

Youth in Minnesota Correctional Facilities and the Effects of Trauma:

Responses to the 2010 Minnesota Student Survey

March 2012



DEPARTMENT OF PUBLIC SAFETY
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Dana Swayze, M.S.W. and Danette Buskovich, M.S.W.

Minnesota Department of Public Safety
Office of Justice Programs, Statistical Analysis Center
445 Minnesota Street, Suite 2300 • St. Paul, MN 55101-1515

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Juvenile Correctional Facilities Participating in the 2010 Minnesota Student Survey

- Anoka County Secure Juvenile Center, Lino Lakes, Pines School
- Anoka County Non-Secure Shelter Facility, Lino Lakes, Pines School
- Arrowhead Juvenile Center, Duluth, Arrowhead Academy
- Boys Totem Town, St. Paul
- Dakota County Juvenile Services Center, Hastings, Riverside School

- East Central Regional Juvenile Center, Lino Lakes, Pines School
- Hayward Group Home, Albert Lea
- Heartland Ranch, Benson
- Hennepin County Home School, Minnetonka, Epsilon Program
- Hennepin County Juvenile Detention Center, Minneapolis, Stadium View School
- ITASKIN Juvenile Center, Itasca, ITASKIN Education Center
- Kids' Peace Mesabi, Buhl, Mesabi Academy
- Mille Lacs Academy, Onamia
- Minnesota Correctional Facility: Red Wing, Walter Maginnis High School
- Minnesota Correctional Facility: Togo, Alice O'Brien School
- Northwestern Minnesota Juvenile Center, Bemidji, First City School
- Prairie Lakes Juvenile Detention Center, Willmar, Prairie Lakes School
- Ramsey County Juvenile Services Center, St. Paul
- Red Lake Juvenile Detention Center, Red Lake Nation
- Southwest Youth Services, Magnolia
- Village Ranch, Cokato
- Washington County Juvenile Detention Center, Stillwater
- West Central Regional Juvenile Center, Moorhead
- Woodland Hills, Duluth, Woodland Hills Academy

For a map of participating and non-participating facilities in Minnesota, see Appendix B. In order to participate in this study, sites had to provide residential detention or correctional services and have an education program onsite.

Executive Summary

The Minnesota Student Survey (MSS) is a 127-item questionnaire administered every three years to 6th, 9th and 12th graders in Minnesota public schools. The survey includes a wide variety of questions related to youth attitudes, behaviors and health indicators. Questions reflect a range of protective factors including connectedness to school, family and community, as well as risk factors such as drug and alcohol use, violence and victimization. The survey originated in 1989 with the most recent administration occurring in 2010. In 2010, 88 percent of school districts participated. In total, 71 percent of 6th, 9th and 12th graders (roughly 131,000 students) completed the 2010 MSS. Twenty-four residential juvenile correctional facilities with onsite education programs also participated in the 2010 MSS.

This report explores how youth in Minnesota correctional facilities who report having experienced trauma on the MSS (N=482) are similar to or different from those who do not. In addition, the responses of a matched sample of youth who have the same age, gender and racial attributes as the youth in correctional facilities, but took the MSS in a mainstream school, are analyzed for their experiences with trauma (N=500). Youth are classified as having experienced trauma if they answered “yes” to at least one of six trauma indicators on the MSS. Specifically, these questions assess if youth have experienced or witnessed domestic abuse at home; experienced familial or non-familial sexual abuse; or experienced abuse, threats or sexual force in a dating relationship.

Understanding trauma is relevant to the field of juvenile justice, and indeed all youth-serving practices, in that childhood and adolescent exposure is connected to myriad issues for youth. These issues include family discord, running away, self-harm and suicide attempts, mental and emotional distress, and increased issues with drugs and alcohol. This report identifies the extent to which these attitudes and behaviors are present in Minnesota youth populations that have experienced trauma, and offers recommendations for trauma-informed interventions and services.

Trauma Prevalence

Child traumatic stress occurs when children and adolescents are exposed to events or situations that overwhelm their ability to cope. Generally speaking, a traumatic experience is one that threatens someone’s life, safety or well-being often resulting in intense feelings such as fear, terror, helplessness and hopelessness.

Research continually demonstrates that youth involved in the juvenile justice system experience trauma at a rate significantly higher than the general youth population. MSS data support these findings in that over half of youth in correctional facilities report at least one form of trauma on the MSS (53%) compared to just over one-quarter of a matched sample of mainstream students (28%). Furthermore, a larger percentage of youth in correctional facilities report agreement with 3-6 trauma indicators (16%) than mainstream students (7%).

In both populations, experiencing and witnessing domestic abuse are the most common trauma indicators reported. While mainstream youth are more likely to report experiencing physical, emotional or sexual abuse in their dating relationships, youth in correctional facilities are more likely to report having been sexually abused by a non-familial perpetrator. Interestingly, of all youth who report 3-6 trauma indicators, a greater percentage of mainstream youth report sexual abuse by a family member than do youth in correctional facilities.

Youth in Correctional Facilities and Trauma

Research also supports that the more trauma youth experience, the more issues there typically are in other aspects of their life. MSS data confirm that youth in correctional facilities who report 3-6 trauma indicators are statistically more likely than youth in correctional facilities with no trauma indicators to report the following:

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- Lower perception of parent caring
- A family member's drug or alcohol use as problematic
- Running away from home
- Higher reports of victimization at school, including being threatened and sexually harassed
- High agreement with feelings of anger, depression, nervousness and worry, stress and hopelessness
- Increased difficulty with concentration, sleep, restlessness and impulsivity
- Self-injurious behavior, suicidal ideation and suicide attempts
- More chemical use and an earlier age of first chemical use
- More reports of damaging property
- More reports of victimizing a dating partner.

These findings suggest that even within the population of youth in correctional facilities, many problematic attitudes and behaviors are significantly higher among those youth who report more types of trauma. Trauma-specific interventions and supports are needed to address trauma histories that may be driving youths' juvenile justice system involvement.

Mainstream Youth and Trauma

Similar to youth in correctional facilities, mainstream youth who report 3-6 trauma indicators are also more likely than their mainstream peers reporting no trauma indicators to express agreement with questions related to problem areas in their life. In addition to all of the findings listed above related to youth in correctional facilities, mainstream youth who experience trauma are statistically more likely than their peers to report:

- Lower perceived caring by friends, adult relatives, adults at school, religious or spiritual leaders, and adults in their community
- Lower school satisfaction

- Additional victimization at school, including property damage, being kicked, hit or bitten, and being offered illegal drugs
- More indicators associated with substance abuse and dependency
- Higher delinquent behavior including getting into fights, driving under the influence, shoplifting and property damage
- Being sexually active

The differences between mainstream youth who report trauma and those who do not are more pronounced even than the differences between youth in correctional facilities who report trauma and those who do not. The MSS responses of mainstream youth further illustrate the destructive affect of trauma on youth well-being.

Youth in Correctional Facilities and Mainstream Youth: Trauma Commonalities

Youth in correctional facilities generally report more problematic attitudes and behaviors on the MSS than mainstream youth. The gap between their experiences and perceptions narrows, however, as the number of trauma indicators reported by mainstream youth rises. Ultimately, a comparable percentage of both mainstream youth and youth in correctional facilities with 3-6 trauma indicators report the following:

- A family member's drug or alcohol use as problematic
- Running away from home six or more times in the past year
- Agreement with feeling angry and depressed
- Difficulty with concentration, restlessness, sleeping and impulsivity
- Suicide attempts
- Using more drugs or alcohol than intended; using despite harming relationships; and using so much drugs or alcohol they could not remember their actions

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- Driving a motor vehicle under the influence
- Damaging property three or more times in the past year
- Having been or gotten someone pregnant two or more times

On several occasions, a greater percentage of mainstream youth report problems than youth in correctional facilities with comparable trauma indicators. These data suggest that the impact of trauma on youth is significant, regardless of whether they are justice system involved.

Practice Implications: Trauma-Informed Care

In response to the prevalence of trauma amid the justice system population, intervention strategies have emerged that are trauma-informed. Trauma-informed care is an approach to engaging people by recognizing the presence of trauma symptoms and acknowledging the role that trauma has played in their lives. The following are examples of activities consistent with trauma-informed care:

Trauma Screening

Because behaviors associated with trauma often look very similar to common delinquent behaviors, trauma screening should be a routine practice performed at the earliest point of contact with the juvenile justice system. Trauma screening generally identifies if there is an immediate safety need for the youth (such as self-harm or suicidal ideation), or if there is a potential mental health or trauma issue that requires an assessment. Assessments are more thorough investigations by a mental health professional to direct clinical interventions.

Evidence-Based Practices

Evidence-based practices (EBPs) are interventions for which there are consistent scientific findings that they improve outcomes for clients. Typically, trauma-focused EBPs include:

- Psycho-education
- Caregiver involvement and support

- Emotional identification and regulation skills
- Anxiety management
- Construction of a trauma narrative
- Personal empowerment training.
- Identification of maladaptive thoughts
- Interpersonal communication and social-problem solving.

Cognitive behavioral approaches have been shown to be particularly effective in addressing trauma among youth in the juvenile justice system.

Family Involvement

A theme that repeatedly emerges in the literature around serving youth with trauma histories is engagement and partnership with families and caregivers. Family members need information about how to support youth who have experienced trauma, how to interpret and respond to their behavior, and how to address trauma in their own lives that may affect their ability to support their children's recovery.

Trauma-Informed Systems of Care

Trauma screenings, evidence-based practices and family involvement are all components of a trauma informed system of care. Integrated systems understand the impact of stress both on youth and families; provide services and supports that prevent, address and ameliorate the impact of trauma; create safe spaces for addressing trauma; and have practices that do not re-traumatize youth.

Trauma-informed organizations and agencies incorporate a trauma focus into their mission and values; train staff at all levels on the effects of trauma; conduct universal trauma screenings; create strength-based environments to address trauma; and involve families. Furthermore, these agencies regularly evaluate their practices and outcomes for evidence that youth and families have improved coping and skills related to trauma.

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Minnesota has several policies and procedures that lay the groundwork for a trauma-informed juvenile justice system, including a statewide mental health screening requirement. In addition, statutes related to both juvenile justice and child welfare promote the practice of placing children who need to be removed from home in the least restrictive placement necessary, and as close to a child's family as possible. Finally, Minnesota Department of Corrections licensing rules restrict or limit the use of seclusion or restraint in facilities; prohibit certain activities such as forced medicating or forced physical exams; and require that professionals working in residential facilities have training on mental health related disabilities, bias and discrimination. Many additional policies exist to protect youths' rights and dignity under a facility's care against re-traumatization.

In addition to these promising activities, the Minnesota Juvenile Justice and Mental Health Initiative, an inter-agency, interdisciplinary task force of professionals and stakeholders, provides a comprehensive list of recommendations to improve services and professional competencies in Minnesota's juvenile justice system. These include:

- Better coordination of services following mental health screens
- Greater efforts to engage families and caregivers
- Review of data collection and data privacy rules around mental health data on justice system-involved youth
- Need for evidence-based, community-based mental health interventions that are effective with justice system involved youth.

Progress on these issues will further move Minnesota juvenile justice towards a trauma-informed system of care.

Introduction

Minnesota Student Survey Overview

The Minnesota Student Survey (MSS) is a 127-item questionnaire administered every three years to 6th, 9th and 12th graders in Minnesota public schools. The survey includes a wide variety of questions related to youth attitudes, behaviors and health indicators. Questions reflect a range of protective factors including connectedness to school, family and community, as well as risk factors such as drug and alcohol use, violence and victimization.¹ The survey originated in 1989 with the most recent administration occurring in 2010.

Content of the MSS is collaboratively determined by the Minnesota departments of Education, Health, Human Services and Public Safety. Many of the questions are dictated by state or federal data collection requirements. Participation in the survey is voluntary such that school districts elect to participate and any individual student may refuse to participate for any reason. Participation in the MSS has historically been high: in 2010, 88 percent of school districts participated. In total, 71 percent of 6th, 9th and 12th graders (roughly 131,000 students) took the 2010 MSS.²

Correctional Facility Involvement

In 2010, 24 out of a possible 29 residential juvenile correctional facilities with onsite education programs participated in the MSS. Twenty-three facilitiesⁱ were licensed by the Minnesota Department of Corrections and one facility operated under tribal authority. This represents an 83 percent juvenile correctional facility participation rate.

While secure facilities (locked settings) were specifically encouraged to participate because those youth are least likely to have had the opportunity to take the MSS in their home school district, both secure and non-secure facilities are represented. Ultimately, 584 useable MSS surveys were collected from youth in correctional facilities.

Purpose

The purpose of this report is to explore how youth in Minnesota correctional facilities who report having experienced trauma on the MSS are similar to or different from those who do not. In addition, a matched sample of youth who have the same age, gender and racial attributes as the youth in correctional facilities, but took the MSS in a mainstream school setting, are analyzed for their experiences with trauma.

For the purpose of this report, youth are classified as experiencing trauma if they answered affirmatively to specific MSS questions related to experiencing or witnessing domestic abuse; experiencing familial or non-familial sexual abuse; or experiencing dating abuse, threats or sexual force in a dating relationship. These questions are detailed further in the Methodology section.

The primary objectives of this report are to:

- Explore whether youth in correctional facilities who have experienced trauma report higher risk factors in the areas of family and school issues, chemical use, mental health, and risk-taking behavior than their peers who report fewer or no trauma indicators.
- Assess whether youth who took the MSS in a mainstream school setting who report trauma have higher risk factors in the areas of family and school issues, chemical use, mental health, and risk-taking behavior than their peers who report fewer or no trauma indicators.
- Compare the MSS responses of youth in correctional facilities who report trauma to those of mainstream youth who report trauma to explore for commonalities and differences in the effect of trauma overall.

i Of these facilities, 11 had secure beds only; five have secure and non-secure beds; and eight have non-secure beds only. Responses from youth in correctional facilities represent a mixture of youth meeting criteria for secure placement and those for whom a non-secure setting is adequate to meet their needs. Schools within correctional facilities were permitted to administer the survey in a manner that was logistically feasible to their operation. Youth held in detention following arrest or pending court may not have been surveyed because of the high turn-over rate of these youth. As such, the sample of youth in correctional facilities may also over-represent youth who are in the facilities on longer term, residential placements. For specific information about the characteristics of participating survey sites, please see Appendix A.

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- Educate the reader about the various types of trauma that affect youth; how these incidents can affect emotions and behavior in youth; and how trauma can contribute to justice system involvement.
- Explore best practices in screening youth for trauma and developing trauma-informed systems of care that meet the unique needs of trauma victims in the juvenile justice system.

Relevance

Exposure to traumatic incidents is relevant to the field of juvenile justice, and indeed all youth-serving practices, in that childhood and adolescent exposure is connected to myriad issues for youth. These issues include family discord, running away, self-harm and suicide attempts, mental and emotional distress, and increased issues with drugs and alcohol. This report identifies the extent to which these attitudes and behaviors are present in Minnesota youth populations that have experienced trauma. Furthermore, research suggests that youth in the juvenile justice system experienced greater trauma in their lives than the youth population as a whole.³

Understanding the nature and extent of trauma among youth in correctional facilities can provide policy makers with information to implement interventions that are trauma-responsive. Youth-serving practitioners will also attain critical information to meet the needs of youth who are themselves victims, and to understand youths' anti-social behaviors or attitudes in the context of their entire psycho-social experience.

What is Trauma?

Child traumatic stress occurs when children and adolescents are exposed to events or situations that overwhelm their ability to cope.⁴ Generally speaking, a traumatic experience is one that threatens someone's life, safety or well-being often resulting in intense feelings such as fear, terror, helplessness and hopelessness.⁵ According to the National Child Traumatic Stress Network (NCTSN), traumatic events include the following categories and summary descriptions:⁶

Sexual Abuse, Assault or Exploitation:

Actual or attempted sexual contact; exposure to age-inappropriate sexual materials; witnessing adult sexual activity; exploitation of a minor by an adult perpetrator; unwanted or coercive sexual contact between minors.

Physical Abuse or Assault:

Actual or attempted infliction of physical pain with or without a weapon, including severe corporeal punishment.

Emotional Abuse or Psychological Maltreatment:

Verbal abuse, threats, debasement, bullying, terrorizing or coercive control.

Neglect:

Deprivation of physical needs such as food, clothing or shelter; medical neglect such as failing to provide treatments or medications; and educational neglect such as preventing a child from attending school.

Serious Accident or Illness:

Unintentional accidents such as automotive, falls or fires; extremely painful or life-threatening medical conditions and treatments such as AIDS, cancer, chemotherapy, and changing of burn or injury dressings.

Witness to Domestic Abuse:

Exposure to emotional abuse, physical abuse or aggressive control by a parent/caretaker towards another in the home.

Traumatic Grief/Separation:

Death of a parent, primary caregiver or separation; abrupt, unexpected or premature death of a close friend, family member or other close relative; abrupt or indefinite separation of a child from a parent or sibling such as in divorce, hospitalization or incarceration.

Victim or Witness to Community Violence:

Exposure to extreme violence in a community, including gang-related activities such as drive-by shootings.

School Violence:

Violence that occurs in a school setting, including school shootings, student suicides, bullying and interpersonal violence among classmates.

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Victim/Witness of Extreme Interpersonal Violence: Includes witnessing acts of homicide, suicide and other similar extreme events.

Natural or Manmade Disasters: Experiencing natural disasters such as tornadoes, hurricanes or earthquakes. Includes the unintentional consequences of human activities including nuclear accidents, bridge collapses, oil spills etc.

War/Terrorism/Political Violence: Exposure to acts of war or terrorism, including bombings, hostage situations, genocide, sniper activity or biological weapons.

Forced Displacement: Forced relocation to a new home due to political reasons. Generally includes political asylum-seekers, or refugees fleeing war or political persecution.

System-Induced Trauma: Traumatic removal from the home; traumatic foster care placement; sibling separation; multiple placements in short time.

According to the NTCNS, traumatic events can be “acute” in that they are singular events or are time-limited in nature, such as a car accident or the loss of a parent. They can also be “chronic” in that they happen repeatedly over an extended time (i.e., abuse), or “varied” in that there is exposure to multiple types of trauma.⁷ As an example, someone experiencing varied trauma may have been the victim of a singular sexual assault, may have suffered the traumatic loss of a caregiver, and may have experienced ongoing emotional neglect.

Effect of Trauma on Youth Developmental

The degree to which traumatic events affect youth can depend on a number of variables. These include the child’s temperament, how the child interprets what has happened, level of exposure, age of the child, child’s coping skills, and degree to which the child has a

strong and healthy support system.⁸ As such, two youth who are exposed to the same event may respond to it differently, or may develop different manifestations of trauma.

Studies have shown that the effects of trauma are cumulative. The greater the number of exposures and the more varied the types of trauma, the greater the risk to a child’s development and psychological health.⁹ Furthermore, trauma where a child is victimized by another is more likely to result in impairment in psycho-social functioning and physical health than other types of trauma such as an accident or a natural disaster.¹⁰

Trauma occurring in early childhood can be particularly damaging in that critical aspects of brain and personality development may be disrupted. The ability to self-regulate, which is critical to success in late childhood and adolescence, can be compromised.¹¹ Abuse and neglect have been shown to adversely affect growth of the brain, nervous system and endocrine systems which compromise acquisition of social skills, emotional regulation and respect for social institutions and mores.¹² Also, people who experience trauma often have higher levels of stress hormones in their bloodstream which places ongoing stress on other biological systems.¹³

Children who experience trauma can also exhibit cognitive impairment. Developmental delays, decreased cognitive abilities, and lower IQ have been observed among those who experience trauma at a young age.¹⁴ Traumatic stress can interfere with children’s ability to think and learn, and can disrupt the course of healthy physical, emotional and intellectual development.¹⁵

Emotional and Behavioral

Again, depending on the age of the child when trauma occurs, and the type of trauma experienced, trauma may manifest itself emotionally and behaviorally in different ways.

It is not uncommon for younger children to recreate certain aspects of the trauma in play, such as shooting or dying if they were exposed to these events. Youth

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may have a preoccupation or fear of death; may have upsetting dreams; may revert to behaviors that are younger than their age such as thumb-sucking or clingy behavior; may report physical complaints such as headaches or stomachaches; or may act out physically or sexually.^{16,17}

Adolescents, being in a stage between childhood and adulthood, can experience a range of symptoms connected to trauma. Adolescents may engage in increased risk-taking, including truancy, risky sexual behaviors or substance abuse; may become socially isolated or withdrawn; may engage in emotion-numbing behavior; may exhibit low self-esteem; or may overreact with hostility or aggressiveness to situations or perceived threats.¹⁸

Youth who are abused or neglected by caregivers may lose their trust in adults and develop disregard or defiance for adults' rules.¹⁹ Youth exposed to traumatic events exhibit a wide range of internal symptoms, including depression and anxiety, but also externalize problems like aggression, conduct problems, defiance and oppositional behavior.²⁰ Difficulty sleeping, concentrating or managing emotions related to depression, anxiety, post-traumatic stress disorder make youth less likely to be successful in academic and social situations.²¹

The problems associated with trauma can persist into adulthood, speaking to the need for early interventions to prevent patterns of maladaptive and problematic behavior.²² People who experienced trauma as children are more likely to develop life-long psychiatric conditions, including personality disorders, ADHD, depression, anxiety, substance abuse disorders, and post-traumatic stress disorder.²³ These can manifest in impaired social relationships, suicide attempts, and delinquent or criminal behavior.²⁴

Post-traumatic Stress Disorder (PTSD)²⁵

When a host of symptoms connected to trauma present themselves simultaneously, one may be diagnosed with post-traumatic stress disorder (PTSD). In order to be diagnosed with PTSD, there must have been an exposure to a traumatic event and the person's response to

the event involves intense fear, helplessness or horror. These symptoms must also be causing significant distress or impairment in important areas of functioning such as social interactions, one's education or job performance.

Individuals experiencing PTSD are evaluated for certain symptoms in three categories: intrusive recollection, avoidant/numbing behavior, and hyper-arousal.

- Intrusive recollection is when thoughts, images or recollections of the trauma exist. These may occur in dreams, in feelings of re-experiencing the trauma, be triggered by sights, sounds or smells connected to the event; may involve "flashbacks" or hallucinations; and may result in a physical responses to triggers like elevated heart rate, sweating, and increased breathing.
- Avoidant or numbing behavior includes avoiding thoughts, feelings or conversations associated with the trauma; avoiding activities, places or people that arouse recollections of the trauma; an inability to recall important aspects of the trauma; detachment or estrangement from others; markedly diminished interest in activities; restricted range of affect (i.e., unable to have loving feelings); foreshortened sense of future such as inability to set long-term goals or not planning for a normal life span.
- Finally, hyper-arousal refers to the existence of the following conditions not present before the trauma: difficulty falling asleep or staying asleep; difficulty concentrating; irritability and anger outbursts; hyper-vigilance or an exaggerated startle-response. Hyper-vigilance is an abnormally increased arousal or response to stimuli and a scanning of the environment for threats.²⁶

How is Trauma Relevant to Justice System Involved Youth?

For youth involved with the juvenile justice system, exposure to trauma is believed to be higher than that of community samples of similarly aged youth.²⁷ Studies estimate that between 25 percent and 34 percent of children in the United States report at least

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one traumatic experience, whereas between 75 percent and 93 percent of youth in the juvenile justice system report at least one exposure.^{28,29} A 2003 Office of Juvenile Justice and Delinquency Prevention survey found that 70 percent of youth in residential placement had some type of traumatic experience, with 30 percent having experienced frequent and/or injurious physical or sexual abuse.³⁰

It is not likely that one traumatic event will contribute to youth becoming violent or anti-social. Typically it is the result of a pattern of abuse or trauma without protection, support or opportunities for healing that place youth at highest risk and apply to youth involved in the juvenile justice system.³¹

Numerous studies support that youth in the juvenile justice system have significantly more symptoms and diagnoses of PTSD than the general youth population, and that girls in the justice system are more likely to develop PTSD than boys.³² Furthermore, youth in the juvenile justice system have higher incidences of traumatic brain injury (TBI) than the general youth population. TBIs resulting from trauma to the head can result from accidents or abuse, but either way can contribute to significant impairment in cognition and regulation.³³

Conduct and behaviors associated with traumatic events can place youth at increased risk of involvement with the child welfare and juvenile justice system.³⁴ Trauma can compromise the ability to exercise adequate emotional control and may make youth more prone to aggressive, violent and sociopathic behavior.³⁵ When exposed to trauma or mistreatment, youth may cope by resorting to indifference, defiance or aggression as self-protective reactions. While risk-taking, fighting or hurting others who are perceived as threats may be a way to survive emotionally, it is often these behaviors that bring youth in to the juvenile justice system.³⁶ Among the juvenile justice population, there is the potential to categorize certain behaviors as defiant, aggressive or disrespectful that may be attributable to trauma.

Justice system practitioners must also be aware that the juvenile justice system itself can be potentially re-traumatizing in nature. Arrest, court appearances,

detention and out-of-home placements are stressful experiences that can exacerbate underlying trauma symptoms.³⁷ Correctional practices such as seclusion and restraint, and forced disrobing or body searches for safety and security purposes, can be traumatic experiences in and of themselves.³⁸ Youth-serving agencies need to be aware of how their practices can further traumatize children or aggravate underlying trauma experiences.

Methodology

Trauma Classification

While the MSS is not designed to comprehensively assess the frequency or intensity of traumatic experiences in the lives of Minnesota youth, it does capture some of the potentially traumatic experiences enumerated by the National Child Traumatic Stress Network in the previous section. Youth are classified as having experienced trauma if they responded affirmatively to any one of the following six questions as worded on the MSS:

1. Has any adult in your household ever hit you so hard or often that you had marks or were afraid of that person?
2. Has anyone in your family has ever hit anyone else in your family so hard or often that they had marks or were afraid of that person?
3. Has an older/stronger member of your family touched you sexually or forced you to touch them sexually?
4. Has any older person outside the family touched you sexually against your wishes or forced you to touch them sexually?
5. Has someone you were going out with ever hit you, hurt you, threatened you or made you feel afraid?
6. Has someone you were going out with ever forced you to have sex or do something sexual when you didn't want to?

In order to be included in this analysis, youth must have provided a response (yes or no) to all six of these questions. Youth are excluded if they did not answer

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all six questions because a non-response cannot be interpreted as either agreement or disagreement with the question. Of the 584 original correctional facility surveys completed, 102 are excluded from analysis. A total of 482 youth in correctional facilities provided an answer to all six trauma related questions.

Similarly, a matched sample of youth who took the MSS in a mainstream school setting was also created. Youth in the mainstream sample reflect the same age, race, gender and Hispanic ethnicity of those youth taking the MSS in correctional facilities. Again, within this sample, youth had to answer all six trauma questions to be included in this analysis. Of the original 584 mainstream students, 500 responded to all six trauma questions. This group was created to see if the experiences of youth in correctional facilities who have experienced trauma are similar to those who experience trauma in Minnesota's mainstream student population.

Youth Grouping By Number of Trauma Indicators

Because research supports that problems increase for youth who experience greater range of trauma, youth in both the correctional facility population and the mainstream student population are grouped by the number of trauma indicators reported. If youth report disagreement with all six questions, they are placed

in the "No Trauma Indicators" group. Youth answering affirmatively to one or two of the six questions are combined into a "1-2 Trauma Indicators" group as are youth who answered affirmatively to three or more trauma questions ("3-6 Trauma Indicators" group).

Comparative Analysis

Using an analysis tool known as a "chi-squared test of independence," true statistical differences between youth who experience trauma and those who do not can be identified.ⁱⁱ Statistical analysis was conducted between the three trauma groups in correctional facilities, and between the three trauma groups in the mainstream population. Similarities and differences between the youth in correctional facilities who experienced trauma and those in the mainstream population who experienced trauma are observed differences only. They have not been evaluated for statistical significance.

Trauma Data Limitations

This report likely underrepresents the level of trauma experienced by youth in correctional facilities in several ways:ⁱⁱⁱ

Summary	Total Surveys	Answered All Six Trauma Questions	Excluded: Did Not Answer All Six Trauma Questions
Youth in Correctional Facilities	584	482	102
Mainstream Student Matched Sample	584	500	84

ii Unless otherwise noted in the text, data in this report will be presented when there is a statistically significant difference based on the Pearson Chi-Square Coefficient ($\chi^2 < .05$).

iii Additional Data Limitations: Representation and Generalizability. While the juvenile correctional facilities that participated in the 2010 MSS have statewide representation, not all facilities participated. There may be some regional representation lacking that may affect demographic distributions in the data. These data reflect a small percentage of youth who experience detention or residential correctional placements in any given year. Effect of Youth Placement on Survey Responses. The MSS is designed to be taken by students while in their community. As such, some questions are asked with short time parameters such as "in the last seven days" or "in the last 30 days." When youth in correctional facilities respond to such questions, they may be reporting on their behaviors and experiences while in the facility, rather than in the community. As such, most questions with short time parameters have been excluded from analysis. Effort has been made to identify responses that may be impacted by youths' placement when included in the report.

Introduction

- Youth are excluded from analysis if they did not respond to all six trauma questions. As such, youth who may have answered affirmatively to one or more trauma questions but left some questions unanswered are not included in the analysis. More youth may have experienced trauma than are captured here.
- Many common types of trauma that affect youth are not captured in the MSS. Youth may have additional trauma exposures, including loss or death of caregivers, friends or other loved ones; being the victim of a crime or a violent crime; witnessing death, violence or injury; or experiencing a severe accident or medical procedure themselves.

Minnesota also has several large immigrant and refugee populations. Some youth in Minnesota’s juvenile justice system have been exposed to violence, relocation and acculturation connected to conflict and war-torn regions, or these issues have affected immediate family members.

- One of the most difficult forms of trauma to capture and measure is that of chronic neglect. Neglect generally means that the basic health and emotional needs of children are not being met, including access to food, sleep, sanitary conditions, clothing and physical care. It also includes unmet emotional needs. The MSS does not capture any indicators of neglect.
- The MSS provides no information about the number of times a youth has experienced each particular trauma indicator (frequency), how long the abuse has been occurring (duration), the age the abuse began (onset) or the severity of the trauma (intensity).

Interpreting Graphs

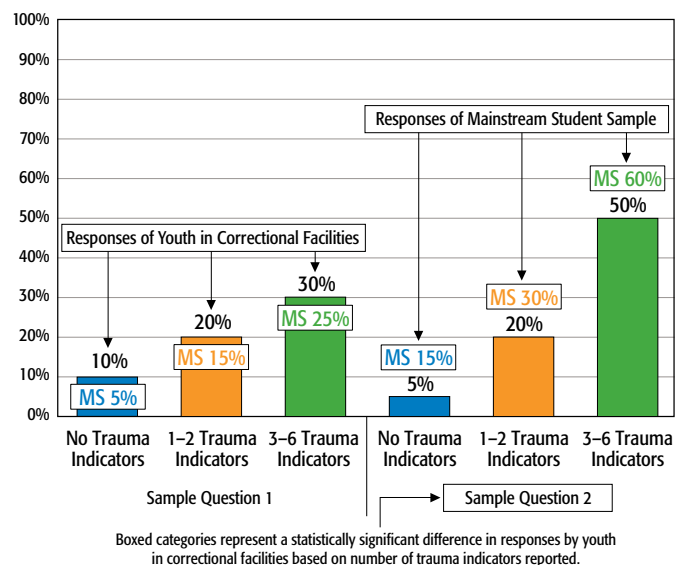
Throughout the majority of this report, MSS responses given by youth in correctional facilities are depicted in bar graphs. Responses are frequently grouped by the number of trauma indicators youth selected on the survey: No Trauma Indicators; 1-2 Indicators, and 3-6 Indicators.

Many graphs also include small text boxes containing the label “MS” followed by a numerical percentage. These boxes represent the responses of mainstream students to the same survey question. In the graph below, for example, mainstream youth are generally less likely than youth in correctional facilities to agree with Sample Question 1, but more likely than youth in correctional facilities to agree with Sample Question 2.

Finally, if the graph contains a blue box, it means that there is a statistically significant difference in responses between youth in correctional facilities based on the number of trauma indicators reported. On Sample Question 2, the blue box indicates that youth in correctional facilities who report more trauma indicators are statistically more likely to answer “yes” than youth in correctional facilities reporting fewer or no trauma indicators. In Sample Question 1, however, despite an increase in youth replying “yes” as the number of trauma indicators increases, it does not reach the level of statistical significance (no blue box).

In the event of a statistically significant difference in the responses of mainstream youth based on the number of trauma indicators reported, the statistical significance will be noted in the body of the report.

Sample Questions: Percent “Yes” Responses

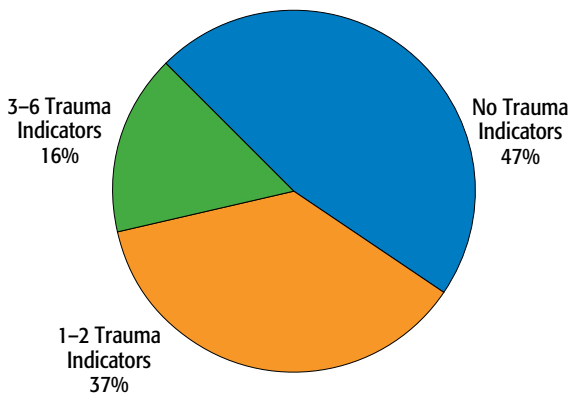


Youth and Trauma: Responses to the 2010 Minnesota Student Survey

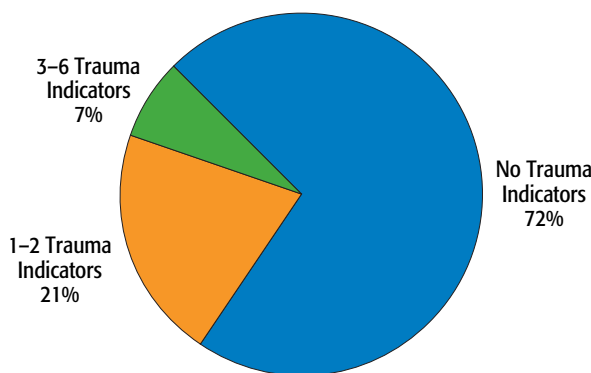
Prevalence of Trauma

MSS data support research findings that justice system-involved youth are more likely to experience trauma, including multiple victimization sources, than the mainstream youth population. Over half of youth in correctional facilities report at least one form of trauma on the MSS (53%) compared to just over one-quarter of a matched sample of mainstream students (28%). Furthermore, a larger percentage of youth in correctional facilities (16%) report agreement with three or more trauma indicators than mainstream students (7%).

**Youth in Correctional Facilities:
Number of Trauma Indicators Reported N=482**



**Youth in Mainstream Schools:
Number of Trauma Indicators Reported N=500**



Types of Trauma Experienced: Youth Reporting 1-2 Trauma Indicators

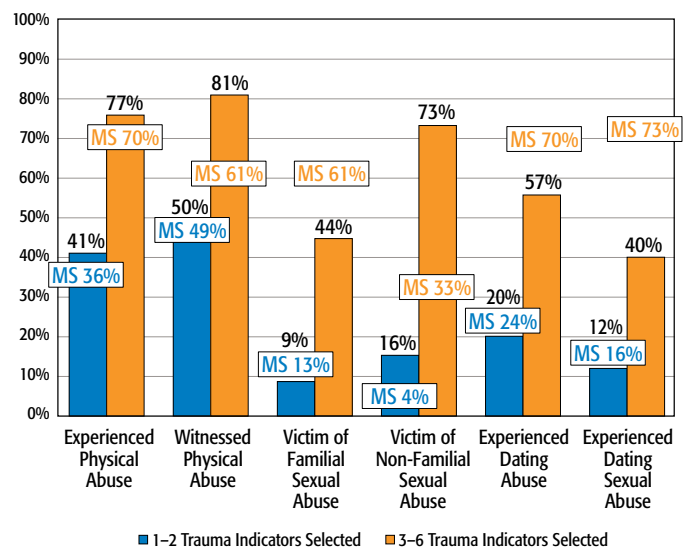
Of youth in correctional facilities who selected 1-2 trauma indicators on the MSS, the most common are experiencing domestic violence and witnessing domestic

violence. Half of youth in correctional facilities who report 1-2 trauma indicators report they have witnessed physical abuse in the household (50%) and four in 10 indicate they themselves have experienced physical abuse (41%). The third most prevalent category of trauma is dating abuse, selected by two in 10 youth (20%).

Mainstream students who selected 1-2 trauma indicators mirror the responses of youth in correctional facilities quite closely. Again, half of the mainstream youth indicate they have witnessed physical abuse in the household (49%) and just over one-third report experiencing physical abuse at home (36%). The third most prevalent category of trauma among mainstream youth is again dating abuse, selected by nearly one-quarter of mainstream youth (24%).

Generally, youth in correctional facilities and mainstream youth who report 1-2 trauma indicators select similar types of trauma at comparable levels. One exception is notable: youth in correctional facilities are four times more likely to report being the victim of non-familial sexual abuse than mainstream youth (16% versus 4%, respectively).

Trauma Indicators Selected



Types of Trauma Experienced: Youth Reporting 3-6 Trauma Indicators

As the number of trauma indicators increases, differences within and between the correctional facility and

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mainstream student population emerge. Again, witnessing and experiencing domestic violence are the most prevalent response categories. Roughly 80 percent of youth in correctional facilities and 60 percent of mainstream youth report that they have witnessed physical abuse directed towards another in their household. Both populations of students report that they themselves experience domestic violence at comparable rates (77% and 70%).

In exploring other trauma indicators, mainstream youth are considerably more likely than youth in correctional facilities to report that they have been the victim of abuse in a dating relationship (70%) or sexual abuse in a dating relationship (73%). While nearly six in 10 youth in correctional facilities report experiencing abuse in a dating relationship (57%), the percent who report sexual abuse in a dating relationship is considerably lower at 40 percent.

The final two trauma indicators pertain to sexual abuse by a familial or non-familial perpetrator. Of youth in correctional facilities who report 3-6 trauma indicators, over seven in 10 youth (73%) indicate that they have been the victim of non-familial sexual abuse; this is the case for one-third of mainstream youth respondents (33%). Conversely, slightly more than six in 10 mainstream youth (61%) report that they have been the victim of familial sexual abuse compared to 44 percent of youth in correctional facilities. The reasons why mainstream youth report more familial sexual abuse and youth in correctional facilities report more non-familial sexual abuse are unknown.

Demographics

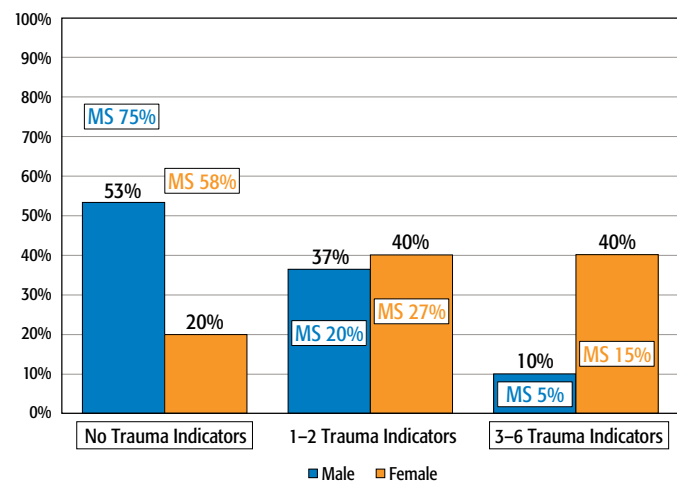
Gender

Studies support that boys and girls report different trauma exposure. Girls are more likely to report experiencing sexual abuse and physical punishment while boys are more likely to express witnessing physical violence.³⁹ Generally, girls report exposure to a greater variety of trauma events than boys.⁴⁰

MSS findings support that girls are statistically more likely than boys to express agreement with trauma.

Eighty percent of girls in correctional facilities respond affirmatively to at least one of the six trauma-related questions, compared to just under half of boys (47%). While boys and girls in correctional facilities are comparable in their reports of 1-2 traumatic indicators (37% and 40%, respectively), girls are statistically more likely than boys to report agreement with 3-6 trauma indicators. Four in 10 girls in correctional facilities (40%) report three or more trauma indicators compared to just one in 10 boys (10%). Over half of boys do not report an experience with domestic abuse, dating abuse or sexual abuse, as compared to only two in 10 girls (20%).

**Youth in Correctional Facilities:
Percentage of Trauma Indicators by Gender**



In the mainstream population, 42 percent of girls report at least one trauma indicator, as compared to 80 percent of the girls in correctional facilities. One-quarter of mainstream boys (25%) report one or more trauma indicators compared to just under half of boys in correctional facilities (47%).

Age

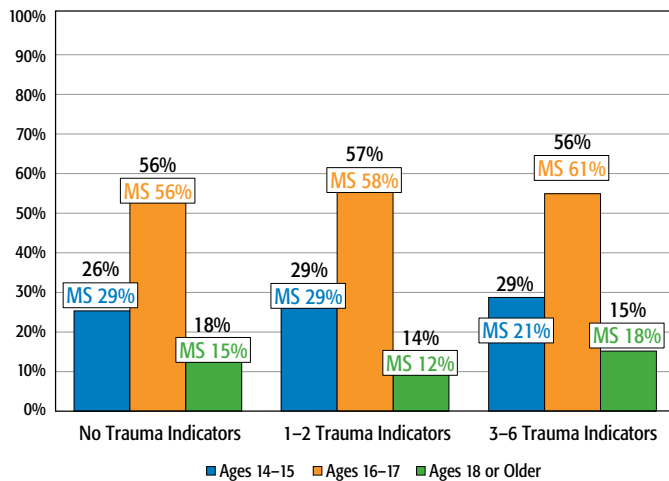
There is very little difference in the age distribution between youth in correctional facilities who report trauma and those who do not. In each group, approximately 28 percent of respondents are ages 14 or 15; roughly 57 percent are ages 15 or 16; and roughly 16 percent are age 18 or older. There is a small percentage of youth in the correctional facility population ages 11

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to 13 (4%), none of whom answered all six trauma questions thus precluding them from analysis in this report.

As is evident in the graph, mainstream youth have a similar age distribution in each trauma category as youth in correctional facilities. There is no statistical difference in the mainstream student sample related to the number of trauma indicators by respondent age.

Age of Respondents by Trauma Group



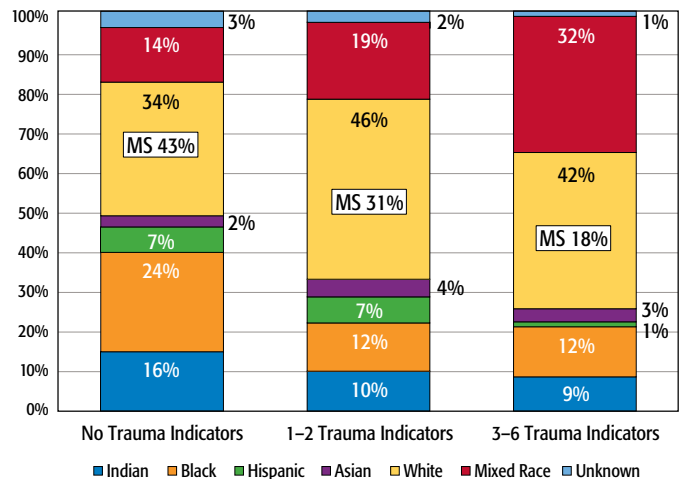
While MSS data do not show any variation in different age by trauma group, studies support that age is related to certain types of victimization. Young children are most likely to be victimized in the home, whereas as children move into adolescence, they are more likely to be victimized by peers and other community members.⁴¹ Generally, research supports that as youth age they report more victimization. Regardless of age, youth are more likely to be victimized as compared to adults.⁴²

Race

All races and ethnicities report experiences with trauma. There are, however, some types of trauma (especially being the victim of a crime) that disparately affect certain communities. Youth from communities of color may have greater exposure to certain types of violence or trauma connected to socio-economic status. People who live in urban areas and disadvantaged communities are more likely to report experience being the victim of a crime or exposure to community violence.⁴³

In the MSS data, there is no statistical difference between youth in correctional facilities and the number of trauma indicators selected by race or Hispanic ethnicity. Among mainstream students, however, youth of color are statistically more likely to select 3-6 trauma indicators than White youth. Of mainstream youth reporting no trauma indicators, 43 percent are White compared to just 18 percent of youth who reporting 3-6 trauma indicators.

Race/Ethnicity of Respondents by Trauma Group

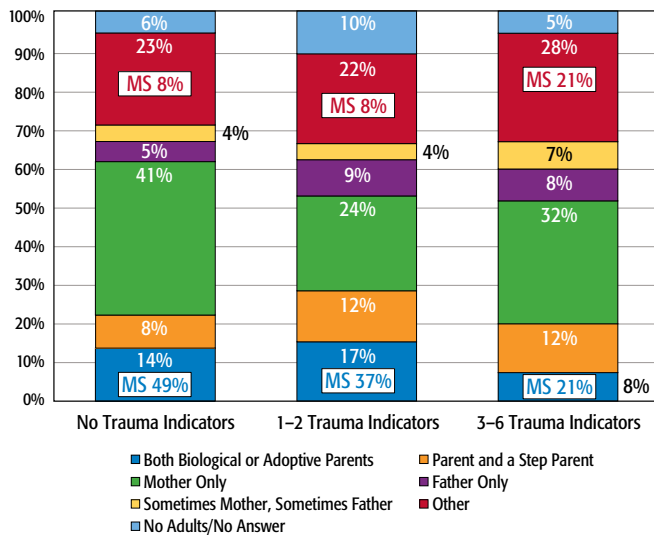


Living Arrangement

Among youth in correctional facilities, there is no statistically significant difference in living arrangement between youth who experience trauma and those who do not. The majority of youth in all trauma categories report living with just their mother, or in an "other" living arrangement. The "other" category includes youth who live with grandparents or other adult relatives, foster parents, or with other adults to whom they are not related.

Youth and Trauma: Responses to the 2010 Minnesota Student Survey

Respondent Living Arrangement by Trauma Group



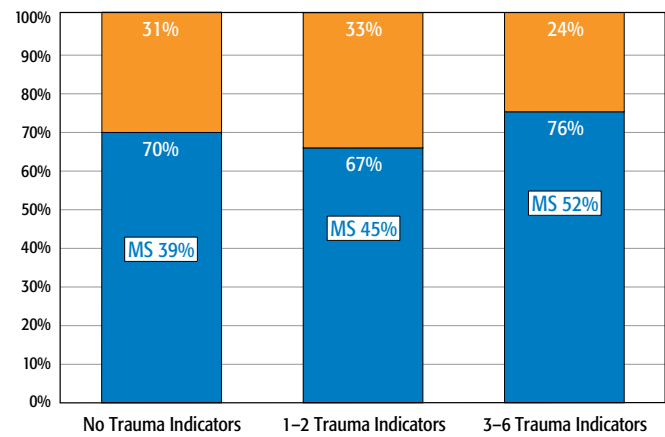
Among youth in a mainstream school setting, however, there is a statistical difference in youths' living arrangement based on the number of trauma indicators reported. As the number of trauma indicators increases, the percentage of youth living with both biological parents decreases from 49 percent to 21 percent. Also, the percentage of youth who report an "other" living arrangement increases from 8 percent to 21 percent. Based on the data provided, it cannot be said whether a youth's living arrangement contributes to or is in response to the trauma indicated.

Free or Reduced Priced Lunch

Research suggests that certain types of trauma, namely being the victim of a crime, are affected by income level. As income level rises, crime victimization declines.⁴⁴ The only question on the MSS that provides information about youths' socio-economic status is whether they report receiving Free or Reduced Priced Lunch (FRPL) at school. Youth are eligible to receive FRPL based on their household income level or if they meet other categorical eligibility criteria.⁴⁵

There is no statistical difference between youth in correctional facilities who report trauma and those who do not as it relates to their Free or Reduce Priced Lunch status. There may not be a sufficient range of family incomes among youth in correctional facilities to illuminate any differences that may exist.

Whether Youth Receive Free or Reduced Priced Lunch



Even among the mainstream population of youth, however, differences in FRPL status by trauma group are not statistically significant. While there appears to be a somewhat incremental increase across the trauma group categories, it is not a sufficient enough difference to conclude that trauma and the FRPL income variable are related.

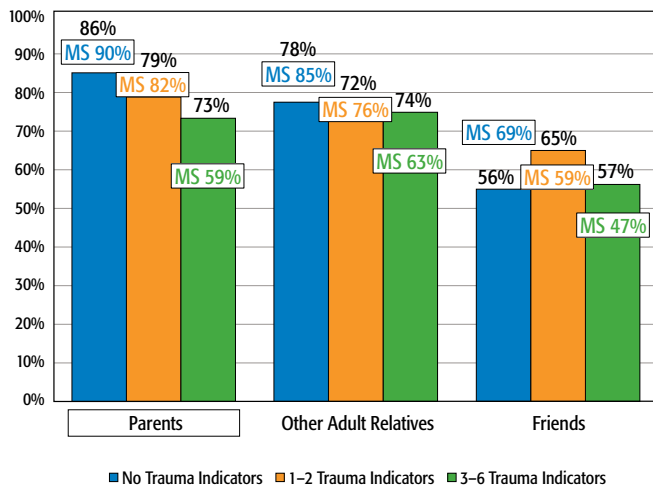
Family and Community Connectedness Parents, Relatives and Peers

MSS data show that youth feel most cared for by their parents, other adult relatives and peers. These caring relationships can be critical to helping youth weather traumatic experiences. Conversely, trauma caused by family members, other trusted adults or peers can seriously compromise youths' trust, attachment and connection to support people.⁴⁶

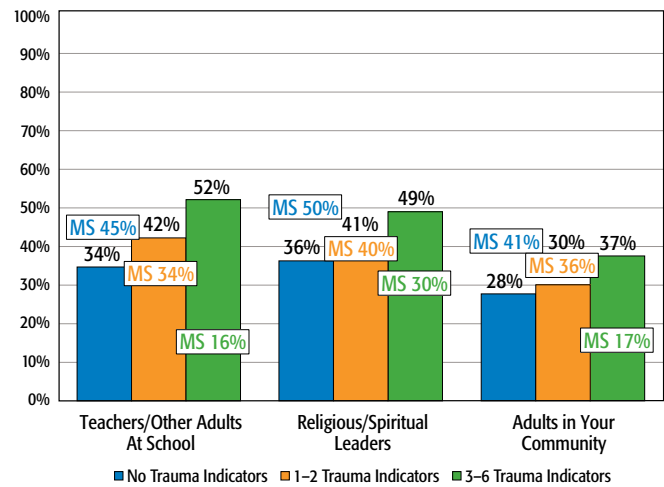
Among youth in correctional facilities, as trauma experiences increase, youth are less likely to report that their parents care for them "quite a bit" or "very much." This is a statistically significant finding. The same is true among youth in the mainstream student sample: As the number of trauma indicators increases, the perception of parent caring declines. For mainstream youth there is also a statistically significant decline in the perception of feeling cared for by other adult relatives and peers.

Youth and Trauma: Responses to the 2010 Minnesota Student Survey

**How Much Youth Feel Others Care About Them:
“Quite a Bit” and “Very Much” Responses**



**How Much Youth Feel Others Care About Them:
“Quite a Bit” and “Very Much” Responses**



The graph illustrates that while mainstream youth start out with higher perceptions of caring than youth in correctional facilities, ultimately mainstream youth who report 3-6 trauma indicators report the lowest perceived caring—lower even than youth in correctional facilities.

Other Supports

Other support people outside of the immediate family and peer network can also either alleviate or contribute to trauma, depending on their relationship with youth. The MSS asks that youth express the degree to which they feel cared for by teachers and other adults in their school, religious or spiritual leaders, and other adults in their community.

For youth in correctional facilities, the more trauma indicators selected, the higher their perceived caring by these non-familial adults. Teachers and other adults at school have the highest perceived level of caring among youth in correctional facilities. This suggests the importance of a support network outside the family and that these individuals may provide replacement support when perceptions of feeling cared for by family and peers decline.

One would expect similar increases in non-familial support among mainstream youth who experience trauma; however, it is not the case. The more trauma events mainstream youth report, the lower their perceived level of caring by others. As trauma increases, mainstream youth report a statistically lower perception of caring by teachers and other adults at school, and community-based adults. Furthermore, the declines in perceived caring are most substantial among youth reporting 3-6 trauma indicators. It is not clear why one population of students report increases in caring by non-family members while the other report decreases when they report similar exposure to trauma.

Family Drug and Alcohol Use

Drug and alcohol abuse in family systems contribute to many problems for youth. Drug and alcohol use in families is connected to neglect of children, physical and emotional abuse, and higher rates of sexual abuse.⁴⁷

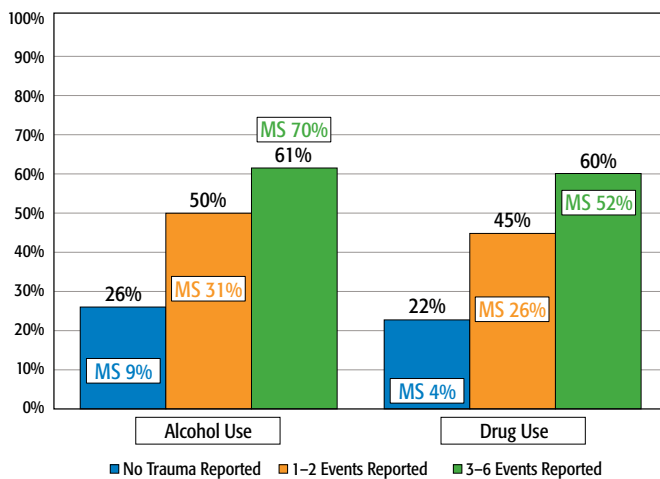
Youth in correctional facilities who report experiencing trauma are significantly more likely to report that alcohol and drug abuse in their families have repeatedly caused family, health, job or legal problems than youth who do not report trauma. While just over one-quarter of youth in correctional facilities who report

Youth and Trauma: Responses to the 2010 Minnesota Student Survey

no trauma state that alcohol use is problematic in their family (26%), this is true for over 50 percent of youth who report one or more traumatic indicators.

The pattern is similar for youth reporting drug abuse in their families: while less than one-quarter of youth in correctional facilities reporting no trauma state that drug use is problematic in their family (22%), between 45 percent and 60 percent of youth who report one or more trauma indicators agree that a family member's drug use is problematic.

Whether Alcohol or Drug Use by a Family Member Has Repeatedly Caused Family, Health, Job or Legal Problems: Percent "Yes"



Like youth in correctional facilities, mainstream youth who experience trauma are significantly more likely to report that a family member's alcohol or drug use is problematic. In the highest trauma category, mainstream youth are more likely to report that alcohol use by a family member is problematic than youth in correctional facilities (70% versus 61%). The graph shows that alcohol and drug abuse are more prevalent in the families of youth in correctional facilities overall, but that it is nearly as common (if not more so) for mainstream youth who report 3-6 traumatic indicators. These data appear to support other sources that link increased physical, sexual and emotional abuse with chemical abuse and dependency in family systems.⁴⁸

Community Safety

The community in which a child lives offers risk and protective factors related to delinquency. Specifically, youth are more likely to engage in anti-social and delinquent behavior when they live in neighborhoods with high poverty, high unemployment and high crime rates. Exposure to violence in the community leads to increased violent behavior by both girls and boys.⁴⁹

There is no statistical difference among youth in correctional facilities by trauma group as to whether they feel safe in their communities or on their way to or from school. Roughly 90 percent of all youth in correctional facilities report feeling safe going to and from school. Over 84 percent of youth report feeling safe at school in all three trauma categories.

Among mainstream youth there is a relationship between trauma indicators and perceptions of safety. Three-quarters of youth reporting 3-6 trauma indicators feel safe in their neighborhood and en route to or from school. At least 90 percent of youth reporting no trauma feel safe in the neighborhood or en route to or from school.

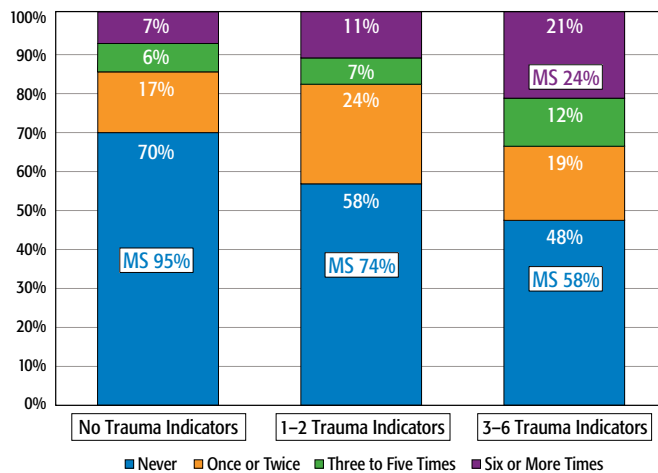
Running Away

Running away is especially concerning because of the great risk for youth to be victimized while away from home. Youth who run away from home are more likely to be in a position where they are coerced or exploited; are given drugs and alcohol; or engage in sexual activity in exchange for food or shelter.⁵⁰

Youth in correctional facilities who report more trauma indicators are statistically more likely to report running away from home in the past year. While 70 percent of youth reporting no trauma on the MSS had no runaway events in the past year, over half of youth reporting 3-6 trauma indicators ran away at least once. Not only do a greater percentage of youth who report trauma say that they have run away, they also report doing so with greater frequency. Over two in 10 youth in correctional facilities who report three or more trauma indicators (21%) report that they have run away from home six or more times in the past year.

Youth and Trauma: Responses to the 2010 Minnesota Student Survey

How Often Youth Have Run Away From Home in the Past 12 Months



Overall, mainstream youth report running away from home far less than youth in correctional facilities. Of mainstream youth who report no trauma, 95 percent did not run away from home at all in the past year. Again, as trauma increases, so do episodes of running away. In fact, a greater percentage of mainstream youth who report 3-6 trauma indicators have run away six or more times in the past year than youth in correctional facilities (24% and 21%, respectively). The relationship between trauma and running away is strong in both population groups.

While research supports that domestic abuse is a contributing factor to youth running away from home,⁵¹ it cannot be presumed from MSS content alone that this is a driving factor in the behavior of the youth surveyed.

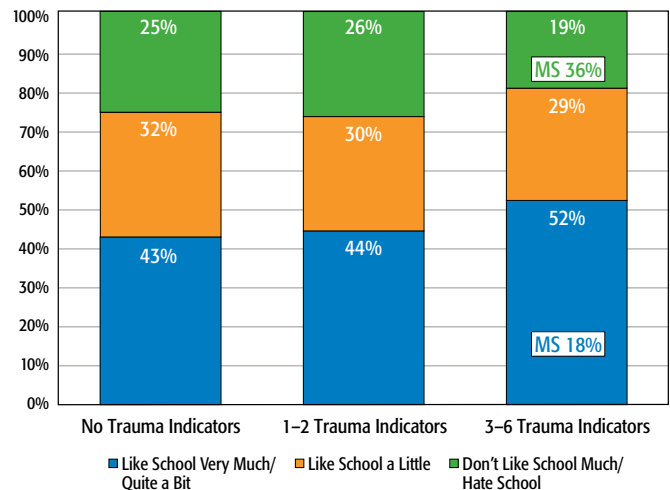
School Connectedness Attitude Toward School

A favorable attitude towards school, school success, school attachment and school commitment are protective factors for all youth.⁵² School connectedness appears especially important for adolescents who experience adversity in their homes because schools are one of the few contexts where adolescents' achievements are recognized and celebrated.⁵³ Exposure to

trauma can have an effect on school success including academic performance, attendance and behaviors.⁵⁴

There is no statistical difference between youth in correctional facilities who do and do not report trauma with regard to whether or not they like school. Between 43 percent and 52 percent of youth in all three trauma categories report liking school "quite a bit" or "very much." The largest percentage of students who report liking school are youth who report 3-6 trauma indicators.

How Youth Feel About School



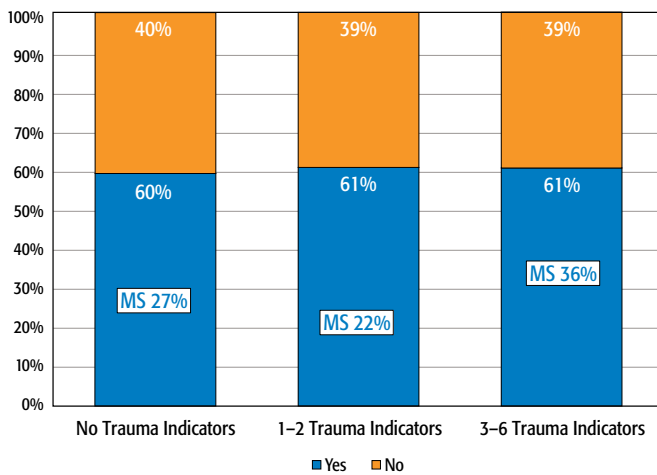
Mainstream youth report a statistically significant decline in liking school as the number of trauma indicators rises. Of mainstream youth with 3-6 trauma indicators, less than two in 10 of mainstream youth report liking school "quite a bit" or "very much" (18%).

Individualized Education Programs

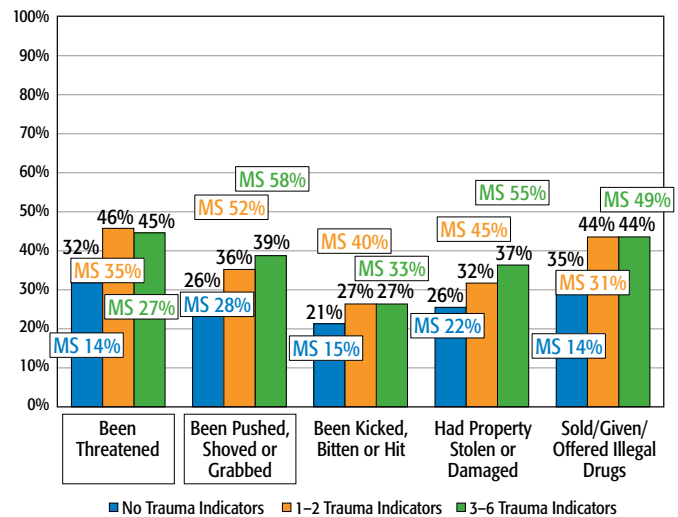
There is no statistical difference between trauma groups in whether or not youth in correctional facilities report having an Individualized Education Program (IEP) at school. Roughly six in 10 youth in all three trauma groupings report that they have had an IEP. While mainstream youth are less likely than youth in correctional facilities to have an IEP in general (22% to 36%), there is also no statistically significant difference across the mainstream trauma groups related to IEPs.

Youth and Trauma: Responses to the 2010 Minnesota Student Survey

Whether Youth Have Had An Individualized Education Program: Percent "Yes"



Victimization At School in the Past Year: Percent "Yes"



School Safety

When one explores school safety issues, there are some statistical differences between trauma groups. Youth who report experiencing any trauma indicators are statistically more likely than those who do not to report having been threatened at school, or having been pushed, shoved or grabbed at school. Youth reporting any trauma also report more agreement with having been kicked hit or bitten at school; having property stolen or damaged at school; or being offered or sold illegal drugs at school. These differences do not meet the threshold of statistical significance, however. These data support research that those who have been victimized in one area are more likely to be victimized in other aspects of life as well.⁵⁵

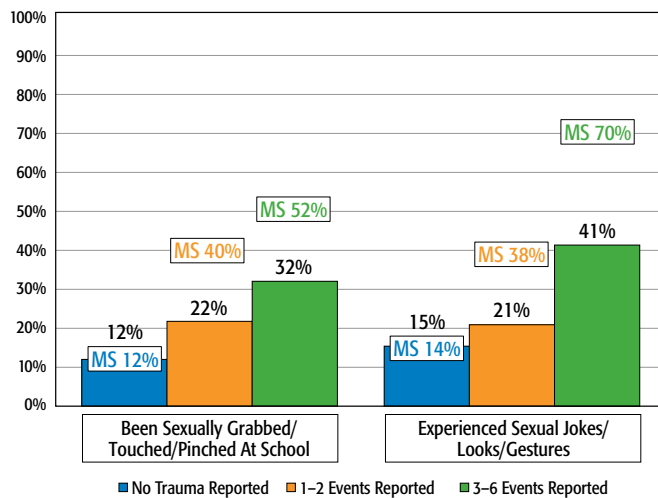
Interestingly, a greater percentage of mainstream youth report being pushed, shoved or grabbed at school; being kicked hit or bitten at school; and having property stolen or damaged at school than youth in correctional facilities. With the exception of threats, mainstream youth report greater victimization at school than youth in correctional facilities.

Sexual Harassment

Another type of victimization that can occur at school is sexual harassment. Among youth in correctional facilities, there is a statistically significant increase in experiencing sexual jokes, looks and gestures at school, and being sexually touched, pinched or grabbed associated with increased trauma. Over four in 10 youth in correctional facilities who report 3-6 trauma indicators report that they have experienced sexual jokes, looks or gestures (41%) and nearly one-third report being sexually touched, pinched or grabbed (32%).

Youth and Trauma: Responses to the 2010 Minnesota Student Survey

Whether Youth Have Experienced Sexual Harassment At School: Percent "Yes"



Mainstream youth also report a statistically significant increase in sexual harassment at school as trauma indicators increase. While harassment among mainstream youth who report no trauma is almost the same as youth in correctional facilities who report no trauma, rates increase sharply thereafter. Mainstream youth report more sexual harassment at school than youth in correctional facilities in both the 1-2 and 3-6 trauma indicators groups. Seven in 10 mainstream youth reporting 3-6 trauma indicators report sexual jokes looks or gestures at school (70%) and over half report having been sexually pinched, touched or grabbed (52%). One explanation is that mainstream youth and youth in correctional facilities have different levels of tolerance for sexual interactions.

Mental and Emotional Health

Youth with diagnosable mental and emotional health conditions are pervasive in the juvenile justice population as compared to the general youth population, and studies support that girls report higher symptoms of traumatic stress than boys.^{56,57}

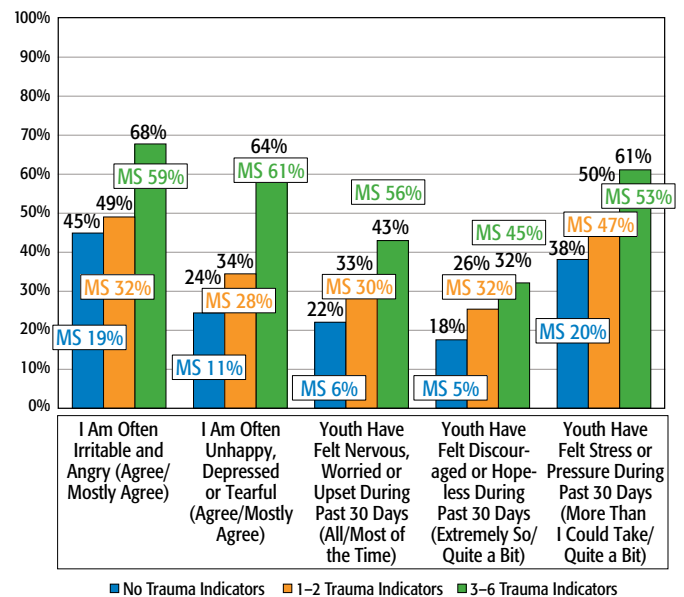
Exposure to severe and cumulative stressors is strongly associated with risk-taking behavior and delinquency.⁵⁸ Stressors are those events that elicit strong, negative responses and are perceived by the individual as

uncontrollable to unpredictable. These events alter the body's stress responses (adrenaline and cortisol levels) and can disrupt cognitive and emotional processing, especially when these stress hormones remain high over time.⁵⁹

Across all questions intended to gauge mental health and emotional well-being, youth who experience trauma report significantly more emotional stressors than youth who do not report trauma. The pattern shows an incremental increase in mental or emotional health concerns as trauma increases at a statistically significant level in both youth populations.

Over four in 10 youth in correctional facilities who report 3-6 trauma indicators agree to feeling nervous, worried or upset in the past month (43%); and over six in 10 report feeling high levels of stress or pressure (61%), feeling unhappy, depressed or tearful (64%), and feeling irritable and angry (68%).

Emotional Well-Being Indicators



It is worth noting that mainstream youth who report 3-6 trauma indicators are nearly as likely, and at times more likely, to agree with these problematic emotional indicators as youth in correctional facilities. While overall agreement among mainstream youth is lower than that of youth in correctional facilities, as trauma

Youth and Trauma: Responses to the 2010 Minnesota Student Survey

increases the gap between mainstream youth responses and those of youth in correctional facilities closes. About six in 10 mainstream youth reporting 3-6 trauma indicators also indicate that they have felt unhappy, depressed or tearful in the past month (61%), and angry and irritable (60%). Over half report feeling significant stress or pressure (53%) or feeling nervous worried or upset (59%).

Manifestations of Emotional Health

Feelings can manifest in behaviors in many ways. Several questions on the MSS explore if a youth's emotional state is potentially manifesting in problematic or disruptive behaviors. Many of these questions are varieties of what might appear on a mental health screening tool. Several of the symptoms are also affiliated with PTSD.

Among youth in correctional facilities, agreement with the problematic manifestations of emotional health increases as trauma increases. Youth reporting 3-6 trauma indicators are most likely to report that they get a lot of headaches or stomachaches (54%); are restless and cannot sit still for long (63%); act before thinking (64%); have trouble sleeping (70%); and have trouble concentrating (76%). These responses are all statistically higher than youth who report 1-2 or no trauma indicators.

Mainstream youth who report more trauma indicators also have statistically higher agreement with problematic manifestations of emotional health. As before, their overall agreement with these indicators starts out lower than those reported by youth in correctional facilities but increase significantly with trauma. As is depicted in the graph, the agreement with problematic manifestations of mental health among mainstream youth with 3-6 trauma indicators is as high, and at times higher, than the same population of youth in correctional facilities. Roughly two-thirds of mainstream youth who report 3-6 trauma indicators agree to having a lot of headaches or stomachaches (63%); restlessness (66%); difficulty sleeping (65%); and acting before thinking (66%). Over seven in 10 report difficulty concentrating (72%). Again, many of these symptoms are consistent with the effects of trauma exposure for youth.

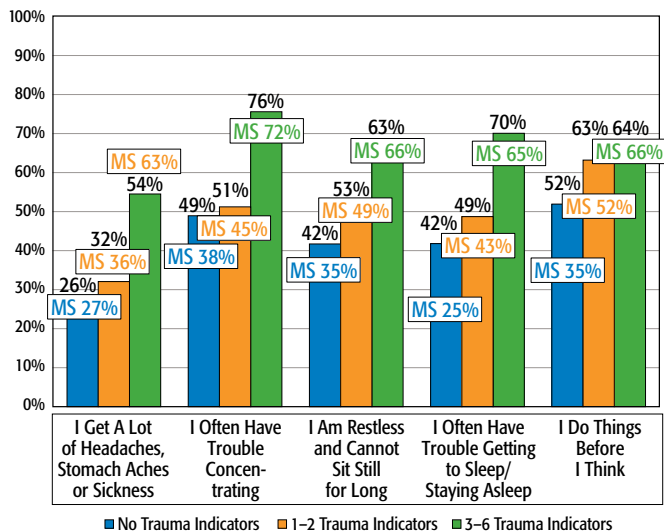
Self-Harm and Suicide

Left untreated, traumatic events can manifest in self-injurious behavior, including cutting or burning, suicidal ideation and suicide attempts. Youth taking the MSS are asked to report whether they have engaged in any of these thoughts or behaviors.

Among both youth in correctional facilities and mainstream students, self-harm, suicidal ideation and suicide attempts rise significantly as trauma increases. Youth in correctional facilities, however, are more likely to report these issues overall than are mainstream youth. Nevertheless, both student populations who report 3-6 trauma indicators report comparable, high levels of self-injurious behavior.

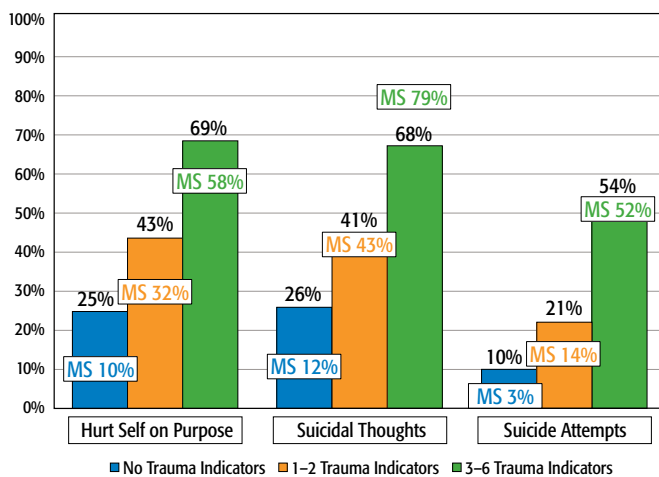
Self-harm and suicidal ideation suicidal thoughts are the most prevalent issues facing both mainstream youth and youth in correctional facilities. Roughly 60 percent to 70 percent of youth who report three or more trauma indicators in both student populations report engaging in self-harm, and roughly 70 percent to 80 percent report suicidal ideation. Over half of both mainstream youth and youth in correctional facilities who have 3-6 trauma indicators report a suicide attempt in their lifetime at 52 percent and 54 percent, respectively.

Emotional Health Indicators

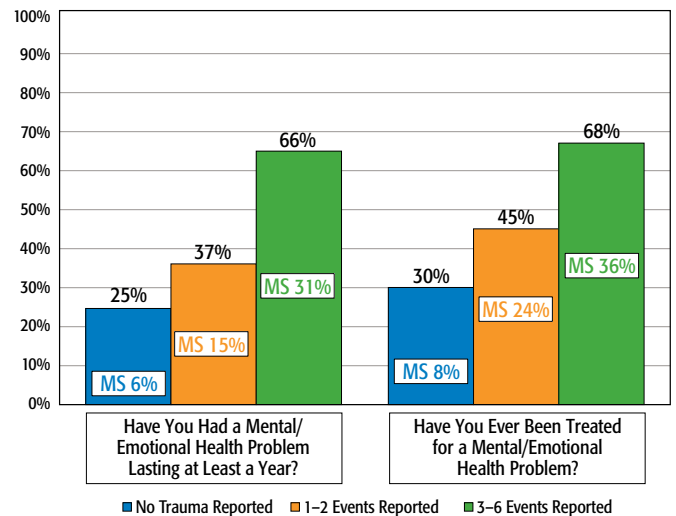


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**Self-Harm, Suicidal Ideation and Suicide Attempts:
Percent “Yes”**



Whether Youth Self-Identify An Ongoing Mental Health Issue or the Receipt of Mental Health Treatment: Percent “Yes”



Mental Health Treatment

Despite that fact that youth in correctional facilities and mainstream youth report comparable levels of emotional stress, similar manifestations of their emotional health, and more self-injurious behavior than those who do not report trauma, these two populations are not equally likely to self-identify as having a mental health problem, nor are they equally likely to receive mental health treatment.

Generally, between one-quarter and two-thirds of all youth in correctional facilities report that they have had a mental health issue lasting at least a year (25% to 66%), and that they have received mental health treatment (30% to 68%). Those reporting more trauma report statistically higher agreement with these questions.

Mainstream youth also experience a statistically significant increase in self-reported mental health issues and mental health treatment as trauma indicators increase, however their rates are much lower than youth in correctional facilities. Roughly half as many mainstream youth who report 3-6 trauma indicators self-report an ongoing mental health problem (31%) or having received mental health treatment (36%) as youth in correctional facilities. Given that the mainstream population reports many attitudes, behaviors and experiences that are comparable to those of youth in correctional facilities with similar levels of trauma, one would hypothesize that their ability to self-identify and that their access to treatment would be more similar.

Minnesota statutes do require that certain justice system-involved youth receive mental health screenings, including the population of youth represented in this report.⁶⁰ It is possible that these screenings result in a larger percentage of the population being referred to mental health services. Conversely, the behaviors of youth who find their way into the juvenile justice system may be more outwardly problematic than those of mainstream youth, resulting in more mental health interventions overall. The reason youth in correctional facilities report more mental health issues and more treatment is not fully known.

Youth and Trauma: Responses to the 2010 Minnesota Student Survey

Alcohol, Tobacco and Other Drug Use

Childhood physical and sexual abuse, and neglect have a strong impact on the prevalence of substance abuse in adulthood. Up to two-thirds of men and women in substance abuse treatment programs report childhood abuse or neglect, and adults abused during childhood are more than twice as likely as those not abused to abuse chemicals.⁶¹ Adolescents with drug and alcohol problems are six to 12 times more likely to have a history of being physically abused and 18 to 21 times more likely to have been sexually abused than those without alcohol and drug problems.⁶²

One theory related to the connection between trauma and chemical use is that the use of drugs and alcohol “medicates” the unpleasant emotional consequences of trauma. Youth may use chemicals to lessen feelings of anger, depression or anxiety.

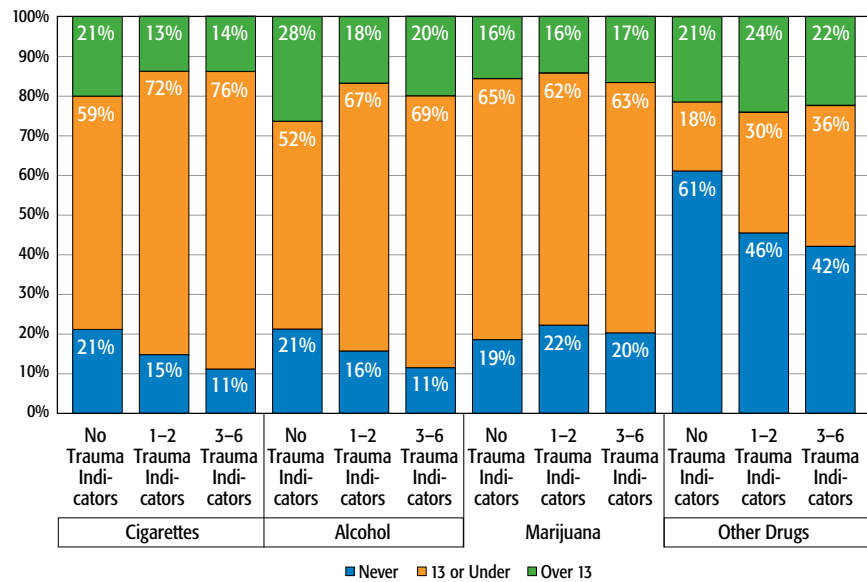
Similarly, chemicals may help youth to overcome feelings of guilt or shame connected to trauma. Regardless, the interplay of trauma, mental illness and substance abuse is well-documented.⁶³

In turn, adolescent use of alcohol and other drugs have consistently been shown to be associated with academic failure, criminal activity and violence,⁶⁴ all behaviors for which youth may come in contact with the juvenile justice system. Studies also show that as substance use among adolescents continues over time, so does the risk for multiple drugs involvement⁶⁵ and the development of adult substance use disorders.⁶⁶

Abstinence and Age of Onset

Across all trauma groups, youth in correctional facilities are more likely than mainstream youth to use chemicals. As it relates to cigarettes, alcohol and drugs other than marijuana, the more trauma indicators youth report, the less likely they are to report abstinence. In addition, as trauma indicators increase, so too does the percentage of youth who report their first chemical use at age 13 or under. Only marijuana use appears to be unaffected by the number of trauma indicators, with roughly 80 percent of youth in correctional facilities in all trauma groups having used, and about six in 10 having their first use occur at age 13 or under. Youth with more trauma are statistically more likely to report using cigarettes, alcohol and drugs other than marijuana than youth reporting less or no trauma.

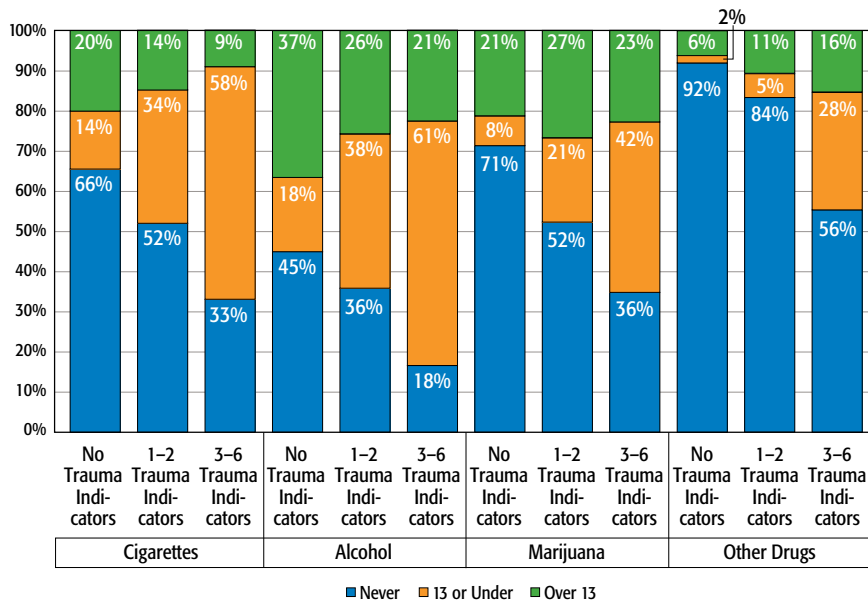
Youth in Correctional Facilities: Age At First Chemical Use



Among mainstream youth, the connection between trauma and substance use is much clearer (graphed separately below) with a precipitous decline in abstinence as trauma increases. The age at which youth first report using chemicals also decreases as trauma increases. Youth experiencing trauma are most likely to report that their use began at age 13 or under. Overall, nearly two-thirds of mainstream youth reporting 3-6 trauma indicators have smoked marijuana (64%) or cigarettes (66%); over eight in 10 have drunk alcohol (82%); and over four in 10 have used drugs other than marijuana (44%).

Youth and Trauma: Responses to the 2010 Minnesota Student Survey

Mainstream Youth: Age At First Chemical Use

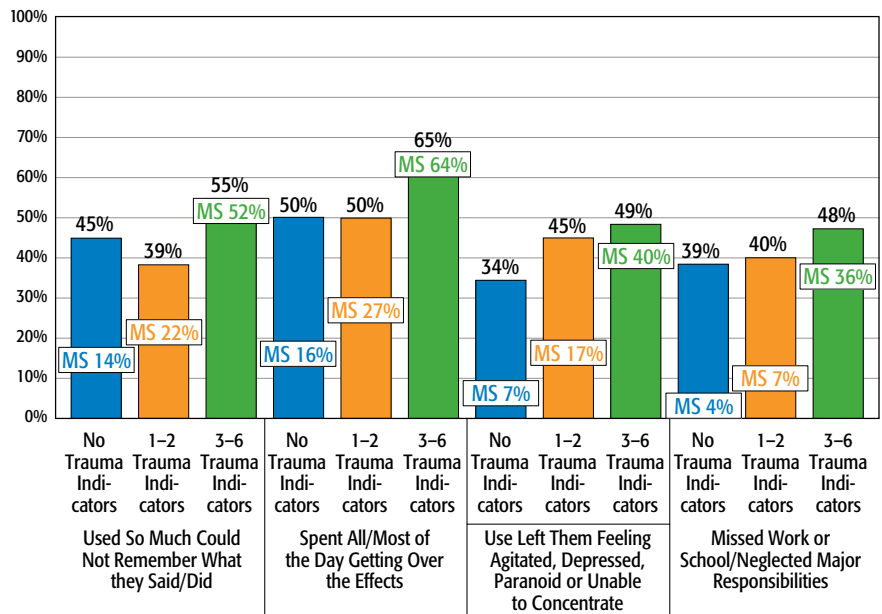


Abuse and Dependency Indicators

The MSS asks youth to respond to questions about consequences associated with their drug and alcohol use. Some of the questions on the MSS mirror content that might appear on a chemical health screening. These questions gauge youths' ability to set limits around their chemical use, changes in their level of tolerance, and personal consequences associated with using.

As trauma indicators increase, youth in correctional facilities report more agreement with questions intended to gauge problematic chemical use. That being said, the increase is generally not statistically significant, perhaps because of higher chemical use across the entire population. Only one question rises to the level of statistical significance among youth in correctional facilities by trauma grouping: youth who experience trauma are more likely to report that their chemical use has left them feeling agitated, depressed, paranoid or unable to concentrate.

Consequences of Drug and Alcohol Use: Percent "Yes"



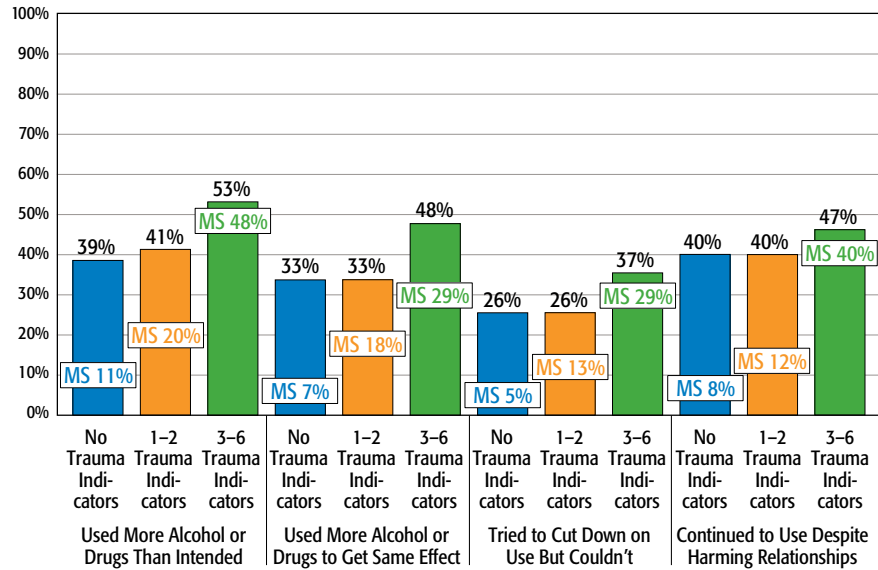
Among mainstream youth, those who report 3-6 trauma indicators report the greatest issues with chemical use. These problems are often as high as those reported by youth in correctional facilities. Over half of both mainstream youth and youth in correctional facilities who report 3-6 trauma indicators state that they have used so much alcohol or drugs that they could not remember what they said or did (52% and 55%); over six in 10

Youth and Trauma: Responses to the 2010 Minnesota Student Survey

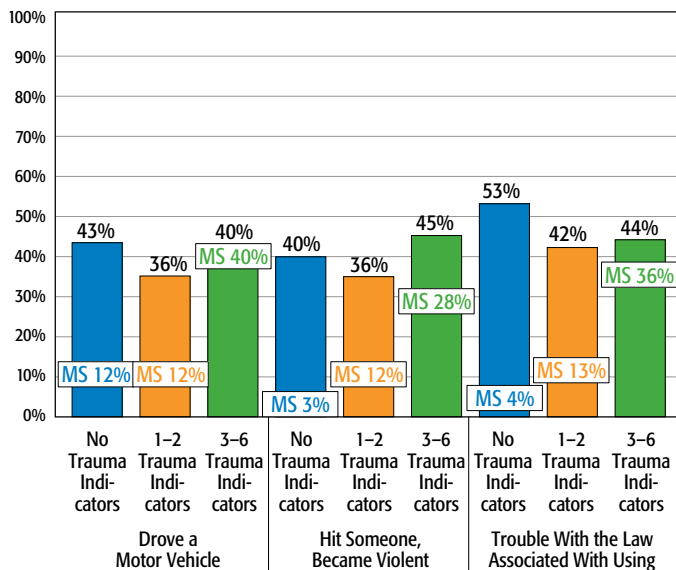
have required an entire day to get over the effects of using (64% and 65%); and four in 10 or more state that their use left them agitated, depressed or unable to concentrate (40% and 52%).

Furthermore, about half of both mainstream youth and youth in correctional facilities who report 3-6 trauma indicators indicate that they have used more drugs or alcohol than they intended, indicative of difficulty setting limits (48% and 53%). Four in 10 or more continue to use despite that it is hurting their relationships (40% and 47%). About three in 10 agree that they have tried to cut back but couldn't (29% and 37%) or that they have to use more drugs or alcohol to get the same effect, indicative of increased physical tolerance (29% and 48%).

Indicators of Drug or Alcohol Abuse and Dependency in Last 12 Months: Percent "Yes"



Public Safety Consequences of Chemical Use in the Past Year: Percent "Yes"



Public Safety Consequences of Alcohol and Drug Use

There is no statistical difference among youth in correctional facilities by trauma group on the public safety consequences associated with their chemical use. Reports of driving a motor vehicle under the influence, hitting others or becoming violent under the influence, and having problems with the law associated with using, are all commonplace among youth in correctional facilities. These affect roughly one-third to one-half of youth in each trauma group.

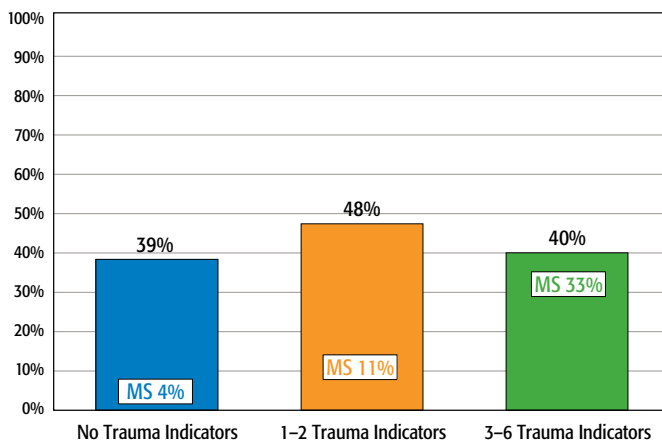
Conversely, there is a statistically significant difference among mainstream youth, who are more likely to report agreement with public safety questions related to chemical use based on their number of trauma indicators. Again, mainstream youth start out reporting less agreement with considerable increases as trauma rises. Over one-third of mainstream youth with 3-6 trauma indicators report trouble with the law associated with using (36%) and equal percentages of mainstream youth and youth in correctional facilities report driving under the influence of drugs or alcohol (40%). Mainstream youth with three or more trauma indicators are also statistically more likely to become violent under the influence than mainstream youth reporting fewer or no trauma indicators.

Youth and Trauma: Responses to the 2010 Minnesota Student Survey

Drug and Alcohol Treatment

Just as issues with substance abuse are more pervasive across the entire population of youth in correctional facilities, so too is the receipt of chemical health treatment. There is no statistically significant difference between youth in correctional facilities who receive substance abuse treatment based on the number of trauma indicators selected.

Whether Youth Have Received Chemical Health Treatment: Percent "Yes"



Among mainstream youth there is a statistically significant increase in treatment as trauma indicators rise. One-third of mainstream youth having 3-6 trauma indicators (33%) state they have received treatment as compared to just 4 percent of mainstream youth reporting no trauma.

Mainstream youth and youth in correctional facilities in the highest trauma category are somewhat comparable in terms of whether they have received treatment for a drug or alcohol problem. Forty percent of youth in correctional facilities and 33 percent of mainstream youth indicate that they have received drug or alcohol treatment.

Delinquent Behavior

Research supports that victims of violence are more likely to be perpetrators of violence, and that those most likely to be victims of crimes are those who report the greatest involvement in delinquent activity.⁶⁷ Furthermore, people who experience childhood trauma are more likely to be arrested for serious crimes both as youth and as adults.⁶⁸ While trauma does not inevitably lead to future illegal behavior, it is observed with sufficient frequency to be considered a specific risk factor for future involvement in the juvenile justice system.⁶⁹ Several questions on the MSS are related to typically lower-level delinquent behavior such as damaging property, shoplifting and getting into fights.

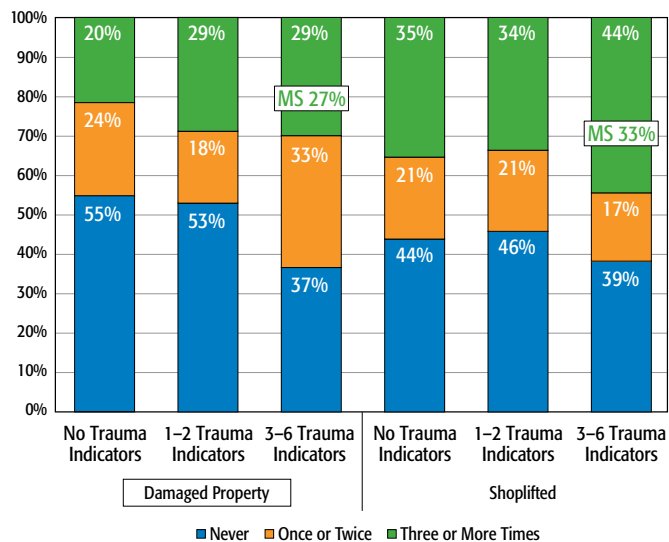
Property Offenses

Youth in correctional facilities who report more trauma indicators are statistically more likely to have damaged property in the past year. They are not, however, statistically more likely to report shoplifting. Shoplifting is prevalent among the entire population of youth in correctional facilities with over half of youth in all trauma categories having shoplifted at least once.

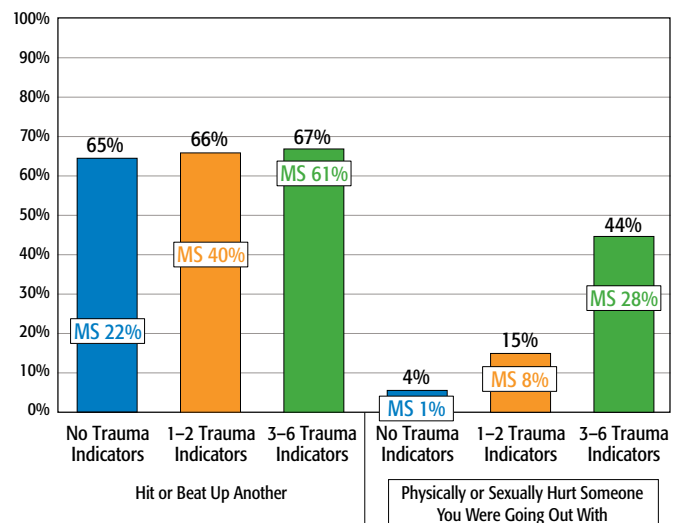
Among mainstream youth, youth with more trauma indicators are statistically more likely than those with fewer or no trauma indicators to both damage property and shoplift. While 88 percent of youth reporting no trauma have not damaged property and 84 percent have not shoplifted, this is true for only 49 percent and 55 percent of youth reporting 3-6 trauma indicators. Again, rates of repeated property damage and shoplifting by mainstream youth approach the same levels of those reported by youth in correctional facilities in the highest trauma groupings.

Youth and Trauma: Responses to the 2010 Minnesota Student Survey

**Property Offenses in the Past 12 Months:
Percent "Yes"**



**Person Offenses in the Past 12 Months:
Percent "Yes"**



Person Offenses

Youth taking the MSS are asked if they have hit or beat up another person in the past year, and if they have ever hurt, threatened or sexually victimized a dating partner. Youth in correctional facilities are not statistically more likely to hit or beat up another person based on trauma group. Approximately two-thirds of youth in each trauma category report this behavior. There is, however, a statistically significant increase in victimizing a dating partner by trauma group. While just 4 percent of youth in correctional facilities with no trauma report victimizing a dating partner, this is true of 44 percent of youth who report 3-6 trauma indicators.

In examining mainstream youth who report a higher number of trauma indicators, there is a statistically significant increase in interpersonal violence. Six in 10 mainstream youth who report 3-6 trauma indicators (61%) report hitting or beating up another in the past year, compared to less than one-quarter of youth who report no trauma indicators (22%). Similarly, mainstream youth who have been abusive in a dating relationship increases with trauma indicators. While just 1 percent of youth reporting no trauma have engaged in dating violence in the past year, this is true for nearly three in 10 youth reporting 3-6 trauma indicators (28%).

These findings suggest that there is a link between experiencing trauma and engaging in anti-social activities or violence against others. While these behaviors may be too prevalent among youth in correctional facilities to show a statistically significant difference, data on the mainstream sample of youth does suggest the potential for increased risk of juvenile justice system involvement based on trauma indicators.

Youth and Trauma: Responses to the 2010 Minnesota Student Survey

Sexual Behavior

Sexual behavior problems can emerge in children and youth in response to traumatic experiences.⁷⁰ These behaviors are rarely about sexual gratification and are more related to managing anxiety, control of one's environment, and self-soothing behavior.⁷¹ While some children with sexual behavioral problems have a history of sexual abuse, many children who act out sexually have not been abused.⁷²

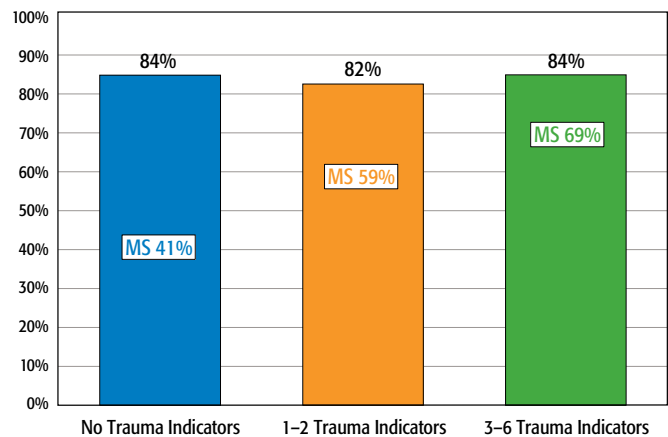
The final section of the MSS asks numerous questions related to youths' sexual behavior. While these questions are not indicative of deviant or problematic sexual behavior, they may illuminate if traumatic experiences among youth affect sexual practices.

Generalizations or conclusions about trauma and sexuality activity based on these MSS data must be made with caution. Some of the following data are representative only of youth who report they have had sex. As such, the population number in each student group is decreased, as is the number of youth in each trauma group. Further exploration of trauma and sexual activity is necessary beyond this study.

Sexual Activity

The vast majority of youth in correctional facilities report that they are sexually active. Over eight in 10 youth in correctional facilities in each trauma grouping (82% to 84%) indicate that they have had sexual intercourse. There is no statistically significant difference in behavior by trauma group. Conversely, youth in the mainstream school setting do report different sexual behaviors based on trauma indicators. Youth who have more trauma indicators are statistically more likely to report that they have had sex and they report having sex with greater frequency than their peers with lesser or no trauma.

**Whether Youth Have Had Sexual Intercourse:
Percent "Yes"**

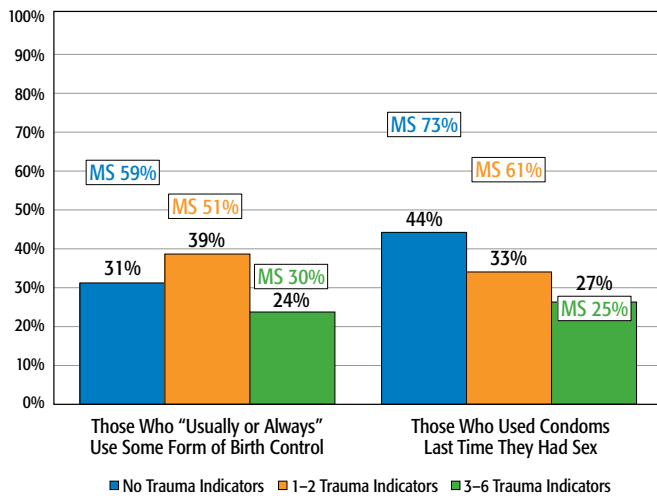


Use of Condoms and Other Birth Control

Another aspect of sexual behavior is whether or not youth are using birth control or condoms to prevent sexually transmitted diseases or pregnancy. Among youth in correctional facilities, regular use of birth control or condoms is infrequent. Fewer than four in 10 of youth in correctional facilities who have had sex report that they "usually" or "always" use birth control, or that they used a condom the last time they had sex. While those youth in correctional facilities who report 3-6 trauma indicators are the least likely to consistently use birth control (24%) or a condom (25%), they are not statistically less likely to do so than their peers.

Youth and Trauma: Responses to the 2010 Minnesota Student Survey

Youth Who Have Had Sex: Use of Birth Control



Among mainstream youth, there is a statistically significant difference between youth who report trauma and those who do not with regard to use of birth control and condoms. While almost six in 10 youth with no trauma indicators "usually" or "always" use birth control (59%), this is true for half as many youth with 3-6 trauma indicators (30%). Over seven in 10 mainstream youth with no trauma used a condom last time they had sex (73%) compared to just one-quarter of youth experiencing 3-6 trauma indicators (25%). As the graph illustrates, birth control and condom use of mainstream youth in the highest trauma category is as low, if not lower, than those with comparable trauma experiences in correctional facilities.

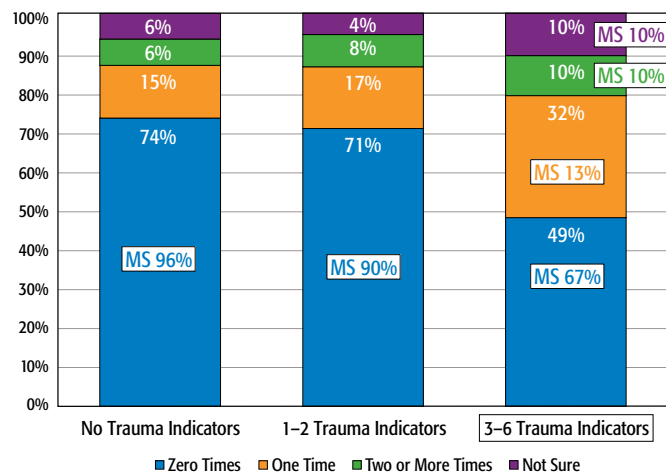
Pregnancy

Finally, youth taking the MSS are asked to self-report the number of times they have been pregnant or have gotten someone pregnant. Overall, a much greater percentage of youth in correctional facilities report a pregnancy than mainstream youth. Among youth in correctional facilities, the significant increase in preg-

nancy occurs within the population of youth reporting 3-6 trauma indicators. It is important to consider that a greater percentage of youth in the 3-6 trauma indicators group in both the correctional facility and mainstream populations are girls.

Forty-two percent of youth in correctional facilities in the 3-6 trauma indicators group report that they have been or gotten someone pregnant at least once. Ten percent have been or have gotten someone pregnant two or more times.

Number of Times Youth Have Been Pregnant/ Got Someone Pregnant



Mainstream youth are considerably less likely to report a pregnancy than youth in correctional facilities. Ninety-six percent of youth reporting no trauma and 90 percent of youth reporting 1-2 trauma indicators have never been or gotten someone pregnant. Of mainstream youth reporting 3-6 trauma indicators however, close to one-quarter (23%) report at least one pregnancy. The same percentage of mainstream youth with 3-6 trauma indicators report two or more pregnancies as youth in correctional facilities (10%).

Discussion and Practice Implications: Trauma-Informed Intervention

MSS data support the importance of addressing trauma among Minnesota youth. In response to overwhelming evidence of the prevalence of trauma amid the justice system population specifically, intervention strategies have emerged that are trauma-informed. Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives.⁷³ These interventions shift the paradigm from one that asks, “What is wrong with you?” to one that asks, “What has happened to you?”⁷⁴

Trauma Identification: Screening

Because behaviors associated with trauma often look very similar to common delinquent behaviors, it is important for juvenile justice practitioners to understand that there are multiple pathways to similar symptom patterns.⁷⁵ Youth who have been exposed to trauma often receive mental health diagnoses such as Attention Deficit Disorder, Oppositional Defiant Disorder or Conduct Disorder based largely on their observable behaviors. These diagnoses may include treatment interventions but are also treated with psychiatric medications to manage behavior without thorough investigation into the underlying causes.⁷⁶

Trauma screening tools can help prevent this diagnostic disconnect by identifying trauma histories in youth. It is ethically imperative that evidence-based tools be used to make accurate diagnoses, and appropriate response and treatment for trauma-exposed youth.⁷⁷ All youth entering the juvenile justice system should undergo a standardized mental health screening to identify the possibility of psychiatric conditions, including traumatic stress disorders, which require immediate attention or further clinical assessment.⁷⁸

Trauma screenings should be a routine practice performed at the earliest point of contact with the juvenile justice system.⁷⁹ The federal Office of Juvenile Justice and Delinquency Prevention states that mental health screening is most likely to be needed at three system stages:

- At the first interview with a youth after referral to the juvenile court, often conducted by an intake officer
- Upon admission of a youth to a pre-trial detention center to await adjudication
- Upon admission to a post-adjudication community program or correctional facility to begin the rehabilitative process.⁸⁰

Trauma screening typically focuses on two core issues: trauma exposure and traumatic stress symptoms. In terms of exposure, it is important to know what trauma incidents happened, at what age and under what circumstances. In terms of symptoms, it is important to know if symptoms are interfering with a youth’s ability to think clearly, and make healthy choices and positive growth.⁸¹

Trauma screenings should be conducted by professional staff who are appropriately trained to administer and interpret screening results. Screenings might be conducted by intake or facility staff, court staff, community-based providers or assessment centers, or mental health collaboratives.^{82,83}

The following are examples of tools that screen for traumatic exposure and stress symptoms among the juvenile justice population:⁸⁴

- Massachusetts Youth Screening Instrument-Second Version (MAYSI-2)
- Traumatic Events Screening Inventory (TESI)
- PTSD Reaction Index (PTDI-RI)
- Trauma Symptoms Checklist for Children (TSCC)
- PTSD Checklist of Children/Parent Report (PCL-PR)

Considerations in the administration of screening tools include time to administer; cost to administer; training required for staff; validity and reliability of the assessment tool on an adolescent or justice system-involved population; and whether the tool is valid and reliable on special populations, including girls, and cultural or racial minority groups.⁸⁵

Discussion and Practice Implications: Trauma-Informed Intervention

Mental health and trauma screening generally identify if there is an immediate safety need for the youth (such as self-harm or suicidal ideation), or if there is a potential mental health or trauma issue that requires an assessment, which is a more thorough investigation.⁸⁶ Conversely, a trauma assessment is typically recommended following a positive trauma screening. Trauma assessments are to be completed by a mental health professional and include interviews with the youth, their families, include collateral contacts such as schools or other treatment providers, observation of youth behaviors and interactions, and use of validated assessment tools.⁸⁷

The content of screening tools can be potentially problematic in the juvenile justice system. If a child has not been adjudicated, youth may not admit to substance abuse or domestic violence that can be used against them or their families. Assessors must be careful to inform youth and families about confidentiality and the limits thereof. One suggested time for screening is that is take place between a finding of guilt and sentencing. This prevents concerns about self-incrimination, but allows courts to consider mental health and trauma in disposition and service planning.⁸⁸

Minnesota Screening Practices

In 2003, Minnesota enacted legislation requiring certain youth in the child welfare and juvenile justice systems to routinely be screened for mental health issues. Some of the stated purposes of Children's Mental Health Screening are to provide a mechanism for integrating mental health into current practices; to provide earlier mental health interventions; and to use standard screening tools.⁸⁹

Youth within the juvenile justice population who are in the mandated screening category are those ages 10 to 18 to have been adjudicated (found guilty) of a delinquent offense; youth accused of a delinquent act who are ordered to be held in continued detention; and youth who have committed a third or subsequent petty

offense. While not required, it is recommended that youth who receive a stay of adjudication or a continuance for dismissal also be screened.⁹⁰

Generally, justice system youth are exempt from screening if they have been screened or assessed for mental health issues in the previous six months; are already under the care of a mental health professional; or if a guardian does not consent to their child being screened.⁹¹

For juvenile justice system-involved youth, two screening tools are approved by the Minnesota Department of Human Services (DHS).^{iv} These are the MAYSI-2 and the Problem Oriented Screening Instrument for Teenagers (POSIT).⁹² The POSIT screens for concerns related to substance abuse, mental health, physical health, family relationships, educational status, and aggressive behaviors/delinquency.⁹³ The MAYSI-2 screens for alcohol/drug use, anger-irritability, depression-anxiety, somatic complaints, suicide ideation, thought disturbance and traumatic experiences. The Traumatic Experience scale is intended to identify whether a youth has had greater exposure to traumatic events in their lifetime compared to other youth.⁹⁴ Unlike the MAYSI-2, the POSIT tool does not have a question grouping that specifically screens for trauma.

In 2009, just under 7,700 youth were identified by Minnesota probation departments as eligible to receive a mental health screening. Close to 3,000 were determined to be exempt from a required screening resulting in just under 4,700 screened. As such, over 99 percent of eligible youth were either screened or had a valid exemption in 2009.⁹⁵ Of the screenings completed, about 2,800 (60%) met the threshold of a "positive screen" for further mental health assessment. About half of youth with a positive screen (1,400) were reported to DHS and referred for mental health assessment.⁹⁶

iv Three screening tools are approved by DHS for use with the child welfare population: The Ages and Stages Questionnaire (ASQ:SE), The Pediatric Symptom Checklist (PSC-35), and the Strengths and Difficulties Questionnaire (SDQ).

Discussion and Practice Implications: Trauma-Informed Intervention

Evidence-Based Practices

Evidence-based practices (EBPs) are interventions for which there is consistent scientific evidence that they improve outcomes for clients.⁹⁷ A number of evidence-based practices are available for treating youth who are impacted by trauma. Typically, trauma-focused EBPs include psycho-education, caregiver involvement and support, emotional regulation skills, anxiety management, construction of a trauma narrative, and personal empowerment training.⁹⁸ Common elements include: (1) emotion identification, processing and regulation; (2) anxiety management; (3) identification and alteration of maladaptive thoughts; and (4) interpersonal communication and social problem-solving. Some interventions also seek to enhance parent-child relations by promoting positive interactions and effective behavior management skills.⁹⁹

The aforementioned “identification and alteration of maladaptive thoughts” is a cognitive-behavioral strategy whereby problematic thought processes are replaced with more positive, accurate or pro-social thoughts. These changes in cognition subsequently lead to changes in attitudes and behaviors.¹⁰⁰ Cognitive behavioral approaches have been shown to be particularly effective in addressing trauma among youth in the juvenile justice system.^{101,102} Research on youth within the juvenile justice population show that the most effective cognitive behavioral treatments are highly structured, emphasize the development of basic skills, and provide individual counseling to directly address behaviors, attitudes and perceptions.¹⁰³

The following are specific examples of EBPs for addressing trauma with youth. Those in italics are cognitive-behavioral therapies for youth experiencing traumatic stress disorders:¹⁰⁴

- Trauma Affect Regulation: A Guide for Education and Therapy (TARGET)
- Trauma Recovery and Empowerment Model (TREM)
- Brief Eclectic Therapy
- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

- Eye-Movement Desensitization and Reprocessing Therapy (EMDR)
- Skills Training in Affective and Interpersonal Regulation (STAIR)

Specifically, TF-CBT has consistently been shown to reduce symptoms of PTSD, as well as symptoms of depression and behavioral difficulties in children who have experienced sexual abuse and other traumas.¹⁰⁵ Studies reveal that more than 80 percent of children show marked improvement in symptoms within 12 to 16 sessions. Participants typically experience significantly fewer intrusive thoughts and avoidance behaviors; are able to cope with reminders and associated emotions; show reductions in depression, anxiety, disassociation, behavior problems, sexualized behavior and trauma-related shame; demonstrate improved interpersonal trust and social competence; develop improved personal safety skills; and become better prepared to cope with future trauma reminders.¹⁰⁶ Follow-up studies have shown that these gains are sustained over time.¹⁰⁷

As it relates to substance abuse, another issue significantly affecting justice system-involved youth, recovery rates are poorer for clients who have histories of victimization and are treated in programs where the link between trauma and substance abuse is not addressed.¹⁰⁸ Best practices support chemical health treatment that assesses clients for abuse and trauma histories; refers clients to appropriate trauma services; integrate trauma as a direct and primary cause of the majority of substance use; learn the direct connection between trauma and substance abuse as self-medication; and actively support and integrate the teaching and use of trauma symptom management skills as an alternative to substance use.¹⁰⁹

Discussion and Practice Implications: Trauma-Informed Intervention

Family Involvement

A theme that repeatedly emerges in the literature around serving youth with trauma histories is engagement and partnership with caregivers. This involves developing meaningful working relationships with parents, extended family, kinship caregivers, adoptive and foster families, and other important family members.¹¹⁰ Family members need information about how to support youth who have experienced trauma, how to interpret and respond to their behavior, and how to address trauma in their own lives that may affect their ability to support their children's trauma needs. Adoptive or foster families also need information about the children's trauma history to understand youth behavior and attachment issues.¹¹¹

Evidence suggests that parents who are able to exhibit less stress and more familial support mitigates the effects of trauma on children. When parents are given strategies to address their issues around their children's trauma, they are better able to support their children leading to better outcomes. Clinical interventions with families include family sessions in conjunction with individual or group treatment; family therapy and family group therapy.¹¹²

There are obstacles too, that may need to be overcome in engaging the families of justice system-involved youth. To begin, a family member may be the perpetrator of violence or abuse against the child, and may not accept ownership for their actions or acknowledge the level of harm their actions have had on their children.¹¹³ When trauma happens outside the family, parents may have feelings of guilt related to not knowing about or being able to stop the trauma from happening.¹¹⁴ It is important that justice system professionals limit judgment and shame that may accompany trauma in families to help families to feel valued and respected.¹¹⁵ Also, consideration should be given to the out-of-home placement of youth. Youth placements in close proximity to families allow for visitation and promote family participation in treatment.¹¹⁶

Trauma-Informed Systems of Care

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), trauma prevention and treatment are promising practices for reducing justice system involvement. While behavioral health providers implement "trauma-specific services" to directly address the impact of trauma in people's lives, it is also important to creating entire service settings that are "trauma informed."¹¹⁷ Trauma-informed systems of care understand the impact of stress both on youth and families; provide services and supports that prevent, address and ameliorate the impact of trauma; create safe spaces for addressing trauma; and, have practices that do not increase the level of trauma youth and families experience or re-traumatize youth.^{118,119}

As an example of a national level strategy, SAMHSA names Trauma and Justice as one of its top strategic initiatives for 2011-2014. Objectives related to this initiative are the expansion of alternative responses and/or diversion for people with behavioral health problems and trauma histories in the criminal and juvenile justice systems; support and training for judges, prosecutors, defense attorneys and probation officers about the complex issues of substance abuse; mental health disorders and trauma to improve decision-making and system approaches to serving the community; and improving the availability of screening and trauma-informed care and treatment on the criminal and juvenile justice systems.¹²⁰

At the agency or organizational level, trauma-informed care incorporates proven practices into current operations to deliver services that acknowledge the role that violence and victimization play in the lives of clients.¹²¹ Implementing trauma-informed approaches to service delivery requires the commitment of service managers and stakeholders. Key activities in establishing a trauma-informed system of care include:¹²²

- A trauma-informed organizational mission and the commitment of resources to support it
- Updated policies and procedures to reflect a trauma-informed mission

Discussion and Practice Implications: Trauma-Informed Intervention

- Universal trauma screening for all clients
- Incorporation of values and approaches focused on safety and prevention for clients and staff
- Strength-based environments and practices that allow for client empowerment
- Ongoing staff training and education in trauma-informed care
- Targeted staff hiring practices

The juvenile justice systems in Connecticut and Florida are examples of states that have implemented trauma-informed strategies. Both have identified that trauma

exposure is of sufficient prevalence among justice system-involved youth to be a top priority, and both have implemented the TARGET model in detention centers, among probation officers and other treatment programs. TARGET is a strengths-based approach designed to enhance self-regulation capacities among youth trauma victims. Practitioners systemwide have been trained, which assures that policies, practices, interventions and language are consistently responsive to youth trauma.¹²³ The state of Florida provides the following list of what trauma-informed practices look like, as compared to those that are not.¹²⁴

Trauma Informed	Non-Trauma Informed
Recognition of high prevalence of trauma	Lack of education on trauma prevalence and universal precautions
Recognition of primary and co-occurring trauma diagnoses	Over-diagnosis of schizophrenia, bipolar disorder and conduct disorder
Assess for traumatic histories and symptoms Cursory or no trauma assessment	Cursory or no trauma assessment
Recognition of culture and practices that are re-traumatizing	Tradition of toughness valued as best care approach
Power/control minimized – constant attention to culture	Keys, security uniforms, staff demeanor, tone of voice
Caregivers/supporters – collaboration	Rule enforcers – compliance
Address training needs of staff to improve knowledge and sensitivity	Patient-blaming as fallback position without training
Staff understand function of behavior (rage, repetition-compulsion, self-injury)	Behavior seen as intentionally provocative
Objective, neutral language	Labeling language: manipulative, needy, attention-seeking
Transparent systems open to outside parties	Closed system – advocates discouraged

Discussion and Practice Implications: Trauma-Informed Intervention

Trauma-informed education and training is needed for professionals across youth-serving systems.¹²⁵ Justice system professionals specifically must be trained to recognize when the behaviors of youth may be a trauma response. For example, trauma-informed professionals know that youth may be hyper-vigilant and be easily triggered into defensive or aggressive responses. As such, policies and practices that promote youth's sense of safety and reduce exposure to traumatic reminders can be implemented.¹²⁶

Finally, justice system agencies are responsible for monitoring their interventions with youth; collecting needed data and information about program application and fidelity to models; and assessing if there is a positive effect on youth's ability to cope. Pre- and post-treatment assessments help provide information about the effectiveness of interventions. As an example, juvenile correctional facilities might use the number of restraints and seclusions, self-injurious behaviors and aggressive incidents to provide information as to if practices are effective or need revision from a trauma-informed perspective.¹²⁷

Minnesota's System of Care

Minnesota has several policies and procedures that lay the groundwork for a trauma-informed juvenile justice system. The aforementioned mental health screening requirement statewide is one that acknowledges the prevalence of trauma amid justice and child welfare system populations. In addition, statutes related to both juvenile justice and child welfare promote that children be placed out of the home in the least restrictive placement necessary, and as close to a child's family as is possible.¹²⁸ Finally, Minnesota Department of Corrections licensing rules require that professionals working in residential facilities have training on mental health issues; restrict or limit the use of seclusion or restraint; and prohibit certain activities such as forced medicating or forced physical exams. These rules also ensure the presence of female staff overnight when girls are in facilities.¹²⁹

In the realm of child welfare, the Minnesota Department of Human Services Children's Mental Health Division is partnering with the Ambit Network at the University of Minnesota to train mental health professionals across the state in the practice of trauma-focused cognitive behavioral therapy.¹³⁰ The Ambit Network is a university-community partnership helping to ensure high-quality care is accessible for Minnesota children and families who have experienced trauma through training and programs.¹³¹

The Minnesota Juvenile Justice and Mental Health Initiative, an inter-agency, interdisciplinary task force of professionals and stakeholders, provided a comprehensive list of recommendations to improve mental health services and professional competencies in Minnesota's juvenile justice system in 2008:¹³²

The need for post-screening coordination:

- Develop a model for post-screening coordination that includes best practice elements
- Provide statewide comprehensive training on mental health and juvenile justice to professionals involved in the juvenile justice system, children's mental health, social services and school personnel, including School Resource Officers
- Web-based education and training materials for use with youth, parents, and community-based and government-based agencies.

The need to better engage families and caregivers as partners:

- Develop a System Navigator function within counties or regions to provide parents with information and assistance concerning the screening process and linking parents to services
- Require juvenile probation officers to receive training in mental health and family engagement strategies as a part of their annual mandatory training hours
- Provide a hiring advantage for juvenile probation positions by adding mental health and family skill-building as a "desirable job qualification."

Discussion and Practice Implications: Trauma-Informed Intervention

The need to collect data that better informs the process and share data without jeopardizing the legal interest of youth as defendants:

- Initiate a review of federal and state privacy and data-sharing statutes related to mental health and juvenile justice
- Clarify mental health screening data definitions and establish an electronic system for collecting screening data.

Need for evidence-based, community-based mental health interventions that are effective with justice-involved youth:

- Apply for grant money to pilot the use of evidence-based interventions
- Assess the potential for deploying existing resources through a financial mapping process
- Work with the Office of the Legislative Auditor to implement cost-benefit studies.

The recommendations of the Minnesota Juvenile Justice and Mental Health Initiative closely mirror strategies used to develop trauma-informed systems of care, including staff training and hiring; family engagement; universal screening and assessment processes; and evaluation and outcome measurement.

Conclusion

A traumatic experience is one that threatens someone's life, safety or well-being often resulting in intense feelings such as fear, terror, helplessness and hopelessness. Youth in Minnesota correctional facilities who participated in the 2010 MSS report more trauma indicators than a matched sample of mainstream school students.

These data support many studies which find that youth involved in the juvenile justice system report exposure to traumatic events at rates significantly higher than the general youth population. Over half of youth in correctional facilities report at least one form of trauma on the MSS compared to just over one-quarter of a matched sample of mainstream students. In both populations, experiencing and witnessing domestic abuse is the most common trauma indicator reported.

The actual rate of traumatic exposure among both populations of Minnesota youth would likely be higher if other types of trauma not covered on the MSS were included. Additional examples of trauma affecting youth not included in the MSS are: loss or death of a caregiver; being the victim of a violent crime; witnessing death, violence or severe injury of another; surviving life-threatening accidents or conditions; and chronic neglect of basic physical and emotional needs.

Youth in Correctional Facilities and Trauma

Research also supports that the more trauma youth experience, the more issues there typically are in other aspects of their life. Trauma can affect mental and emotional health, substance use, relationships, school attachment and anti-social behaviors. MSS data confirm that youth in correctional facilities who report 3-6 trauma indicators are statistically more likely than youth in correctional facilities with fewer or no trauma indicators to report the following:

- Lower perception of parent caring
- A family member's drug or alcohol use as problematic
- Running away from home
- Higher reports of victimization at school including being threatened and sexually harassed
- High agreement with feelings of anger, depression, nervousness and worry, stress and hopelessness

- Increased difficulty with concentration, sleep, restlessness and impulsivity
- Self-injurious behavior, suicidal ideation and suicide attempts
- More chemical use and an earlier age of first chemical use
- More reports of damaging property
- More reports of victimizing a dating partner.

These findings suggest that even within the population of youth in correctional facilities, many problematic attitudes and behaviors are significantly higher among those youth who report more types of trauma. Trauma-specific interventions and supports are needed to address trauma histories that may be driving youths' juvenile justice system involvement.

Mainstream Youth and Trauma

Similar to youth in correctional facilities, mainstream youth who report 3-6 trauma indicators are also more likely than their mainstream peers reporting fewer or no trauma indicators to express agreement with questions related to problem areas in their life. In addition to all of the findings listed above related to youth in correctional facilities, mainstream youth who experience trauma are statistically more likely than their peers to report:

- Lower perceived caring by friends, adult relatives, adults at school, religious or spiritual leaders, and adults in their community
- Lower school satisfaction
- Additional victimization at school including property damage, being kicked, hit or bitten, and being offered illegal drugs
- More indicators associated with substance abuse and dependency
- Higher delinquent behavior, including getting into fights, driving under the influence, shoplifting and property damage
- Being sexually active.

Conclusion

The differences between mainstream youth who report trauma and those who do not are more pronounced even than the differences between youth in correctional facilities who report trauma and those who do not. The MSS responses of mainstream youth further illustrate the destructive affect of trauma on youth well-being.

Youth in Correctional Facilities and Mainstream Youth: Trauma Commonalities

Youth in correctional facilities generally report more problematic attitudes and behaviors on the MSS than mainstream youth. The gap between their experiences and perceptions narrows, however, as the number of trauma indicators reported by mainstream youth rises. Ultimately, a comparable percentage of both mainstream youth and youth in correctional facilities with 3-6 trauma indicators report the following:

- A family member's drug or alcohol use as problematic
- Running away from home six or more times in the past year
- High agreement with feeling angry, depressed, trouble concentrating, restlessness, trouble sleeping and impulsivity
- Suicide attempts
- Using more drugs or alcohol than intended; using despite harming relationships; and using so much drugs or alcohol they could not remember their actions
- Driving a motor vehicle under the influence
- Damaging property three or more times in the past year
- Having been or gotten someone pregnant two or more times.

On several occasions, a greater percentage of mainstream youth report problems than youth in correctional facilities with comparable trauma indicators. These data suggest that the impact of trauma on youth is significant, regardless of whether they are justice system-involved.

Practice Implications: Trauma-Informed Care

The very prevalence of trauma in the experiences of justice system-involved youth places systems serving these youth at minimum with the obligation to understand how these experiences affect youth behavior and interactions. Juvenile justice organizations and agencies that are trauma-informed are those that:

- Prioritize trauma and mental health screening
- Train staff on the effects of trauma
- Use evidence-based treatment interventions
- Review policies and procedures for practices that may hinder healing opportunities or re-traumatize youth
- Actively engage families.

Minnesota prioritizes trauma-informed care through mandatory statewide mental health screenings for certain youth involved in the juvenile justice system. Minnesota statutes and residential facility licensing rules also express preference for placing youth close to their families and limiting or prohibiting practices that might re-traumatize youth under the care of the juvenile justice system. Nevertheless, Minnesota must continue to prioritize comprehensive mental health services and trauma-informed interventions for justice system-involved youth across the state consistent with the recommendations of the Minnesota Juvenile Justice and Mental Health Initiative.

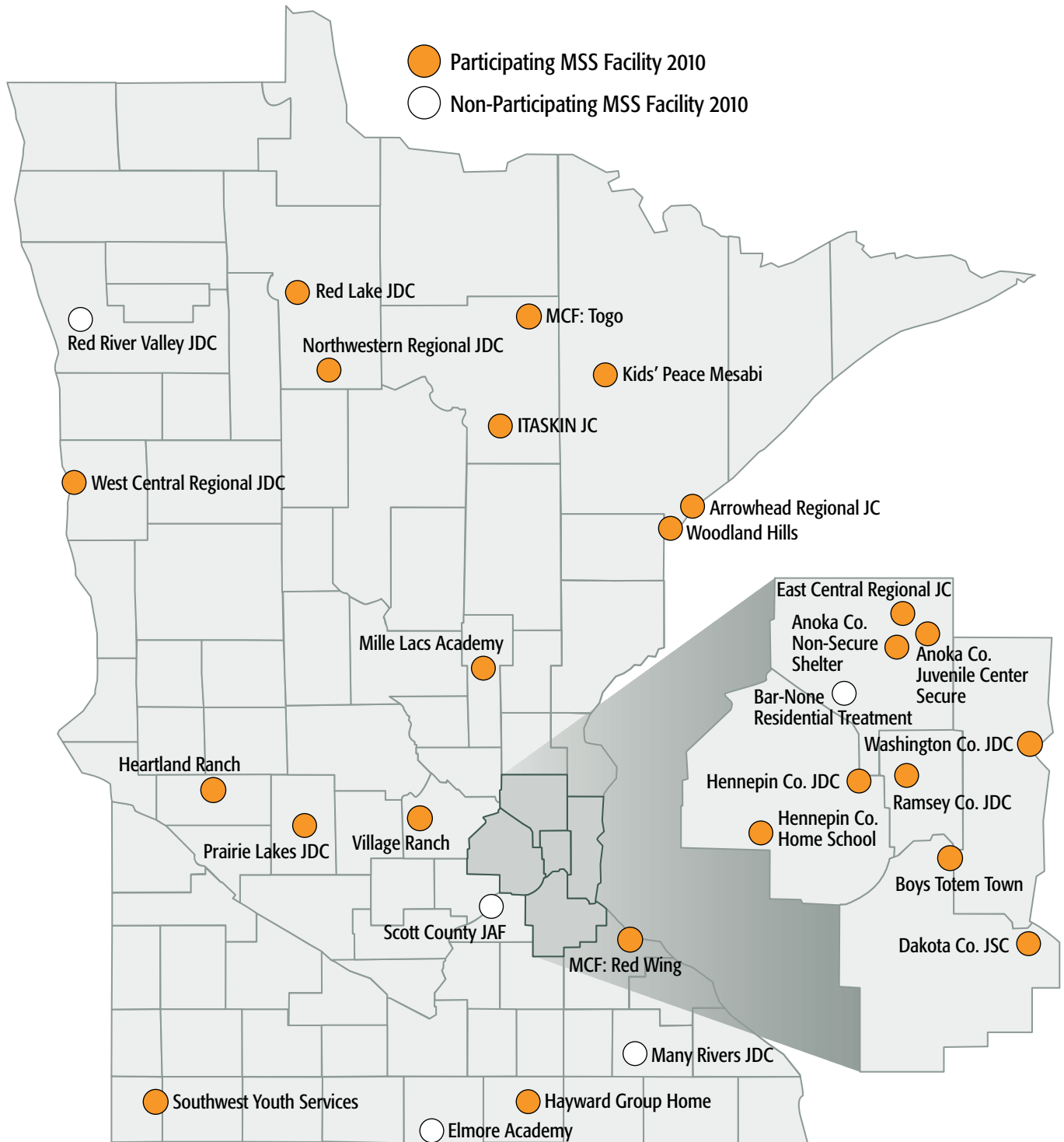
Characteristics of Participating Facilities

Based on licensing information maintained by the Minnesota Department of Corrections, participating facilities had the following characteristics in 2010:

- Eleven participating facilities have secure beds only; five have both secure and non-secure beds; and eight have only non-secure beds.
- Nine facilities are in the seven-county Twin Cities Metro area; the remainder are in greater Minnesota.
- Eight facilities have maximum populations of fewer than 30 youth; eight facilities have maximum populations of 30 to 65 youth; and eight facilities have maximum populations of over 80 youth.
- Ages of youth in the program vary with admission criteria. Generally, the minimum age of admission is 10 years old and the maximum age is 19. Age criteria are determined in part by the risk level served and programs offered.
- Seventeen facilities house both male and female youth; six facilities house only males; and one facility houses only females. In facilities that accept both males and females, girls and boys are housed and programmed separately, consistent with best practices.
- Seventeen facilities provide pre-dispositional detention and post-dispositional residential placement; six facilities are post-disposition residential placement only. Only one facility offers pre-adjudication detention only.
- The youth length of stay in the facilities can range from a few days to over a year, depending on the treatment services offered and whether youth are pre- or post-adjudication holds.

Appendix B

Location of Department of Corrections Licensed Youth Facilities Eligible for MSS Participation



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