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What Do the Voices of Incarcerated Females Tell Educational Leaders About the Need for Mental Health Resources in PK-12 Programs?

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**WHAT DO THE VOICES OF INCARCERATED FEMALES TELL EDUCATIONAL
LEADERS ABOUT THE NEED FOR MENTAL HEALTH
RESOURCES IN PK-12 PROGRAMS?**

BY

Phyllis Burger

A Dissertation
in Partial Fulfillment of the
Requirements for the Degree of
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February 2018

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WHAT DO THE VOICES OF INCARCERATED FEMALES TELL EDUCATIONAL LEADERS ABOUT THE NEED FOR MENTAL HEALTH RESOURCES IN PK-12 PROGRAMS?

Phyllis Burger, Ed.D

Concordia University, Saint Paul, 2018

Statistical reports confirm that the female incarcerated population is not only increasing, but the frequency of mental disorders among this vulnerable population is accelerating.

Women's pathways to crime show that gender matters significantly in shaping criminality. The frequency of mental disorders among incarcerated females is much higher than that in the general female population; it is higher than that of incarcerated men. There is abundant literature about women in prison, however, little about the characteristics of females in county jails. The goals of this study were to understand both the demographics and characteristics of females in jail and responsive programming upon reentry to community, as well as to identify mental health resources necessary to meet the needs of PK-12 learners.

Among females, the most common pathways to crime are based on survival of abuse, violence, trauma, and substance abuse experienced during childhood. Such experiences can have damaging effects on learning, behavior, and health; learning how to cope with such experiences is an important part of healthy child development. This study examined childhood trauma experienced by individuals prior to age 18. It is a call for educators, families, and other adults to activate supportive relationships and resources. The study explored the impact of educational mental health support, or the lack thereof, for children and youth, well into the adult years.

Keywords: adverse childhood experiences, childhood trauma, mental illness, incarcerated females, reentry, PK-12 education, principals, school mental health resources

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Phyllis Burger

DEDICATION

This study is dedicated to the 11 women who shared your stories with me. You are incredibly courageous. I am forever grateful to you for your candid dialog, and trusting me with your life story. Your participation in this study leaves a legacy for educators to create a path of guidance and support for the children and youth in our schools as they develop a healthy understanding of self - mentally, physically, socially, and spiritually. I pray it will be revealed to you how important and valued you are as an individual, as a female, and as a family and community member.

Your stories are far from over.....

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CHAPTER ONE: INTRODUCTION

Among the most abandoned and misunderstood individuals in society today are the more than 1.2 million females in jails, prisons, and community correctional facilities (Kaeble & Glaze, 2016). Over 40 years ago, the United States (US) incurred an “era of mass incarceration” (Tripodi & Pettus-Davis, 2013, p. 31), resulting in the highest incarceration and criminal justice involvement rates in the world (Guerino, Harrison, & Sabol, 2011). The acceleration of prisoners during that time was nearly 200,000 people incarcerated in US prisons in 1971 compared to approximately 1.6 million in 2010 (Guerino et al., 2011). A Bureau of Justice Statistics report (Glaze, & Kaeble, 2014) stated that the female jail population is the fastest growing correctional population since 2010. Concurrently, a recent posting by the Washington, DC Bureau of Justice Statistics (Carson, 2015) reports that between 1980 and 2014, the number of incarcerated females increased by more than 700%. “Though many more men are in prison than females, the rate of growth for female imprisonment has outpaced men by more than 50%” (Carson, 2015, p. 1). Furthermore, Carson states this is the result of extensive law enforcement efforts, enforcement of rigid drug sentencing laws, and “post-conviction barriers to reentry that uniquely affect females” (2015, p. 1).

Existing research focuses on the over-arching theme of the upsurge of incarceration of females, but few current studies exist that emphasize the different trajectories of incarceration for men and females (Tripodi & Pettus-Davis, 2013). For example, according to a study published by the Justice Department's Bureau of Justice Statistics (BJS), more than half of all incarcerated individuals in prison and jail have a mental health concern (National Resource Center of Justice Involved Women, 2017). The BJS study also found that 73% of the females in state prisons and 75% of females in local jails have symptoms of mental disorders, compared with 12% of females

in the general population (National Resource Center of Justice Involved Women, 2017).

According to James and Glaze (2006), female inmates in local jails frequently had more mental health problems, at a rate of 75% as compared with their male counterparts in jail at 63%.

Early studies reveal that incarcerated females who experience mental health and substance use addictions are also victims of childhood trauma (Tripodi & Pettus-Davis, 2013). Research by Lynch, Fritch, and Heath (2012) state that incarcerated females report notable rates of exposure to interpersonal violence such as child sexual and physical abuse, partner violence, and mental health problems. Therefore, understanding the diversity of childhood victimization, such as physical and sexual abuse, and the relationship of past trauma is important when providing treatment to adult incarcerated females (Tripodi & Pettus-Davis, 2013). This body of work supports the notion that early intervention through school mental health services for children is essential. School programs with resources and support systems in place for those impacted by adverse childhood experiences will better equip students as they grow into adulthood. The purpose of this dissertation writing is to expand the literature on childhood victimization of incarcerated females so as to support educational leaders in their efforts to aid PK-12 students impacted by trauma.

This chapter will explore the wider context of incarcerated females with mental illness and the subsequent effects of reentry to the community. Additionally, it will explore the impact of abuse and trauma children and youth experience and support systems needed during their Pre-Kindergarten (PK) through grade 12 school years and well into the adulthood. An outline of the chapters to follow will provide a more detailed account offering substantial justification for the importance of research with a focus on females in jail with mental illness.

Background

According to Tripodi and Pettus-Davis (2013), “The War on Drugs has been particularly damaging for females” (p. 31). Some researchers consider the sharp increase of incarcerated females to be directly linked to the increase in illegal drug use among females and an increase in drug-related convictions (Covington, 2008; Green, Miranda, Daroowalla, & Siddique, 2005). National trends show nearly 30% of all female offenders are arrested for drug-related crimes, and an additional 33% report using drugs or buying drugs when arrested (Guerino et al., 2011). With the lingering required mandatory sentences, females have “found themselves incarcerated, and subject to Draconian [excessively harsh and severe] sentences because the men in their lives persuade, force, or trick them into carrying drugs” (Gaskins, 2004, p. 1533).

Historically, incarcerated females have received the same type of services based purely on the needs of their male counterparts. This treatment continues even though female prisoners have different and unique problems (Hunter & Greer, 2011). Houser and Welsh (2014) found that “female offenders often have unique pathways into the criminal justice system, along with higher rates of mental illness, drug use, and co-occurring disorders compared with males. However, incarcerated females are still a very understudied population in criminal justice research” (p. 664).

Despite these higher rates for female prisoners, few correctional programs and prisoner reentry programs address histories of trauma and mental health problems (Bergseth, Jens, Bergeron-Vigesaa, & McDonald, 2011; Calhoun, Messina, Cartier, & Torres, 2010). Limited interventions exist that target the unique needs of incarcerated females, and even fewer programs are trauma-informed (Messina, Grella, Cartier, & Torres, 2010).

Tripodi and Pettus-Davis (2013) conducted a study to understand the prevalence of childhood victimization and its association with adult mental health problems, substance abuse disorders, and further sexual victimization. Their work contributes to the literature by offering current insight of prior victimization experiences and substance use and mental health problems with a random sample of female prisoners. The prevalence and associations of victimization experiences of women prisoners may lead to programming interventions for this population. Therefore, the body of work by Tripodi and Pettus-Davis (2013) is important in the continued development of targeted, trauma-informed interventions for current and former female prisoners.

Nearly 80% of children in the United States recount exposure to some type of violence or adverse childhood experiences (ACEs) before adulthood (Miller-Graff & Cheng, 2017). While violent experiences at any point in one's life may account for serious and negative health and development consequences, childhood exposure to trauma carries serious physical and mental health consequences (Miller-Graff, Cater, Howell, & Graham-Bermann, 2015). Although extant literature has primarily focused on the cumulative effect of violence and adversity across a lifespan, there is also evidence that exposure to violence and adversity early in life places individuals at risk, whereby victimization in adulthood becomes more likely, particularly in the context of adult intimate relationships (Ornduff, Kelsey, & O'Leary, 2001; Renner & Slack, 2006).

Dr. Gabor Mate, author of *In the Realm of Hungry Ghosts*, posits that one of the main causes of addiction is a history of childhood trauma (2010). Mate notes that obsessive repetition of behaviors that offer a temporary release from a negative event in life and cause long-term problems are what addiction is all about (2010). These behaviors appease the effects of childhood trauma; therefore, viewing addictions through the lens of trauma helps people heal

(Mate, 2010). Maiberger (2017), in response to an interview with Dr. Mate, quotes Mate as saying

less than 5% of his patients heal from addictions and he feels that the way society is set up to punish the addict does not encourage healing. He feels the concept of ‘War on Drugs’ means there is a ‘War on Addicts’ and that society ostracizes these people instead of helping them heal what is really the issue - childhood trauma (para. 4).

Statement of the Problem

Statistical reports confirm that the female incarcerated population is not only increasing, but the frequency of psychiatric disorders among this vulnerable population is accelerating as well. According to Bloom, Owen, and Covington (2003), women’s pathways to a crime show that gender matters significantly in shaping criminality. The frequency of psychiatric disorders among incarcerated females is much higher than females in the general population, and it is higher than incarcerated men. Among females, the most common pathways to crime are based on survival of abuse, violence, trauma, and substance abuse (Bloom et al., 2003). Very few interventions exist that target the unique needs of incarcerated females and even fewer programs are trauma-informed (Messina et al., 2010).

The review of the literature supports the need for an intentional research focus on incarcerated females and mental illness. One of the purposes of this study is to explore the link between mental illness and the impact of childhood trauma among incarcerated females. This study also extends the literature on correctional programs and reentry programs addressing the history of females who experienced childhood trauma and mental illness issues.

A final purpose of this study is to determine what mental health resources may be helpful in responding to the childhood trauma experiences of PK-12 children and youth in our current education programs. Traditionally, schools have viewed their roles as educators delivering curricula and supporting student learning. The importance of recognizing the profound effect that

trauma can have on learning has been outlined above. If students are to find significance in their learning and be successful, schools must take a more holistic view of their students. A child submerged in domestic violence, for example, will not be able to be present in the classroom unless someone acknowledges that child's pain and assists the child in beginning to manage the emotional impact of the trauma in their life (Wolpow, Johnson, Hertel, & Kincaid, 2009).

Research Questions

This study will attempt to answer the questions:

RQ1: What do incarcerated females describe as the linkages between childhood trauma and mental illness?

RQ2: What are the implications for educators concerning the impact of childhood trauma, mental illness, and incarcerated females?

RQ3: What issues affect the reentry of incarcerated females with mental illness and childhood trauma from jail to community?

Significance to the Field

This research is significant in that it will add to the literature incarcerated females with mental illness and, further connect this to the literature on trauma-informed education. While most of the existing research focuses primarily on females in prisons, few studies are found on females in jail. Thus, these body of works will attempt to provide information from the voices of females in what is considered a short-term incarceration experience versus years and years of incarceration. Likewise, current research lacks any substantial findings of successful reentry to the community within the previously mentioned population.

According to a 2014 national report published by the Treatment Advocacy Center (TAC) in 2012, there were an “estimated 356,268 inmates with severe mental illness in prisons and

jails” (TAC, 2014, p. 6). During the same time, there were nearly 35,000 patients with severe mental illness in state psychiatric hospitals. Therefore, this data equates the number of mentally ill persons in prisons and jails to be ten times the number in state hospitals (TAC, 2014). This same report revealed that in the state of Minnesota, the largest public institution for seriously mentally ill people is the Security Hospital at St. Peter. This site is for patients who are restricted to forensic cases and sex offenders. There are few options available for mentally ill individuals who need hospitalization because all other state hospitals are no longer in operation. According to Judge Steve Halsey, the Hennepin County Jail in Minneapolis, Minnesota holds 100 to 200 inmates with severe psychiatric disorders every day. These represent one-quarter of the jail’s population (McEnroe & Howatt, 2013). A Minnesota Senator summarized the situation during an interview by stating: “We’ve been using our criminal justice system as a substitute for a well-functioning mental health system, we’ve sort of criminalized mental illness and addiction” (Minnesota Public Radio, 2013).

The purpose of this study is to explore the link between mental illness and the impact of childhood trauma among incarcerated females in jail. This study encompasses the literature on correctional programs and reentry programs addressing the history of females who experienced childhood trauma and mental illness issues. It also extends the literature addressing Adverse Childhood Experiences (ACEs) and mental health resources for children and youth in PK-12 schools in Minnesota.

Limitations and Delimitations

A limitation of this study is a lack of access to incarcerated females at the selected county jail in southern Minnesota when there was a mandatory lockdown at the facility for an extended time. Additionally, the facility was experiencing a small number of females in jail during the planned time of conducting the study. Some of the women did not participate in an interview due to awaiting a court appearance or work release programs during the scheduled visitation hours.

A delimitation of this study is that the researcher has purposefully decided to conduct research at a jail, and not a prison. The choice to conduct the interviews in the jail supports the need for studies in local jails rather than adding to the plethora of studies in a prison environment. The study includes one-hour interviews with incarcerated females at the jail. The researcher is mindful that the goal is to ascertain *what* the females have experienced, and *how* they experienced it; these are their stories. There will be no discussion or interviews with any other individuals inside or outside of the jail, or about the life experiences of the females.

Another delimitation of this study is that the researcher has purposefully selected education leaders from urban, suburban, charter, and rural schools in Minnesota to interview. The researcher desired to narrow the scope of the study to the state of Minnesota. Creswell (2012) encourages researchers to focus on a singular area, then expanding to a larger audience.

Definition of Terms

This section is dedicated to fundamental concepts, as defined from the literature, and serves as the operational definitions used throughout this writing:

Adverse childhood experiences (ACEs) are stressful or traumatic events experienced in the household before the age of 18. ACEs include any of the following: physical abuse, sexual

abuse, emotional abuse, physical neglect, emotional neglect, mother treated violently, and substance misuse within the household, household mental illness, parental separation or divorce, incarcerated household member (Centers for Disease Control and Prevention [CDC], 2016).

Housed out of facility (HOF) is a strategy the Minnesota Department of Corrections (MN DOC) uses to address over-crowding issues. When the number of MN DOC inmates exceeds facility capacity, inmates are moved to select county jails. The inmates are individually screened and are housed at a medium- or minimum-security facility (Housed out of facility (HOF): Impact on families, n.d.).

Jails are short-term facilities that are usually administered by a local law enforcement agency and are intended for adults but sometimes hold juveniles before or after adjudication. Jail inmates usually have a sentence of less than one year or are being held pending a trial, awaiting sentencing, or awaiting transfer to other facilities after a conviction (Bureau of Justice Statistics, 2017A)

Prisons are long term facilities run by the state or the federal government and typically hold felons and inmates with sentences of more than one year. Definitions may vary by state (Bureau of Justice Statistics, 2017B).

Mental health in childhood means reaching developmental and emotional milestones, and learning healthy social skills and how to cope when there are problems. Mentally healthy children have a positive quality of life and can function well at home, in school, and in their communities (CDC, 2017).

Mental disorders among children are described as serious changes in the way children typically learn, behave, or handle their emotions, which cause distress and problems getting through the day (CDC, 2017).

Trauma means exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: directly experiencing the traumatic event(s); witnessing, in person, the traumatic event(s) as it occurred to others; learning that the traumatic event(s) occurred to a close family member or close friend (in case of an actual or threatened death of a family member or friend, the event(s) must have been violent or accidental); or experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (American Psychiatric Association [APA], 2013, 2018).

Trauma-informed and culturally-sensitive schools, provide increased access to behavioral and mental health services, effective community collaboration, an increased feeling of physical, social, and emotional safety among students, and positive and culturally responsive discipline policies and practices that increase school connectedness. School psychologists, counselors, and social workers can be leaders in this initiative by providing increased mental health services (Craig & Stevens, 2016; Plumb et al., 2016).

Summary

A Bureau of Justice Statistics (2013) report stated that the female jail population is the fastest growing correctional population in the United States, since 2010. Current extant literature focuses on the prevalence of the incarceration of females, but few studies exist that emphasize the trajectories of incarcerated females. Early studies reveal that incarcerated females who experience mental health and substance use addictions are also likely victims of childhood trauma (Tripodi & Pettus-Davis, 2013). Research by Lynch et al. (2012) stated that incarcerated females report notable rates of exposure to interpersonal violence, such as child sexual and physical abuse, partner violence and mental health problems (as cited in DeCou, Lynch, DeHart, & Belknap, 2016).

Therefore, understanding the diversity of childhood victimizations, such as physical and sexual abuse, and the relationship of past trauma to current mental state is significant when providing treatment to adult incarcerated females (Tripodi & Pettus-Davis, 2013). Most incarcerated females in jail will re-enter their communities, making re-entry an imminent process (Arditti, 2012). This study attempted to disclose the importance of the association between childhood victimization and subsequent mental illness, to advocate for appropriate and helpful intervention assistance to incarcerated females, and to promote successful re-entry outcomes for females when released to their communities. It also extends the literature and discussion with school principals regarding childhood trauma, Adverse Childhood Experiences (ACEs), and mental health resources for children and youth in PK-12 schools in Minnesota. The effects of complex trauma are not always visible, and may manifest in several ways, including behavioral issues at school. Disjointed and haphazard community-based interventions and current educational policy do not address the problem of ACEs, and children are left to suffer the impacts of trauma (Plumb, Bush, & Kersevich, 2016).

Organization of the Dissertation

What follows is a literature review (Chapter Two) representing current and essential research addressing childhood victimization, mental illness, and intervention and re-entry programs for incarcerated females. Additional related study topic areas will be included. Research methodology (Chapter Three) provides a detailed description of the research instruments, sample population, data collection, and analysis procedures. Results (Chapter Four) will summarize the collected data and the analysis performed relevant to the dialog that is to follow. Discussion (Chapter Five) will represent the writer's interpretation of the results, implications, conclusions, and possible recommendations for future studies.

CHAPTER TWO: LITERATURE REVIEW

The purpose of this review of literature endeavors to provide an overview of current research about incarcerated females with mental illness, the effects of childhood trauma, and reentry of females from jail to community. Additionally, this review may identify reasons for further study regarding traumatic childhood experiences and the lifelong impact on health and quality of life, and the increased risk of female criminal behavior and social consequences. This chapter provides a literature review with five primary themes; 1) female pathways to incarceration, 2) adverse childhood experiences, 3) impact of childhood trauma and learning for PK-12 students, 4) history of victimization and 5) reentry to community.

Literature Review

Women's Pathways to Incarceration

An estimated one in 100 people in the United States are in prison or jail, with females entering the criminal justice system at nearly twice the rate of men (Pew Center on the States, 2008). Data recorded mid-year 2004 to mid-year 2005 demonstrated an 8% increase in the number of female inmates, compared with a 4.3% increase for male inmates (Harrison & Beck, 2006). While men constitute the majority of incarcerated people in the U.S., the rate of incarcerated females doubled by the year 2010 (Drapalski, Youman, Stuewig, & Tangney, 2009; Guerino et al., 2011; Sabol, Minton, & Harrison, 2007).

The upsurge in female incarceration rates has been attributed to: a) the War on Drugs shifting policy in the US to criminalization of illicit substance use and distribution, b) removing judicial discretion for some offenses, thereby requiring mandatory minimum sentencing, and c) lack of correctional programming designed to meet incarcerated women's needs (Bloom, Owen,

& Covington, 2004; Gaskins, 2004; Hall, Prendergast, Wellisch, Patten, & Cao, 2004; Messina, Burdon, Hagopian, & Prendergast, 2006; Petersilia, 2003; Wolf, 2006).

Wolf (2006) posits that women's pathways to incarceration differ systematically from those of men. For example, according to Kelly, Peralez-Dieckmann, Cheng, and Collins (2010), a woman is more likely to be arrested as a minor participant in a crime if she knowingly or unknowingly drives a partner to buy drugs. Kelly et al. further note that "females are less likely to provide the prosecutor with information to reduce their sentences, either because as minor participants they do not have such information or because they are protecting their partners" (2010, p. 39).

The opening plenary speaker for the 2015 National Conference on Addition Disorders and Behavioral Healthcare Summit (NCAD), Stephanie Covington, stated "Trauma also affects men and females differently" (as cited in Brown, 2015, p.1). Covington went on to share an example of the differences by saying

females attribute positive and negative experiences differently than men. And while humiliation is a man's greatest fear, for a woman it is abuse and harm. Because of this, what feels unsafe for a woman may not be something a man would even acknowledge or consider as dangerous or harmful (as cited in Brown, 2015, p.1).

Females incarcerated in prisons and jails across the country have entered a system designed on a male model of criminal justice. "These are invisible women," says Dr. Stephanie Covington, a psychologist and co-director of the Center for Gender and Justice, an advocacy group based in La Jolla, California. "Every piece of the experience of being in the criminal justice system differs between men and women" (Deziel, 2018). This model does not acknowledge or accommodate the unique needs of females. For example, incarcerated females are more likely than men, to have custody of their children (Belknap, 2001), and to have been victims of sexual abuse, and domestic violence throughout their lives (Snell & Morton, 1994).

The research about females in prison says very little about the characteristics of females in local jails. A study in California by Kelly et al. (2010) sought greater understanding about the character traits of females in jail to develop responsive programming. A cross-sectional survey was conducted with 346 females in an urban jail. Descriptive statistics were generated, and a logistic regression analysis was performed to examine contributors to multiple arrests. Of the 346 females surveyed, 65.3% were incarcerated for minor charges, while 58.9% had been incarcerated four or more times. The majority had children younger than age 18, and nearly one-third had children younger than age five. The study revealed partner abuse and involvement in the juvenile justice system with multiple arrests (Kelly et al., 2010). The findings by Kelly et al. indicated that many females in jail find themselves in a cycle of numerous arrests and violence. The majority of females in jail parented school-aged or younger children, had minimal education, and underwent both mental health and substance use problems. Violence was common throughout their lives, with approximately 75% of females experiencing some form of physical abuse as children, and 47% experiencing some form of sexual abuse; 84% experienced abuse from their current or past partners (Kelly et al., 2010)

Partner abuse and involvement in the juvenile justice system were associated with multiple arrests. Furthermore, the high rate of domestic violence among participants in this study has implications for both females and their children. Because of the frequent co-occurrence of domestic violence and child maltreatment (Schechter & Edleson, 1999), children who witness domestic violence are far more likely to become perpetrators in the future.

The results of the Kelly et al. (2010) study in California are further corroborated by research conducted by Tripodi and Pettus-Davis (2013). Tripodi and Pettus-Davis (2013) initiated a study to understand the widespread presence of childhood victimization and its

association with adult mental illness, substance abuse disorders, and sexual victimization of incarcerated females. A random sample of 125 female prisoners from two state prisons in North Carolina were interviewed. All participants participated on a voluntary basis. The results of this study demonstrate that in this sample of female prisoners, those who were both physically and sexually victimized as children were more likely to be hospitalized as an adult for a psychological or emotional problem. The females who were sexually victimized, or both physically and sexually victimized, exhibited an increase toward attempted suicide. Females who experienced physical victimization as children and who were both physically and sexually victimized were more likely to have a substance use disorder. This study concludes with a discussion about the prison's role in providing mental health treatment for female prisoners. This discussion forms the basis of Tripodi and Pettus-Davis' assertion that the trajectories of females to prison disproportionately include childhood victimization and subsequent mental health and substance use problems (2013).

Research conducted by Noonan and Rohloff (2015) affirm that suicide is the leading cause of death among females in jail and “accounted for nearly 34% of the deaths that occurred in jails in the United States from 2000 to 2013” (as cited in DeCou et al., 2016, p. 254). Noonan and Rohloff (2015) also reported females in the general population had a completed suicide rate of approximately five deaths per 100,000 people (Centers for Disease Control and Prevention [CDC], National Center for Injury Prevention and Control, 2015). Given this body of work by Noonan and Rohloff, it would appear to bear importance in considering factors that may explain the higher rates of suicide. DeCou et al. (2016) found that in addition to high rates of suicidal behavior, incarcerated females reported significant rates of exposure to personal violence, such

as child sexual and physical abuse, and mental health challenges (Green et al., 2005; Lynch et al., 2012; McDaniels-Wilson & Belknap, 2008).

Adverse Childhood Experiences (ACEs)

Adverse Childhood Experiences (ACEs) is the term given to describe various types of abuse, neglect, and other traumatic experiences that may potentially happen to individuals under the age of 18. Three categories of adverse experiences were considered. Childhood abuse included emotional, physical, and sexual abuse; neglect included both physical and emotional neglect; and household challenges encompassed growing up in a house where there was substance abuse, mental illness, violent treatment toward a mother or stepmother, parental separation or divorce, or a member of the family was in prison. Respondents were given an ACE score between zero and ten based on the number of adverse experiences they reported. The study posits that childhood experiences have a lifelong impact on the physical and mental health and quality life (CDC, 2016; Felitti et al., 1998). Felitti et al. assert that the ACE study showed dramatic links between adverse childhood experiences and at-risk behavior, psychological issues, serious illness, and the leading causes of death (1998). ACEs harm children's developing brains so profoundly that the effects emerge decades later; in fact, they can cause chronic disease, mental illnesses, and even violence (Colman et al., 2013).

Drs. Vincent Felitti and Robert Anda initiated the genesis of the ACEs research (Felitti et al., 1998). The ACE questionnaire was designed using selected questions from published surveys (Wade et al., 2017). Prior to this survey there had been little study of the relationship between early childhood adverse experiences and the onset of adult medical problems and behaviors (Felitti et al., 1998). The ACE survey data was collected from two waves of a sample of 17,000 adult members of Kaiser's Health Maintenance Organization (HMO) in San Diego,

California between 1995 and 1997. Each participant in the study completed a confidential survey regarding their childhood experiences and current health status and behaviors. Almost two-thirds of the adults surveyed stated they had experienced at least one ACE, and subsequently, the majority of those respondents reported more than one ACE (Felitti et al., 1998). Participants in this study reflected a cross-section of middle-class American adults. The information from these surveys were combined with results from their physical exams to form the study's findings (Felitti et al., 1998). Leitch (2017) noted "the release of the study findings was shocking to many when they showed the extent to which adverse childhood events negatively shaped future social and physical health outcomes, including life expectancy" (p. 2).

According to Leitch (2017), the findings revealed that with the increase of traumatic events a child experienced, it was more likely they would, as an adult, suffer a plethora of health and behavior problems including alcoholism, chronic pulmonary disease, depression, illicit drug use, liver disease, adolescent pregnancy, and numerous others (CDC, 2014A; Felitti et al., 1998). Furthermore, adults with the highest number of ACEs had a life expectancy 20 years less than those without high levels of ACEs. Leitch also noted that the study sample did not consist primarily of low-income minority adults, a demographic often found to be "at risk." "The study was comprised of white, middle and upper income employed people; those who might be expected to have had a more stable childhood environments because of parents' employment and income" (Leitch, 2017, p. 2) .

ACEs Expanded

Studies using the ACE questionnaire have expanded beyond the original sample of white, adult, HMO patients to include special populations such as children of alcoholics (Dube et al., 2001). A study by Geller, Garfinkel, Cooper and Mincy, (2009) found children with an

incarcerated parent had a higher pervasiveness of ACEs than in the original Kaiser sample. ACE studies of justice-involved populations, such as one conducted by Baglivio et al. (2014), wherein the authors examined occurrences of ACEs in a population of 64,329 juvenile offenders in Florida. This study reported the frequency of each ACE, and assigned an ACE composite score across genders. The Baglivio et al. analysis “indicates offenders report disturbingly high rates of ACEs and have higher composite scores than previously examined populations” (2014, p. 1). Studies by Messina and Grella (2006), Miller and Najavits (2012), Reavis, Looman, Franco and Rojas (2013), and Dierkhising et al. (2013) all bring an awareness of the association of early childhood trauma and offender behavior. The studies consistently found higher rates of childhood trauma in incarcerated populations and offender groups. For example, the Reavis et al. study (2013) with incarcerated males showed ACE scores above 4 to be four times higher than in a normative male population.

The attention given to the impact of adverse childhood experiences on future health and functioning, the ACE study demonstrates the importance of gathering information early in the lives of children and their families, and designing timely intervention programs with resources and support systems that target violence and neglect. It also emphasizes the importance of collecting trauma histories from individuals and centers on the essential role of prevention in early childhood learning and program design. A particularly important contribution the ACE survey has made to the offender and incarcerated populations is to emphasize the importance of trauma-targeted interventions in jails and prisons as well as in diversion programs. These studies findings reinforce the role of educational leaders to assert programs that identify situations where children experience overwhelming trauma and are unable to turn to their caregivers for help.

History of Victimization

Global study. Few studies exist that examine cross-national variation in exposure of childhood adversities. In 2010 the World Health Organization (WHO) sought to address these problems by exploring the prevalence of retrospectively reported childhood adversities with the first onset of a wide variety of mental disorders (Kessler et al., 2010). This study charted the life course in epidemiological surveys distributed in 21 countries in a (WHO) World Mental Health (WMH) Survey Initiative. The WMH surveys were administered in nine countries classified by the World Bank as high income (Belgium, France, Germany, Israel, Italy, Japan, Holland, Spain, US), six high to middle income (Brazil, Bulgaria, Lebanon, Mexico, Romania, South Africa), and six low to lower-middle income (Colombia, India, Iraq, Nigeria, People's Republic of China, Ukraine). This mass distribution of surveys was dispersed to adults aged 18 and older. A total of 51,945 adults participated in the survey interviews. Twelve dichotomously scored childhood adversities occurring before age 18 were assessed, including three types of interpersonal loss (parental death, parental divorce, or other separation from parents), four types of parental maladjustment (mental illness, substance misuse, criminality, or violence), three types of maltreatment (physical abuse, sexual abuse, or neglect) and two other childhood adversities (life-threatening respondent physical illness or family economic adversity). The childhood adversity categories appear to be similar to the Adverse Childhood Experiences questionnaire designed by Felitti et al. (1998).

Several WMH countries omitted selected childhood adversities (sexual abuse in Iraq and Shenzhen, neglect in South Africa, parental divorce, and neglect in the six Western European countries and neglect and parent psychopathology in Israel) based on concerns about respondents being uncomfortable disclosing such information. The WHO researchers, Kessler et al., (2010),

universally decided not to exclude this large subset of countries or the missing childhood adversities from the study analysis. To compensate for the missing data, the researchers included a separate dummy predictor variable to indicate whether each childhood adversity was assessed.

The overall results of the study indicated that similar proportions of respondents reported childhood adversities in high- (38.4%), high-middle- (38.9%), and low-lower-middle- (39.1%) income countries. Parental death was the most common childhood adversity (11.0–14.8%). Other common childhood adversities included physical abuse (5.3–10.8%), family violence (4.2–7.8%) and parental mental illness (5.3–6.7%). Of particular interest is that the analysis of the study found one consistently strong survey category representing maladaptive family functioning that included parental mental illness, substance misuse, criminal behavior, domestic violence, physical and sexual abuse, and neglect.

The WMH results suggest that large proportions of children are exposed to childhood adversities. The study further showed that childhood adversities often co-occur and that clusters of childhood adversities associated with maladaptive family functioning are linked with the highest risk of mental disorders. This understanding has important implications for intervention. To name one example: prevention of ACEs, or improvement in conditions due to a single childhood adversity among individuals exposed to so many, would likely be ineffective.

A study by Sanchez, Luna, and Mundt (2016) aimed to establish that exposure to physical or sexual violence (PSV) existed prior to imprisonment for prisoners in Spain and to explore whether people exposed to PSV accessed mental health treatment during imprisonment. This descriptive study featured a cross-sectional design. A random sample of inmates aged 18 - 74 from eight adult prisons for men and females operated under the Spanish Prison System located in the southeast of Spain. In the sample of 2484 male and 225 female prisoners, socio-

demographic variables, exposure to PSV prior to imprisonment, and mental health treatments during imprisonment were assessed. Frequencies were calculated as percent values with 95% confidence intervals (CI). The study concluded that a history of physical and sexual violence was present in 35.2% of the male prisoners and 40.0% of the female prisoners. A high percentage of prisoners, 70% male and 76% female with exposure to PSV, were receiving mental health treatment during imprisonment (Sanchez et al., 2016).

Decades of Violence

Few studies have examined the role of early trauma in criminal behavior, particularly with females. Cortoni, Levenson, Willis, & Prescott (2015) noted a large study conducted by Harlow (1999) encompassing the records of hundreds of thousands of inmates and probationers in the United States. Harlow's study (1999) revealed the predominance of early mistreatment and "found that 36.7% of female state inmates and 36.6% of jail inmates reported sexual or physical abuse before 17 years of age" (as cited by Cortoni et al., 2015, p. 260). While the ACE questionnaire was not used, researchers utilized historical reports of relevant abuse variables. Prior abuse was associated with an increased likelihood of violence, and household dysfunction which frequently co-occurred with child abuse (Cortoni et al., 2015). "Of state inmates who were placed in foster homes or institutional care as children, 87% of the females reported childhood physical or sexual abuse. Similarly, of prisoners who reported that a parent or caretaker drank heavily or used drugs, 76% of females reported early abuse" (Cortoni et al., 2015, p. 260).

A study by Browne, Miller, and Maguin (1999) provides critical data regarding the presence and severity of lifetime physical and sexual victimization among incarcerated females. While the study was conducted nearly two decades ago, the outcomes represent an ongoing

concern about the lives of incarcerated females and their trajectories to jail or prison. At the time this study was written, the United States had the highest rate of incarceration in the industrialized world, even higher than that of former police states such as South Africa and the former Soviet Union. The most dramatic increase over the previous ten years had been in the number of incarcerated females, which had nearly quadrupled (Beck & Gilliard, 1995). A large part of this rapid growth has been due to the increased use of prison for drug rather than violence-related, offenses. For example, in 1986, one in every eight incarcerated women was serving time for drug-related offenses; by 1991, that number had risen to one in three (Snell & Morton, 1994).

Parallels between the literature on long-term effects of violence by inmates, and the predominant reasons for female incarceration, noted above, suggest that a further understanding of incarcerated women's prior trauma histories is of particular importance. Empirical studies indicated a strong association between histories of family violence and development of later alcohol and drug problems in survivors, irrespective of whether samples were drawn from clinical or community populations. In summary, female victims of child sexual molestation or severe physical child abuse by parental figures are noted as significantly higher at risk for substance abuse and addiction as teenagers and adults than females who have not had these experiences (Brown & Anderson, 1991; Miller, Downs, & Testa, 1993; Straus & Kantor, 1994; Windle, Windle, Scheidt, & Miller, 1995). Given the multiple decades of research there does not seem to be a shelf-life on the continual reference to female victimization.

A cross-sectional survey conducted by Kelly et al., (2010) of 346 female offenders in a California county jail system was used to serve as a baseline for the implementation of gender responsive programming in a corrections program. A 50-item survey was designed for this study. The survey included questions on demographics and personal history, history of incarceration

and involvement in the juvenile justice system. Of interest to this researcher were the fifteen survey questions about their history of physical, sexual and partner abuse and the eight items focused on the mental health history of the females which included diagnoses, drug use and substance use treatment.

The women's responses to the abuse history revealed childhood physical abuse, 79 women (23.4%) had no positive responses to abuse questions; 228 participants (68.3%) had between one and seven yes responses, and 27 participants (8.1%) had more than seven responses, according to the researchers, suggests serious child abuse. Responses to the childhood abuse questions, the survey items about sexual abuse, there were 94 women (27.9%) saying yes to one to three of the questions, and 64 women (19%) answered yes to all four items. Partner physical abuse responses of 183 women (53.7%) showed one and three positive responses and 104 women (30.5%) had a positive response to all four items.

The mental health history information of the women gathered from this study noted a variety of psychiatric diagnoses such as depression (34.1%) and anxiety (22.5%). More severe diagnoses included bipolar disorder (15%), posttraumatic stress disorder (15.9%), and schizophrenia (4%). A total of 274 women (79.2%) acknowledged substance use, with methamphetamine being the most widely used drug by 199 women. Kelly et al., also reported that most of the women in jail had school-aged or younger children, minimal education, and both mental health and substance use problems (2010).

Despite a body of literature that exists on women in prison, little research has been conducted about female offenders at the jail level. This article introduced the needs of this population of incarcerated females who returning to their families and community living.

According to a report generated by the Vera Institute of Justice (2016) “one of the most significant underlying issues women in jail grapple with is mental illness” (p. 10). Serious mental illnesses (SMI) such as depression, bipolar disorder, and schizophrenia affects nearly 32 percent of women in jails, a rate more than double that of jailed men, and more than six times that of women in the general public (Lynch et al., 2012; as cited in Swavola, Riley, & Subramanian, 2016). According to the Bureau of Justice Statistics (BJS), 75 percent of women in jails reported having had symptoms of a mental health disorder in the past 12 months (James & Glaze, 2006). Lynch et al. (2012) pointed out that females in jail report high rates of victimization including childhood sexual abuse, sexual assault, intimate partner violence and post-traumatic stress disorder (PTSD) (as cited in Swavola et al., 2016).

Justice For All (2016), the Vera Report, asserts that “the extent to which women in jail report having experienced trauma is startling: 86 percent report having experienced sexual violence in their lifetime, and 60 percent report caregiver violence” (p. 11). The report suggests that jail intake staff often fail to detect trauma unless symptoms are vividly apparent.

Reentry to Community

Research conducted by Hunter and Greer (2011) focused on gaining insight into the challenges that females face in achieving sustainable familial, financial, and emotional lives after release from prison. Hunter and Greer’s analysis is “derived from the first wave of data from a three-year longitudinal study of the experiences of females being released from prison in a midwestern state” (2011, p.198). The first wave of data, collected during the summer of 2008, consisted of interviews with 41 incarcerated females in a midwestern prison who were soon to be released. In the initial interviews, the women shared personal histories and the paths of their criminal involvement, as well as their expectations and hopes of reentering mainstream society.

The purpose of Hunter and Greer's (2011) study was to "investigate the ways in which the females prepared for reshaping their identities from offenders to ex-offenders (p. 199).

The examination of the baseline interviews focused primarily on the women's perceptions of their life experiences and how, as a result of those experiences, they saw themselves as they prepared to leave the prison. Many of them described traumatic experiences as children and adults that made forming an image of self-confidence difficult. The women in Hunter and Greer's (2011) study had trouble describing who they were as individuals. The authors noted that "most of the females described their sense of self as ill defined, unstable, and extremely fluid" (Hunter & Greer, 2011, p. 1). The participants reported using drugs and alcohol during different points in their lives to overcome feelings of insecurity. A majority of the females referenced an addict identity as a basis for making sense of their life experiences.

The study's sample was selected from the population of incarcerated females in one midwestern state. Hunter and Greer identified three main criteria for participating in their study: "having a release date prior to December 2008, being older than the age of 18, and having a post-release address somewhere within the same state" (p. 204). The majority of the participants were recruited through the Pre-Release Class, which is mandated by the prison for females nearing their release dates. An additional 10 participants were recruited from a boot camp program, an in-state program whereby incarcerated females must meet certain criteria; if they successfully complete the demanding program requirements and graduate from boot camp, the prison portion of their sentences would be reduced. Hunter and Greer had more females interested in participating than they could accept. The researchers provided purposeful sampling, toward the end of their recruitment stage to reflect the overall population of the nearly 500 females incarcerated state-wide.

Some of the demographics considered in purposefully guiding the sampling process were age, race, geographic location of reentry, length of sentence, number of children, and type of offense. Their ages at the time ranged from 20 to 53 years, with an average age of 36. Thirty of the females in our sample identified as White (73 %), six as Black or African American (15 %), two as Native American (5 %), and three as Hispanic (7 %). The sample was almost evenly split between those releasing to metro communities versus rural areas in the state. The offenses for which the females were incarcerated varied. Twenty-one females (51 %) were incarcerated for drug-related crimes ranging from possession to sales or manufacturing of illicit drugs. Eleven (27 %) were convicted of some type of property crime (e.g., theft, forgery, counterfeiting). Five (12 %) had person offenses (e.g., manslaughter, assault). The remaining four (10 %) had crimes categorized by the Department of Corrections as “other” (e.g., driving while intoxicated, possession of a weapon) (Hunter & Greer, 2011, p. 204).

The amount of time served ranged from 4 months to 16 years, with an average of two years. The majority of the participants had served less than three years. Almost half were parents of minor children, with twelve having children older than the age of 18, and eight had no children.

Hunter and Greer stated that the interviews were two hours in length and “included questions about family histories, living situations prior to incarceration, expectations and aspirations upon release, the current state of relationships with family or other significant persons in their lives, and children’s placement during incarceration” (2011, p. 205). Hunter and Greer analyzed the interviews by reviewing the ways in which incarcerated females’ self-identities developed and continued to develop as they each worked to understand their past experiences and then transition to the community.

When asked about their childhood, many immediately shared their stories of neglect, trauma, and abuse. Sixteen [16] of the females reported physical abuse or neglect, ten reported sexual abuse, 11 reported witnessing violence between parents, 26 reported parental substance abuse, and 16 reported transitory childhoods. The majority of the females described at least one

of these childhood experiences, and two reported all five. The study further reported that 19 of the females recounted abuse as adults from intimate partners.

Hunter and Greer state that the “women’s reports of various types of instability and trauma are not surprising, and are consistent with previous research on incarcerated females (Chesney-Lind & Pasko, 2013); however, the women’s narratives offer intriguing insight into the relevance of these experiences for their identity development” (2011, p. 207). Evident in their narratives, “the females believed that those experiences disrupted their ability to form a defined sense of who they were as individuals, and those nebulous “selves” often followed them into adulthood” (Hunter & Greer, 2011, p. 207). This writer concludes that Hunter and Greer’s (2011) study raises concern for incarcerated females in jail. However, there is a dearth of studies, sources or correctional facilities providing a required Pre-Release Class for females exiting jail and reentering the community.

Reentry - More Challenges for Females

The escalating effects of incarceration are particularly apparent with regard to mental health disorders, further challenging the female’s ability to reenter her community and successfully renegotiate her role as mother, when appropriate (Arditti, 2012). Arditti further posits that one can surmise incarcerated females are particularly vulnerable to these effects due to their history of trauma, and the possibility that even acute, psychological disorders may not have been diagnosed while incarcerated (2012). Arditti and Few (2008) ascertain that substance use combined with mental health challenges are overlooked upon reentering family and community life (as cited in Arditti, 2012).

In addition to the challenges that may present with unmet mental health and treatment needs, reentry mothers face the challenge associated with not only finding and sustaining legal

employment, but simultaneously creating a smooth transition as they reunite with their children (Arditti, 2012). Brown and Bloom (2009) maintain that many mothers reentering their communities must deal with the multiple demands of employment and caregiving responsibilities lacking financial resources or support from the fathers of their children (as cited in Arditti, 2012). The path for post-incarcerated females, it seems, continues to be contentious at best.

Reentry: Factual Reality

According to the Federal Interagency Reentry Council (2011) more than 700,000 individuals in the United States are released from state and federal prisons each year. Nearly 95 percent of all offenders will be released and returned to their communities (Pew Center on the States, 2008). Simultaneously, 9 to 10 million more people will cycle through local jails annually (Merica & Perez, 2013). The costs of imprisonment and jail in the past two decades have grown at a faster rate than nearly any other state budget item (Federal Interagency Reentry Council, 2011). The average cost per day, per inmate is \$78.95, (Pew Center on the States, 2008). In the state of Minnesota, the average annual cost per inmate is \$41,364 (2016, <http://www.insidegov.com/>). The United States spends more than \$68 billion annually on federal, state, and local corrections facilities (Federal Interagency Reentry Council, 2011). Berg and Huebner (2011) maintain that most ex-offenders lack a competitive resume, employment credentials, and are under-skilled relative to the general population of job-seekers. They have the added social stigma of an arrest or prison record, and because of their criminal record, face a narrow range of job opportunities, all considerable barriers to employment. Additionally, studies show that employers are unwilling to hire ex-offenders even when they exceeded the qualifications for the position (Berg & Huebner, 2011). However, studies by the Pew Center on the States contends that by reducing the rate of offenders who return to prison, communities are

safer and families are more intact, and can therefore, begin to reinvest incarceration dollars into other critical areas (2008). Individual successful reentry to community and the workforce results in: 1) safer neighborhoods, 2) stable families, 3) prosocial structured activity for an ex-offender, 4) reduced taxpayer costs for incarceration, 5) living wages for an ex-offender to support self and family, and 6) income for restitution to victims, court, and correctional supervision fees, continued mental and behavioral health treatment, and child support, as needed (Berg & Huebner, 2011).

ACEs and PK-12 Education

According to Plumb et al. (2016), ACEs have become a common and prevalent problem for our students in school. Plumb et al. further posit that there is a positive correlation between ACEs and physical, emotional, and mental health complications across the life-span (2016). Recent statistics provided by the National Institute of Mental Health (2016) site mental health facts for children and teens as

- 20% of youth ages 13-18 live with a mental health condition;
- 11% of youth have a mood disorder;
- 10% of youth have a behavior or conduct disorder;
- 8% of youth have an anxiety disorder;
- 37% of students with a mental health condition age 14 and older drop out of school, the highest dropout rate of any disability group;
- 70% of youth in state and local juvenile justice systems have a mental illness; and
- Suicide was the third leading cause of death among individuals between the ages of 10 and 14, 90% of those who died by suicide had an underlying mental illness (Cash & Bridge, 2009; National Alliance on Mental Illness, 2017, para. 1).

Impact of Trauma

The impact of trauma on the developing brain is significant and manifests differently during each stage of development (Blanco et al., 2015; Du et al., 2015). Perry (2006) maintains that if a child undergoes sustained, severe, and unpredictable trauma, that child may experience hyperarousal or hypoarousal causing a child to be in a persistent fight, flight or freeze mode. Wolpow et al. (2009) explain that “trauma is an extreme form of stress that affects the brain development of children and can cause adverse reactions in all areas of life, including behavior and learning” (Plumb et al., 2016, p. 40). Simply put, children who experience high levels of trauma are unable to achieve academic success. Studies demonstrate that, because the brain of a child is more agile than that of an adult, excessive adversity changes the child’s brain chemistry (Center for Youth Wellness, 2017; Du et al., 2015; Wolpow et al., 2009).

ACEs Impact on Children and Youth

The impact of ACEs on children may manifest in multiple ways. One such way may be that the child has difficulty with critical brain functions such as focusing, learning, self-regulation, and decision-making (Center on the Developing Child, 2017). These brain malfunctions may mimic symptoms associated with attention deficit hyperactive disorder (ADHD), when in fact they are result of childhood trauma (Siegfried & Blackshear, 2016). Attachment disorders, such as being unable to trust others and regulate emotions, may present as aggression or self-harm (Center on the Developing Child, 2017; Dvir, Ford, Hill, & Frazier, 2014). A study conducted by Scott, Burke, Weems, Hellman, and Carrion (2013) of 701 children at the Center for Youth Wellness found that a child with four or more ACEs was 32 times more likely to be labeled as learning or behaviorally impaired, as compared to a child with no ACEs. Children may feel helpless, unloved, and unlovable, and may blame themselves for their ACEs,

thus instilling guilt and shame as a result (Center on the Developing Child, 2017; Dvir et al., 2015; Scott et al., 2013).

Trauma-Sensitive Schools

Severe trauma and the healing potential of childhood trauma can have a major positive impact on children's social-emotional, cognitive, and academic growth (Ganzel & Morris, 2011). Environmental hardship associated with poverty, such as unsafe housing and inconsistent or nonexistent caregiving, is associated with higher stress levels, even in infants (Blair & Raver, 2012). Disparities may appear early, as 20.5 % of children from families living in or near poverty exhibit behavioral or emotional difficulties, compared to 6.4 % of children from financially stable homes (Howell, 2004). The negative effects of trauma in children are caused by both prolonged adversity and the absence of a supportive network of adults who teach coping (Garner et al., 2011). Incorporating trauma-informed approaches in schools is crucial to meet the needs of children who face exposure (Jensen, 2009).

School administration, counselors, teachers, and classroom aides are in a prime position to help students develop coping skills, build resilience, model emotional processing and problem solving, and establish psychological safety by establishing consistent expectations and familiar safe, routines (Baum, Rotter, Reidler, & Brom, (2009). Teachers can also be instrumental in delivering classroom-based interventions that address mental health (Wolmer, Hamiel, Barchas, Slone, & Laor, 2011). School personnel are often aware of the adversity faced by their students, but may not feel adequately equipped to respond to students' mental health needs (Anderson & Bronstein, 2012).

Culturally Responsive Trauma-Informed Approaches

A culturally responsive school recognizes and validates the cultural and racial identity of each student, understands the historical context and experiences for students' cultural groups in American society, and responds affirmatively with flexible pedagogy to meet a range of learning styles (Tanner, 2013). A trauma informed school realizes the prevalence of trauma in children; recognizes the physiological and relational impact of trauma on students and school personnel; responds by translating this knowledge into practice as part of school-wide supports; and reduces re-traumatization by adopting practices that promote healing and growth rather than punishment and exclusion (Colman et al., 2013). Establishing trauma-informed approaches in a culturally responsive context also requires that all students see positive representations of their culture in the educational process (Goldberg et al., 2014) to foster increased resilience and cultural pride.

Synthesis of Research Findings

Although female offenders are the fastest growing population in U.S. prisons, they are a relatively small percentage of the overall prison population, which may explain the limited number of gender-specific treatment resources available for females in prison (Roe-Sepowitz, Bedard, Pate, & Hedberg, 2014). Incarcerated females are likely to have a history of child abuse, domestic violence, substance abuse, mental illness, and/or economic marginalization (Hunter & Greer, 2011; Scroggins & Malley, 2010). Approximately 60% of females in state prisons have experienced physical or sexual abuse in the past (Greenfeld & Snell, 2000). Tripodi and Pettus-Davis (2013) noted that compared with men, incarcerated females report higher rates of prior victimization, mental illness, and high rates of substance abuse, all of which appear to be connected.

Further still, a study conducted by the Bureau of Justice Statistics (2014) found that 75% of females in local jails have symptoms of mental disorders, compared with 12% of females in the general population (National Resource Center of Justice Involved Women, 2017). Three quarters of the females who had a mental health problem also met the criteria for substance dependence or abuse (James & Glaze, 2006). Addicted females are more likely to experience co-occurring disorders such as depression, dissociation, posttraumatic stress disorder, other anxiety disorders, eating disorders, and personality disorders (Covington, Messina, & Bloom, 2017).

ACEs have become a common and prevalent problem for school students, and it has been established that there is a positive correlation between ACEs and physical, emotional, and mental health complications across the life-span (Plumb et al., 2016). Children who experience high levels of trauma are unable to achieve academic success. The negative effects of trauma in children are caused by both prolonged adversity and the absence of a supportive network of adults who teach coping (Garner et al., 2011). Incorporating trauma-informed approaches in schools is crucial to meet the needs of children who face exposure (Jensen, 2009).

Summary

This literature review provided an overview of current research related to incarcerated females with mental illness, the effects of childhood trauma, and reentry of females from jail to community. Additionally, this review of the literature identified reasons for further study regarding traumatic childhood experiences and their lifelong impact on health and a female's quality of life, increased risk of female criminal behavior, and social consequences. There were five primary themes presented in this chapter: 1) female pathways to incarceration, 2) adverse

childhood experiences, 3) impact of childhood trauma and learning for PK-12 students, 4) history of victimization and 5) reentry to community.

The review of the literature provided studies indicating that jails and prisons have similar populations. Despite a body of literature that exists on females in prison, little research has been conducted on female offenders in jails. However, the majority of the research cited childhood trauma as having a significant negative impact on incarcerated females. Additionally, the review of literature confirms that childhood trauma impacts student learning and academic success. What must be assessed is whether or not PK-12 schools are addressing ACEs and are equipped to provide the necessary mental health support systems.

CHAPTER THREE: METHODOLOGY

The purpose of this study was to explore the link between mental illness and the impact of childhood trauma among incarcerated females, as it furthermore discusses Adverse Childhood Experiences (ACEs) and mental health resources for children and youth in PK-12 schools in Minnesota. This study also extended the literature on correctional and reentry programs addressing the history of females who experienced childhood trauma and mental illness issues. Houser and Welsh (2014) found that “female offenders often have unique pathways into the criminal justice system, along with higher rates of mental illness, drug use, and co-occurring disorders compared with males. However, incarcerated females are still a very understudied population in criminal justice research” (p. 664). This chapter describes the study’s research questions, description of the research framework, instruments, sample population, data collection, and analysis plan.

Research Design

The research design for this study is a qualitative phenomenological design (Husserl, Merleau-Ponty, Sartre as cited by Woodruff, 2016). This research adopted a theoretical framework that prioritizes the personal experiences of incarcerated females as they share their stories within the context of early childhood and youth experiences, pre-jail histories, and incarceration and also to consider their post-jail lives. Some may claim that obtaining multiple perspectives of women’s incarceration and reentry (e.g., the views of correction officers or family members) is necessary to gain a broader perspective. However phenomenological studies rooted in social constructivism theories seek to understand the world in which the participants live (Guba & Lincoln, 2005, Creswell, 2013). Thus, the goal of this study was to examine the world from the point of view of each participant. The researcher was mindful that the goal was to

ascertain *what* the females experienced and *how* they experienced it, these are their life stories (McMillan & Schumacher, 2010).

This research also addressed Adverse Childhood Experiences (ACEs) and mental health resources for children and youth in PK-12 schools in Minnesota. The researcher of the study conducted one-on-one interviews with selected educational leaders of PK-12 schools in Minnesota. The selection of leaders represented urban, suburban, an alternative learning center, charter, rural, and private schools. The educational leaders were asked to respond to questions about the mental health needs of students in their school, district resources for students, and professional development for teachers and staff.

Role of the Researcher

Interviews with Incarcerated Females

The researcher conducted phenomenological, one-on-one in-depth interviews with participants. An over-arching goal of this research was to hear the personal stories of incarcerated females in jail; intentionally listening to them unfold their life journey. Another goal was to document the barriers and obstacles they experienced upon reentry to community. What is preventing them from attaining and maintaining a life of success with family and at work? When, if ever, have they felt as though they are an integral part of society and community? Additionally, this research sought to deepen the understandings of how PK-12 educators can better respond to the needs of students who have experienced trauma. In the past, as a volunteer at the selected county jail, this writer experienced hearing small sound-bites of incarcerated females. Those experiences have impacted the decision to choose this topic and deepened the desire to understand the meaning of the events, situations, and experiences of this population of incarcerated females.

The primary advantage of this researcher's experiences and goals stated above is the exposure to the reality of their lives very different from that of the researchers. .

The landscape of qualitative research establishes the researcher as the data collection instrument. According to Burke (2014) "it is reasonable to expect that the researcher's beliefs, political stance, cultural background (gender, race, class, socioeconomic status, educational background) are important variables that may affect the research process" (p. 2). Not only was it important for the researcher to be mindful about the influence positionality had on the process, it was imperative that the researcher be straightforward in communicating positionality with interviewees. Transparency of positionality and researcher intentions were a central component of the research. The researcher's purpose of the study was communicated in interviews with the women and with the education leaders in two waves; the first during the introductory review of the study and again at the beginning of each interview.

The researcher was aware of the importance of "establishing trust, being genuine, maintaining eye-contact and conveying through phrasing, cadence and voice tone" (McMillan & Schumacher, 2010, p. 357) and was intentionally listening and interested in what the women had to share, thus thwarting a rigid approach. Given the short period of time allowed with the women, the researcher initiated building trust with the women during the initial introduction phase of the research prior to the 1:1 interviews, such as intentional one-to-one interactive dialog answering questions and affirming the value of their participation in this research, one-to-one eye contact and thanking the women who volunteered to participate in the study.

Interviews with Education Leaders

The researcher invited selected education leaders in Minnesota to take part in this portion of the research. The choice of education leaders represented urban and suburban schools, an

alternative learning center, as well as charter, rural, and private schools. It is important to recognize the varied group of educational leaders selected as representation of the diverse PK-12 student populations. The researcher's resources provided opportunities to reach out to all of those selected, thus providing an inclusive interview process was represented accurately. Some of the participants were known to the researcher and others were “nominated” by trusted education leaders and scholars. The education interviewees were asked to respond to questions about the mental health needs of students in their school, district resources available for students, and professional development offered to teachers and staff.

Research Questions

The primary research questions for this study are:

RQ1: What do incarcerated females describe as the linkages between childhood trauma and mental illness?

RQ2: What are the implications for educators concerning the impact of childhood trauma, mental illness, and incarcerated females?

RQ3: What issues affect the reentry of incarcerated females with mental illness and childhood trauma from jail to community?

Setting Population and Sample

The first research setting population and sampling procedure included incarcerated females, in a county jail in southern Minnesota. Participants at the facility were aged 18 and older. One week before the one-on-one interviews began, the researcher visited the jail sharing information sharing sessions describing the research purpose, timeline, overview of the interview questions, and the ACEs questionnaire (see Appendices 1 and 2). A participant consent form was available, and signed by participants before an interview was conducted (see Appendix 3).

Participants were volunteers only. There were no penalties for anyone choosing not to take part. Those consenting to the interview received \$25 deposited to their account at the county jail.

The second interview setting, population and sampling procedure included selected Minnesota PK-12 school principals and a director of an Alternative Learning Center (ALC). The selection of principals represented urban, suburban, an alternative learning center, charter, rural, and private schools. The researcher contacted each educational leader prior to the formal interview to provide information about the research purpose, its timeline, and a brief overview of the interview questions (see Appendix 4). A participant consent form was signed before an interview was conducted (see Appendix 5). Participants were volunteers only. There were no penalties for anyone choosing not to participate.

Data Collection and Instrumentation

Jail Setting

Data collection with the females at the jail began by utilizing the Adverse Childhood Experiences (ACEs) questionnaire to assess different types of abuse, neglect, or other trauma instances during childhood. The ten-question survey used in the landmark study by Kaiser-Permanente and the Center for Disease Control and Prevention is free and open for use (*Got your ACE score*, 2018). The researcher conducted in-depth, open-ended, one-on-one interviews with participants to capture the individual ‘story’ of each female. The one-on-one interviews were conducted on-site at the county jail in a secured room. A laptop audio recording system was used to record the interview. The interviewer followed the same set of designed questions for each interview. After the recorded session, the researcher checked for interviewer reliability with each interviewee. If for any reason, a question caused the participant to feel uncomfortable or upset, the interviewee was offered the choice to decline to answer the question/s, or stop the

interview. None of the 11 interviewees, however, declined to answer any of the questions or to stop the interview session.

The interview questions were analyzed by three outside experts, one with extensive knowledge and experience with mental illness and the criminal justice system in Minnesota, one educational leader with PK-12 school-wide district knowledge of teacher training and development criterion in the state of Minnesota as it pertains to mental health, and an education professional with a wide range of educational leadership experience addressing mental health issues in the PK-12 education system as well as research, writing, and publication success. Prior to conducting the interviews, the interviewer participated in professional development sessions facilitated by social workers, law enforcement and school psychologists in interview techniques to capture individual life experiences. A second reader was used to cross-check the data, reference, and categorize the interview data into themes and sources for understanding.

PK-12 Education Leaders

Data collection with the principals and the director of an Alternative Learning Center (ALC) utilized a set of six-questions designed by the researcher. The questions were field tested by three experts in the field of education. One with knowledge and experience with mental illness of children in K-12 schools, one educational leader with PK-12 school-wide district knowledge of teacher training and development criterion in the state of Minnesota as it pertains to mental health, and an education professional with a wide range of educational leadership experience addressing mental health issues in the PK-12 education system as well as research, writing, and publication success. The researcher then conducted one-on-one interviews with participants utilizing WebEx, an audio-visual platform. The participant responses to the questions were typed by the interviewer as the interviewee responded to the questions. The

interviewer followed the same set of designed questions for each interview. After the recorded session, the researcher checked for interviewer reliability with the interviewee. A second reader was used to cross-check the data, reference, and categorize the interview data into themes and sources for understanding.

Data Analysis

According to McMillian and Schumacher (2010) “the primary data of qualitative interviews are verbatim accounts of what transpires in the interview session” (p. 360). To ensure the researcher captured verbatim accounts the researcher immediately, after completing each of the interviews, conducted a review with the participant. Together the interviewee and the researcher reviewed the recorded script thus ensuring accuracy of data collected. At the conclusion of each of the one-to-one interviews the researcher reviewed the recorded transcripts for clarity. Additionally, the researcher made side-bar notes, “self-reflections on the rapport, the interviewee’s reactions, additional information, and extensions of interview meanings” (McMillian & Schumacher, 2010, p. 360).

The structure of the data analysis followed systemic processes noting significant statements from the women, to detailed descriptions summarizing what they experienced and how they had experienced it (Moustakas, 1994). Utilizing the Moustakas (1994) model, the researcher continued to analyze the data for the duration of the research study. The data was categorized to break down all the collected data via a charting system, capturing key words and phrases used to describe the interviewees lived experiences. Utilizing the data from the charting system the researcher was able to identify and arrange the information into themes. The data was then shared with a second reader to cross-check the transcripts, data in the charts, and review themes to ensure an authentic and accurate review of the interviews.

Protection of the Participants

The interviews with participants at the jail were audio recorded and all data stored electronically within a secure and confidential manner by the researcher. The researcher alone has had access to the virtual lock and will determine when and how the recordings will be destroyed. The interviews with the principals and the director were not virtually recorded, only the typed document was secured in a confidential electronic file folder by the researcher. The researcher determined the order of the questions in each interview. Additionally, demographic questions were incorporated at the beginning, throughout, or at the conclusion of the interview per the choice of the researcher. Pseudo names only are used in the research data. The confidentiality of the participants was of the utmost priority. There was no deceptive design in this study. The interviewer was intentional at all times with the role and responsibilities as researcher. External consultants signed a confidentiality form prior to providing research review and feedback.

Assumptions, Limitations, and Delimitations

An assumption of this research study assumes that females with four or more ACEs scores are at risk for a lifelong impact on their physical and mental health. Research has documented an increased prevalence of mental disorders among individuals experiencing childhood abuse and trauma relative to their age peers (Briere, Woo, McRae, Foltz, & Stizman, 1997; Silverman, Reinherz, & Gianconia, 1996). In particular, childhood abuse has been associated with subsequent development of posttraumatic stress disorder, borderline personality disorder dissociative symptoms and depression (Felitti et al., 1998).

The sample population limits this study demographically as participants interviewed were volunteers only. Additionally, the participant sample was determined by the number and

diversity of females incarcerated during the selection and interview period. The researcher was granted a 30-day timeframe by the Commander of the county facility to present the purpose of the study to the women in the jail, secure consent from the women for participating in the study and conducting the one-to-one interviews with the women. The time approved in the jail to conduct the interviews were in three hour increments per visit. The activities that incurred during those three hours included security entrance, setting up the room, materials and lap-top for the one-to-one interviews, correction officers notifying the interviewee and sending to the interview room, conducting the interview and interviewer reliability check. The interviews were 60-90 minutes in length, therefore only one or two interviews per evening on-site took place. The nearly 20 hours of actual on-site interviews occurred in a two-week calendar course of time.

A delimitation of this study was that the researcher purposefully decided to conduct research at a jail and not a prison as current research does not provide an abundance of phenomenological study for this population. The study includes a one-hour interview with incarcerated females at the jail. The researcher was mindful that the goal was to ascertain *what* the females have experienced and *how* they experienced it, as these are their stories. There was no dialog or interviews with any other individuals inside or outside of the jail, the life experiences of the females. Another delimitation of this study is that the principals of the schools and the director of the ALC were selected to represent urban, suburban, and rural settings. Additionally, this researcher is a former PK-12 classroom teacher, special education director, and elementary principal.

CHAPTER FOUR: REPORTING THE FINDINGS

Introduction

The purpose of this study was to explore the link between mental illness and the impact of childhood trauma among incarcerated females in jail. A component addressed adverse childhood experiences and mental health resources for children and youth in PK-12 schools in Minnesota. This study also includes the relationship between correctional programs and reentry programs addressing the history of females who experienced childhood trauma and mental illness issues.

This chapter includes the study of the populations chosen for this dissertation writing, as well as the data results discovered. The data results are comprised of two sets of responses. The first are the responses to the ACE's questionnaire and in-depth interview questions conducted with incarcerated females at a county jail. The second set represents the responses to interview questions from selected Minnesota principals and a director of an Alternative Learning Center (ALC). The responses are organized based on similarities and/or differentiated data and shared in paragraph form. Included in each section are tables and narrative succinctly summarizing the responses.

Instrumentation and Implementation

The ACEs questionnaire is a set of 10 questions measuring 10 types of childhood trauma experienced before the age of 18. (See Appendix 1.) Five of the questions seek a response to personal trauma such as physical abuse, verbal abuse, sexual abuse, physical neglect, and emotional neglect. The remaining five questions are related to other family members: a parent who is an alcoholic, a mother who is a victim of domestic violence, a family member in jail, or a family member diagnosed with a mental illness. The questionnaire and scoring system was

designed by Drs. Felitti and Anda in conjunction with the CDC-Kaiser Permanente ACEs study, and is universally available for use (CDC, 2016; Felitti et al., 1998).

The author of this study elected to develop the questions used for the two interview settings. The questions and the subsequent revisions were two-fold: 1) questions based off of the research conducted for this dissertation and surmising the lack of data about incarcerated females in jail, their trauma, and their reentry to community, and 2) questions formulated about the current need and provision of mental health services and resources in PK-12 schools in Minnesota. A triad of individuals, known to the author, aided the researcher in the design and development of the interview questions. One is known as an expert in research analysis and data design, another has extensive knowledge and experience with mental illness and the criminal justice system in Minnesota, and a third is an education professional with a wide-range of educational leadership experience addressing mental health issues in the PK-12 education system as well as research, writing and publication success.

In order to accomplish the goal of understanding the life stories of the females from childhood experiences to incarceration, the researcher used a phenomenological data analysis (Creswell, 2013). As prescribed by Creswell, the researcher provided “significant statements or themes that were then used to write a description of what the participants experienced” (2013, p. 82). Additionally, the researcher wrote a description of the context that influenced how the participants experienced the phenomenon, referred to as a structural description, providing the reader the opportunity to sense or better understand the life stories of the females interviewed (Creswell, 2013). To best accomplish an understanding of the mental health resources, programs, and professional development available in PK-12 schools, the use of grounded theory research was used to firmly justify emergent themes derived from the interviews with the educational

leaders (Creswell, 2013). After interviews with the females in the jail and those with the educational leaders were transcribed, the researcher shared the information with a consulting advisor, who has both education and criminal justice leadership expertise, as a cross-check of the themes identified by the author to ensure accuracy in capturing the data collected.

The interview questions written for the females in jail (see Appendix 2) focused on their personal experiences, as they shared their stories within the context of early childhood and youth experiences, pre-jail histories, and incarceration and were further asked to consider their post-jail lives. The questions designed for the educational leaders' interviews (see Appendix 4) addressed Adverse Childhood Experiences (ACEs) and mental health resources available for children and youth in PK-12 schools in Minnesota, as well as school districts' professional development offerings to staff and faculty.

Study Population

The first research setting population and sampling procedure included incarcerated females, in a county jail in southern Minnesota. The participants at the facility volunteered to be interviewed; all were older than age 18. One week before the one-on-one interviews began, the researcher was at the jail, under the supervision of the Commanding Officer, and facilitating information-sharing sessions describing the research purpose, the timeline, an overview of the interview questions, and the ACE's questionnaire (see Appendices 1 and 2). A participant consent form was available, and signed by participants volunteering to be interviewed (see Appendix 3).

The second research population interviews were conducted with selected Minnesota PK-12 school principals, and a director of an Alternative Learning Center (ALC) to address Adverse Childhood Experiences (ACEs) mental health needs and resources for children and youth in PK-

12 schools. The director leads a suburban ALC which functions as an intermediate school district. The selection of principals represented urban, suburban, an alternative learning center, charter, rural, and private schools. The researcher contacted each of the education leaders prior to the formal interview to offer information about the research purpose, timeline, and a brief contextual overview of the interview questions (see Appendix 4). A participant consent form was signed prior to interviews conducted (see Appendix 5). Participants were volunteers only.

Interviewee Responses

Interviews with the Females at the Jail

The ACE questionnaire was administered first and completed by each of the participants, after which the interviewer began the one-to-one in-depth interview. Demographical information was gathered during the interviews. Pseudo names were assigned to each interviewee to protect the confidentiality of each participant. For this study, respondents' narratives highlight their personal stories about their upbringings, relationship with parents, educational experiences, childhood abuse or other traumatic experiences, sibling and friendship relationships, their own use of drugs and/or alcohol while growing up. The females also discuss their adult lives, including relationships and situation related to their criminal involvement, a sense of acceptance, belonging or contribution in community outside of jail and reentry to community plans when released from jail. Table 1 shows demographics considered in purposefully guiding the sampling process as age, ethnicity, and birth order, level of education, marital /partner relationships, and number of children. Their ages at the time of the interviews ranged from 25 to 49 years. Five of the females in the sample identified as White, one as African America, two as Native American, two as Hispanic, and one as Chinese.

Eight of the interviewees did not complete high school, however, five had completed GEDs, and one was completing her GED. Three had continued education beyond high school, two at technical school, and one at community college. Two of the females were married, one identified as divorced, and one with a partner. All but one of the females had children. Two had adult children, while eight of the interviewees had children ranging in age from one month to 18 years. See Table 1. below for a recap of these demographics.

Table 1.
Demographic Information of Females Interviewed

<i>Pseudo Name</i>	<i>Age</i>	<i>Ethnicity</i>	<i>Birth Order?</i>	<i>Level of Education?</i>	<i>Married Partner Single?</i>	<i>Children</i>
<i>Lucy</i>	28	White	oldest-2 younger	HS, plus 2 years at Community College	S	Y-3 years
<i>Sarah</i>	25	Native American	oldest-1 younger	dropped out HS senior year	P	Y-7, 5, 3, 2 years
<i>Nian Zhen</i>	49	Chinese	youngest-2 older	N/A	D	Y-23 years
<i>Danielle</i>	49	White	youngest-1 older	GED	S	Y-30 years
<i>Karen</i>	36	Jewish Native	oldest-1 younger	GED	M	Y-13, 11, 10 years
<i>Nancy</i>	30	White	No siblings	10th grade	S	Y-11, 10, 1 month
<i>Martha</i>	37	Hispanic	only child-3 step sibs	HS-some Tech School	M	Y-18, 17, 15, 12, 7 twins, 6 years
<i>Emily</i>	28	Mexican	middle-3 older, 3 younger	GED	S	Y-7years
<i>Lila</i>	25	African American	middle-2 older, 1 younger	working on GED	S	N
<i>Susan</i>	32	White	oldest-1 younger	GED	S	Y-17 years
<i>Constance</i>	39	Native American	middle-3 older, 3 younger	GED-1 year tech school	S	Y-17, 12, 11, 9 years

Table 2 provides pre-incarceration data, and information about whether or not this incarceration was the interviewee's first encounter in jail, as well as her anticipated duration in jail. All but two of those interviewed were employed prior to incarceration. Employment experiences included working for a house cleaning business, in fast food restaurants, as a machine operator in a candy plant, as a daycare provider, in construction, and as a medical assembly line worker for a Fortune 500 company. At the time of incarceration, seven of the 11 had health insurance. Just one of the 11 women was a resident of the county jail where the interviews took place; the ten others' home residences were outside of the county facility. Seven of the ten were serving sentences for offences occurring in the present county, while three of the interviewees were housed out of facility (HOF). Two of those HOF had been in jail several times prior to their current prison term; however, one had never committed a crime prior to the one for which she was sentenced to prison. The length of time being served by the women in the county facility was 17 days to 10 months.

Table 2.
Profiles of Incarcerated Females

<i>Pseudo Name</i>	<i>Employed Prior to Incarceration?</i>	<i>Health Insurance?</i>	<i>Wash. Co. Residence?</i>	<i>1st time in jail</i>	<i>Length of time in this county jail?</i>
<i>Lucy</i>	Y	Y	Y	N	17 days, waiting for tx Teen Challenge
<i>Sarah</i>	Y	N	N	N	not sure, hoping for tx center
<i>Nian Zhen</i>	Y	Y	N	Y	8-10 months
<i>Danielle</i>	Y	N but Y when employed	N	N HOF	< year
<i>Karen</i>	Y	Y	N	N	7 days, then to complete time at another county jail.
<i>Nancy</i>	N	Y	N	N	Court date in four months
<i>Martha</i>	N	N	N	N	Court next day
<i>Emily</i>	Y	N	N	N	up to a year, then prison 5 yrs.
<i>Lila</i>	Y	Y	N	Y HOF	6-7 years in prison
<i>Susan</i>	Y	Y	N	N	18 days, back to resident county jail to complete time.
<i>Constance</i>	Y	Y	N	N HOF	10 yrs. prison

The ACEs questionnaire was completed by each of the participants and was a focal point of the interview dialog. Table 3 (next page) summarizes the interviewee’s responses for each of the 10 questions.

Table 3.
ACE Questionnaire Scores

<i>Prior to your 18th birthday.....</i>	<i>Number of 'yes' responses</i>
1. Did a parent or other adult in the household, often, or very often: Swear at you, insult you, put you down, or humiliate you? Or, act in a way that made you afraid that you might be physically hurt?	11/11
2. Did a parent, or other adult in the household, often or very often: Push, grab, slap, or throw something at you? Or, ever hit you so hard that you had marks or were injured?	9/11
3. Did an adult at least 5 years older than you ever: Touch or fondle you, or have you touch their body in a sexual way? Or, attempt to actually have oral, anal, or vaginal intercourse with you?	3/11
4. Did you often or very often feel that: No one in your family loved you or thought you were important or special? Or, your family did not look out for each other, feel close to each other, or support each other?	7/11
5. Did you often or very often feel that: You did not have enough to eat, had to wear dirty clothes, and had no one to protect you? Or, your parents were too drunk or high to take care of you, or take you to the doctor if you needed it?	4/11
6. Were your parents ever separated or divorced?	6/11
7. Was your mother or stepmother: Often or very often pushed, grabbed, slapped, or had something thrown at her? Or, sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? Or, ever repeatedly hit at least a few minutes or threatened with a gun or knife?	3/11
8. Did you live with anyone who was a problem drinker, or alcoholic, or who used street drugs?	9/11
9. Was a household member depressed or mentally ill, or did a household member attempt suicide?	6/11
10. Did a household member go to prison?	3/11

Using the CDC-Kaiser Permanente ACE study (CDC, 2016; Felitti et al., 1998) each type of trauma counts as a score of one. The higher the ACE score, the more likely the person will experience addictive behavior and acquire chronic disease (CDC, 2016). Dr. Nadine Burke-Harris (2018) a pediatrician delivering targeted care to vulnerable children, notes that people

with four or more ACEs are “more than twice as likely to have a stroke” (p. 216). The ACE study also revealed that people with a score of 4 are twice as likely to be smokers, and seven times more likely to be addicted to alcohol. Additionally, CDC says respondents with more than four ACEs are more likely to be violent, to have more marriages, more broken bones, more drug prescriptions, experience chronic depression, and have more autoimmune diseases (CDC, 2016; Felitti et al., 1998). People with an ACE score of 6 or higher are at risk of their lifespan being shortened by as much as 20 years (ACEs Science 101, ACEs Science FAQs, 2018).

Findings Gleaned from In-Depth One-on-One Interviews with Incarcerated Females

Reasons Why Incarcerated

When asked why the interviewees were in jail, 9 of the 11 said possession of or selling illegal drugs.

Constance recounted that,

“This is not my first time in jail. I spent nine months in a jail in Wisconsin, and some days in Hennepin Co. jail. I was flagged with 25 lbs. of meth. I ended up here and took the rap for ‘him’ so ‘he’ wouldn’t have to go to jail. When I get out of here I will be homeless because I will be on probation and have to stay in this county. I have no job; my job has been as a drug dealer. I will sleep in my car, I have an SUV, big truck.”

Lucy shared,

“This is not my first time incarcerated. I got caught with a needle with some meth in it and I did three and a half years of probation and was sober. Then two months before I was supposed to get off probation I relapsed and it wasn’t just a one-time thing it was like a snowball into this big black hole.”

Danielle stated,

“I started smoking pot probably when I was eleven, then cocaine and a little while after that I was introduced to meth, probably between 12 and 15 years old. I experienced mushrooms and acid. I’ve been in jail and prison for the last 15 years.”

Sarah explained how she becomes a repeat offender,

“No, this is not my first time in jail, I don’t even know how many times it has been. I keep coming back on the same charge, they release me on conditions and I keep violating the conditions. Like they set you up for failure. I feel like they let you go and say stay sober. Like [I’m] a statistic out on the street and when all I know is to get high.”

Childhood Trauma

According to the results of the ACE scores 11/11 of the females in jail responded yes to the question: Did a parent or other adult in the household, often or very often: swear at you, insult you, put you down or humiliate you? Or, act in a way that made you afraid that you might be physically hurt? Some of the women described brutal beatings at very young ages. Susan recounts remembering being physically abused as early as age four.

“My dad would just get angry at us if we did something wrong or if he thought I was looking at him, he would get mad. He would throw things, like a glass plate at me, and it would hit me really hard in my chest. My mom was always doing drugs and wouldn’t help us.”

Sarah remembers her mother’s boyfriends hit her (mother).

“When I was really little I remember walking in her room and this dude had her by her hair, and then grabbed her by her ear. I just remember standing by that door and she was crying. I was young like 3 or 4 years old, I was scared.”

Constance recalls her mother “being really mean me.”

“I was in school at Head Start, I was four years old. She would hurt me both emotionally and physically. She did really mean things to me. She was physically violent toward me. She would hit me with broom handles so hard they would break on my back. She would kick me so hard I couldn’t breathe. She would lock me in a closet by myself for a day or two, sometimes just for an hour or two, it would depend on if my dad was around or not.”

Lila was eight years old when her father would do things that really frightened her.

“As soon as my mom would go to work, she worked a night shift, he would treat us bad. He would tell me and my older sister to go to our room and not come out. We couldn’t even come out to go to the bathroom, he was like do what I say! We were really scared of him.”

Danielle was three years old when her dad died. Her mother raised her on her own, but she worked all the time. Danielle remembers

“At the age of 10 or 11 I started to not come home when I was supposed to. I got whipped with a coffee cord. She swore at me because she was mad at me. If I didn’t get whipped with the coffee cord it was the willow tree stick. Back then it was a lickin', today it would be abuse. When she hit me, I always had welts on me.”

The stories shared by the women about their childhood experiences aligns with what the research says about intense and consistent stress and the effects on the brain. Early trauma shifts the trajectory of brain development (Burke-Harris, 2018). For example, an environment characterized by fear and neglect, alters the brain circuitry and emotional response, moving far from safety, security, and love. The earlier the distress, the more profound the effect. This researcher maintains that consistent, toxic stress experienced during childhood, results in the likelihood that the child will be at risk for developmental, relationship and health problems later.

Lucy started using meth at the age of 14.

“My step-dad was an alcoholic and a meth user and he actually got me started on meth when I was 14. I’ve been dealing with addiction for my whole life. I mean for a year straight he would make me get high with him, and then my mom would find out and then they would both ground me for what he got me started on. There was a good time in my life. I got sober and met my daughter’s father. I got pregnant, and during that time it was the happiest time of my life. I went back to Century to be a lab technician. I had my daughter and then I relapsed.”

Talked to Teachers or Counselors

When asked if the interviewees ever talked to a teacher or a counselor at school about being hit, or their parent/s using drugs, the responses were very similar:

“No, I was too embarrassed to tell my teachers, I didn’t want anyone to know, I didn’t want to be judged. I didn’t want anyone to have anything they could use against me. I got teased on the school bus a lot, the school bus driver knew about everything but never did anything.” (Lucy)

“No, I was too embarrassed to tell teachers about the drug use at home.” (Susan)

“Where I come from the school on the reservation, my family ran the school, they knew what was going on. I was told if anyone asked me, not to say anything. My mom was the problem drinker. My mom learned how to beat me on my arms so they couldn’t see the bruises. That’s just the way it was.” (Constance)

“With the belt situation, I never told anyone. But when I was older, I would always be sent away, because I got into fights with her (my mother), and I got sent to JDC. I never liked school, I got sent away and had to be in a Treatment Center, I went to school there.” (Sarah)

“No, I never told anyone at school, I really wasn’t sociable. When my dad locked me in my room, I was told not to tell anyone outside of the family. Kids picked on me at school because of my learning disability. But in the special room I liked my teachers. One teacher I really liked a lot. She treated me like her daughter, she helped me dress up for picture day. She put ribbons in my hair.” (Lila)

“When I got hit with the electrical cord I never told anyone. I just always felt that if I told anybody.... I didn’t want to be taken away from my mother. I know she did love me, she never threatened me with kicking me out of the house.” (Danielle)

“I know there was a counselor at my high school, I guess I just never thought about talking to her. I don’t ever remember there being the option to talk to someone like that.” (Nancy)

“I went to school with marks up and down my back and on my side. The teacher called CPS (Child Protective Services). They asked my brother and me what happened and we got put in foster care. I think I was five or six going into Kindergarten. I blocked out a lot of my life back then.” (Karen)

As demonstrated by the women’s stories above, trauma can be particularly challenging for educators to address because students often do not share the distress they’re feeling in a way that’s easily recognizable. Students can become masters at making sure teachers do not see them in pain for fear of retribution by caretakers in the home, or as Nancy stated, they are not aware of who to talk to or the services available to help them. Educators can be the difference for all of their students, however, when it comes to children and youth of trauma, classroom teachers may be their lifeline. Thus, reinforcing the need for professional training for all staff, teachers, and support personnel, as well as resources needed to help these children and their families thrive.

Table 4 displays ACE categories cited by the participants in this study.

Table 4.

ACE Categories Cited by Participants

ACE Category	Number of Female Interviewees in Jail
Verbal, emotional abuse	9
Physical abuse	8
Sexual abuse	1
Emotional neglect	3
Physical neglect	1
Substance abuse in home	7
Mental illness in home	7
Incarcerated household member	3

Mental health diagnosis prior to incarceration. All the females interviewed stated that as an adult they had a mental health disorder, such as anxiety, depression, bipolar, attention deficit hyperactivity disorder (ADHD). Each of them had been medically diagnosed with these disorders and had been on prescribed medication prior to incarceration. This substantiates the study conducted by Kelly et al. (2010), that the mental health history of women experiencing trauma at a young age reported diagnoses such as those described by the female interviewees.

Awareness of Reentry Programs

Very few of the women were aware of a reentry to community program. Susan stated that

“It would be nice if we could still do the reentry program here (at current county jail), even though we are not a resident. They have a lot of cool stuff like housing, employment, but you have to be a resident of this county.”

The county jail facilities throughout the state of Minnesota offer a reentry assistance program. It is the choice of the women to participate in the program and receive assistance regarding attaining a driver's license, medical insurance if needed, and information about housing and employment opportunities. However, as stated previously, there are a lack of correctional facilities providing a *required* Pre-Reentry program for females exiting jail and returning to their community.

Three Most Important Things

When asked "*When you are released from jail, what are the three most important things you need help with to stay out of jail?*" Overwhelmingly the interviewees stated: 1) stay sober, go to a treatment center, be with only sober friends, non-drug users; 2) support, community support, family support, any support system to get direction in life, 3) to get a job and housing, to be with my children again. One of the females stated: "I really don't know, my life will never go back to what it was like before, I have a record now. I don't think about the future, I am too scared."

The escalating effects of incarceration and, diagnosed or undiagnosed, mental health disorders, can further challenge the female's ability to reenter her community successfully. As noted previously, Arditti (2012) believes that incarcerated females are particularly vulnerable when reentering community due to their history of trauma, and the possibility that even acute, psychological disorders may not have been diagnosed while incarcerated (2012). Substance use combined with mental health challenges are often overlooked upon reentering family and community life (as cited in Arditti, 2012).

Interviews with PK-12 Educational Leaders

The goal of interviewing education leaders in selected Minnesota PK-12 schools was to ascertain the perceived mental health needs of students, types of trauma students are experiencing, and mental health resources available for their student population. Additionally, the researcher explored what district programs were in place to provide training and professional development for staff and faculty, specifically regarding trauma and mental health needs of students. The purpose of this was to examine the juxtaposition of the resources in place alongside the stories that young women shared about their childhoods to elucidate ways in which educational systems may be made to be more responsive to students experiencing trauma.

Demographics of Education Leaders

Table 5 provides a profile of each of the education leaders' experience, school setting, and grade level of students; gender and ethnicity information was also gathered. The school settings represented rural, urban, suburban, private, charter and an alternative learning center. PK-12 student populations were all represented: four PK programs and four high school settings and six elementary settings ranging from grades K-6. Five of the education leaders were female, four were male. Ethnicity of the educational leaders interviewed included one Asian, one Hispanic, and seven Caucasian. There was a wide range of years of experience from first year administrator to 24 years administrative experience, offering a median age of 10.2 years.

Whether a first-year education leader, or one with more than two decades of leadership experience, all educators agree the mental health needs of students in schools necessitate a call to action in developing and articulating trauma informed schools, staff, teachers, and community support agencies.

Table 5.
Education Leaders Profile Information

Educational Leader #	School Setting	Grade Level of Students @ School	Years as Education Administrator	Gender	Ethnicity
1	Rural	Elementary, 2-4	1	F	Caucasian
2	Urban, Charter	PK, Elementary, MS, HS	5	M	Caucasian
3	Private, Rural	HS	24	M	Caucasian
4	Suburban	PK, Elementary	6	F	Caucasian
5	Urban, Charter	Elementary, K-6	7	M	Asian
6	Urban	PK, Elementary, K-5	6	F	Hispanic
7	Urban	PK, Elementary	22	F	Caucasian
8	Suburban, Rural	HS	10	M	Caucasian
9	Suburban ALC School	HS 9-12 ALC	11	F	Caucasian

Diagnosed Mental Disorders and Trauma Experiences

Table 6 provides an overview of the types of diagnosed mental disorders and known traumatic events PK-12 students experienced in the schools of the nine educational leaders interviewed. Student anxiety resonated in nearly every school setting. Eight of the nine interviewees attributed the identified mental disorders to stressful or traumatic events in the lives of the students. One interviewee said a primary reason for the high level of anxiety reported by students is the pressure to perform well academically. This tension stemmed from parental and self-imposed expectations to honor the status and ranking of the schools' state-wide distinction of excellence. Additionally, the educational leader noted a need for mental health resources for students outside of the school setting.

A known adverse childhood experience common among most of the students is that of an incarcerated mother or other female caretaker. While two of the education leaders responded as not aware of an incarcerated mother or female caretaker, one did state that other faculty or personnel, such as counselors or social workers would have knowledge of this information.

The leaders responding ‘yes’ all emphasized a need for school programs offering counseling and/or a social worker for the students. An issue impeding sufficient support is that related to the actual time a social worker can spend one-to-one with a student. It is not unusual for a social worker to be assigned to a caseload of 300 plus students, resulting in 10-minute sessions, once or twice a week with a students. School counselor ratios are even higher with less and less attention given to counseling students with mental health needs. The educators interviewed, particularly at the high school level, note that a primary role of the counselor is to help students prepare for college or careers guidance.

Table 6.

Diagnosed Mental Disorders and Traumatic Events Experienced

Education Leader (EL) Setting & Student Population	Mental Disorders Among Students Serious changes in the way children typically learn, behave, or handle their emotions.	Adverse Childhood Experiences Stressful or traumatic events experienced; abuse, neglect, household challenges.	Incarcerated Mothers or Female Caretakers? Y/N
EL #1 Rural Grades 2-4	Anxiety, ADHD	Incarcerated mother/caretaker	Y
EL #2 Urban, Charter PK-12	Anxiety, ADHD, PTSD, bi- polar, mood and conduct disorders	Emotional, physical, abuse and neglect; incarcerated mother/caretaker	Y
EL #3 Private, Rural High School	FASD	Abuse, emotional, physical, sexual; Incarcerated mother/caretaker	Y
EL #4 Suburban PK-5	Anxiety, stress, depression, behavior disorders. (Mental Disorders as result of ACE)	All ten components of ACE Incarcerated mother/caretaker	Y
EL #5 Urban, Charter K-6	Explosive Behavior Disorder, ODD, PTSD	Witness parent and/or others death. Refugee confinement, abuse, neglect. Incarcerated mother/caretaker	Y
EL #6 Urban PK-5	Anxiety, FASD, Autism, behavior disorders	Social, emotional, and physical neglect, poverty, homeless; Incarcerated mother/caretaker	Y
EL #7 Urban PK	Anxiety, ADHD, FASD, behavior disorders	Social and emotional trauma/abuse, fear for safety, Incarcerated mother/caretaker	Y
EL #8 Suburban, Rural HS	Anxiety, depression (pressure to perform)	No known ACEs primarily chemical health services needed	N
EL #9 Suburban ALC 9-12	Anxiety, depression, eating disorders	Alcoholism, homeless	N

Internal and External School Resources

Table 7 is a summary of the Education Leaders school settings and provides a review of internal and external sources and services for students and parents. The services provided, whether in the school setting or via external services through county or community resources, are

diverse. Some school settings are able to provide services holistically for their students, such as a variety of mental health services, medical and physical health programs, and education resources for parents. Simultaneously others seem to lack the availability of even the basic counseling and education services for students and family in the school or community. Therefore, the options for students requiring extended services outside of school, community or county programs required as much as a one to two-hour drive to receive mental health assistance.

Table 7.

District Intervention Resources: Internal and External

Education Leader (EL) Setting & Student Population	District MH Intervention Programs/Resources Available for students	MH resources available through county, district, and community resources
EL #1 Rural Grades 2-4	Student Support Coordinator, Assistant Principal (discipline & behavior), SPED staff, Student Assistant Team	Community Resource Group, Financial, HR, Early Childhood, Youth Outreach, Hunger & Poverty
EL #2 Urban, Charter PK-12	Some available, but not to capacity needed, Restorative Justice Practices for SPED students, but not for all students, therapeutic support	Four uniquely contracted program services for families & children, cultural wellness center
EL #3 Private, Rural High School	Dist. does testing/assessment for FASD, alternative HS	District nurse
EL #4 Suburban PK-5	FT counselor, psychologist, behavior intervention specialist & 2 FT assistants, 2 student intervention teams (SIT), 2 FT nurses	Clinical Psychologists, 360 family- support worker
EL #5 Urban, Charter K-6	District counselors, social workers, psychologist, SPED team	County social services, MDE to guide to resources to access such as health and counseling services.
EL #6 Urban PK-5	1:1 services, inclusive instruction, psychologist, social worker, nurses, counselors	County child protection services, Co. MH therapy in school, Meals on Wheels, clinic next to school, medical/dental/eye services, YMCA for DCD students, 2 SPED teachers, ECEC program, state education agency, SPED assist.
EL #7 Urban PK	Social worker, OT, speech therapy, Services for ADHD, LD, ECSE, ECFE,	County: parenting classes, family advocates Dist. ECSE, ECFE, 0-3 program Community OT, free exams from medical doctors and dentists come to school, Grant for translators, ParentAware pilot program
EL #8 Suburban, Rural HS	Flex time (2 days/week), counseling & wellness center, MH therapy & chemical health services	County counseling & wellness center, MH therapy & chemical health services, FamilyMeans
EL #9 Suburban ALC 9-12	Two FT counselors to provide one- to-one counseling for male and female groups, sober group counseling, relationship group, pregnancy/child care programs	County agency to provide mentoring/counseling for students, probation officers

Professional Training and Development

Table 8 provides the reader with a review of the stressful and traumatic experiences students incur and the mental health and trauma training school staff and faculty receive. The information exposes a disparity between student traumatic experiences and the training and professional offerings to staff, classroom teachers, support services and administrators. In many settings, it is the school support services personnel who facilitate the training and development programs in their area of expertise such as drug and alcohol use. In some cases, school personnel are sent to a training event to gain knowledge of a particular topic and return to share that information with others in the district. One education leader had an extensive training background about ACEs, and engaged in working with the entire school faculty regarding student needs, and providing the resources necessary to help students and parents.

Of concern is that none of those closest to the students, the classroom teachers, have taken part in any trauma-informed professional development or training. Strategies, resources, and support systems were lacking in all nine school settings with respect to participating in an authentic trauma informed program.

Table 8.

District Training and Professional Development

Education Leader (EL) Setting & Student Population	Adverse Childhood Experiences Stressful or traumatic events experienced; abuse, neglect, household challenges.	Professional Development for faculty/staff
EL #1 Rural Grades 2-4	Incarcerated mother/caretaker	Some-trauma all staff, guest speakers, police officers, not a lot of resources, have to travel to larger cities
EL #2 Urban, Charter PK-12	Emotional, physical, abuse and neglect; incarcerated mother/caretaker	Extensive; Trauma & the brain, Documentary (Paper Tigers) 50% of training is Restorative Practices and Trauma
EL #3 Private, Rural High School	Abuse, emotional, physical, sexual; Incarcerated mother/caretaker	Dean of students provides Mental Health training to staff/parent training, school nurse
EL #4 Suburban PK-5	All ten components of ACE Incarcerated mother/caretaker	offered 5-6 times per year: Conscious Discipline (brain function), ACP, police
EL #5 Urban, Charter K-6	Witness parent and/or others death. Refugee confinement, abuse, neglect. Incarcerated mother/caretaker	Monthly: expert in social & emotional needs
EL #6 Urban PK-5	Social, emotional, and physical neglect, poverty, homeless; Incarcerated mother/caretaker	1 hour/week: Responsive Classroom, Second Step; social/emo training, equity/social needs, 'coaches' on each team provide one- to-one as needed with staff
EL #7 Urban PK	Social and emotional trauma/abuse, fear for safety, Incarcerated mother/caretaker	ParentAware, Child Abuse, various; sign language, CPR, domestic violence
EL #8 Suburban, Rural HS		Not a lot of training on ACE, but MH & chemical substance abuse training
EL #9 Suburban ALC 9-12	Alcoholism, homeless,	ACE, SW for SPED & ALC, MAAP (MN Assoc. of Alt. Programs)

Conclusion

The purpose of this study was to explore the link between mental illness and the impact of childhood trauma among incarcerated females in jail. Further still, a component addressed adverse childhood experiences and mental health resources for children and youth in PK-12 schools in Minnesota. This study also includes the relationship between correctional programs and reentry programs addressing the history of females who experienced childhood trauma and mental illness issues.

Findings gleaned from the in-depth one-on-one interviews with the eleven females in jail revealed substantial childhood trauma in their early lives. All eleven women had a score of four or more ACEs signifying the likelihood of obesity, substance use, depression, and anxiety, as well as lung, heart, and liver disease. ACEs are also linked to homelessness and criminal justice involvement. The women's ACE scores align with the stated information above, as 9 of the 11 said they were in jail for possession of or selling illegal drugs.

The women explained as children and youth in school they were too embarrassed to tell teachers or counselors about what was happening at home. For some, the parents had instructed the females early in their lives not to tell anyone. Of particular interest is that at the high school level there seemed to be an unawareness of the role of a school counselor as one to go to for assistance, therefore reaching out to a counselor was not an option. It is important to take note of the women's life experiences during their PK-12 education, as trauma can be challenging for educators to address. Students often do not share the suffering and pain they are feeling in a way that is easily recognizable.

All the females interviewed stated that as an adult they had a mental health disorder, such as anxiety, depression, bipolar, attention deficit hyperactivity disorder (ADHD). Interestingly,

these same mental disorders were named by the educational leaders as primary mental health needs associated with the students in their schools. The women stated a primary need when exiting jail and returning to their communities was support, *community* support, *family* support, a *support system* to help guide their direction to a healthy and contributing family and community member.

The women's reentry to community needs correlate with the education leaders expresses a need for more resources, training, and development to be offered to teachers and staff to aid students and parents. It seems plausible then that there is an opportunity to intentionally develop and implement trauma informed schools, teachers, leaders, staff, and community support resources for both PK-12 students and incarcerated females returning to family and community.

CHAPTER FIVE: DISCUSSION

The purpose of this study was to explore the link between mental illness and the impact of childhood trauma in the population of incarcerated females in jail. This study encompasses a literary analysis on correctional and reentry programs, addressing the history of females who experienced childhood trauma and mental illness issues. It also extends the literature addressing Adverse Childhood Experiences (ACEs) and mental health resources available for children and youth in PK-12 schools in Minnesota. Methodologically, this study was designed to identify factors common to females with mental illness who are at risk for criminal activity before they enter the criminal justice system.

Statement of the Problem

This research study examined the link between mental illness and the impact of childhood trauma among incarcerated females in jail, and the factors affecting the reentry of incarcerated females with mental illness and childhood trauma from jail to their communities. This study furthermore identified factors common to women with mental illness, at risk for criminal activity, before entering the criminal justice system. Lastly, this research sought to address implications for education leadership concerning the impact of childhood trauma, mental illness, and incarcerated females.

Review of the Methodology

This researcher conducted a qualitative phenomenological study and adopted a theoretical framework that prioritized personal experiences of incarcerated females as they shared their stories within the context of early childhood and youth experiences, pre-jail histories, incarceration, and as they furthermore considered their post-jail lives. The goal of this study was to examine the world from the point of view of each participant. The study of the incarcerated

female population chosen for this dissertation was comprised of two sets of responses. The first was the participants' responses to the ACE's questionnaire, followed by one-on-one, in-depth interviews with those who volunteered to be a part of this study. Furthermore, this research addressed the implications for educators regarding Adverse Childhood Experiences (ACEs) and mental health resources available for children and youth in PK-12 schools in Minnesota. The researcher conducted one-on-one interviews with selected education leaders who responded to questions about the mental health needs of students in their school, district resources available for students, and district professional development programs for teachers and staff. These findings were analyzed alongside the experiences of the women to compare the impact of ACEs in the lives of the women, and the known ACEs of students in PK-12 school children, as stated by the education leaders interviewed.

Summary of the Results

The women in this study presented significant verbal, emotional, and physical abuse, and substance use in the home, mental illness in the home and an incarcerated household member well before the age of 18. All of the participants reported more than four ACEs, which according to the CDC-Kaiser Permanente ACE study (CDC, 2016; Felitti et al., 1998) and further work by Dr. Nadine Burke-Harris (2018), rendered the women more likely to experience addictive behavior and acquire chronic diseases, stroke, drug, and alcohol use, as well as the inclination to be violent, to experience chronic depression, and to have more autoimmune diseases. An ACE score of 6 or higher generally shortens a lifespan by 20 years (ACEs Science 101, ACEs Science FAQs. (2018)). The interviews with the women confirmed either a medically diagnosed mental illness, or the women expressing feelings of deep depression, anxiety, panic attacks, and loss of sleep. Prior to incarceration more than half the women were taking

prescribed medicine for their mental illness. Nine of the eleven interviewed were in jail due to illegal substance use, one for human trafficking, and one for violent acts committed. The mental disorders described by the women were also identified by the educational leaders as primary mental health needs associated with the students in their schools.

The student needs identified by education leaders and those expressed by the women in jail preparing for reentry to community are similar in that each state a need for support systems to be in place to guide students, parents, and the women to resilience and a healthy life. The women need to stay sober, and to be with sober friends and non-drug users. They seek community support systems to find and maintain employment, and to be with and take care of their children. The education leaders acknowledge the need for more internal and external programs and services to identify, guide and assist students, as well as their parents, with mental health issues. An urgent need for trauma informed education programs for teachers, administration, staff, parents, and community members is evident.

Reentry

If women are to be successfully reintegrated into society, there must be a continuum of care that can successfully transition them as contributing members of that community. The females interviewed stated three things they need to be successful when leaving jail: 1) a strong support system, family, community, programs to help guide them in life, 2) on-going treatment to stay sober and/or to remain non-drug users, and 3) assistance in becoming gainfully employed and in locating acceptable housing to support the return of their children to their care.

The planning process for women to leave jail must begin early on in their incarceration, both proactive short and long-term planning, rather than rushed and little-to-no-time to prepare them for their exit from jail. Several women stated not having someone to pick them up at jail,

and nowhere to return to, except perhaps the path that got them to jail. Women reentering the community after incarceration require transitional services from the institution collaborating with outside community services to aid these women in reestablishing themselves with their families. Ideally, an all-inclusive, wide-range approach of reentry services would include community-based programs to enter institutional program settings at the beginning of a woman's jail sentence. In particular those with identified mental disorders would be intercepted and placed in community services programs with social workers, counselors, medical supervision, if necessary, and community mentors to come alongside them for support and connection to society.

A program such as the restorative model of justice could be a means for assisting female offenders and preparing them for transitioning back to neighborhoods and communities. The restorative justice framework is based on healthy relationships, and healing, thus replacing punitive actions with restorative practices (Payne & Welch, 2017). A look at the primary themes and issues affecting women in the criminal justice system reveals that women's issues are also broader societal issues: sexism, racism, poverty, domestic violence, sexual abuse, and substance use. The ultimate solution to this problem is to maintain a functioning public mental health treatment system so that individuals with mental disorders are not placed in jails. To this end public officials must reform mental illness treatment laws and practices to eliminate barriers for treatment.

Suggestions for Future Research

Education Leaders Report Student Mental Health Needs

The interviews conducted with the education leaders cited student anxiety, depression, and ADHD as the primary mental health disorders throughout the PK-12 demographic. The diagnosed or suspected mental health needs appear to be linked to neglect, abuse, and household

challenges. Environmental exposure, causing post-traumatic stress disorders is connected to related conduct disorders, such as explosive behavior and attachment disorders. Students are exposed to significant trauma prior to attending PK school programs, causing developmental delays, emotional and behavioral challenges, and physical health problems. Students at the elementary, middle-school, and high-school levels are experiencing excessive trauma at alarming rates (Saunders & Adams, 2014).

Students have an overwhelming need for holistic support services, such as being aware of self-regulation, focusing on academic achievement, and caring for their physical and emotional well-beings. County and in-district services are accessed as much as possible for students; however, services appear to be limited. PK programs provide a wide range of services including, but not limited to, student counseling, medical, dental, occupational, and physical and speech therapy, family counseling, and adult parenting training and education. Special education services are provided for PK-12 students; however, it was noted by this researcher that there is an extreme lack of social worker and clinical services available. An exception would be the ALC, as it is designed to provide a two or three ratio of students to one teacher and support personnel.

The education leaders work with district, community, and county services available to them. Effective collaborative partnerships are essential to meet the needs of their student populations. Seven of the nine school education leaders acknowledged awareness of a female caretaker of one or more of their students as having been incarcerated. Interestingly, those who have direct student contact received the least amount of formal training about ACEs. Teacher and staff training and education is heavily reliant on community experts, counselors, and local police for overarching topic discussions, awareness trainings, and any type of tactical training.

However, there is an existing lack of trauma-based training for school staff resulting in a deficiency of trauma-informed school strategies.

Research Study Implications for Educators

The ACE scores of incarcerated females interviewed for this study, their childhood experiences, identified mental health needs, and reentry to community all challenge a connecting concern for PK-12 students in Minnesota schools. Not only are the women's stories confirming the need for multiple support resources to prepare and guide them toward successful transition to the community, the mental health needs of students are beckoning for similar support systems. One of the first steps would be for all PK-12 schools to become trauma-sensitive and trauma-informed schools by training educators to better understand the impact of trauma on academic achievement and behavior.

Culturally-sensitive and trauma-informed schools offer increased access to behavioral and mental health services, effective community collaboration, an increased feeling of physical, social, and emotional safety among students, as well as positive and culturally responsive discipline policies and practices that increase school connectedness. School psychologists, counselors, and social workers can be leaders in this initiative by providing increased mental health services (Craig & Stevens, 2016; Plumb et al., 2016). Data has shown when school-employed mental health professionals are able to provide consultation to teachers and direct mental health services to students, there is an increase in academic achievement scores and a decrease in behavioral problems (Reeves, Umbreit, Ferro, & Liaupsin, 2017).

Suggestions for Future Research

Education Leaders and PK-12 Schools

There are several topics from this writing that ought to be considered for future research. This study suggests an analysis to determine factors needed to support the successful implementation of trauma-informed and trauma-sensitive schools. This author contends there is a great need for a body of work to address education and community elements needed to be culturally responsive to students, families, and individuals transitioning from traumatic life events. Additionally, research about resilience, mental illness, and PK-12 students; what factors are necessary for PK-12 students to reach a resilient mindset to overcome mental disorders and thrive in their community with healthy lifestyles? Furthermore, research must define and measure resilience and develop a successful framework to support student success academically, mentally, and socially.

ACEs and Criminal Justice Programming

The neuroscience-based information, referred to as *neuro-education*, can offer relevant information to the field of criminal justice. Some of these expanded areas include, but are not limited to:

- Implementing and evaluating the efficacy of trauma-informed care relating to offenders reentering the community,
- Identifying the protective characteristics of Juvenile Mental Health as a community justice strategy,
- Development and support of a court-based mental health treatment database encouraging multi-systemic review and accountability, and

- Integrating trauma-informed, solution-focused strategies in law enforcement interaction, juvenile court, family court, specialty court systems, and prison institutions.

Further research to discover the value of redesigning the offender (intake) information gathering processes, across the aging span, and to decrease re-traumatization would be a worthy starting point, for both juvenile and adult facilities. Furthermore, a study to establish what skills learned from education programs would be of value to guide the development of self-regulation and resilience-oriented and skills-based programs for incarcerated juvenile and adults in jails. In particular, the significance of self-regulation, resilience skills-based programs, and structured support systems, ought to be a required step for reentry to the community.

Summary and Conclusion

This dissertation sought to answer three questions, the first question being: What do incarcerated females describe as the linkages between childhood trauma and mental illness? The interviews with the incarcerated females in jail, reported a higher frequency of adverse childhood experiences. Each of the 11 women interviewed scored four or more ACEs when completing the ACEs questionnaire. They assert that drug and alcohol use started in their middle school and high school years, and was in part, an escape from the childhood trauma they experienced in the home. In some instances, the women were introduced to drug and alcohol use by a parent or adult living in the home. Many problems were noted regarding learning in school, such as anxiety, depression and diagnosed ADHD. Most of the women were truant and dropped out of school at the earliest opportunity.

The second research question asked: What are the implications for educators concerning the impact of childhood trauma, mental illness, and incarcerated females? The implications for education leaders advocate for an expedient response to the mental health needs of all students.

It is vital that leaders in education proactively incorporate trauma-informed and trauma-responsive schools with a high sense of urgency, thus offering services and programs that foster safe connections and beneficial resources for traumatized youth. Accomplishing this will empower students with a healthy mindset and resilience for leading productive and successful lives with families, at work, and in their communities.

The third research question posed: What issues affect the reentry of incarcerated females with mental illness and childhood trauma from jail to community? The addictive behaviors placed the women at risk for being unemployed, incurring lifelong mental health and physical challenges and to homelessness and criminal justice involvement. Incarcerated females exiting jail, reporting a higher frequency of adverse childhood experiences are at risk for addictive behaviors, drug and alcohol use, being unemployed, and are more likely to incur lifelong mental health challenges. The interviews with the women revealed a lack of support systems available to aid in direction for self-fulfillment, care for family members, and in how to contribute proactively to community. Therefore, a future of successful reentry to community is tentative.

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APPENDIX 1

Adverse Childhood Experiences Survey

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often or very often...Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt? If yes enter 1 _____

2. Did a parent or other adult in the household often or very often...Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?
If yes enter 1 _____

3. Did an adult person at least 5 years older than you ever...Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you? If yes enter 1 _____

4. Did you often or very often feel that ...No one in your family loved you or thought you were important or special? or Your family did not look out for each other, feel close to each other, or support each other? If yes enter 1 _____

5. Did you often or very often feel that ... You did not have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it? If yes enter 1 _____

6. Were your parents ever separated or divorced? If yes enter 1 _____

7. Was your mother or stepmother: Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit at least a few minutes or threatened with a gun or knife? If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
If yes enter 1 _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide? If yes enter 1 _____

10. Did a household member go to prison?
If yes enter 1 _____

APPENDIX 2

One-On-One Interview Questions

Revised Interview Questions
(IRB Modification Approved)

Biographical Information

Age, ethnicity, religious/spiritual, birth order, level of education, marital status, married? partner? single? Children, age of children, employment status prior to incarceration in jail, health insurance?

Are you a Washington Co. inmate? Or Department of Corrections (DOC, lease inmate) or Federal inmate? city (home base) for reentry

Background Information Incarceration

Is this your first time in jail? (yes/no) If no, how many times have you been in jail?

Why are you here?

How long is your sentence?

Your Story: The real purpose of this interview is to hear your personal story....I want to understand from you...

ACEs prior to age 18

The ACEs you checked...how old were you when these experiences happened?

Was there a family member or friend you talked to, went to for help? Tell me about that....

When this happened to you], Was there someone at school you could talk to about what was happening? (Teacher, counselor, the principal?) Tell me about that...

In what way did someone at your school help you?

How do feel these experiences have affected your life, then/now?

Adult Life: ACE and Mental Health

How would you describe your physical well-being?

Do you have a mental health disorder such as depression, anxiety, drug, or alcohol abuse?

Has it been diagnosed by a doctor? Are you taking any prescription medication from a doctor?

The mental health challenges you face, are you aware of anyone else in your family with the same issues? (family, siblings).

How would you describe your life today with family, at work, friends?

When have you felt as though you are an integral part of community and society? Tell me about...

What is preventing you from living a healthy life?

Do you think any of the ACE's experiences have affected your mental health? How?

Reentry

When are you going to be released from jail?

What are your plans when you leave jail and go back to your community?

Has anyone helped you or talked to you while in jail about what to do first when you leave jail?

Are you aware of any reentry assistance programs available here at the jail?

When you are released how are you getting from jail to?

Do you know where you will live? Is it temporary or established?

How are you going to get money for food?

Where are you going to work?

If children, will they return to you?

What are your emergency plans for personal safety for you and your children?

What are your plans for getting help you with your _____(mental illness)?

Do you know you can get an ID card? Reentry Assistance?

[if the interviewee has not received a high school diploma] Do you have any plans to complete your GED? Are you aware of the process to complete your GED?

When you are released from jail what are the three most important things you need to you to help you stay out of jail?

APPENDIX 3

Consent Form - Females 18 and Older

WASHINGTON COUNTY JAIL

INVITATION TO PARTICIPATE

You are invited to participate in a research study about females in jail, and their re-entry to community when released from jail. This study is being conducted by Phyllis Burger, Doctoral Student, supervised by Dr. Jerry Robicheau, her adviser, from the College of Education at Concordia University St. Paul. This study is being conducted as part of Ms. Burger's dissertation completion requirements. Your participation in this study is voluntary. Please read the information below and ask questions about anything you do not understand, before agreeing to participate in the study.

PURPOSE OF THE STUDY

The purpose of this study is to understand reentry experiences of incarcerated females from jail to community. The study attempts to learn about any adverse childhood experiences the females have had, and how those experiences may reflect on their path to incarceration and to their expected reentry transition.

\ This study will be conducted at the Washington Co. Jail with 12-15 females in the jail. The researcher is mindful that the goal is to ascertain *what* the females experienced and *how* they experienced it. These are *their stories*.

PROCEDURES

If you agree to be in this study, we would ask you:

- 1) Complete a ten-question survey about your childhood experiences, those that took place before the age of 18;
- 2) Secondly, to participate in a 60-90-minute interview with Phyllis Burger. The purpose of the one-on-one interview is to allow the researcher, Phyllis Burger, to capture the individual *story* of each female, your childhood experiences, what led to your incarceration in jail and finally your expectations about reentry to the community.

RISKS and BENEFITS of the STUDY

As a volunteer participant, you will be asked to complete a ten-question survey followed by a one-on-one interview with the research, asking you to respond to a set of questions. If for any reason, a question makes the participant feel uncomfortable or upset, you may decline to answer that question or to stop the interview. If after the interview you wish to speak further about your experiences, a chaplain or other religious volunteers are available every day or night at the jail. Any other needs would be at the consideration of the jail medical personnel during their weekly visits to the jail.

There is no immediate, direct benefit to participating in this study. However, as females, *you will impact the future* in addressing the needs of incarcerated females who experienced adverse childhood experiences, the impact of those experiences in your life, your incarceration in jail and reentry to community needs.

COMPENSATION

Those consenting to the interview will receive \$25 deposited to their account in the county jail. The county jail will deposit the check directly into the inmate's commissary account for future commissary and hygiene purchases.

CONFIDENTIALITY

The researcher will then conduct in-depth, open-ended one-on-one interviews with participants to capture the individual ‘story’ of each female. The one-on-one interviews will be conducted on-site at the county jail in a secured room. A laptop audio recording system will be used to record the interview. The interview recording and all data will be stored electronically in a secure and confidential manner by the researcher. Only the researcher will have access to the recorded data. Pseudo names only will be used in collecting and organizing the research data. The confidentiality of the participants is of the utmost priority. There is no deceptive design in this study.

PARTICIPATION and WITHDRAWAL

Participation in this study is voluntary. If for any reason, a question makes you feel uncomfortable or upset, you may decline to answer that question or to stop the interview and withdraw from the interview.

I understand the procedures described above. My questions have been answered to my satisfaction, and I agree to participate in this study.

Printed Name of Participant

Signature of Participant

Date

Signature of Witness

Date

APPENDIX 4

Interview Questions - PK-12 Leaders

Research Question

What do the Voices of Incarcerated Females tell Educational Leaders about the Need for Mental Health Resources in K-12 programs?

Definition of Terms

Mental health in childhood means reaching developmental and emotional milestones, and learning healthy social skills and how to cope when there are problems. Mentally healthy children have a positive quality of life and can function well at home, in school, and in their communities. (Centers for Disease Control and Prevention, 2017. Retrieved from <https://www.cdc.gov/childrensmentalhealth/basics.html>)

Mental disorders among children are described as serious changes in the way children typically learn, behave, or handle their emotions, which cause distress and problems getting through the day. (Centers for Disease Control and Prevention, 2017. Retrieved from <https://www.cdc.gov/childrensmentalhealth/symptoms.html>)

Adverse childhood experiences (ACEs) are stressful or traumatic events experienced in the household before the age of 18. ACEs include any of the following: physical abuse, sexual abuse, emotional abuse, physical neglect, emotional neglect, mother treated violently, and substance misuse within the household, household mental illness, parental separation or divorce, incarcerated household member. (Centers for Disease Control and Prevention, 2016. Retrieved from <https://www.cdc.gov/violenceprevention/acestudy/>)

Demographic Information

School Setting: Urban, Suburban, Private, Charter, Rural

Grade Level: PK, Elementary, Middle School, High School, K-8, K-12

Education Leader: Number of years in administration?

Gender:

Race:

INTERVIEW QUESTIONS

- 1) (Given the definitions above) What are the known or suspected mental health needs of students in your school?
- 2) What kinds of resources do students in your school with mental health issues need?
- 3) What district intervention programs/resources are available for students with mental health needs?
- 4) What resources are available through county, district, and community resources?
- 5) What types of professional development or training is provided for faculty and staff about serving students with Adverse Childhood Experience (ACE).
- 6) Are you aware of any children/students of incarcerated mothers or women caretakers?

APPENDIX 5

Consent Form - PK-12 Education Leaders

INVITATION TO PARTICIPATE

You are invited to participate in a research study about childhood trauma, mental health needs and resources for students in PK-12 school programs; incarcerated females in jail, and their childhood experiences and mental health needs during re-entry to community when released from jail. This study is being conducted by Phyllis Burger, Doctoral Student, supervised by Dr. Jerry Robicheau, her adviser, from the College of Education at Concordia University St. Paul. This study is being conducted as part of Ms. Burger’s dissertation completion requirements. Your participation in this study is voluntary. Please read the information below and ask questions to clarify any of the topics reviewed before agreeing to participate in the study.

PURPOSE OF THE STUDY

The purpose of this study is to attempt to answer the question: What do the Voices of Incarcerated Females tell Educational Leaders about the Need for Mental Health Resources in PK-12 programs?

The research study will explore childhood trauma, mental health needs and resources for students in PK-12 school programs, incarcerated females in jail, and their childhood experiences and mental health needs during re-entry to community when released from jail. This portion of the study will be conducting one-on-one interviews with selected principals of PK-12 schools in Minnesota.

PROCEDURES

If you agree to be in this study, we would ask you:

- 1) Respond to six questions about mental health needs of students in your schools, district resources for students, and professional development for teachers and staff.

RISKS and BENEFITS of the STUDY

There is no immediate, direct benefit to participating in this study.

COMPENSATION

There is no financial compensation for participants.

CONFIDENTIALITY

The researcher will conduct open-ended one-on-one interviews with participants. Only the researcher will have access to the recorded data. School names will not be identified, and will be addressed as PK-12 school #1, #2...#10, when organizing the research data. Individual interviewee names will not be used in the study. There is no deceptive design in this study.

PARTICIPATION

Participation in this study is voluntary.

I understand the procedures described above, and I agree to participate in this study.

Printed Name of Participant

Signature of Participant

Date

Signature of Witness

Date

APPENDIX 6

Approval to Conduct Research at the Washington County Jail

Date: March 28, 2017

Dear Concordia University Faculty,

I have been asked by Doctoral student Phyllis Burger about the possibility of conducting research at the Washington County Jail by interviewing female offenders. I have reviewed Ms. Burger's proposal as well as the methods and processes she will be using to conduct her research. I have talked to Ms. Burger about jail expectations, safety, and security procedures that she will have to comply with while in our facility. Ms. Burger is compliant with the jails policies and procedures and has passed a criminal history check recently with our department. I will ensure that Ms. Burger has received the complete jail orientation in the coming months. I will also meet with Ms. Burger in person well before her first offender interview. I think Ms. Burger's research is important and I am happy to assist in any way that I can.

I hereby authorize Ms. Burger to meet with female offenders at the Washington County Jail to complete her research project. If more information is needed please feel free to contact me anytime.

Sincerely,

Cmdr. Roger Heinen
Jail Administrator



APPENDIX 7

Human Subjects Review Committee Approvals



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TO: burger@csp.edu
CC: Humans Subjects Review Committee File

The IRB Human Subjects Committee reviewed the referenced study under the exempt procedures according to federal guidelines 45 CFR 46.306 (a)(2)(i): **STUDY OF THE POSSIBLE CAUSES, EFFECTS, AND PROCESSES OF INCARCERATION, AND OF CRIMINAL BEHAVIOR, PROVIDED THAT THE STUDY PRESENTS NO MORE THAN MINIMAL RISK AND NO MORE THAN INCONVENIENCE TO THE SUBJECTS.**

Study Number: 2017_43
Principal Investigator: Phyllis Burger
Title: Incarcerated Females the Effects of Childhood Trauma and reentry to community.

Classification: ___ Exempt X Expedited ___ Full Review

Approved X

Approved with modifications: _____ [See attached]

Declined _____ [See attached]

Upon receipt of this letter, you may begin your research. Please remember that any changes in your protocol need to be approved through the IRB Committee. If you have questions, please call the IRB Chair at (651) 641-8723.

Human Subjects Review Committee

July 1, 2017 . *Signature, Chair*
Date

Concordia University • 1282 Concordia Avenue • St. Paul, Minnesota 55104-5494 • 651-641-8230 • www.csp.edu

Request for Modification or Addendum to Previously Approved Study

Concordia University, St. Paul Institutional Review Board

Instructions: Please complete and send the form and any attachments electronically to cross1@csp.edu.

If you have any questions, contact Stephen Ross at (651) 641-8723.

Note: If your changes are limited to personnel only, you do not need to complete this form. Personnel changes can be sent via email to cross1@csp.edu.

Principal Investigator: **Phyl Burger**

IRB # Study Title: **What do the Voices of Incarcerated Females tell Educational
2017_43 Leaders about the Need for Mental Health Resources in PK-12 school?**

1. Modification/Addendum Description (*check all as appropriate*)

- Modification to currently approved protocol
- Modification to currently approved informed consent
- Other type of modification (e.g., recruitment method)
- Addendum: an addition of a new element to the study

2. Check one:

- This modification/addendum **does not increase** risks to subjects enrolled in the study.
- This modification/addendum **increases** risks to subjects enrolled in the study.

3. Describe modification/addendum:

By submitting this request, the Principal Investigator (and responsible faculty member if PI is a student) accepts responsibility for ensuring that all members of the research team: 1) complete the required CITI training and any other necessary training to fulfill their study responsibilities, 2) follow the study procedures as described in the IRB approved application and comply with *Concordia University, St. Paul's Protocols and Procedures for Research Involving Human Subjects* and all IRB communications and 3) uphold the rights and welfare of all study participants.

The parties (i.e., the IRB and the Principal Investigator and responsible faculty member if PI is a student) have agreed to conduct this application process by electronic means, and this application is signed electronically by the Principal Investigator and by the responsible faculty member if a student is the PI.

My name and email address together constitute the symbol and/or process I have adopted with the intent to sign this application, and my name and email address, set out below, thus constitute my electronic signature to this application.

Phyl Burger

PI Name

Dr. Jerry Robicheau

Responsible Faculty Name if PI is a student

burger@csp.edu

PI Email Address

robicheau@csp.edu

Responsible Faculty Email address if PI is a student

For modifications and addendums, attach **revised** protocol and/or consent form. Please highlight all changes and submit any new material. *Note: please submit as separate files.*

- Copy of grant/contract/agreement wording (*if changed or new*)
- Updated consent form(s)
- Letter(s) of Agreement (*if changed or new*)
- Instruments (Survey questions, interview questions, etc.) (*if changed or new*)
- Other (*please describe*): A new element added; questions for conducting interviews with
PK-12 Principals

APPENDIX 8

Consultant Confidentiality Agreement Form



Concordia

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As a consultant or data records assistant in partnership with Phyl Burger, doctoral candidate in the Education Doctorate program at Concordia University St. Paul, I hereby affirm my agreement to the following:

- I agree that any research writing, data, or records shared with me are for the sole purpose of completing processes and procedures as stated in the doctoral candidates' methodology writing.

I agree to treat all information shared with the upmost integrity and shall maintain such information in total confidentiality and will take all reasonable precautions to prevent disclosure to any party other than Phyl Burger.

I agree that any and all confidential information in all tangible embodiments including all information held in computer memory of software, in electronic storage media, and/or in the form of email or attachments shall remain the property of Phyl Burger, and upon request shall be promptly returned, and all electronic embodiments shall be erased.

Consultant/Data Records Assistant

Date

Phyl Burger, CSP doctoral candidate

Date

Witness

Date