



“Mental Health and Trauma among Youth in Secure Confinement”

A Proposal by the Tow Youth Justice Institute

University of New Haven

Summary of Scope

Purpose. This proposal addresses the opportunity to assess the mental health and trauma among Connecticut’s youth who are in secure confinement under the supervision of CSSD, DCF, and DOC. The potential to address the legislative mandate stated in Public Act 14-217, which calls for the assessment of mental health in CT, can be expanded beyond the data currently being collected on youth as they enter and exit institutional supervision in Connecticut. This research would align CT with advanced research effort on the overlap of youth, mental health, and juvenile justice in Virginia, Minnesota, Nebraska, Utah, and Texas.

Goals. The TYJI Research Team will 1) identify assessments specific to the mental health, recent traumatic events, and head trauma of youthful offenders, 2) propose assessments for agency approval that could be included in the existing entry and exit processes at each agency, and 3) wait until after the proposed multi-year period has elapsed, then researchers will assess mental health and trauma among youth in secure confinement in Connecticut.

Recent Research on Juvenile Justice Reform and Mental Health

A report by the Annie E. Casey Foundation (2013) found that juvenile incarceration in the United States peaked in 1995 with 107,637 youth in confinement on a single day. The report noted that between 1995 and 2010, overall youth incarceration rates dropped by 41%, and they continue to decline. Though many may argue that the state of juvenile justice is in its best form yet with profoundly reduced incarceration and increased diversion practices, it is now, more than ever, imperative that we continue such efforts while also working to thoroughly understand the youth that *penetrate deeper* into the system, assess and address their needs, and ultimately improve outcomes.

National trends show that the majority of confined juveniles have a diagnosable mental illness, disorder, and/or emotional disturbance. For example, Teplin et al. (2008) compared the prevalence rates of psychiatric disorders between two groups; youth processed as adults and youth processed as juveniles. Utilizing a random sample of 1,829 youths admitted into the Cook County Juvenile Temporary Detention Center (CCJTDC) in Chicago, Illinois, Teplin et al. (2008) found that approximately 66% of youth suffer from a range of psychiatric conditions including affective, anxiety, disruptive behavior, and substance use disorders. Similarly in Connecticut, a 2012 report by Connecticut's Judicial Court Support Services Division showed that the state's justice involved youth reported many of the same psychiatric conditions on the Massachusetts Youth Screening Instrument-Version 2 (MAYSI-2) identified in Teplin et al.'s (2008) study.

Trauma is another important mental health factors, which is prevalent among juveniles in secure confinement. Several studies have shown that the rates of trauma among juveniles in secure confinement are alarming (Teplin et al, 2008; Hennessy et al, 2004; Pearson & Jurich, 2005). Prior research have

estimated that between 75% and 93% of youth entering the juvenile justice system report experiencing at least one traumatic event compared to 34% of non-juvenile justice involved youth reporting at least one such event (Adams, 2010). Studies in Connecticut similarly have revealed that as high as 90% of juveniles in secure confinement report traumatic-exposure during their lifetime prior to confinement.

Similarly, Traumatic Brain Injury (TBI) is often the “hidden” disability that is undiagnosed, yet it can be the cause of many cognitive problems and associated with mental health issues (New York Model TBI System, 2006; Helgeson, 2015). Studies have shown that head injuries are associated with mental health problems such as severe depression, anxiety, substance abuse, difficulty controlling anger, and suicidal tendencies (Lewis et al., 2004; Helgeson, 2015). Because TBI can lead to poor judgment, deficits in communication and learning, skills, behavioral and personality disorders, these individuals are at increased risk to drop out of school and become involved in and penetrate deeper into the criminal justice system (Helgeson, 2015; U.S. Department of Health and Human Services, Health Resources and Administration, 2011).

Research has shown that youth with TBI are more likely to have received a psychiatric diagnosis, reported earlier onset of criminal behavior/substance use, and more lifetime substance use than those who do not have a report history of TBI (Perron & Howard, 2008). Centers for Disease Control and Prevention (CDC) found that 27-87% of inmates report having head injury or TBI as compared to 8.5% in general population (Schofield et al., 2006; Slaughter et al., 2003). Those working to improve the detection of TBI and provide proper services for those suffering rely on the state government, agencies, researchers, individuals, and their families to better address this issue that so heavily connects to higher levels of juveniles and incarceration rates (Helgeson, 2015). Several states such as Virginia, Minnesota, Nebraska, Utah, and Texas have recognized this important issue in juvenile justice and have received

federal and/or local funding to include screening and identification of TBI as part of their intake process (Virginia Collaborative Policy Summit, 2013).

In 2012, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) conducted the Survey of Youth in Residential Placement (SYRP) (Sedlak & McPherson, 2010). As a part of a constellation of surveys conducted to provide statistics concerning youth in custody in the juvenile justice system, the SYRP included a portion that addressed issues such as fair and reasonable treatment, solitary confinement, control, and use of restraint. The survey showed that 33% of confined youth reported staff use of unnecessary force, 28% report being physically restrained by handcuffs, wristlets, security belt, chains, or a restraint chair, and 35% report being isolated. Of this latter 35%, 87% of them say that isolation lasted for longer than 2 hours and 55% report being isolated for over 24 hours. The American Civil Liberties Union and their Human Rights Watch reported that certain conditions of confinement, including solitary confinement and prolonged isolation, could cause or exacerbate mental health disabilities or other serious mental health problems in adolescents (Kysel, 2012). Thus, with such a high prevalence of trauma and mental health disorders among juvenile offenders, it is essential that the institutions and facilities that handle these youth effectively assess these youth mental health and trauma symptoms—not just prior to detention, but also prior to their discharge.

Focus of Study

High rates of trauma and mental health disorders among youth in confinement combined with the frequent use of isolation, seclusion and restrains within juvenile facilities presents a profound threat to the wellbeing of adolescent offenders whose pre-existing conditions may be aggravated or who may develop new mental health issues due to conditions of confinement. As a population that is inherently

vulnerable due to cognitive and emotional immaturity (Casey, 2008; Steinberg, 2009), there is a need to not only further assess current rates of trauma in juvenile facilities, but also to develop a more comprehensive picture of youth in confinement in order to more intensively investigate the impact of juvenile justice policies and practices on outcomes.

The assessment tools which this study seeks to implement in state-run juvenile facilities allows us to assess a wider range of factors that play a significant role in youth mental health, functioning, and development. There are few studies, if any, that have assessed fluctuations in trauma and mental health symptoms during the juveniles' stays in secured confinement, particularly in brief detention lasting only a few days, which accounts for most detained youth (Finkel, 2015).

Methodology

This study will focus its analysis on the following three questions:

1. What is the relationship between mental health symptoms and trauma among youth in secure confinement facilities?
2. What is the extent to which mental health symptoms and trauma are related to rearrests within 2 years post release?
3. What is the effect of secure confinement on youth's mental health and trauma symptoms at discharge while controlling for mental health and trauma symptoms at baseline?

For the purposes of the study, the BASC-3, CROPS, and a Head Injury measure will be given to each juvenile at intake and discharge over a two-year period at the Connecticut Juvenile Training School (CJTS), Pueblo Unit, and the Juvenile Temporary Detention Centers (JTDCs). Because the timing of

administering these self-reports is essential to the study design, we ask that the juvenile take the assessments within 24 hours of intake and within 24 hours prior to discharge from confinement. For youth in Juvenile Temporary Detention Centers (JTDCs) where their stays are relatively brief, only those youth who are returned to detention after their initial court appearance will be administered these assessments as part of the intake and their discharge assessment (BASC-3 and CROPS) will be re-administered within 24 prior to their next court appearance. Given that most youth in detention do not return to detention after their second court appearance, these youth will not be given these assessments again if they are sent back to the same detention facility a second time.

Unlike the data collection timeline for CJTS, Pueblo, and the JTDCs, which will be for two years, the data collection timeline for Manson Youth Institution (MYI) and York Correctional Institute (YCI) will be for four years. The rationale for this longer period of data collection is that the average length of stay for youth at these facilities is between three to four years and it is important to have a timeline that covers the average length of sentence for purposes of baseline and discharge assessment. Each youth at MYI and YCI will be given the BASC-3 and CROPS at admission and then again at discharge, which will be at the youth's 18th birthday when he/she is transferred to adult general population, the youth's discharge from sentence, or the youth's discharge to early release program/parole, whichever comes first.

Because these measures are self-reports, each site will maintain folders for each youth where their BASC-3 and CROPS intake and discharge assessments will be securely kept. This intake-discharge assessment model allows us to get a comprehensive picture of the juvenile's mental health and traumatic symptoms at baseline as well as when they are returning to the community at discharge. We will also be following and tracking recidivism for two years post discharge, which allows the investigators to

investigate whether youth with more severe mental health issues and trauma circulate into the criminal justice system more frequently. The content of these instruments in addition to the process of assessing and reassessing will allow us to look at relationships between mental health, executive functioning, trauma, and recidivism while controlling for baseline scores. Furthermore, this process will also allow us to identify any changes in short-term fluctuations in their mental health profile and trauma following confinement, which will be brief for most juveniles. Even if a juvenile is transferring from one facility to another, the juvenile should be given the assessment at intake at their new facility. We will statistically control for these points in the data when we conduct our analyses.

Mental Health. The Behavior Assessment System for Children, Third Edition (BASC-3) (Reynolds & Kamphaus, 2015) is a comprehensive self-report measure that provides a multi-dimensional approach to understanding the emotions and behaviors of children and adolescents. It builds upon the BASC-2, an empirically validated assessment instrument, by including indices of the executive functioning of adolescents. The most recent version also provides access to the most current norms available in child psychology and the populations served. The BASC has been used successfully in various studies that range from the assessment of children traumatized by natural disaster to troubled youth in juvenile justice settings (Evans & Oehler-Stinnett, 2008; Kennedy et al., 2011). The BASC-3 also has built-in validity indexes to maximize reliability.

Trauma. The Child Report of Post-traumatic Symptoms (CROPS) (Greenwald & Rubin, 1999) is a brief acute trauma self-report measure. The CROPS is based on current research on child trauma, incorporating trauma symptoms beyond the Diagnostic and Statistical Manual of Mental Disorders' (DSM) diagnosis for PTSD while also broadening the notion of trauma to extend to major loss experiences within a briefly defined period of 7 days. This allows trauma symptomology to be tracked

over time and for the researchers to monitor the extent to which trauma progresses and a youth recovers. The CROPS is a quick, convenient, and effective, tracking of acute trauma over the 7 days prior to taking the assessment. For our purposes, this type of acute assessment is ideal as other tools focus on lifetime trauma (Hyman and Snook, 2002; Briere et al., 1995). The majority of youth are sent to short-term detention facilities, which makes assessing acute trauma difficult. Most measures inquire about lifetime trauma, which prevents the measures from identifying the extent to which youth are traumatized in the facilities. Though an adolescent's history is important, in investigating spikes in trauma experienced in secure facilities, an acute assessment is more appropriate. The CROPS has been used in relatively large juvenile justice studies and demonstrated strong reliability and validity (Greenwald & Rubin, 1999; Greenwald et al., 2001).

Head Injury. A self-report head injury measure will be used to assess for history and symptoms of head trauma. The measure is based on a tool used as part of the Pathways to Desistance Study (Schubert et al., 2004). The descriptive items were developed for the Pathways study based on a consultation with two neuropsychologists (Lisa Marrow, University of Pittsburgh School of Medicine and Charles Nelson, University of Minnesota). These items establish the presence of brain injury (e.g. how many times the subject had a head injury that resulted in the loss of consciousness), the age at which the injury occurred and the extent of the injury (e.g. presence of seizures and medical treatment). The tool was modified for purposes of the current study.

Limitations of the Study

The proposed study requires that youth in confinement be assessed at different facilities. At the current time, there are plans that might affect the facilities that are currently in operation, as well as the

potential that new facilities could become operational. It is the goal of the researchers to continue the study throughout the period and incorporate any new facilities serving youth into the collaborative effort to assess the mental health and trauma of youth in secure confinement in Connecticut.

Anticipated Contributions

The assessment of the trauma and mental health of youth in secure confinement will allow agencies to have more information on measures that empirical research has identified as critical to identifying and providing services to youth who have experienced traumatic events. With the completion of the research project, a report will be presented that answers the research questions presented with the potential of comparing CT youth with data collected on youth in other parts of the United States. The findings can also be used to contribute to the state of academic knowledge on juvenile justice reform.

Areas Not Under Review

This study will not address the relationships between mental health and trauma symptoms among diverted youth or adjudicated youth who are released back in the community rather than sent to secure confinement. This study will also not include youth who are in residential facilities.

Timeline

It is suggested that the implementation of this proposal begin as soon possible. After there has been time for implementation of the assessments and the two-year follow up period, the TYJI Research Team would formally request specific data needed to address the research questions.