The Bridges Program at Howard House: An Application of General Strain Theory

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Abstract

Social problems are complex and multifaceted, and as such, so are the potential solutions. For instance, criminality is frequently accompanied by substance abuse and for some individuals, additional psychological or social difficulties also exist. Consequently, the criminal justice system and affiliated organizations face the challenge of treating individuals who may be experiencing multiple problems simultaneously. The Bridges treatment program at Howard House in Edmonton, Alberta provides programming for clients that may be experiencing multiple forms of risk including criminality, substance abuse and challenges to mental health. This research project analyzes the Bridges treatment program within the context of general strain theory, evaluating the program's effectiveness in providing emotional, behavioral, and cognitive coping strategies to address the multiple sources of strain experienced by clients.

Literature Review

The Problems of Crime, Substance Abuse, and Mental Illness

We have only to turn to the news media to see that crime, substance abuse, and mental illness are considered to be social problems in our society. The headline of a top story in the local newspaper tells us of 78 people arrested, as police lay 435 charges following the seizure of numerous guns and drugs during three separate, yet connected raids in Edmonton, Alberta (Griwkowsky, 2015, p. 3). Another story is about a recent information session held by the Edmonton Catholic school board where the Edmonton Police Service announced that as of August 2015, there were more than 145 fentanyl related deaths in Alberta (Robb, 2015, p. 3). A third story is a about a young male in police custody, who was ordered to have an extended psychological assessment to determine if he is mentally fit to stand trial for murder (The Canadian Press, 2015). Although media representations are often biased in a way that contributes to moral panics, criminality, substance abuse and mental illness are real issues that affect people's lives. In fact, police report that they frequently encounter individuals who may not only be criminally active, but also dealing with substance abuse issues and mental illness (White, Goldkamp, Campbell, 2006, p.301). The problem is even more significant when we shift our focus from *mental illness* (which refers to diagnosable conditions associated with impaired functioning) to *mental health* (which refers to a more general state of well-being that involves the everyday ability to cope with life stresses). Individuals with mental illnesses can experience positive mental health if their illnesses are effectively treated, and conversely, people without mental illnesses can experience poor mental health because of excessive life stressors or ineffective coping strategies (Mental Health Commission of Canada, 2013, p. 3-4). As a result, for individuals with comorbid criminality, substance abuse, and/or mental health issues, it is

important to treat those issues simultaneously. Because the benefits of treatment are most apparent when they occur at earlier stages in life, the treatment of comorbidity in youth is especially important. For that reason, the question becomes how to most effectively address the joint issues of criminality, substance abuse, and/or poor mental health in youth populations. Therefore, by reviewing the current research literature on the factors associated with crime, substance abuse, and poor mental health, as well as the range of treatment options available, what constitutes more *effective* treatment may become clear.

Explaining Criminality, Substance Abuse, and Poor Mental Health

Explanations for criminality, substance abuse, and poor mental health can be theoretically- or empirically-based; they may focus on biological, psychological, or sociological factors. Biological explanations focus on the traits or pathologies that characterize the physical bodies of some individuals. For example, in the early 20th century individuals who were criminally active were viewed as primitive creatures who were constrained by their biology. Criminals were often referred to as “atavists” or “evolutionary throwbacks” and criminal activity was associated with various bodily characteristics (Lombroso, as cited by Caputo & Linden, 2009, p. 232-234; Sheldon, as cited by Caputo & Linden, 2009, p. 238-239). Although those early biological theories of crime were discredited, other biological explanations are offered today. For example, evolutionary neuroandrogenic theory has been extended to explain several genetic factors which may place individuals at higher risk for criminality, substance abuse, and poor mental health issues, including the following: heritability, personality, and sex differences (Ellis & Hoskin, 2015, p. 62-63). Similarly, researchers have identified certain biological factors that may be associated with substance abuse or mental illness, such as genetic predispositions (Kendler, Ohlsson, Sundquist, Sundquist, 2015, p. 555-559; Rahmani, Paul, Nguyen, 2014, p. 297-299).

Psychological explanations focus on the traits or pathologies that characterize the psychological processes of some individuals. At times, these psychological processes may integrate some biological components. For example, the explanation for substance abuse offered by opponent process theory explains that there are two internal processes that work together, producing both desirable and adversarial effects in the formation of addiction. More specifically, there is an underlying process that produces an adversarial progression that creates both pleasurable and adverse effects for the substance abuser. Initially the pleasurable effects are intense, with only mild adverse effects allowing the individual to keep using drugs; however, as their drug use continues the pleasurable effects diminish in intensity and the adverse effects strengthen (West, 2006, p. 40). Koob and Volkow (2010) go into more detail describing the neurocircuitry involved in opponent process theory, as they explain how substances appropriate receptors in various areas of the brain which motivates the substance abuser to continue using drugs (p. 219). Moreover, although abstinence can reduce the effects of the opponent processing system, this theory maintains the belief that the system may never fully recover, leaving the individual always vulnerable to relapse (West, 2006, p. 41-43). Unfortunately, many people, especially those in the medical health profession, adhere to a disease model of addiction which suggests that substance abuse is a disease which can be treated, but not cured (West, 2006, p. 76). Nevertheless, in the domain of psychology, the *DSM-V* describes addiction as involving problematic patterns of substance use causing severe impairment or distress over a 12-month period characterized by cravings, tolerance, withdrawal, and a general lack of motivation for non-drug related activities (Barlow, Durand, Stewart, Lalumiere, 2015, p. 385-400).

Other psychological explanations emphasize the cognitive components of psychological processes. For instance, cognitive bias theory argues that an addict's memory stores cognitive

cues related to their substance use which triggers an emotional response resulting in behaviors like substance abuse (West, 2006, p. 56-58). Cognitive models have also been applied to criminality and mental illness. For example, Walters and DeLisi (2013) found cognitions, especially those related to antisocial personalities, can partially explain the continuance of crime in an individual (p.138). Similarly, a recent article explains a linkage between cognitions related to dealing with stressful situations and symptoms of depression (Stecca et. al., 2013, p. 138).

Social psychological explanations begin to shift their focus away from the characteristics of individuals themselves and toward the way social situations affect individual thoughts, feelings and behaviours. For instance, social learning theory professes that cognitive cues are developed through the system of rewards and punishments an individual is exposed to in his or her social environment, by observing and listening to those systems others are exposed to and by imitation (Bandura, Burgess & Akers, Akers as cited in Bereska, 2014, p. 56-57). Social learning theory is also used to explain substance abuse (West, 2006, p. 105-107). In other words, people learn both acceptable and unacceptable behavior from their peers, their families, and their surroundings. Through these social psychological processes, youth develop cognitive cues that may support criminal behaviour, substance use, or problematic coping strategies.

From a sociological lens, many biological and psychological explanations individualize the problems of criminality, substance abuse, and poor mental health as individual characteristics which, in some cases (e.g., genetic predispositions) may be resistant to change. However, individual choices and experiences are embedded within larger sociocultural structures. If criminality, substance abuse, and poor mental health were strictly biological or psychological in nature, there would be no differences among varying social groups or on the basis of social factors. However, a recent study identifies influences such as poor neighbourhoods, low

education, and unemployment as social factors that place individuals at a higher risk for developing criminality and/or substance abuse issues (Munford & Sanders, 2015, p. 617). More comprehensively, empirical research finds that a wide range of individual factors (e.g., low self-esteem), family factors (e.g., overly strict or overly-lax parenting), school factors (e.g. feeling a lack of belonging), and community factors (e.g. living in a community characterized by social disorganization) are associated with all aspects of comorbidity in youth—criminality, substance use and abuse, and poor mental health.

Sociological theories also draw attention to the social environments in which youth live. For instance, learning theories attribute people's behaviour to processes of learning. More specifically, Sutherland's differential association theory argues that it is through interactions with intimate groups of others (i.e. families, peers) that individuals learn the motives and techniques associated with their behaviours, whether those behaviours are associated with succeeding in school, or conversely, those associated with crime, substance use, or coping with life's stresses (Sutherland, as cited in Bereska, 2014, p. 52-53). Additionally, Functionalist theories attribute people's behaviour to characteristics of the social structure. In fact, Robert Merton's strain theory states that criminality occurs because of a gap between an individual's goals and their ability to reach these goals (Merton, as cited by Bereska, 2014, p. 42-44; Hackler, 2009, p. 284). In Merton's view, people may turn to crime in an "innovative" mode of adaptation or to substance abuse as a "retreatist" mode of adaptation; he argued that even mental illness could be an outcome of the "retreatist" mode of adaptation (Merton, as cited by Bereska, 2014, p. 44). Extending on Merton's theory, over the last few years Agnew's general strain theory has become perhaps the most frequently-used positivist theory in studies of deviant behaviour (Agnew, 1992, 2001, 2006). It has been applied to a wide range of negative outcomes, including criminality,

substance abuse, self-harm, suicide ideation, and more (Agnew, as cited in Bereska, in press, p. 2-17). Agnew argues strain (such as poverty, socially-disorganized communities, poorly-equipped schools, and so on) creates negative emotions and we use coping strategies to deal with those negative emotions; however, the specific coping strategies that we use can lead us to negative outcomes (that is, deviant behaviour) or non-deviant outcomes (that is, non-deviant behaviour) (Agnew, as cited in Bereska, in press, p. 2-16, 2-17). Moreover, if behavior associated with crime, substance abuse, or poor coping skills is learned, the associated costs are incredible.

Costs related to Crime, Substance Abuse, and Mental Illness

The costs associated with crime, substance abuse, and mental illness affect individuals, their families, and the larger society. At the societal level, the costs of crime are considerable. For example, it costs $80 000 a year to incarcerate one individual (Bell, 2012, p. 305). Furthermore, although these costs vary considerably according to the type of offence, the Corrections Canada 2013-14 report on plans and priorities indicates that more than a billion dollars were expected to be spent on incarceration in 2015-16 (Toews, p. 17). Unfortunately, after many individuals are set free from incarceration, they often reoffend. Therefore, while incarceration detains the individual, it does not necessarily treat the individual. Additionally, while costs related to substance abuse vary from province to province, a recent report published by the Canadian Center on Substance Abuse indicates costs to society are $40 billion per year (Pirie, Jesseman, National Treatment Indicators Working Group, 2013, p. 3). These are tremendous costs.

The costs of mental illness are considerable as well. According to the Mental Health Commission of Canada (2013), treatment, care, and support services for people experiencing mental illness run in excess of $50 billion per year (p. 15). If we were to consider not just

individuals with mental illnesses, but also those who have poor mental health (without an existing mental illness), those costs would be magnified even further.

Families are affected by crime, substance abuse, and poor mental health as well, each of which can strain family relationships and threaten bonds between family members. For instance, substance abuse affects families as they worry about their loved ones, lose confidence in and come to distrust the substance abuser, and come to feel increasingly vulnerable . . . essentially, substance abuse rips families apart (Alvarez, Gomes, Xavier, 2014, p. 645). Moreover, parental substance abuse affects children since parents who abuse drugs often cannot adequately provide for a developing child. In fact, for several children in need of protection, at least one parent has substance abuse issues. Additionally, many of these children are not returned to their parents (National Center on Addiction and Substance Abuse, U.S. Department of Health and Human Services, Worcel, Furrer, Green, Burrus, Finigan as cited in Bruns, Pullman, Weathers, Wirschem, Murphy, 2012, p. 218). In other words, children of substance abusing parents are removed from the home and placed in foster care in the custody of the government, sometimes permanently, which creates an overwhelming burden on children's services. Sadly, these children don't understand why they have lost their parents, often resulting in feelings of abandonment, as well as other psychological and/or developmental issues.

Costs are also born to those individuals who engage in criminal activity or substance abuse, or who have poor mental health. Level of education, employment prospects, and income can all be affected, however of particular note are the implications for how they think about themselves and their futures. Once an individual's criminality, substance abuse, or poor mental health is detected by others, they are given a label—such as "thief," "addict," or "crazy." But labels can have a whole set of consequences in of themselves. More specifically, labelling theory

proposes that once an individual is given a label, others begin to treat that person differently, and the label becomes internalized so that the individual no longer sees the act as being a mistake or bad choice but rather begins to define themselves according to the label (Lemert as cited in Bereska, 2014, p. 70-74; Stebbins, 2009, 372-374). Therefore, the person's attitudes and behaviors come to reflect the attitudes and behaviors coinciding with their label. Basically, the label can become a self-fulfilling prophecy. Additionally, once given a label of addict or criminal, not only do they identify themselves by this label, others begin to identify them by the label. Their peers may stop associating with them, their families might even stop talking to them. Potential employers may see only the label and refuse to hire them. This loss of social networks is known as the process of stigmatization. In fact, Goffman (1986) explains that stigma is formed by a connection between the characteristic and label (p. 4). In other words, the characteristics of committing a crime or using drugs are connected to the label of a criminal or an addict. Even though the individual feels no different from others, they come to be perceived as the label by others, as well as themselves (Goffman, 1986, p. 108). Therefore the individual begins to seek out others who share the label (Goffman, 1986, p. 23).

Moreover, as Munford and Sanders (2015) explore the connections between individual choice, social structures, and social capital in factors such as education, employment, family, peers, and neighbourhoods, they found that individuals with substance abuse and criminality issues feel as though they lack control over their lives. Therefore, they make choices based on the best available choice within a host of unfavorable options. As result, these individuals exhibit a limited form of agency regarding the choices they are able to make in their life (p. 617). In sum, a lack of effective social structures, processes, interactions, and capital combined with

limited agency places considerable strain on the substance abuser which reinforces motivations for abusing substances and criminality.

In sum, crime, substance abuse, and poor mental health carry tremendous costs for society, families, and individuals. Thus, providing effective treatment for those experiencing these issues would benefit those individuals, their families, and society.

Treating Criminality and Substance Abuse, and Improving Mental Health

Criminality is treated in a variety of ways, ranging from incarceration to probation to fines and/or restitution. Individuals who are experiencing poor mental health have a variety of medical and psychosocial supports available to them. For instance, individuals experiencing mental illness may benefit from psychotropic medications, counselling, support groups, community-based programs, or in severe cases, even hospitalization. Treatments for substance abuse are also multifaceted. Some treatments are based on medical supports. For example, individuals with an opioid addiction are offered replacement drugs like methadone. Methadone maintenance therapy is a pharmacological form of treatment in which an opiate substitute such as methadone is administered in controlled amounts as a replacement drug so that the individual can maintain a functional lifestyle (Bahr, Masters, Taylor, 2012, p. 162). While undergoing treatment, methadone has shown to be effective as an alternative in treating substance abuse and it is associated with a reduction in opioid use within a prison setting (Bahr, Masters, Taylor, 2012, p. 162; Hedrich et. al., 2011, p. 511); however, not many people are enthusiastic about using this particular medical support. In fact, studies have shown that many people, including those within the justice system and the medical profession, regard those with substance abuse issues (especially an opioid abuse issue) as unworthy of treatment (Johns, 1994, p. 1551-1552; McMillan & Lapham, 2004, p. 60). Nevertheless, about one-third of the individuals who partake

in a methadone maintenance treatment do well by alleviating some of the more adverse effects of recovering from an opioid addiction (Johns, 1994, p. 1552). Furthermore, it was found that while addiction staff may view the addicted individual as having a disease (following from the disease model applied to addictions) which implies there is no cure, historically, many substance abusers are reluctant to share this view (Ball, Graff, Sheehan 1974, p. 93-95).

Other forms of treatment move away from the medical model, providing an alternative form of treatment. Here the form of treatment the public is probably most familiar with is 12-step meetings such as Narcotic Anonymous or Alcoholics Anonymous. More specifically:

> Twelve-step programs assume that substance dependence is a life-long disease that can be managed but not cured. The program is based on 12 steps of recovery that individuals strive to attain while regularly reporting their progress and struggles. Key components of 12-step programs are (a) recognizing that you will always be an addict, (b) weekly or biweekly meetings with a nonprofessional support group of individuals with similar problems, (c) recognizing and relying on a higher power, (d) performing service to others, and (e) group and individual counseling sessions. (Bahr, Masters, Taylor, 2012, p. 165)

Still, 12-step support groups often adhere to the disease model of addiction, requiring the individual to accept the lifelong label of “addict”. As labelling theories point out, internalizing a negative label can carry significant consequences. Moreover, little research has been done to support the efficacy of 12-step programs (Bahr, Masters, Taylor, 2012, p. 165). But most importantly for the purposes of this research project, these commonly utilized methods fail to treat criminality, substance abuse, and mental health simultaneously.

Moreover, barriers and stressors such as unemployment, relationship break downs, and homelessness have also been identified as high risk factors (Davies, Elison. Ward, Laudet, 2015, p. 5). If these barriers are not addressed the strain on individuals perpetuating crime, substance abuse, and poor mental health continues. For that reason, treatment addressing lifestyle barriers with a cognitive behavioral foundation is ideal for improving comorbid issues of criminality, substance abuse, and poor mental health.

Cognitive Behavioral Therapy

Cognitive behavioral therapy has been used to treat criminality, substance abuse and a variety of mental illnesses including depression and anxiety (Barlow, 2015, p. 57, 415). It has a social learning foundation and is commonly referred to as a relapse prevention model (Newring, Loverich, Harris, Wheeler as cited in O'Donohue & Fisher, 2008, p. 422; Barlow, Durand, Stewart, Lalumiere, 2015, p. 415). Therefore, cognitive behavioral therapy is not a first step form of treatment. Rather, it is intended for individuals who have already began their recovery to continue to improve their lives.

Cognitive behavioral therapy (CBT) was developed from both cognitive theories and behavioral theories but is more than just a combination of the two theories; it involves a multitude of techniques, (Kouimtsidis, Reynolds, Drummond, Davis, Tarrier, 2007, p. 7). One common cognitive technique in CBT involves educating the individual and enhancing motivation for therapy/change. Here the therapist must remember it is the client's perceptions that are important, rather than the therapist's own reality. The therapist encourages the client to reflect on his or her behaviour (such as drug use or criminal acts) and guides them to a point where the client can recognize his or her own problem. Another technique is referred to as "the Socratic method" which involves responding with questions to try and guide the client to his or

her own solutions. In particular, individuals are encouraged to keep a daily thought record, recording specific interactions, initial beliefs, emotions, responses, outcomes, and alternative ways of handling the situation. Furthermore, distraction methods may be utilized allowing the individual to place focus elsewhere. Additionally, clients can be encouraged to compare the advantages of their behavior with the disadvantages. Also, flash cards can help the individual reinforce their newly learned responses as automatic responses that he or she won't have to consciously think of. Alternatively, the individual can create a map with arrows to try and identify the core beliefs that are influencing his or her automatic thoughts. Lastly, another common technique involves having the client imagine specific situations so that they may practice their newly acquired skills (Kouimtsdis, Reynolds, Drummond, Davis, Tarrier, 2007, p. 37-49).

Common behavioral techniques utilized in CBT include the following: keeping an activity journal to help identify problematic behaviors, relaxation training, physical exercise, role-play scenerios, behavioral experiments to validate the clients' willingness to change, as well as positive reinforcement to encourage optimistic cognitions and/or behaviors. Rewards for positive reinforcement can include items such as books, movies, food, clothing, or transportation and are used to reinforce behaviors like therapy attendance, therapeutic engagement, and effort in lifestyle improvement (Kouimtsdis, Reynolds, Drummond, Davis, Tarrier, 2007, p. 52-58). Ultimately, in cognitive-behavioral therapy, it is believed that the clients' perception of a situation is paramount because their perceptions of a situation affect their emotional, as well as, behavioral responses (Kouimtsidis, Reynolds, Drummond, Davis, Tarrier, 2007, p. 24). Therefore, using a symbolic interactionist perspective is ideal because it also emphasizes individual subjective understandings, views of society, social issues, and of one's self.

Additionally, cognitive behavioural therapy is focused on looking at alternative perspectives to develop different responses when difficult situations arise (Kouimtsdis, Reynolds, Drummond, Davis, Tarrier, 2007, p. 25). More specifically, a CBT model involves utilizing various techniques to help the individual identify maladaptive cognitions, emotions, and behavioural responses so that they can learn more adaptive ways of avoiding or coping with the difficult situation (Kouimtsidis, Reynolds, Drummond, Davis, Tarrier, 2007, p. 25). As a result, the client is able to find a more constructive outlet.

Prior to partaking in cognitive behavioral therapy, first the therapist must create a detailed assessment of the client, placing emphasis on things such as motivation, education, as well as, reasserting self-control and building trust (Kouimtsdis, Reynolds, Drummond, Davis, Tarrier, 2007, p. 33). Although there is no set number of sessions prescribed in cognitive behavioral therapy, it often involves a relatively short time period of at least 12 sessions that are focused, in the moment, and case specific (Kouimtsdis, Reynolds, Drummond, Davis, Tarrier, 2007, p. 62, 11). Each session lasts about 50 minutes which is divided up into three parts. During the first fifteen minutes, the therapist and client will review what has transpired since the last session, discuss current issues, reflect on past sessions, reviewing any homework that may have been assigned, and discuss the format of the current session (Kouimtsdis, Reynolds, Drummond, Davis, Tarrier, 2007, p. 65). For the next twenty minutes, problems such as depression, anxiety, low self-esteem, aggression and impulse control, trauma and/or abuse, relationship issues, treatment engagement, high risk behavior, criminal behavior, and sleep issues are addressed (Kouimtsdis, Reynolds, Drummond, Davis, Tarrier, 2007, p. 122-141). Finally, the last 15 minutes, are used for the client to ask any questions or provide any feedback regarding their treatment that they may have, and to assign reflective homework for the following session. While

I have just explained a basic CBT format, cognitive behavioral therapy actually has over 80 different techniques which can be combined and utilized depending on individual case specific needs, making it one of the most versatile therapies available. (O'Donohue & Fisher, 2008, p. 2-3).

Cognitive behavioural therapy also works well in a group setting with only a few differences. Whereas it is recommended that an individual CBT session should last for approximately 50 minutes, it is advised that group sessions run for about two hours because it allows for more flexibility, as well as for more individuals within the group to become engaged during the session, and for more through engagement in behavioral activities like role-play and/or imagined exposure scenarios ((Bieling, McCabe, Antony, 2009, p. 95). Additionally, group CBT consists of four phases. The first phase focuses on the therapeutic alliance, and building group cohesion (Bieling, McCabe, Antony, 2009, p. 42). The next phase occurs once individuals start becoming more comfortable with the people around them and begin expressing concerns over problems that they are experiencing in their own lives; however they may still be questioning the process and still feel hesitant (Bieling, McCabe, Antony, 2009, p. 43). The third phase or "working phase" takes place as the group engages in a variety of in-session and out-of-session cognitive and behavioral activities aimed at promoting individual reflection and ultimately, improved lifestyle maintenance (Bieling, McCabe, Antony, 2009, p. 43). In the end, during the last phase, individuals are asked to consider the ways in which they have grown, the barriers have they have broken through, and where they plan to go from this point (Bieling, McCabe, Antony, 2009, p. 43).

As a result, group dynamics can contribute to individual cognitive behavioral therapy sessions in a variety of ways: motivational feedback from group members helps foster the same

motivational optimism in other members or the group as a whole; members are given the opportunity to recognize that they are not alone in their struggles; members get to learn from others (besides the therapist) who they may be better able to relate to; group format allows the focus to be shifted from the individual to the group, alleviating tensions; social learning occurs as members model more positive responses; and group solidarity builds trust, friendships, and bonds (Bieling, McCabe, Antony, 2009, p. 26-30). Therefore, it is important that individuals are allowed to interact, respond, and feed off each other in positive ways within a group setting (Bieling, McCabe, Antony, 2009, p. 34-39); however, it is worth noting that some problems with group setting such as ineffective leadership, the formation of subgroups not conducive to recovery, or personality conflicts between participants may arise (Bieling, McCabe, Antony, 2009, p. 45). For that reason, Harris and Brazeau (2012) emphasize the importance of focusing on individual strengths valued by both the individual and society to create strong group cohesion, a positive group environment, better self-esteem, and better treatment outcomes (p. 344).

Furthermore, although group cognitive behavioral therapy has been shown to have great efficacy for treating youth over the years when compared to other forms of treatment, premature dropout rates are still high; however, other factors such as an individual's ability for abstract reasoning, coping skills treatment, and group dynamics have the potential to produce greater success (Harris et al. 2012, p. 334; Rotgers & Nguyen as cited in O'Donohue, 2009, p. 305-306). Additionally, a recent study conducted by Gonzales, Anglin, Glik, and Zavalza (2013) regarding youth's perceptions about recovery needs and drug avoidance behaviours while in treatment for addiction indicates four themes: promotion of community involvement, learning to use effective coping strategies, explaining alternative options, and information education (p. 300-301). Therefore, cognitive behavioural therapy seems to be a good approach for addressing the needs

identified by youth to improve their lives and become more positive members of society. Furthermore, CBT serves as the foundation for many treatment programs including the Bridges treatment program offered at Howard House.

Literature Review: Conclusion

We know from research on the comorbidity of criminality, substance abuse, and poor mental health that the factors associated with those phenomena are complex and multifaceted, ranging from the micro level to the macro level. Nevertheless, not all individuals who experience these phenomena are the same. They have different ethnicities and come from varying backgrounds. As a result, treatment has to be careful not to try to fit all individuals into the same set of stereotyped expectations (Perry, 2013, p. 538). In other words, what works for one individual may be very different than what will work for another individual. Therefore, the question is to what extent do cognitive behavioral therapy based programs, such as the Bridges treatment program offered at Howard House, facilitate the development of positive coping strategies in the face of strains experienced at the individual, school, family, and community levels?

Methodology

Bridges Treatment Program

The Bridges program is a collaborative partnership between the Edmonton John Howard Society, Edmonton Public Schools, and Alberta Health Services that helps young male offenders experiencing criminality, substance abuse, and often mental health issues, who are serving their sentences within the community. It is a 90 day residential program consisting of eight beds which can accommodate up to 36 individuals per year (EJHS, 2012/2013, p. 9). The Bridges treatment program a cognitive behavioral therapy program that utilizes various techniques to help the individual identify maladaptive cognitions, emotions, and behavioural responses so that

they can learn more adaptive ways of avoiding or coping with difficult situations (Kouimtsidis, Reynolds, Drummond, Davis, Tarrier, 2007, p. 25). Moreover, the John Howard Society's policy on "Input from Persons Served and Other Stakeholders" (effective April 2015) requires that program planning and development be based on input from both staff working with those programs and clients being served by programs such as the Bridges program at Howard House.

Data collection

The research consisted of 9 semi-structured qualitative interviews with people employed by the Bridges program. A case study was also done with a client (aged 18+) who, at the time of the study, was being served by the program. All interviews were conducted at the Bridges program offered at Howard House, in a private room.

Data analysis

The purpose of the interviews was to record participant responses about the program in order to analyze what sources of strain clients faced in the program and what strategies were learned to cope with those sources of strain.

The responses provided during the interviews were analyzed to determine common sources of strain among clients in the program and what strategies were clients learning to cope with those sources of strain. A content analysis of program documents was also done. Program documents included the following: the treatment curriculum, the social/life skills curriculum, a parent-guardian handbook, the residential handbook, and the policies and procedures manual.

Recruitment of Participants / Sampling

People employed with Bridges were recruited through an open-ended email invitation, sent out by the agency, inviting potentially-interested participants to contact the primary researcher via email to schedule an interview. No compensation was provided to this group.

The case study was conducted with a client (aged 18 and over) being served by the Bridges program at the time of the study. Because clients do not have access to email they were recruited through a poster placed in a common area of Howard House; the poster included details for contacting the researcher in person (as the researcher was on site conducting the content analysis) or through a staff member to schedule an interview. The case study participant was given a $10 Tim Horton's gift card, provided by MacEwan University, to compensate them for their time. The case study participant was notified of the honorarium on the poster, and at the time consent was obtained. They were also reminded that they could withdraw their consent at any time without penalty, keeping the gift card.

Inclusion and Exclusion Criteria

Inclusion criteria included all individuals working with the Bridges program, and individuals, aged 18 and over, being served by the program. For ethical and legal reasons, individuals under 18 who are participating in the program will be excluded. Also, because this study comprises an evaluation of the program, any individuals not affiliated with Bridges will be excluded.

Results

The results identified multiple sources of strain faced by clients participating in the Bridges that exist at the individual, school, family, and community level. Moreover, the Bridges program provides cognitive, emotional, and behavioral coping strategies so clients are better prepared to deal with those individual, school, family, and community sources of strain.

Sources of Strain

Individual level. The program documents indicate that staff and clients work together to identify barriers and create goals to overcome those barriers. Some common sources of strain identified at the Individual include boredom, individual emotional states, and self-esteem.

Boredom. In fact, staff members expressed that "boredom is one of the big ones" (Staff 1) and explained that:

> idle hands are the devils playground . . . so if we can teach the boys to keep themselves occupied and hopefully encourage some investment in prosocial activity we find it often helps them to . . . avoid the boredom that leads to a lot of these kinds of things," (Staff 4)

as well as, expressed "when the boys aren't in school, they tend to get really really bored and it leads to behavioral concerns" (Staff 3).Therefore, boredom is a source of strain experienced at the individual level by clients in the Bridges program at Howard House.

Individual emotional states. Individual Emotional States are another common source of strain found at the individual level. A staff member clarified that:

> most of the time when [the clients] come into the program they understand a single emotion that is angry, and they interpret everything else as anger, So that results in a lot of negative interactions with peers, with parents, with professionals, with teachers because whether they're embarrassed, or whether they're disappointed to them it's like anger and they tend to act on that as though it was anger. (Staff 4)

Staff also expressed:

> The emotion part is really important because if you interpret non-angry emotions as anger and react as though it was anger you are likely to become aggressive with people, potentially violent with people that you may not become violent with in a situation where you recognize the emotion for what it was. (Staff 4)

Self-Esteem. Finally, self-esteem was identified as an individual source of strain.

Staff expressed for clients that:

> Not hearing how bad they are, how stupid they are, that they can't succeed all the time.. . .all those negative things they have heard in the past from, I don't know, lawyers, parents, parents friends, peers, teachers, it can be quite the extensive list of negativity. (Staff 7)

In sum, boredom, individual emotional states, and self-esteem are identified as sources of individual strain.

School level. Some common sources of strain identified at the school level include negative experiences and poor academic performance. These sources of strain are evident in staff comments explaining problems such as "not having positive experiences in school" or articulating "You don't know how many times I've heard a kid say 'that was my first credits I ever earned in school'" (Staff 1) or a staff expressing "a student that's 18 and has got 0 credits, what are the chances of him going to finish high school, so let's try and be employable (Staff 5). All in all, negative experiences and poor academic performance are identified as sources of strain experienced by clients in the Bridges program at the school level

Family level. Sources of strain at the family level can include negative role models, family violence, and histories of crime and substance use. These sources of strain are articulated as a staff member explained that "it's really a mixed bag" and articulated:

> I've meet some really good parents, they are very engaged, very interested, very helpful, and very supportive and I've met parents who for instance would call their child in the program for legal advice . . . and when you end up with parents that are very very

> antisocial or very very neglectful or not engaged or even resistant to what we are trying to do, it can lead to some serious challenges. (Staff 4)

And as another staff member expressed that:

> Most of our youth, in my opinion, have missed out on a lot of things that are part in parcel of a more healthy development whether that be not having a positive male role model, seeing family violence and abuse, having a family dynamic where substance use is the accepted norm with everyone . . . those kinds of things. (Staff 1)

Or as another staff explains that "the kinda kid that struggle with behavior growing up, often times the parents are just on him, and on him, and just pointing out all the negatives" (Staff 7). For those reasons, family dynamics can also identified as sources of strain in an individual's life.

Community level. At the Community level, Cognitive Behavioral Therapy programs focus on individual responsibilities within a community environment. Therefore, staff expressed that "negative interactions with peers, with parents, with professionals, [and] with teachers" were sources of strain and explained that "typically we focus on their freedom, their legal concerns, as well as relationships with family, with friends, with future significant others, their education and potential work environments" (Staff 7). Additionally, the client case study emphasized that:

> We are here to work on ourselves. So, we are here to realize that what we did was wrong and it ended up us in jail. So, it's allowed me to realize that what I do affects the community, what I do affects myself as well, and I work on myself, not my family, not my friends. (Case Study)

Therefore, in response to these individual, school, family and community sources of strain, the Bridges Treatment program at Howard House provides cognitive, emotional, and behavioral coping strategies.

Coping Strategies

Cognitive coping strategies. Cognitive coping strategies provided at Bridges involve challenging maladaptive thoughts such as behavior justifications, blaming, and jail house mentalities. Behavior justifications refer to the ways in which clients rationalize their behavior, Blaming involves blaming other people or outside factors for their actions, and jailhouse mentalities include tough guy personas, big egos, and paranoia. Additionally, clients are assigned cog-logs as homework. It was clarified by a client that:

> Cog-logs basically challenge your thoughts . . . your perceptions, your behaviors and asks questions like how is this helping you? How is it affecting others? Are you staying safe? When thinking about this stuff is it keeping you out of trouble? . . . And then basically we have to challenge it on the other side to healthy thoughts, healthy habits, and healthy perceptions. (Case Study)

The case study also stated:

> The program helps me deal with . . . negative influences that I've had in my past and helping me realize now that they are negative. So, how I thought stealing cars was the greatest thing in the world, I found out that it actually isn't and it doesn't help me. (Case study)

Moreover, one staff elaborated that “It gives us an opportunity to get them to not only recognize again but also to challenge their thoughts and to recognize that their perception of the situation is not the only perception of the situation” (Staff 6).

Another staff member articulated:

> So instead of focussing on the negative stuff that they’ve seen in themselves and that part of their guise that they have out there of being this antisocial badass, we try to replace that with more positive things and build up those things that the rest of society sees as positive. So we try to build up their confidence and those areas. (Staff 3)

On a cognitive level the program also helps with healthy relationships. One staff explained:

> we do some work with boundaries so establishing what types of relationships are healthy, what types of relationships are negative for them, how, what the risk level is for them moving forward in those relationships if they expect to continue on with their peer relationships or their family relationships whether they’re healthy, whether they’re unhealthy, how they can go about setting boundaries to set themselves up for success once they leave here. (Staff 7)

The case study confirmed, explaining that:

> It helps me create healthy relationships by understanding that the relationships I have had in the past could affect my behaviors and thoughts, and how the relationships I want to have with family, friends, etc. in the future would allow me to realize my skills that I have learned here and create healthy relationships. (Case study)

Additionally, a Staff member explained:

> The relationship building is huge. So all of the things like that kind of build into motivational interviewing and recognizing the stages of change and really taking the time to build relationships because you could have the best counsellor, the best approach, the best program and if you don't have a relationship with the youth nothing happens. And it seems to be a situation where if the relationship is there, in my opinion, if the relationship is there and you catch the youth at that moment when they are saying "yeah there's this piece of something that I don't like that maybe I want to change and you have those two happening at the same time then you can maybe ground them a bit but even that window for maybe I don't like this can close really quickly right? But if you have that relationship there, even if you miss the window and it closes quickly you can kind of use those motivational interviewing kind of questions and pointing out "you know you said you'd really like to go to school and play on the football team, how is that going to work if your hanging around with friends getting high all the time?" and you can use that relationship, hopefully, to reopen that window. (Staff 1)

Cognitive skills are also utilized during runs in the river valley. The case study elaborates:

> the first run I went on, I was totally like I can't do this, it's not even worth it, why am I doing this and all I got from the staff is 'you can do it', 'you're doing great', 'keep up the good work', 'you're pushing yourself', you're doing great', and it's just like total encouragement. (Case Study)

Additionally, Chart 1 illustrates that the anonymous client surveys shows 100% of clients last year either agreed or strongly agreed that the program helped with healthy problem solving, approximately, 90% felt the program helped them understand things that led to committing

crime, 84% believed the program helped them understand things that led them to substance abuse, and 90% agreed they were more aware of supports available to them (see Appendix A).

Emotional coping strategies. Emotional Coping Strategies taught while in the Bridges program at Howard House include:

Understanding the difference between primary emotions such as frustration, sadness, or embarrassment and secondary emotions like anger by using things like "I feel statements" (social skills workbook, 2013, p. 5, p.10) which help the kids recognize and express their emotions more appropriately. More specifically, program documents indicate "an 'I feel ' statement emphasizes self-control and ownership of your feelings" by using statements like " I feel embarrassed (emotion) when you yell in public (what happened) because then people stare at us and treat us differently (why you felt the emotion)" (social skills curriculum, p. 10). The clients are also provided with an extensive list of primary emotions to use. Moreover, Staff explained:

> We follow that up by looking at emotions, both primary and secondary, and how those, how displaying or how they act upon their emotions has impacted them as well in the past and in the present like here in a program (Staff 3)

So basically, anger is a secondary emotion that masks primary emotions like frustration, embarrassment, or sadness and the clients learn to express their primary emotions rather than anger. The clients also engage in relaxation techniques such as deep breathing, counting backwards, and visualization.

Staff also expressed "It is helpful to them in helping them respond more appropriately to their emotional state as opposed to just reacting aggressively with violence" (Staff 4) and that "[they]

like . . . having the opportunity to teach the boys how to do things like deescalating their anger . . . essentially how to get along with the world without hurting people" (Staff 4).

Behavioral coping strategies. Finally, Behavioral coping strategies includes things like providing the clients with alternative prosocial activities so clients can deter sources of strain such as boredom, or find alternative peer groups to associate with. One staff member stated:

> Twice a month there is a local church that has floor hockey. I don't even recall how we got originally connected up with them but they know who we are and what we do . . . We'll just make teams and pay ball hockey . . . they've done . . . a big basketball tournament once a year. (Staff 1)

Another staff member explained:

> For instance, this Friday, I think what we're going to do for my group is going to be around health, wellness, and communication. So . . . We'll go on a hike with them and I'm going to get them to explore things and communicate to find different things kind of like in nature and talk about how you can do healthy activities that are free. (Staff 6)

Additionally, the client case study exclaimed "we go a few times a month to a tea place and we sit down and have tea . . . it's just relaxing knowing that prosocial activities can be fun" (Case Study). Other activities include playing sled hockey at the attendance center nearby or going for runs in the river valley with staff, which the client expressed "aren't the greatest but they are fun" (Case Study). Also, when clients have free time they can learn to entertain themselves by watching television, playing board games, or playing cards. Also, during the winter, some of the kids built a snow fort in the backyard.

Moreover, Chart 2 illustrates that data from the anonymous clients surveys show approximately 98% felt the program helped provide prosocial recreation and 100% either agreed or strongly agreed the Bridges program helped teach healthy communication (see Appendix A).

Other skills taught during the weekly meetings include: Learning to be assertive by giving and receiving positive feedback or constructive criticism, empathetic assertion, escalating assertion. Cueing, fogging, taking responsibility, and following instructions (social skills curriculum). Program documents indicate “empathetic assertion is a form of assertion that involves sensitive listening, and paying attention to the other person’s feelings” (social skills curriculum, 2013, p. 17). Conversely, program documents explain escalating assertion involves “a series of responses that increase in assertiveness in order to obtain a desired outcome” (social skills curriculum, 2013, p. 20). Cueing is a skill indicated by program documents “that allows you to give others useful feedback in the moment . . . [it] is a way you can help others” (social skills curriculum, 2013, p. 16). Also, program documents express “fogging” is an assertiveness technique that allows you to receive criticism comfortably without becoming anxious or defensive” (social skills curriculum, 2013, p. 22). Furthermore, staff explained as part of the onsite school curriculum clients learn budgeting skills as they engage in:

> A financial management game that shows they get different careers and it shows them it doesn’t matter what career you are, you can be successful financially, and once they see that you can make money legitimately, I think that’s a big thing not just with crime. And we probably play that once a month and I know there’s lots of schools throughout the province that use that as part of their curriculum. (Staff 5)

Discussion

In accordance with Agnew's general strain theory, cognitive behavioral therapy based programs such as the Bridges treatment program at Howard House identify sources of strain at multiple levels: the individual level (like boredom, emotional states, and low self-esteem); the school level (such as low grades); the family level (including abuse, neglect, and substance use); and the community level (in interactions with others). The program also addresses those sources of strain by providing cognitive, behavioral, and emotional coping strategies that help high risk youth make positive changes in their lives.

Finally, Chart 3 shows the data from the anonymous client surveys indicates that 96 % of clients either agreed or strongly agreed that the support and counselling they received while in the Bridges program helped them make positive changes in their lives (see Appendix B). Moreover, Chart 4 illustrates that 100 % of clients either agreed or strongly agreed that they would recommend the Bridges program to other people (see Appendix B). Therefore, cognitive behavioral therapy based programs such as the Bridges program at Howard House helps youth affected by criminality, substance abuse and/or poor mental health by identifying sources of strain and teaching effective/alternative cognitive, emotional, and behavioral coping strategies.

Recommendations

However, when asked what recommendations people would make to further enhance the program the case study explained "I think the program as is, is pretty good" (Case Study). However, Staff members emphasized things like adding a family component, having a transitional worker, and adding some mandatory follow-up, would further in enhance the program. More specifically, one Staff expressed:

> It's not a family based treatment program but family dynamics are so huge. . . So we miss sometimes being able to help reaching the dynamics of the environment they will be going back too so that they don't have to revert to old behaviors . . . [so] I think adding a piece in there somehow about family therapy, family, engagement, family dynamics would be good. (Staff 1)

Another staff member articulated:

> A more sound transition worker would probably be the biggest aspect I would like to see involved here. We do get some help from people downtown at John Howard. In the past they've had a grant that allowed for a fulltime transition worker from Bridges. It was really effective . . . There was just a level of wrap around service at that point that was really imperative. Unfortunately they didn't get the grant after that first year and haven't had the position back here since. (Staff 7)

And another Staff member explained

> I think it is the follow up after they leave here because I think a lot of them don't get the kind of follow up they are supposed to . . . They probably need counselling for 6 months to a year once they leave here . . . because 3 months is really short if you think about it because most of these kids have been entrenched in the lifestyle for many years. (Staff 8)

Moreover, Agnew's General Strain Theory lends further support for those recommendations. Although there are social psychological components to the theory, it is still a structural theory, in that it proposes characteristics of the social structure contribute to strain. For example, people living in marginalized locations in the social structure are more likely to experience a wide range of sources of strain (such as poverty, socially-disorganized communities, poorly-equipped

schools, and so on) (Bereska, in press, p. 2-17). Because those structural factors will remain in place once clients leave the program and return to their communities, transitional programming would be helpful in them learning to use all of the skills they developed at Bridges in the "real world." It's one thing to develop cognitive, emotional, and behavioural coping strategies while at Howard House--but it's a whole different ballgame learning to apply those strategies in the complexity of the social world outside of Howard House. Even one staff expressed:

> The reality is this is a bubble type environment if you will and when they go back into the community, yes we are in the community, but you know when the restrictions aren't on them, it's going to be mom or dad or PO or social worker or whomever that's going to be youth worker, that's going to be in their world. (Staff 1)

The theory also proposes that strain is more likely to lead to negative emotions (and subsequently the possibility of deviance) if that strain is perceived as unjust, severe, and outside of the individual's control (Agnew, 2001). Structural factors such as poverty fit those criteria. But various non-structural factors fit those criteria as well, such as living in a conflict-ridden family, or being harassed/bullied/discriminated against (based on race, sexual orientation, etc.) (Bereska, in press, p. 2-16). When clients return to the community, in some cases they may be returning to those types of family environments, or they may be subject to discrimination if, for instance, they are indigenous youth or bullying if they identify as an LGBT youth. Follow up services and Transitional programming would, once again, help these youth to use their new skills to combat against poor mental health in the face of family conflict, racial discrimination, or bullying.

Limitations

Because interviews could not be done with clients under the age of 18, only one client's perspective is reflected in the analysis. A wider range of clients would enhance this study by

providing more insight about the program from the client's perspective. Therefore, further studies should be done in which the voices of all clients at the program can have the opportunity to be heard. Additional studies could also use symbolic interactionism to analyze how the interactions within the program contribute to the clients understanding of themselves and the world around them, through the processes like role modelling and the looking glass self.

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APPENDIX A

Chart 1:

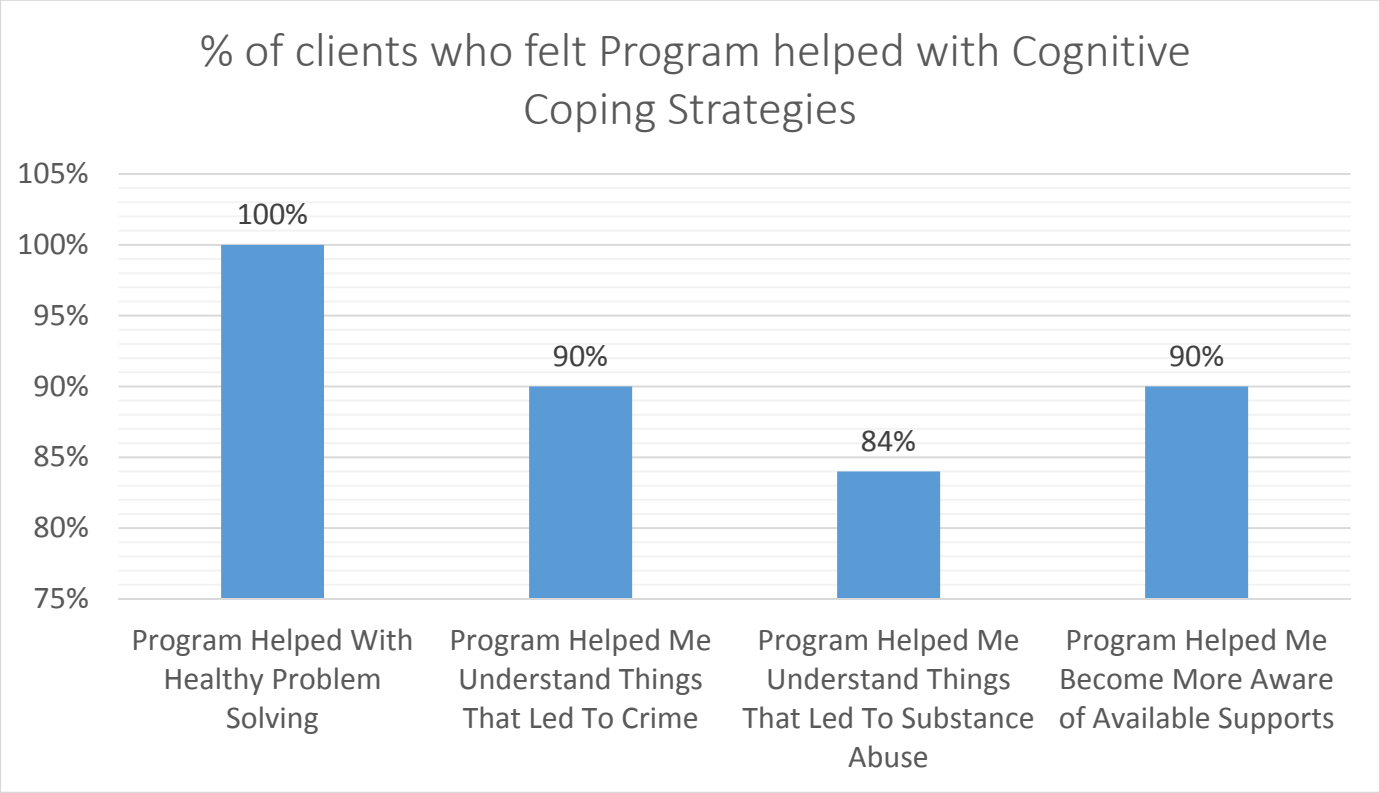
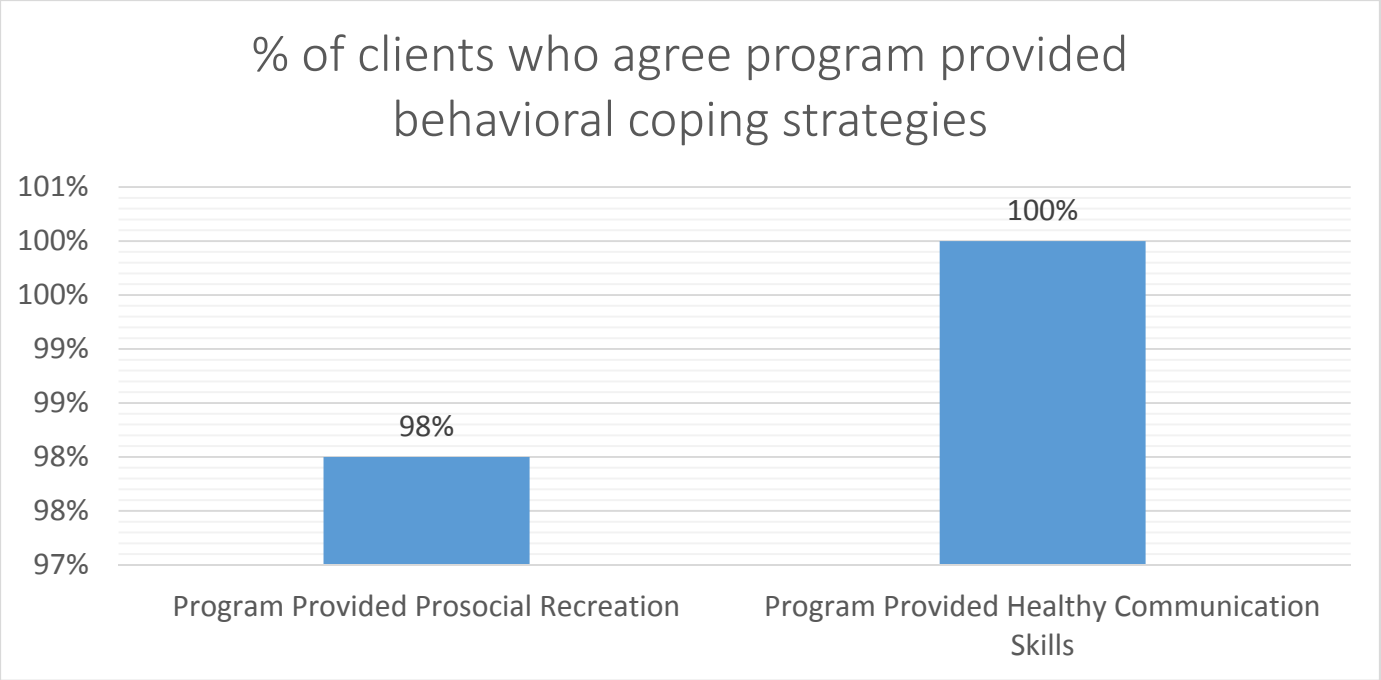


Chart 2:



Appendix B

Chart 3:

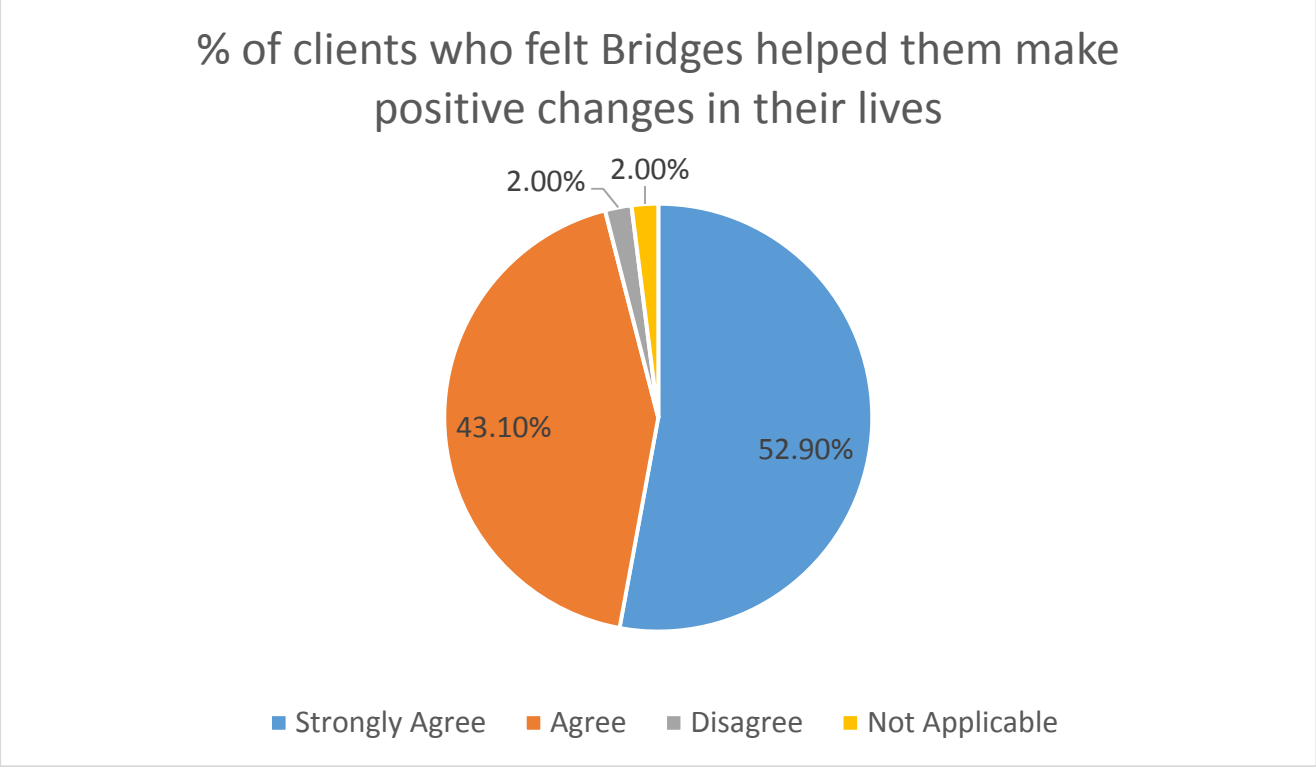
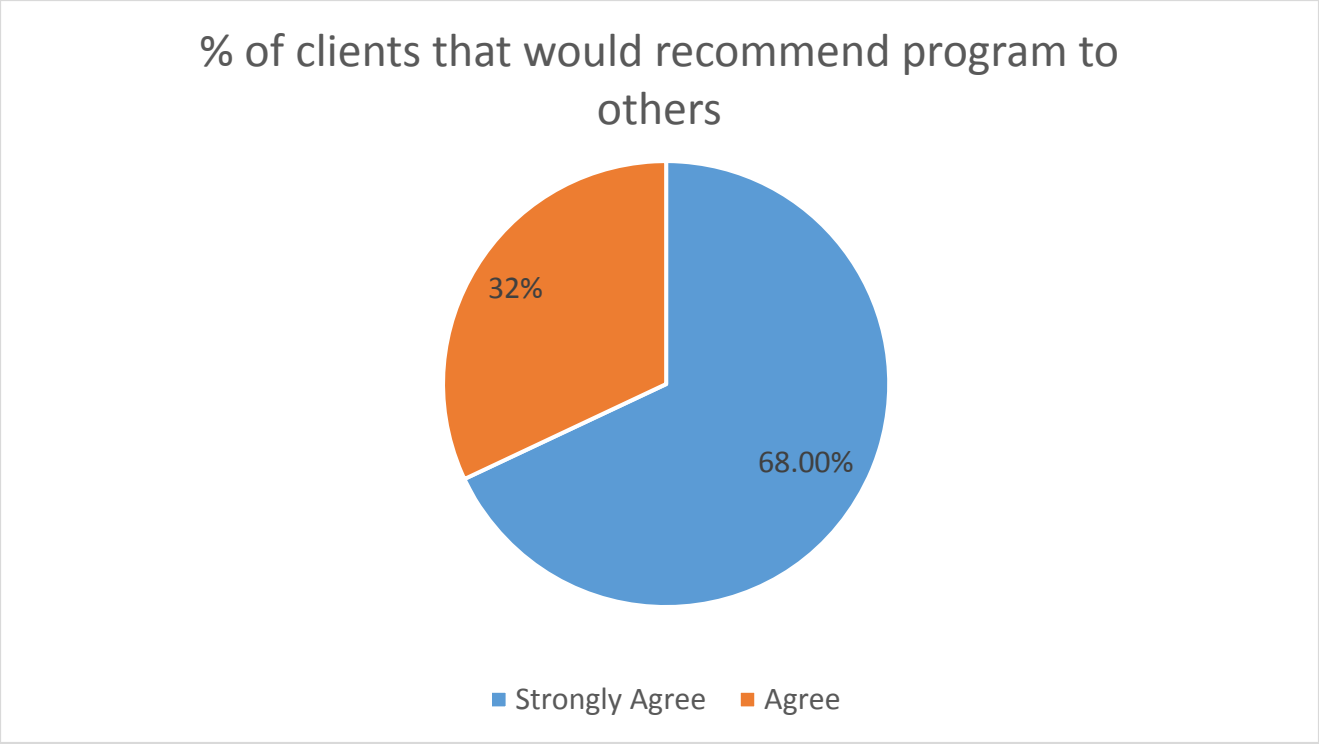


Chart 4:


% of clients that would recommend program to others
32%
68.00%
Strongly Agree
Agree