By John Beazoglou, MSW, LCSW

BACKGROUND
Substance abuse is a severe national problem affecting 24.6 million Americans ages 12 years and older in 2013. According to NIH data, the highest incidence of past-month illicit drug use occurs in age groups 16-17 (15.8%), 18-20 (22.6%), and 21-25 (20.9%)\(^1\). Concurrently, the U.S. Department of Justice estimates 2.5 million juvenile arrests occur annually. In Connecticut, about 83,000 adolescents 12 years and older have a diagnosable substance abuse or dependence disorder, and a subset of these adolescents also become entangled in the juvenile justice system and delinquency. The relationship between substance abuse and juvenile delinquency has been well documented over the years and remains a leading criminogenic factor for continued problems with the law and recidivism\(^2\).

The initial intervention offered to adolescents in the Connecticut juvenile justice system occurs with the Court Support Services Division (CSSD). Over the past five years, CSSD has come in contact with an estimated 60,000 youth who have committed crimes or been referred to juvenile court for intervention/supervision. In 2014, CSSD worked with roughly 11,000 juveniles through their court support and diversion programs. These adolescents received a multitude of community-based interventions including clinical treatments, juvenile probation, congregate care placement, and in-home family interventions. However, despite all these efforts, a small percentage of the adolescents do not benefit from the CSSD services and interventions and continue down a path of crime, community disruption, and/or remain a risk to public safety. Annually, about 300 complex youth (2.5% of the clients served by CSSD), who have not responded to community-based interventions, are eventually adjudicated as delinquent youth and placed into the custody of the Department of Children and Families (DCF).

The Connecticut Juvenile Training School (CJTS) is the only secure DCF-operated facility for treating youth who have been adjudicated as delinquents by the juvenile courts. CJTS has become a source of controversy regarding the treatment of youth in their care and custody, treatment services, recidivism, and operating costs. However, CJTS has been criticized for “momentary events, rather than systemic dysfunction”, and has not received an evidence-based evaluation of the type of juveniles being treated in the facility, the treatment protocols and processes, and the outcomes of their services. This brief paper attempts to fill that void.

The criticism and distortion of CJTS, regarding its care and treatment of the adolescents in its custody, has been propagated through a series of misrepresentations and innuendos based on a lack of information. Throughout Connecticut,
Myth and Reality

Connecticut Health Quarterly | 17

Journalists and advocacy groups alike mischaracterize CJTS as a place where adolescents are brutalized and not provided with “the right” rehabilitative and mental health services. National experts in the field of juvenile justice have come forth comparing CJTS to other juvenile facilities where “...children stuffed clothing in cracks around their toilets to keep the rats out of their cells and where beatings by the staff were commonplace” or where staff “...beat or sexually abused youth or sold them drugs”3. Nothing can be further from the truth. With all the criticism enveloping CJTS, it is important to note that CJTS is fully transparent. Stakeholders, including advocacy groups, have the ability to review all case records, incident reports, videos (cameras monitor all movement of staff and youth on campus 24/7), and may interview the adolescents. No other facility or program in Connecticut, possibly in the country, offers this level of transparency. In other words, nothing is hidden within the walls of CJTS.

OBJECTIVES

The purpose of this paper is to provide an evidence-based comprehensive understanding of (a) the characteristics of juveniles placed at CJTS; (b) the physical structure of the CJTS; (c) the screening, diagnosis, and interventions specific to substance abuse; and (d) their outcomes after juveniles are discharged in the community. Specifically, this paper will detail substance abuse relapse outcomes for juveniles discharged from CJTS in FY 2014 and FY 2015.

CHARACTERISTICS OF JUVENILES IN CJTS

CJTS annually admits, on average, 300 juveniles between 14 and 19 years of age, who have not responded to community-based interventions and are eventually adjudged as delinquent youth and placed into the custody of the Department of Children and Families (DCF). By the time these adolescents arrive at CJTS, virtually every other system in Connecticut has failed them. Juveniles are committed through juvenile court as a delinquent for either an 18-month or 4-year period, depending on the series of crimes and/or court violations committed. Juveniles who are issued an 18-month commitment serve an average 6-month stay at CJTS, while juveniles with a 4-year commitment stay an average of 1 year. Many of these juveniles were neglected and abused by parents, grew up in impoverished and dangerous neighborhoods, failed to engage with teachers and school administrators, and either slipped through the cracks in the mental health care system or had providers who failed to correctly diagnose or treat their problems. They are the adolescents who have been resistant to treatment interventions and have been identified by the court as a threat to the community and in need of a secure treatment facility.

Race/Ethnicity - An analysis of the FY 2014 and FY 2015 data for juveniles discharged from CJTS highlights the demographics of the population served, as shown in Exhibit 1.

In addition to the disproportional minority representation in Connecticut’s juvenile justice system, a nationwide problem, their overall behavioral and mental health is complex. Many detained youth have psychiatric disorders. The most recent study found that even after excluding conduct disorder (symptoms of which include delinquent behaviors), about 60% of detained males had a psychiatric disorder, far exceeding community rates4.

Exhibit 2 breaks down CJTS youth by complexity of disorders. Advocacy groups and public policy experts believe that many youth in the juvenile justice system suffer from comorbidity, more than one alcohol, drug or mental disorder5. The Surgeon General’s Report on children’s mental health notes that...
youth with comorbidity may be arrested because our fragmented mental health system has little to offer them. Related research also suggests that rates of alcohol, drug or psychiatric comorbidity among juvenile detainees may be quite high. CJTS juveniles discharged within the past two fiscal years show comorbidity patterns similar to national data. To simplify and help categorize the multiple diagnostic disorders, mental health diagnoses were classified into four categories: Behavioral Disorders, Substance Abuse Disorders, Psychiatric Disorders, and Neurodevelopmental Disorders. Exhibit 2 provides an even finer breakdown, showing various combinations of disorders and the number of each type of disorder (in parentheses).

Juvenile delinquency is not just a problem in the major cities of Hartford, New Haven, Waterbury and Bridgeport. Youth placed at CJTS come from all corners of the state: over the past two fiscal years, CJTS youth have come from 55 of Connecticut’s 169 towns.

### CONNECTICUT JUVENILE TRAINING SCHOOL

Opened on August 27, 2001, CJTS is the only secure DCF-operated facility for treating juveniles who have been adjudicated as delinquent by the juvenile courts. CJTS is located on 32 acres of land in Middletown, CT, and has a campus-style design with six buildings surrounding a central courtyard and an operational bed capacity of 154.

### SCREENING, DIAGNOSIS, AND TREATMENT

While adolescents are in the care of CJTS, the staff delivers comprehensive and evidence-based clinical, educational and medical services. Clinical, medical and educational assessments and services are provided for all youth upon admission to the facility. Clinical services include evidence-based models in individual, family and group therapy based on treatment needs. Clinical services also include case management in preparing youth for their movement to the community or a congregate care setting. Clinical services are offered 24/7, including a licensed clinician on-call and available to the adolescents at all times. Medically, all youth undergo a complete health screening and a physical examination. Access to medical, psychiatric and dental care is provided and

### Exhibit 2: Diagnostic Disorders of Juveniles in CJTS, FY 2014 & FY 2015

<table>
<thead>
<tr>
<th>Diagnostic Categories</th>
<th>FY 2014</th>
<th>FY 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral (1), Substance Abuse (2), and Neurodevelopmental Disorders</td>
<td>6%</td>
<td>17%</td>
</tr>
<tr>
<td>Behavioral (1), Substance Abuse (2), Psychiatric and Neurodevelopmental Disorders</td>
<td>18%</td>
<td>16%</td>
</tr>
<tr>
<td>Behavioral (1), Substance Abuse (2)</td>
<td>24%</td>
<td>14%</td>
</tr>
<tr>
<td>Behavioral (1)</td>
<td>13%</td>
<td>13%</td>
</tr>
<tr>
<td>Behavioral (1), Substance Abuse (2), Psychiatric Disorders</td>
<td>6%</td>
<td>12%</td>
</tr>
<tr>
<td>Behavioral (1), Neurodevelopmental Disorder</td>
<td>11%</td>
<td>9%</td>
</tr>
<tr>
<td>Behavioral (1), Psychiatric, and Neurodevelopmental Disorders</td>
<td>8%</td>
<td>7%</td>
</tr>
<tr>
<td>Behavioral (1), Psychiatric Disorders</td>
<td>3%</td>
<td>6%</td>
</tr>
<tr>
<td>Other</td>
<td>11%</td>
<td>6%</td>
</tr>
</tbody>
</table>

Source: CJTS

### Exhibit 3: Comparison of Initial Screen and Diagnosis of Substance Abuse Disorder, FY 2014 & FY 2015

<table>
<thead>
<tr>
<th></th>
<th>FY2014</th>
<th>FY2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Endorsing Substance Use on Admission</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnosed with Substance Abuse Disorder</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: CJTS
incorporated in the individual treatment plans, as well as the discharge plans. CJTS also offers 24/7 medical/nursing services.

Each youth receives a career interest inventory, a vocational interest and aptitude assessment, as well as a life skills assessment through the school. The Walter G. Cady School is located at CJTS and falls under the Unified School District #2. The Cady School offers a complete educational experience with academic and vocational offerings tailored to meet residents’ needs. Finally, all youth receive services from the rehabilitative department, which offers a wide variety of recreational programming and therapeutic interventions, including art and music therapy.

The mission of CJTS is to provide a safe, secure and therapeutic environment that enables growth and success. National best practices interventions and standards are integrated into facility operations with the goal of reducing risk of re-offending, preparing youth for community re-entry and developing positive outcomes.

**EARLY INTERVENTION AND SCREENING**

Intervention and treatment for all youth entering CJTS begin immediately upon admission. A licensed professional—mental health clinician, clinical social worker, or clinical psychologist—meets with the adolescent to start the screening and assessment process to identify risk factors, diagnosis, needs and clinical course of treatment. The Global Appraisal of Individual Needs Short Screener (GAIN-SS) is one of many validated instruments used to assess the need for immediate clinical intervention. The GAIN-SS is designed to provide a quick and accurate screen of multiple behavior disorders and to aid in patient triage and clinical referral, treatment planning, and program evaluation. The GAIN-SS is one of only a few available screeners that addresses both mental health and substance abuse problems, and has been validated in multiple patient populations (e.g., general healthcare settings, individuals in the criminal justice system, and homeless populations). It focuses on four separate domains: Internalizing Disorders, Externalizing Disorders, Substance Abuse Disorders, and Crime/Violence. Beyond a screening instrument, the GAIN-SS serves as a quality assurance tool to measure the consistency of screenings and diagnosis.

Data collected from the GAIN-SS for FY 2014 and FY 2015 were analyzed to see if subsequent diagnoses were consistent with initial screenings. The importance of this inquiry is to ensure that youth are being appropriately diagnosed and their clinical needs, specific to substance abuse, are being met. When working with adolescents in the juvenile justice system, youth tend to have a stronger motivation to under-report drug involvement, for fear of punishment. In FY 2014, 58% of the youth admitted to CJTS endorsed, upon admission, that they had used drugs within the past year. Concurrently, 57% of the youth admitted to CJTS during FY 2014 were diagnosed with a substance abuse disorder. The significance of this data is that screening and diagnosis are consistent; there does not appear to be an over-reporting and/or under-reporting of drug use amongst the youth. In FY 2015, 64% of the youth admitted to CJTS endorsed on the GAIN-SS having used drugs over the past year, and 63% were diagnosed with a substance abuse disorder. The results from both fiscal years suggest that youth are being accurately diagnosed within CJTS. Exhibit 3 (page 18) outlines the figures detailed above.

After the initial screening by the licensed mental health clinician, the assessment process continues. Over the next 30 days, testing, a record review, interviews with the youth and family, data are collected and observations are noted as the clinician completes a comprehensive psychosocial clinical assessment. This amalgamation of information results in a clinical formulation describing the youth, behavioral and mental health dis-
orders are identified, and an individualized treatment plan is constructed. At this point, all youth diagnosed with a substance abuse disorder receive a treatment recommendation. Most of those youth identified with substance abuse needs enter the Seven Challenges program, a substance abuse treatment intervention. Exhibit 4 (page 19) gives a breakdown of the specific substance abuse disorders amongst the youth eventually discharged from CJTS during FY 2014 and FY 2015.

There are relatively few studies on adolescent substance abuse treatment. The methodologically stronger ones have usually found that most adolescents receiving treatment have significant reductions in substance use and problems in other life areas in the year following treatment. Studies suggest that the average rate of sustained abstinence after treatment is 38% (range, 30–55) at 6 months and 32% (range, 14-47) at 12 months. Variables most consistently related to successful outcomes are treatment completion, low pretreatment substance use, and social support and nonuse of substances by peers and parents, but insufficient evidence exists to compare the effectiveness of treatment types.

Despite some consensus about the value of substance abuse treatment for delinquent youth, information about its prevalence and availability is inadequate and inconsistent. In 2007, a national survey was conducted to assess substance abuse treatment and other correctional service programming of 141 juvenile institutional and community corrections facilities. Educational programming and drug and alcohol education were the most prevalent types of correctional and substance abuse services. Other common services included physical health services and mental health assessment, provided to about 60% of youth across facilities, and mental health counseling, life and communication skills, and anger management, provided to about half of the youth. Substance abuse treatment, as with most other services, was more prevalent in large, state-funded residential facilities (where 66% provided treatment) than in local detention centers (20%) and correctional facilities (56%). More detailed data showed that the number of youth receiving treatment in all types of facilities on any given day was very low.

As previously mentioned, juveniles diagnosed within CJTS with a substance abuse disorder are provided with the Seven Challenges program, a substance abuse treatment intervention. The Seven Challenges program is an evidence-based program that has been used in at least 35 states by more than 300 agencies and organizations, as well as in Canada and Puerto Rico. Skills training, problem solving, and sometimes family participation are integrated into sessions that address drug problems, co-occurring problems, and life skills deficits. In addition to participating in group therapy sessions, adolescents write in a set of nine Seven Challenges Journals, and clinicians and youth engage in a written process called “Supportive Journaling.” CJTS has been utilizing the Seven Challenges program since 2004 as the primary clinical model for treating adolescents with a substance abuse disorder. The model consists of weekly group therapy, individual therapy and daily journaling. Over the course of the first few years of operation, considerable implementation efforts were made to train staff and clinicians, educate youth, and build motivation and standards within CJTS.

Over the past 6 years, as shown in Exhibit 5, participation has averaged 76% in the Seven Challenges program for CJTS youth with a substance abuse diagnosis. Factors that prevent 100% participation amongst substance abuse diagnosed youth within CJTS include: some of the youth entering CJTS...
during each year were new admissions to the facility and were still on the Intake Unit when data were collected; some returnees were designated to be at CJTS for a short time; some youth were scheduled to begin Seven Challenges in the immediate future; and some had been identified for a community-based residential substance abuse program.

**DISCHARGE OUTCOMES**

During FY 2014, 244 juveniles were discharged from CJTS, with 141 carrying a substance abuse diagnosis. Exhibit 6 shows that, overall, 86% of the adolescents discharged from CJTS successfully completed their delinquency commitment or maintained their delinquency commitment in the community, a congregate care setting, or CJTS.

**TREATMENT OUTCOMES: RELAPSE**

As previously mentioned, juveniles placed at CJTS typically enter as a delinquent for either an 18-month or 4-year period, depending on the series of crimes and/or court violations committed in the community. Juveniles with an 18-month commitment serve an average stay of 6 months at CJTS, while juveniles with a 4-year commitment serve an average stay of 1 year. Of note, juveniles can also enter CJTS under a revocation status if they had failed to adhere to expectations within the community or congregate care setting, or CJTS. CJTS discharged 244 juveniles in FY 2014 and 287 in FY 2015. The average length of stay for youth admitted and discharged from CJTS during FY 2014 and FY 2015 was about half a year, 180 days and 175 days, respectively.

One of the important performance metrics of CJTS for juveniles diagnosed with substance abuse is the number or percent of juveniles who relapse to substance use after they have completed CJTS treatment and were discharged to the community. Here we report the outcomes of juveniles who were treated for substance abuse during FY 2014 and FY 2015.

Of note, outcome measurements are not fully formed and consistently reported in the United States, even though such measurements are formulated and adopted elsewhere in the world. While studies have established demographic information about those needing and receiving treatment, as well as the facilities that offer such treatment, short- and long-term outcomes are scantily reported. Historically, documentation of outcomes has been inconsistent and has relied heavily on estimated figures. In this study, the outcome measure consists of the average length of abstinence of juveniles with a substance abuse diagnosis. For such juveniles who entered CJTS in FY 2014, the average length of abstinence is 21 months.

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Length of stay</th>
<th>Relapse</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>179</td>
<td>positive</td>
</tr>
<tr>
<td>2014</td>
<td>196</td>
<td>negative</td>
</tr>
<tr>
<td>2015</td>
<td>122</td>
<td>positive</td>
</tr>
<tr>
<td>2015</td>
<td>183</td>
<td>negative</td>
</tr>
</tbody>
</table>
For those who entered CJTS in FY 2015, the average length of abstinence is 9 months. The difference between the two groups largely reflects the shorter period of potential abstinence for those who entered CJTS more recently.

In FY 2014, of the 244 juveniles discharged from CJTS, 141 carried a substance abuse diagnosis. These youths entered and were discharged from CJTS sometime between 6/1/2013 and 7/1/2014. They received substance abuse treatment, the Seven Challenges program, on average, for about six months and were discharged to the community. Again, after a careful review of the electronic case records (by 10/1/2015) and documented results of urine screens, 74 of the 181 juveniles, or 41%, remained drug free at the time the data were collected. The implied period of abstinence is about 9 months. These numbers for FY 2014 and FY 2015 are extraordinary, considering that national studies indicate one-third abstinence for 90 days.

Some critics of CJTS and similar facilities in other states have claimed that such programs simply exacerbate behavioral problems. If that were so, longer stays ought to increase the likelihood of a positive urine test for drugs. However, Exhibit 7 suggests that, in both study years, those testing positive for drugs had been at CJTS for a shorter period, on average, than those who tested negative. These results are consistent with the literature suggesting longer periods of substance abuse treatment equates to better outcomes.

**DISCUSSION**

As Connecticut moves forward in its effort to lead the nation in juvenile justice reform, much talk has surfaced about moving away from an institutional and one-size-fits-all approach, often branded by the services offered at CJTS. The criticism and misrepresentation of CJTS regarding its “barb-wired” fence, locked doors, and political genesis (hints of corruption) is unfortunate and misleading. The fact is that juvenile delinquents will always exist no matter how small their number. Connecticut will always need a facility with a fence and locked doors to help treat this small population and ensure the safety of the youth and public.

This need will intensify if Connecticut raises the age of the juvenile justice system’s jurisdiction, through age 20 instead of age 17, and allows low-risk young adults aged 21 through 25 to have their cases heard confidentially, their records sealed, and the opportunity to have those records expunged, as is proposed. To divert the 20-25 year old away from the adult prison system, the juvenile justice system will need to develop programs and services for this population. The question will arise if and how CJTS will play a role in providing rehabilitative services to these young men. The outcomes from this brief two-year study of substance abusing youth at CJTS is promising, considering that this cohort includes some of the most complex and damaged adolescents in the state of Connecticut. In fact, when comparing substance use relapse outcomes of youth discharged from CJTS to the “typical” adolescent, the results are remarkable.

“The outcomes from this brief two-year study of substance-abusing youth at CJTS is promising, considering that this cohort includes some of the most complex and damaged adolescents in the state of Connecticut.”
While at CJTS, juveniles are given a safe and secure place to grow, learn, and rehabilitate for a brief period of time. They are discharged home with a new set of skills and with hope for the future. No matter how well CJTS performs in diagnosing and treating juvenile delinquents there will always be recidivism. The truth is that the youth who leave CJTS and are returned to their communities are disadvantaged in many ways, often lacking in aftercare services and facing community violence, struggling school districts, poverty, and few options for change. And despite these deficits, young men leaving CJTS are refraining from continued drug use. In addition, the majority of them are successfully completing their delinquency commitment in their communities. As Connecticut moves forward, it will be important to avoid falling victim to the rhetoric, and to see CJTS for what it is: a valuable resource comprised of dedicated and experienced mental health professionals who should be a part of the proposed reforms in the juvenile justice system.

CONCLUSION

Research on the course and features of substance abuse recovery, following adolescent treatment, is scarce, especially for those involved in juvenile delinquency. Most delinquent youths have conduct disorder accompanied by one or more substance abuse disorders. Historically, programs and interventions to reduce substance abuse and juvenile delinquency have been generally unsuccessful. The criminogenic risk factors that make a young person prone to delinquency are based in too many systems (the individual, family, neighborhood, schools, etc.) for isolated treatment methods to be effective. Although the sample size is small, outcomes from the Connecticut Juvenile Training School and the Seven Challenges program are promising. The number of juveniles who are diagnosed, successfully treated and discharged to be integrated in their community, after being adjudicated as delinquent youth and placed in CJTS custody, is remarkable. One needs to remember that those same youth were once deemed unfit to be placed in any of the other community based programs in Connecticut, including clinical treatments, juvenile probation, congregate care placement, and in-home family interventions. This performance reflects the quality, commitment and dedication of the CJTS staff to make a difference in the lives of a small number of young men who many thought were beyond reach.

John Beazoglou is a Clinical Supervisor at CJTS

Myth and Reality

(Continued from page 15) Mize efficiency and effectiveness, and to minimize cost, by providing a wide range of services, including less intensive services, while meeting the needs of individuals at each point along the substance use risk continuum. The data support the view that the CT SBIRT programs were well integrated with local specialty treatment systems, as well as within their host medical settings, resulting in smooth transitions along the continuum of care. Efficiency was further enhanced by situating SBIRT services in high-risk, high-volume population settings such as FQHC’s and by establishing strong partnerships with community agencies.

The CT SBIRT program is a unique approach to addressing Connecticut’s considerable substance misuse problems. Although it may not solve all alcohol, drug and tobacco problems, it has proven to be a feasible, efficient and effective component of a broader public health approach to the problems of substance misuse.

Bonnie McRee is Assistant Professor, Department of Community Medicine and Health Care, UConn Health.

Janice Vendetti is Research Associate, Department of Community Medicine and Health Care, UConn Health.

Thomas Babor is Professor and Chair, Department of Community Medicine and Health Care, UConn Health.

Alyse Chin is Program Director, CT Department of Mental Health and Addiction Services.
Beazoglou REFERENCES (to be posted online)


