as adults who can offer them more stable resources. They must have these relationships with others so they are able to express their feelings and go to the person if they need help. Studies show that a child’s early family relationships will provide the groundwork for how later relationships are formed (Bretherton, 1985, as cited in Dalton, Frick-Horbury, & Kitzmann, 2006). When a child’s relationship is not properly developed with a parent or caregiver, this jeopardizes the child’s ability to trust others in the future. This assertion is based on the attachment theory (Bowlby, 1973, as cited in Dalton et al., 2006), which describes how a child can have a secure, avoidant or anxious-ambivalent attachment (Cooper, Shaver, & Collins, 1998).

Relationships may be even more important for the young offender. Male and female young offenders often have trouble coping and are less effective at accessing resources in the school and health system. It is important that these offenders learn ways to develop and improve relationships, so that they are able to have people they trust to help them through difficult times. Developing relationships is also beneficial to the young offender because having a close friend or trusted person to talk to is a protective factor against committing crime.

*Link to Offending.* Studies have shown that poor parental care is often linked to adolescent offending (Laybourn, 1986, & Wilson, 1980, as cited in Chambers, Power, Loucks, & Swanson, 2000). For example, punishment and lack of supervision can lead to juvenile delinquency (Haapasalo & Tremblay, 1994, as cited in Haapasalo, 2001). The environment that parents/caregivers provide for their children has an effect on how attachments and relationships between the parent/caregiver and child develop. Parental conflicts, alcohol abuse, mental problems, and criminality have also been associated with criminal behaviour in offspring (Loeber & Stouthamer-Loeber, 1986, as cited in Haapasalo, 2001).

In a study on attachment styles of adolescents by Cooper et al. (1998), it was found that adolescents who fit the criteria for the anxious-ambivalent attachment had higher rates of property offenses, truancy and substance use than avoidant or secure attachments. Adolescents with anxious-ambivalent attachments have the highest levels of problem and risky behaviours (Cooper et al.).
**Missing Elements in Agency Programming.** There is little programming at the facilities that addresses how to build and maintain relationships. The programming that does however is specifically for girls. This program is a Girls’ Group module which addresses relationships by encouraging girls to talk about characteristics of healthy and unhealthy relationships. In a copy of a power-point presentation found at one of the facilities prepared for SLYA by Bonnell (date unknown), the purposes of the Girls’ Group are briefly discussed. This is a psycho-educational program that provides information on various issues that address the needs of girls in ways that promote group discussion and thought. No other information could be found on these Girls’ Group modules.

**Recommendations.** A study by Pleydon and Schner (2001), found that female young offenders and adolescent girls did not significantly differ in the amount of closeness and companionship with their best female friend. This study shows that female young offenders are capable of having close relationships with their peers. Perhaps, if building relationships with peers is not an area of concern for females, it may be beneficial for the agency’s programs to focus more on building prosocial relationships with adults such as parents, teachers, and counsellors. This approach may help counteract the “don’t trust anyone over 30” attitude and show the female young offenders that adults are there to offer guidance and direction. Currently, there is nothing that suggests males have difficulty forming relationships with either peers or adults. It is recommended that treatment for males be directed at peer and adult relationships.

It is also recommended that the agency continue to use the Girl’s Group module while including males in listing characteristics of healthy and unhealthy relationships and that the group practice communication skills.

**Coping with Physical Abuse**

**Definition.** Physical abuse has been defined as the non-accidental injury from acts of violence by an adult, most often due to parental anger towards the child (Abrams, 1981; and Kelly, 1983, as cited in Malinosky-Rummell & Hansen, 1993). The National Center on Child Abuse and Neglect (NCCAN, 1988, as cited in Malinosky-Rummell & Hansen, 1993) defines physical abuse as acts of commission that show harm or endanger the child. According to Starr (1988, as cited in Cruise, Jacobs, & Lyons, Jr., 1994), definitions of abuse vary as to which acts are considered harmful and other variables such as intent to injure. Due to these varying definitions, there is little agreement on a common definition of physical abuse (Cruise et al., 1994). Another reason that finding a definition of physical abuse has been difficult is because it is seen from many perspectives: “Law enforcement, social services, courts, and mental health have worked and continue to work with abused children using discipline-specific methods of investigation, intervention, and prosecution. Because representatives from each discipline have different roles, each has subscribed to a different definition of what constitutes child abuse” (Cruise et al., 1994). For the purpose of this thesis, physical abuse will be defined as the non-accidental intent to harm a child by an adult out of anger or for discipline--though the definitions of abuse from other sources used in this thesis may differ.

**Long Term Effects of Physical Abuse.** Childhood and adolescent physical abuse can not only leave the physical damage of injuries, but also many mental health and behavioural problems. Aggressive and violent behaviour, such as extrafamilial and dating violence, has been

There is a relationship between childhood abuse and the adolescent substance use (Malinosky-Rummell & Hansen, 1993). Cavaiola and Schiff (1988, as cited in Malinosky-Rummell & Hansen, 1993) found that adolescents who were abused engaged in substance use at an earlier age than adolescents who were not abused. Kroll and so on (1985 as cited in Malinosky-Rummell & Hansen, 1993) found that abused alcoholic men engaged in more “suicide drinking” (heavy drinking despite serious medical condition such as liver failure) than non abused alcoholic men.

Abuse also affects individuals through mental health problems. Chu and Dill (1990, as cited in Malinosky-Rummell & Hansen, 1993) found that abused females scored high on the Symptom Checklist-90-Revised (SCL-90-R) on the subscales on Anxiety, Hostility, Paranoid-Ideation, Psychoticism, whereas Bryer, Nelson, Miller, & Krol (1987) found that abused females scored high on Depression, Phobic Anxiety, Anxiety, Somatization, Paranoid-Ideation, and Psychoticism (as cited in Malinosky-Rummell & Hansen, 1993).

**Link to Offending.** Many studies have shown that those who were abused as children are more likely to offend in adolescence and adulthood than those who were not abuse. Dutton & Hart (1992, as cited in Haapasalo & Moilanen, 2004) found that that childhood abuse did in fact increase the risk of violent crimes committed in adulthood. Smith & Thornberry (1995, as cited in Haapasalo & Moilanen, 2004) found that abuse during childhood was related to later adult criminal records, especially violent crimes.

**Missing Elements in Agency Programming.** Currently there are no treatment programs at the agency’s custody facilities that help male or female young offenders cope with past physical abuse. This is unfortunate, since physical abuse has been shown to lead to offending (Haapasalo & Moilanen, 2004). If treatment if provided for young offenders during adolescence, it may prevent offending in adulthood.

**Trauma-Focused Cognitive Behavioural Therapy.** Trauma-Focused Cognitive Behavioural Therapy (TFCBT) was developed by combining cognitive and behavioural interventions with child therapies that focus on enhancing interpersonal trust and empowerment for males and females who are 3-18 with PTSD symptoms (Substance Abuse and Mental Health Service Administration, 2008). TFCBT was developed by Judith A. Cohen and Anthony P. Mannarino and is the only trauma-focused therapy that has received high ratings among adolescent trauma therapies (Saunders, Berliner, & Hanson, 2003, as cited in Mahoney, Ford, Ko, & Siegfried, 2004). Those who received TFCBT experienced improvement in behavioural problems, PTSD symptoms, depression, negative attributions about the traumatic event (e.g. self-blame), anxiety and defiant and oppositional behaviours (Substance Abuse and Mental Health Service Administration, 2008).
Recommendations. According to Courtois & Bloom (2000, as cited in Palmer, Stalker, Gadbois, & Harper, 2004), those suffering from the effects of physical abuse should not be looked upon at having a mental illness, but rather their symptoms are a response to an extraordinary stress. Victims of abuse are most likely suffering from posttraumatic stress disorder (PTSD). Treatments developed for PTSD include psychoeducation approaches, cognitive-behavioural approaches, anxiety management techniques, and psychopharmacology (Palmer et al., 2004).

Group counselling, however, has been found to have positive effects for children and adolescents who have been physical abused (Daro, 1988, as cited in Howing, Wodarski, Gaudin, Jr, & Kurtz, 1989). This is due to the therapeutic effect of peer interaction (Furman, Rahe, & Hartup, 1979, as cited in Howing et al., 1989), especially with adolescents (Euster, Ward, Varner, & Euster, 1984, as cited in Howing et al., 1989). PTSD programs assist in alleviating emotional pain for youth and have the cost savings of treating more than one youth at the same time. Because of this, it is recommended that group counselling PTSD program be used in the agency to treat young offender suffering from the effects of physical abuse.

PTSD programs should educate adolescents about PTSD, including the causes and symptoms of PTSD, provide skills for dealing with symptoms, encourage them to explore their feelings, and inspire them to improve their interpersonal relationships (Palmer et al., 2004). Programs should also demonstrate skills for everyday living, explain how to build social support networks, and teach how to create and maintain personal and social safety (Courtois & Bloom, 2000; Johnson, Feldman, Southwick, & Charney, 1994, as cited in Palmer et al., 2004). Youth should also be encouraged to verbalize their thoughts and feelings, address aggression, improve social interactions with peers and adults, identify and decrease cognitive deficiencies, and support mastery of developmental stages (Steward, Farquhar, Dicharry, Glick, & Martin, 1986; Twentyman, Rohrbeck & Amish, 1984, as cited in Howing et al., 1989).

In a study by Palmer et al. (2004) of group counselling characteristics, some of the most beneficial components of a group were a sense of community, the normalizing effects of sharing similar experiences, feeling accepted, and making connections with others. The least beneficial components were experiencing pain at hearing others’ stories, feeling alienated from the group, and feeling overwhelmed by the number of people in the group.

Palmer et al. (2004) also suggests that youth be assessed for their readiness before they begin counselling, and that staff administering PTSD programs attend a required course about trauma to better understand what they are teaching the youth. Therefore, it is recommended that pre-group assessment of youths be done as well as PTSD-specific training be delivered to the staff before they hold group meetings.

A more specific treatment program recommended is trauma-focused cognitive behavioural therapy used to treat adolescent offenders suffering from PTSD. Because staff training can be costly, it is recommended that the agency find a professional who has already been trained in TFCBT to run the program.

Stress Management

Definition. Rowe (2006) defines stress as a stimulus that can cause tension to the person experiencing it. The person’s response is either coping with the stimulus or adapting to it, which may or not be accomplished (Hetherington, 1984, as cited in Rowe, 2006). According to Rowe (2006), coping involves:
...a dynamic process between a person and his/her environment, whereby the individual who has a set of resources, commitments, and values interacts with his/her environment, which has its own set of resources, constraints, and demands, to form a coping response. If the individual is going to be successful in managing his/her environment, such coping behaviour must be adapted over time as the environment and the person influence each other (p. 603).

Everyone experiences stress in one way or another, but it is hypothesized that young offenders are less effective at accessing resources to help them than nonoffending adolescents. This may lead them to feel they must deal with their stressor alone, which of course only increases their stress. It is necessary to teach adolescents how to cope with stress because they will continue to experience stressors daily (Hains, 1994). Adolescents must cope with conflicts with parents, academic and peer pressures, dating anxiety, parental expectations and career and education decisions (Omizo, Omizo, & Suzuki, 1988, as cited in Hains, 1994). In order for adolescents to manage stress, it is imperative that they adapt effective coping techniques (Compass, 1987, as cited in Hains, 1994).

Methods of Coping. Many adolescents cope differently with stress. The ways in which they cope can be negative or positive. Usually, negative coping mechanisms will not solve the problem, but suppress it instead. Some negative coping strategies are self-blame, self-criticism (Stark, Spirito, Williams, & Guevremont, 1989, as cited in Donaldson, Prinstein, Danovsky, & Spirito, 2000) and denial.

Folkman and Lazarus (1980, as cited in Rowe, 2006) developed two types of positive coping strategies. Problem-focused Coping involves doing something to fix a stressful experience and Emotion-focused Coping is where one learns more about a stressful event, which gives them more understanding and control over it (Rowe, 2006).

Missing Elements in Agency Programming. There is little stress management programming at the facilities. The programming that the facilities do use for stress management is a Girls’ Group module. Little information could be found on the Girls’ Group modules. Since the Girls’ Group stress management program consists of only one module, not many aspects of stress management are addressed. Another program the agency uses at the facilities is entitled Stress Management–Identifying Stressors. No information could be found on this program.

Benefits of Stress Management Programs. Stress management programs not only help those who have limited coping strategies change the way in which they cope in different situations, but also help individuals to develop behaviour patterns that can generalize to other stressful situations (Rowe, 2006).

A study by Hains (1994) showed benefits of a school-based, cognitive-behavioural stress management program for adolescents. The adolescents were trained in cognitive restructuring and reported improvements in trait anxiety, self-esteem, depression, and trait anger. In a study by de Anda (1998), adolescents in a stress management program that used cognitive coping techniques and relaxation reported an increase in the effectiveness of their coping strategies, while the control subjects reported a decrease in their effectiveness of coping strategies over the same period of time. These results show that instruction in coping techniques is more beneficial than the trial and error method of coping strategies most adolescents use (De Anda). Rowe
(2006) found that adolescents who were taught better coping strategies dealt with stress more effectively, felt a strong sense of personal accomplishment, and were less emotionally exhausted.

**Recommendations.** Since cognitive-behavioural programs have been shown to be beneficial in helping adolescents develop coping techniques, it is recommended that a cognitive-behavioural based stress management program be used in the facilities. According to Hains (1994), cognitive-behavioural coping techniques are beneficial to adolescents who find it difficult to control their stress, and these techniques will help them to develop skills for future stressful situations. Stress management programs should also identify the “signs and symptoms” of stress (De Anda, 1998). This is to help youth recognize stressful situations before they happen so they are better prepared to deal with them.

A stress inoculation training model was developed by Meichenbaum (1985, as cited in Hains, 1994). The program identifies stressors and reconceptualises stress in terms of the physiological reactions, behaviours, cognitions and emotions (Hains, 1994). The program teaches cognitive restructuring and how to apply techniques to stressful everyday events while encouraging group members to practice applying these techniques (Hains, 1994). This program is recommended for use in the facilities. A summary of the program’s phases can found in Appendix G (Meichenbaum, 1985 as cited Hains, 1994).
CHAPTER IV - DISCUSSION

The purpose of this project was to find the most important need areas of young offenders and examine the agency’s treatment programming used for these areas at the facilities. After asking managers and staff of the facilities to rate the importance of need areas for young offenders it was determined that the following were considered to be the most important to address: cognitive distortions, substance use and abuse, emotion regulation, anger management, self-harm, sexual abuse, stress management, conduct problems, eating disorders/body image, coping with physical abuse, relationships and sexuality. This author focused on six of the twelve need areas, while a colleague focused on the remaining six. Key concepts in the recommended treatments are listed in Appendix E. A summary of the recommendations made can be found in Appendix F.

Only half of the need areas reviewed currently had programming. The programming that was available however was specifically for girls (sexuality, relationships and stress management). This works well for the all-female facility, but it is an unfortunate omission for the facility that houses both male and female young offenders. It is unclear as to why there is no treatment programming for males in a facility that holds males. Nothing has been found in the literature stating that group counselling for building relationships must be gender-specific. Therefore, it was recommended that the programming for this area be adapted to include males. There was however, evidence that sexuality group counselling be gender specific and held in all-female and all-male sessions due to its intimate nature. It was recommended that based on the Girls’ Group sexuality module, a group for males be adapted and held.

A cognitive-behavioural stress management program geared towards both males and females was recommended. There was a Girls’ Group module for stress management but cognitive-behavioural therapies had more support in the literature than psychoeducational programs. Regarding programs for coping with physical abuse, a PTSD treatment program, such as trauma-focused cognitive behavioural therapy, was recommended for use for both males and females due to the traumatic stress abuse creates. Currently there is no treatment programming used to address issues caused by physical abuse. This area is important to address because intervention may prevent or decrease future offending.

Linehan’s DBT was found to be the best choice to address emotion regulation and self-harm. This treatment was developed especially to treat the emotion dysregulation and self-harm that comes with borderline personality disorder and that is also found in other disorders. Linehan’s (1993) Skills Training Manual for Treating Borderline Personality Disorder contains handouts for participants to fill out about their emotional experiences, teaching them how to identify emotions and alter their behaviour. These manual handouts are ideal to treat young offenders who have short and long term stays. The handouts can be examined during group counselling while the youth is in the facility and can be given easy-to-understand handouts upon release. The handouts are also available online for no cost. Because DBT has been shown to be effective in reducing self-harm and improving emotion regulation, and because the agency currently has no programming for either, Linehan’s DBT is recommended for use in these areas.

Strengths and Limitations. This thesis’ strength was that the review of treatment programs used in the agency’s custody facilities was well needed. This thesis provided the agency with a review of effective programming for various need areas of young offenders to use in its facilities. Managers of the facilities were pleased when they learned the programs were
going to be reviewed and recommendations made regarding replacing or altering the treatment programs. Another strength of the thesis is that it also benefits the young offenders who come into the facilities. By delivering appropriate treatment for the needs of the youth, they can learn adaptive coping techniques.

Some limitations of this thesis must be noted. The first is that there were only 18 copies of the YONQ distributed in total and a 50% response rate. Were there no time restrictions on this thesis, it would have been possible to distribute a larger amount of questionnaires and allow more time for staff and managers to respond. The short timeframe for research on available treatment programs is another limitation. Having had more time to research treatments for the need areas, a more thorough job could have been done in terms of finding the best programs to use.

Multilevel Challenges to Service Implementation. There are several challenges of program review among various levels. At the client level, clients at facilities may not be getting effective, up-to-date treatment. At the program level, programs may not be the correct ones to address client’s needs, treatment programs are unorganized, incorrectly labelled or not labelled at all. This makes it very hard to find information on them, and programs addressing certain need areas may be too long for short-length stays at facilities. At the organizational level, agencies may be unwilling to change or update programming and/or does not have effective treatment for clients. Finally, at the societal level, if clients are not getting effective treatment and being released, society will suffer damages when crimes are committed again.

Contribution to the Behavioural Psychology Field. This thesis has contributed valuable information to the behavioural psychology field, more specifically in the area of young offenders. By completing a review of treatment programming for various need areas, it has shown which types of programs are best suited for the specific needs and gender of young offenders. This thesis also demonstrates that agencies should perform regular reviews of their treatment programming as well as the literature to remain up to date with best practices. The agency’s most recent review of programming has been carried out for this thesis.

Future Research. Future research should examine other important need areas for young offenders and whether they are of the importance same for males and females. The efficacy of group therapy programs for these need areas for young offenders should also be investigated. Future research at the agency should involve conducting more frequent reviews and evaluations of the current programming to ensure treatment is effective and best practices are being used. The agency should always search for group treatment programs as they are more cost-effective and make certain that the programs can be used for both males and females (unless otherwise specified).
REFERENCES


APPENDIX A: Young Offender Needs Questionnaire (YONQ)

Students Caroline Fleming and Martha McCann from the new Behavioural Psychology Degree program at St. Lawrence College are conducting a review of counselling programs run at St. Lawrence Youth Association. In order to do this, we would appreciate your input on various subjects relevant to young offenders.

Instructions:
1. From the list below, please circle 12 areas you feel are the most important for female youth offenders.

2. Rank these in order of importance (1 being the most important need area, 12 being the least)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Anger Management</td>
</tr>
<tr>
<td>2.</td>
<td>Social Skills</td>
</tr>
<tr>
<td>3.</td>
<td>Eating Disorders/Body Image</td>
</tr>
<tr>
<td>4.</td>
<td>Communication Skills</td>
</tr>
<tr>
<td>5.</td>
<td>Cognitive Distortions</td>
</tr>
<tr>
<td>6.</td>
<td>Life Skills</td>
</tr>
<tr>
<td>7.</td>
<td>Coping with Abuse (Physical)</td>
</tr>
<tr>
<td>8.</td>
<td>Sexual Abuse</td>
</tr>
<tr>
<td>9.</td>
<td>Relationships</td>
</tr>
<tr>
<td>10.</td>
<td>Spiritually/Religion</td>
</tr>
<tr>
<td>11.</td>
<td>Self-harm</td>
</tr>
<tr>
<td>12.</td>
<td>Depression and Suicide</td>
</tr>
<tr>
<td>13.</td>
<td>ADD/ADHD</td>
</tr>
<tr>
<td>14.</td>
<td>Sexually Transmitted Diseases</td>
</tr>
<tr>
<td>15.</td>
<td>Sexuality</td>
</tr>
<tr>
<td>16.</td>
<td>Substance Use and Abuse</td>
</tr>
<tr>
<td>17.</td>
<td>Conduct Problems</td>
</tr>
<tr>
<td>18.</td>
<td>Borderline Personality Disorder</td>
</tr>
<tr>
<td>19.</td>
<td>Anti-Social Personality Disorder</td>
</tr>
<tr>
<td>20.</td>
<td>Stress Management</td>
</tr>
<tr>
<td>21.</td>
<td>Family Problems</td>
</tr>
<tr>
<td>22.</td>
<td>Grief and Loss</td>
</tr>
<tr>
<td>23.</td>
<td>Relaxation</td>
</tr>
<tr>
<td>24.</td>
<td>Emotion Regulation</td>
</tr>
<tr>
<td>25.</td>
<td>Education</td>
</tr>
<tr>
<td>26.</td>
<td>Self-esteem</td>
</tr>
<tr>
<td>27.</td>
<td>Trust building</td>
</tr>
<tr>
<td>28.</td>
<td>Personal Hygiene</td>
</tr>
<tr>
<td>29.</td>
<td>Bullying</td>
</tr>
<tr>
<td>30.</td>
<td>Anxiety</td>
</tr>
<tr>
<td>31.</td>
<td>Other (please explain):</td>
</tr>
<tr>
<td>32.</td>
<td>___________________________</td>
</tr>
</tbody>
</table>

Thank you
APPENDIX B: Current Programs Implemented At Sundance

Educational
- Cognitive Behavioural Intervention: Educational Program
- Honouring Our Diversity (Girls Circle)
- Values, Influences and Peers (VIP)
- Goal Setting: Introduction (Girls group modules)
- Goal Setting: Identifying Goals (Girls group modules)
- Goal Setting: Action Plan (Girls Group modules)
- Problem solving/Decision making (Girls group modules)
- Celebrating Diversity (girls group modules)
- Homophobia and discrimination
- Mental health: Education around suicide, depression, self harm and substance use
- Know Your Rights

Conduct Problems
- Cognitive Behavioural Intervention: Offenses/Dispositions
- The Self-Control Workbook: Exercises to control inattention, impulsivity and hyperactivity (Berg, 1990)
- Conduct Management Workbook (Berg, 1990)

Substance Use/Abuse/ Addiction
- The Recovery Workbook: Exercises to Deal With Drugs and Alcohol (Berg,1990)
- Mind/Body Spirit (Girls Circle)
- Paths to the future (Girls circle)
- Sex and Alcohol: Date rape drugs (girls group modules)
- Substance use (discussion group)
- Substance abuse(discussion group)
- Gambling (discussion group)

Anger Management
- The Anger Control Workbook: Exercises to Develop Anger Control Skills (Berg, 1990)
- Conflict Resolution (girls group modules)
- Anger: What is anger? (girls group modules)
- Expressing Anger: Promoting Assertive ways of managing anger (girls group modules)
- Cognitive Behavioural Intervention: Anger Management
- Anger Awareness and Interpersonal Problem Solving: (Baker, 1996)

Article I. Cognitive Distortions
- The Power of Positive Thinking (Girls Group Modules)
- Cognitive Behavioural Intervention: Distorted Thinking
- Cognitive Behavioural Intervention: Self-Talk

Article III. Eating Disorders
- Body Image (Girls circle)
- Body Image (Girls group modules)
- Body Image and the Media (Girls Group Modules)
- Nutrition (Girls Group Modules)
- Eating Disorders (Girls Group Modules)

Article V.

Article VI. Self-Awareness
- Young Women’s Lives (Myhand & Kivel)
- Mind/Body Spirit (Girls Circle)
- Being a girl (Girls Circle)
- Expressing my individuality (Girls circle)
- Who I am (girls circle)
- Inner vs. Outer Self (Girls’ Group Modules)
- Who am I on the Inside? (Girls Group Modules)
- Self-Concepts: Personal Values (Girls Group Modules)
- Self-Esteem (Girls Group Modules)
- Spirituality: Mind, Body, Spirit Connection

Article VII.

Article VIII. Relationships
- Friendship (Girls Circle)
- Cognitive Behavioural Intervention: Family Factors
- Paths to the future (Girls circle)
- Healthy Relationships: Healthy vs. Unhealthy (Girls group modules)
- Sexual Assault (Girls Group Modules)
- Safe Dating (Girls group modules)
- Healthy Sexuality: Attitudes, Exploring Abstinence (Girls group modules)
- Healthy Sexuality: Birth Control, Pregnancy and STI’s (girls group modules)
- Healthy Sexuality: Decision making (girls group modules)
- STI’s (girls group modules)
- Partner abuse and dating violence (discussion group)

Social Skills
- Social Skills Lessons and Activities for Grades 7-12 (Begun)
- Communication: Verbal/Non-verbal, one and two way communication (Girls group modules)
- Communication: Assertiveness training (girls group modules)

Article IX.

Article X. Stress Management
- Stress Management: what is stress? Coping strategies (girls group modules)
- Stress management: Identifying individual stressors and strategies

Article XI.

Article XII. Life Skills
- Grief and Loss
- Employment Readiness
APPENDIX C: Current Programs Implemented At Achievement St. Lawrence

Educational
- Cognitive Behavioural Intervention: Educational Program
- Honouring Our Diversity (Girls Circle)
- Values, Influences and Peers (VIP)
- Goal Setting: Introduction (Girls group modules)
- Goal Setting: Identifying Goals (Girls group modules)
- Goal Setting: Action Plan (Girls Group modules)
- Problem solving/Decision making (Girls group modules)
- Celebrating Diversity (girls group modules)
- Homophobia and discrimination
- Mental health: Education around suicide, depression, self harm and substance use
- Know Your Rights

Conduct Problems
- Cognitive Behavioural Intervention: Offenses/Dispositions
- The Self-Control Workbook: Exercises to control inattention, impulsivity and hyperactivity (Berg, 1990)
- Conduct Management Workbook (Berg, 1990)

Substance Use/Abuse/ Addiction
- The Recovery Workbook: Exercises to Deal With Drugs and Alcohol (Berg, 1990)
- Mind/Body Spirit (Girls Circle)
- Paths to the future (Girls circle)
- Sex and Alcohol: Date rape drugs (girls group modules)
- Substance use (discussion group)
- Substance abuse (discussion group)
- Gambling (discussion group)

Anger Management
- The Anger Control Workbook: Exercises to Develop Anger Control Skills (Berg, 1990)
- Conflict Resolution (girls group modules)
- Anger: What is anger? (girls group modules)
- Expressing Anger: Promoting Assertive ways of managing anger (girls group modules)
- Cognitive Behavioural Intervention: Anger Management
- Sunburst Curriculum Module: Resolving Conflicts
- Sunburst Curriculum Module: Handling Your Anger
- Anger Awareness and Interpersonal Problem Solving (Baker, 1996)

Article XIII.

Article XIV. Cognitive Distortions
- The Power of Positive Thinking (Girls Group Modules)
- Cognitive Behavioural Intervention: Distorted Thinking
- Cognitive Behavioural Intervention: Self-Talk
- Sweeten Your Self-Talk
Article XV.

Article XVI. Eating Disorders

- Body Image (Girls circle)
- Body Image (Girls group modules)
- Body Image and the Media (Girls Group Modules)
- Nutrition (Girls Group Modules)
- Eating Disorders (Girls Group Modules)
- Accept the good and the bad
- Celebrate yourself

Article XVII.

Article XVIII. Self-Awareness

- Young Women’s Lives (Myhand & Kivel)
- Mind/Body Spirit (Girls Circle)
- Being a girl (Girls Circle)
- Expressing my individuality (Girls circle)
- Who I am (girls circle)
- Inner vs. Outer Self (Girls’ Group Modules)
- Who am I on the Inside? (Girls Group Modules)
- Self-Concepts: Personal Values (Girls Group Modules)
- Self-Esteem (Girls Group Modules)
- Spirituality: Mind, Body, Spirit Connection
- Sunburst Curriculum Module: Self-Esteem
- Get to Know Yourself
- Stay True To Yourself
- Realize You are Responsible For Your Own Happiness
- Don’t Worry About What Others think
- Give Yourself a Break
- Learn from your pain
- Go Beyond your comfort zone

Article XIX.

Article XX. Relationships

- Friendship (Girls Circle)
- Cognitive Behavioural Intervention: Family Factors
- Paths to the future (Girls circle)
- Healthy Relationships: Healthy vs. Unhealthy (Girls group modules)
- Sexual Assault (Girls Group Modules)
- Safe Dating (Girls group modules)
- Healthy Sexuality: Attitudes, Exploring Abstinence (Girls group modules)
- Healthy Sexuality: Birth Control, Pregnancy and STI’s (girls group modules)
- Healthy Sexuality: Decision making (girls group modules)
- STI’s (girls group modules)
- Partner abuse and dating violence (discussion group)
- The Teen Relationship Workbook (Moles)
- Let Others Love You
- Building positive relationships
Social Skills
- Social Skills Lessons and Activities for Grades 7-12 (Begun)
- Communication: Verbal/Non-verbal, one and two way communication (Girls group modules)
- Communication: Assertiveness training (girls group modules)

Article XXI.

Article XXII. Stress Management
- Stress Management: what is stress? Coping strategies (girls group modules)
- Stress management: Identifying individual stressors and strategies

Article XXIII.

Article XXIV. Life Skills
- Grief and Loss
- Employment Readiness
### Section 24.01 APPENDIX D: Youth Offender Needs Questionnaire Results

<table>
<thead>
<tr>
<th>Need Area</th>
<th>Number of times chosen (out of 9)</th>
<th>Ranks</th>
<th>Mean</th>
<th>Overall importance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Article XXV. Cognitive Distortions</td>
<td>7</td>
<td>1,1,1,2,3,5,11</td>
<td>3.4</td>
<td>1</td>
</tr>
<tr>
<td>Substance Use and Abuse</td>
<td>7</td>
<td>1,3,4,4,6,10,12</td>
<td>5.7</td>
<td>2</td>
</tr>
<tr>
<td>Emotion Regulation</td>
<td>6</td>
<td>1,1,2,3,9,9</td>
<td>4.2</td>
<td>3</td>
</tr>
<tr>
<td>Anger Management</td>
<td>6</td>
<td>1,1,4,6,6,8</td>
<td>4.3</td>
<td>4</td>
</tr>
<tr>
<td>Self-Harm</td>
<td>6</td>
<td>4,4,6,7,7,10</td>
<td>5.4</td>
<td>5</td>
</tr>
<tr>
<td>Sexual Abuse</td>
<td>6</td>
<td>3,3,6,9,10,11</td>
<td>7.0</td>
<td>6</td>
</tr>
<tr>
<td>Stress Management</td>
<td>6</td>
<td>4,7,7,7,8,10</td>
<td>7.2</td>
<td>7</td>
</tr>
<tr>
<td>Conduct Problems</td>
<td>5</td>
<td>2,5,5,6,11</td>
<td>5.8</td>
<td>8</td>
</tr>
<tr>
<td>Eating Disorders/Body Image</td>
<td>5</td>
<td>2,6,6,9,9</td>
<td>6.4</td>
<td>9</td>
</tr>
<tr>
<td>Coping with Abuse (Physical)</td>
<td>5</td>
<td>2,2,5,11,12</td>
<td>6.4</td>
<td>10</td>
</tr>
<tr>
<td>Relationships</td>
<td>5</td>
<td>4,6,7,7,9</td>
<td>6.6</td>
<td>11</td>
</tr>
<tr>
<td>Sexuality</td>
<td>5</td>
<td>3,8,11,11,12</td>
<td>9.0</td>
<td>12</td>
</tr>
<tr>
<td>Self-Esteem</td>
<td>4</td>
<td>1,2,10,10,</td>
<td>5.8</td>
<td>13</td>
</tr>
<tr>
<td>Depression and Suicide</td>
<td>4</td>
<td>2,5,8,9</td>
<td>6.0</td>
<td>14</td>
</tr>
<tr>
<td>Family Problems</td>
<td>4</td>
<td>8,8,11,12</td>
<td>9.8</td>
<td>15</td>
</tr>
<tr>
<td>Anxiety</td>
<td>4</td>
<td>10,11,12,12</td>
<td>11.3</td>
<td>16</td>
</tr>
<tr>
<td>Communication Skills</td>
<td>3</td>
<td>2,4,8</td>
<td>4.7</td>
<td>17</td>
</tr>
<tr>
<td>Trust Building</td>
<td>3</td>
<td>5,9,11</td>
<td>8.3</td>
<td>18</td>
</tr>
<tr>
<td>Bullying</td>
<td>3</td>
<td>7,8,12</td>
<td>9.0</td>
<td>19</td>
</tr>
<tr>
<td>Borderline Personality Disorder</td>
<td>2</td>
<td>3,4</td>
<td>3.5</td>
<td>20</td>
</tr>
<tr>
<td>Education</td>
<td>2</td>
<td>1,8</td>
<td>4.5</td>
<td>21</td>
</tr>
<tr>
<td>Social Skills</td>
<td>2</td>
<td>5,7</td>
<td>6.0</td>
<td>22</td>
</tr>
<tr>
<td>Sexually Transmitted Diseases</td>
<td>2</td>
<td>5,10</td>
<td>7.5</td>
<td>23</td>
</tr>
<tr>
<td>ADD/ADHD</td>
<td>1</td>
<td>3</td>
<td>3.0</td>
<td>24</td>
</tr>
<tr>
<td>Anti-social Personality</td>
<td>1</td>
<td>5</td>
<td>5.0</td>
<td>25</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>9</td>
<td>9.0</td>
<td>26</td>
</tr>
<tr>
<td>Relaxation</td>
<td>1</td>
<td>10</td>
<td>10.0</td>
<td>27</td>
</tr>
<tr>
<td>Spirituality/Religion</td>
<td>1</td>
<td>12</td>
<td>12.0</td>
<td>28</td>
</tr>
<tr>
<td>Life Skills</td>
<td>1</td>
<td>12</td>
<td>12.0</td>
<td>29</td>
</tr>
<tr>
<td>Personal Hygiene</td>
<td>0</td>
<td>0</td>
<td>0.0</td>
<td>30</td>
</tr>
<tr>
<td>Grief and Loss</td>
<td>0</td>
<td>0</td>
<td>0.0</td>
<td>31</td>
</tr>
</tbody>
</table>
## APPENDIX E: Key Concepts in the Recommended Treatments

<table>
<thead>
<tr>
<th>Need Area</th>
<th>Key Concepts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional Regulation</td>
<td>Dialectical Behaviour Therapy; encourages patients to differentiate between rational and irrational thoughts</td>
</tr>
<tr>
<td>Self-Harm</td>
<td>Dialectical Behaviour Therapy; encourages patients to differentiate between rational and irrational thoughts</td>
</tr>
<tr>
<td>Sexuality</td>
<td>Psychoeducational modules; encourages education on the subject and promotes group discussion</td>
</tr>
<tr>
<td>Relationships</td>
<td>Psychoeducational modules; encourages education on the subject and promotes group discussion</td>
</tr>
<tr>
<td>Coping with Physical Abuse</td>
<td>Programs created for Posttraumatic Stress Disorder such as Trauma-Focused Cognitive Behavior Therapy (TFCBT); encourages interpersonal trust and empowerment, some psychoeducational aspects</td>
</tr>
<tr>
<td>Stress Management</td>
<td>Stress inoculation model; develops positive coping techniques</td>
</tr>
</tbody>
</table>
APPENDIX F: Summary of Recommendations Made to Agency

Emotion Regulation
- Use Linehan’s Dialectical Behaviour Therapy (DBT)
- Use Linehan’s (1993) *Skills Training Manual for Treating Borderline Personality Disorder*
- Staff member/manager with good relationship with the youth should run the program

Self-Harm
- Use Linehan’s Dialectical Behaviour Therapy (DBT)
- Use Linehan’s (1993) *Skills Training Manual for Treating Borderline Personality Disorder*
- Staff member/manager with good relationship with the youth should run the program

Sexuality
- Continue to use Girls’ Group modules
- Programs should be gender specific
- Adapt modules for males to address same issues
- Include homophobia module

Relationships
- Continue to use Girls’ Group module
- Include males in sessions
- For females, focus may need to be shifted from building relationships with peers to adults
- Further research programs address relationship building and maintain for adolescents

Coping with Physical Abuse
- Use treatment programs created for posttraumatic stress disorder (PTSD) such as trauma-focused cognitive behavioural therapy.
- Programs should educate youth on symptoms of PTSD, encourage them to express thoughts and feelings and teach skills to help cope with stress
- Youth should be assessed for readiness for program
- Staff should attend a course about trauma/PTSD before administering the program
  Trauma-Focused Cognitive Behavior Therapy (TFCBT) is recommended for use
  (Substance Abuse and Mental Health Service Administration, 2008).

Stress Management
- A cognitive-behavioural program should be used
- Program should be geared towards both males and females
• Program should help youth to recognize stressful situations and teach them proper coping techniques that can be applied in various situations
• Meichenbaum’s (1985) stress inoculation training is recommended

NOTE: Copies of relevant articles were given to agency.
APPENDIX G: Summary of Stress Inoculation Treatment Phases

1. Conceptualization Phase

During the group/individual sessions of this phase:

- stressors are identified
- stress in terms of physiological reactions, behaviors, emotions, and cognitions is discussed
- negative and self-defeating cognitions are identified
- self-monitoring sheets are distributed to help identify and monitor negative and self-defeating cognitions
- self-monitoring sheets are gone over in the following session(s)

2. Skill Acquisition Phase

During the group/individual sessions of this phase:

- cognitive restructuring is taught by challenging and restructuring self-defeating cognitions that were identified in the conceptualization phase
- self-defeating thoughts are examined for evidence for and against cognitions and alternative explanations for stress events are examined
- cognitive restructuring is practiced
- clients and trainers together examine the accuracy of the negative cognitions and then develop more realistic thinking for the situation
- clients are given further opportunity to practice cognitive restructuring by "substituting" the more realistic thoughts while imagining their recent stressors within the session(s)
- Incidents and attempts of cognitive restructuring are recorded on self-monitoring sheets

3. Application Phase

During the group/individual sessions of this phase:

- cognitive restructuring is further practiced in anticipation of a future or potential stressor
- clients reveal a likely stressful event that could occur before the next session and apply cognitive restructuring while in imagery and later record the restructured thoughts on a self-monitoring sheet
- the last session is used to discuss whether clients had opportunities to use the skill and how well the prepared responses and applications helped them
- the session ends with a discussion of how the techniques can be used in the future