YOUTH IN CRISIS: PRACTICAL STEPS WHEN MENTAL HEALTH ISSUES ARISE

LYNN KESSEL, MA, LPC-S, SUPERVISOR; ASSISTANT DIRECTOR MENTAL HEALTH SERVICES, WCJS

JR HANCOCK, ATTORNEY AT LAW- ATTORNEY ADVOCATE WCJS CORE PROGRAM

31ST ANNUAL JUVENILE LAW CONFERENCE

TUESDAY, FEBRUARY 27, 2018

WHAT IS THIS SESSION ABOUT?

IN THE JUVENILE JUSTICE SETTING.....

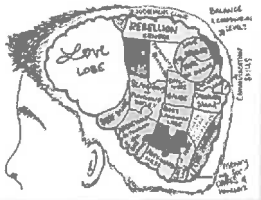
- What is a mental health crises and how do we handle it?
- What statutes address mental health examination and how do they work together practically?
- What community resources are available to help us out when dealing with youth with mental health issues?
- What can I do when dealing with youth in crisis?

HIGHLY VISIBLE TOPIC IN TEXAS

- January 2018 – the Supreme Court Justices and the Court of Criminal Appeals of Texas met to initiate the establishment of the Judicial Committee on Mental Health
- 2013 – Texas Senate Bill 1356 mandating Trauma Informed Care training for all Juvenile Supervision Officers (JSOs) & Juvenile Probation Officers (JPOs)

COMMON DENOMINATOR – WHO ARE WE WORKING WITH?

THE AVERAGE TEENAGE BRAIN



CHALLENGE -- WHO ARE WE WORKING WITH?

Chronological age

Developmental age

Street smarts

DEFINITION OF TRAUMA

- The experience of a real or perceived threat to life or bodily integrity **or** the life or bodily integrity of a loved one **and** causes an overwhelming sense of terror, horror, helplessness and fear. NCTSN, 2014
- Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being SAMHSA, 2014

SYMPTOMS OF TRAUMA

- Causes changes in the brain and increased cortisol levels in the body
- Causes developmental delays
- Distrust of others
- Anger, lack of control of emotions
- Hypervigilance/dissociation
- Difficulty describing feelings
- Isolation, avoidance
- Generalized anxiety; specific anxieties or fears
- Inability to focus, hold attention, control impulses, memory impairment
- Dysregulation
- Poor boundaries
- Inability to envision a future, ill-equipped to make a decision, lack of self-sufficiency
- Resistance to transitions

PREVALENCE

JUSTICE POLICY INSTITUTE & TEXAS SYSTEM OF CARE

- General Population: 14%-34% of children have experienced at least one traumatic event
- Youth in Juvenile Justice System: 75%-93% have experienced at least one traumatic event
- Average number of 6 traumas reported by JJ Youth
- Youth in the JJ population have rates of PTSD comparable to those of service members returning from Iraq

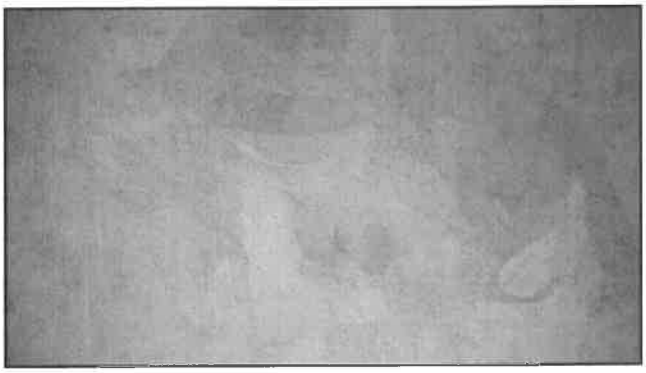
IMPACT ON OUR SYSTEM

JUSTICE POLICY INSTITUTE & TEXAS SYSTEM OF CARE

- 8x higher arrest rates than same age peers
- Abuse/neglect as a child INCREASES the likelihood of arrest as a juvenile by 59%
- 70-92% of incarcerated girls report sexual, physical or severe emotional abuse in childhood

LOCAL STATS – WILLIAMSON COUNTY

- MAYSI screening – 70% report a trauma history
- Youth assessed as a high risk to reoffend have an average of 2.5 more ACEs than youth assessed as a low risk to reoffend
- Youth with higher ACE scores tend to penetrate deeper into the system and require a higher level of care
- 1 out of 4 youth assessed as low risk to reoffend were identified as having current mental health problems; while 2 out of 3 youth classified as high risk to reoffend were identified as having current mental health problems.



THIS FOUNDATIONAL KNOWLEDGE IS IMPORTANT BECAUSE....

- It will help as we look at how to deal with a youth in crisis...and on a daily basis.
- It will help as we develop plans and solutions to cases you are working with.

TYPES OF MENTAL HEALTH CRISES

SUICIDE IDEATION

- Verbal or written suggestion of wanting to end one's life
- Behavior suggesting of such
- Recent inexplicable change in behavior
- Severe depression

PSYCHOSIS

- Delusions
- Hallucinations
- Disorganized thinking
- Grossly disorganized speech or abnormal motor behavior

SOME BASICS RESOURCES

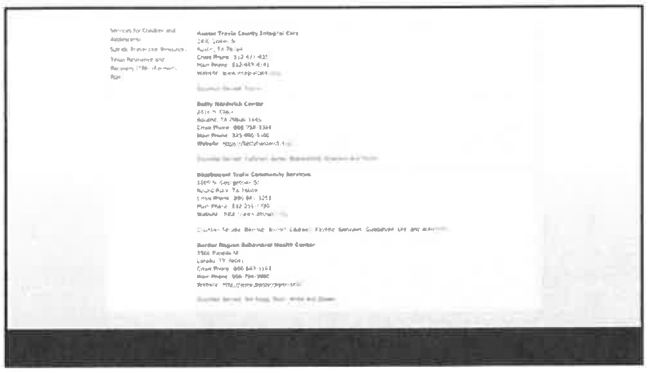
- LMHA – SHOW SLIDE OF WEBSITE WITH CONTACT INFORMATION
- MOT/CIT
- COLLABORATIONS BETWEEN LMHA AND SHERIFFS' OFFICES
- COMMUNITY PROVIDERS
- COLLABORATIONS BETWEEN PROBATION DEPT AND ANY OF THESE ENTITIES FOR THOSE WHO DO NOT HAVE MH PROFESSIONALS ON STAFF
- TRAININGS AVAILABLE

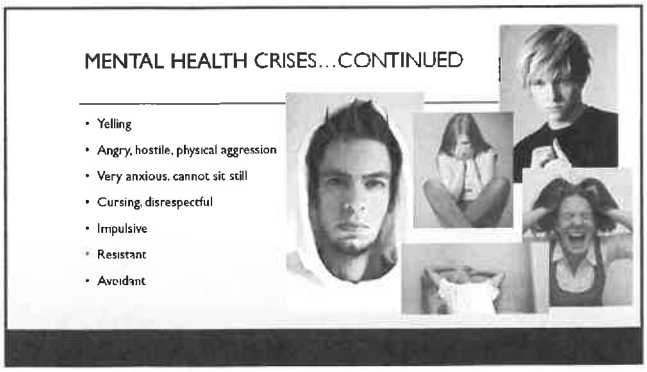
HTTPS://WWW.DSHS.TEXAS.GOV/MHSA/LMHA-LIST/

List of all Local Mental Health Authorities in the State of Texas.

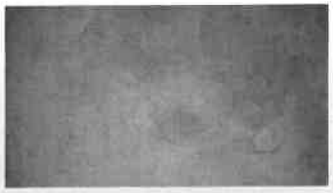
Every single county in the State of Texas is covered by an LMHA.

This listing also shows phone number to call for crises.




MENTAL HEALTH CRISES…CONTINUED
• Yelling
• Angry, hostile, physical aggression
• Very anxious, cannot sit still
• Cursing, disrespectful
• Impulsive
• Resistant
• Avoidant

THE BIOLOGY OF TOXIC STRESS (TRAUMA)



SO WHAT DO WE NEED TO DO TO INCREASE OUR SUCCESS WITH THESE CLIENTS?

- VIEW THE YOUTH THROUGH A NEW LENS

- INITIATE A CULTURE SHIFT IN YOUR ORGANIZATION OR WORK GROUP

A NEW LENSE

- What's happened to you?
- Survival behavior
- Respond to the need
- Building missing skills
- Nurture
- Teach
- Discipline
- Build trust
- Can't

- What's wrong with you?
- Willful disobedience
- Reacting to the behavior
- Shaming for lack of skills
- Ostracize
- Blame
- Punishment
- Engage in power struggle
- Won't

SCREENING/ ASSESSMENT

01

MAYSI-2 screening (universal; required for all referrals)

Massachusetts Youth Screening Instrument, 2nd version

Includes a trauma scale

02

PACT (required prior to court disposition)

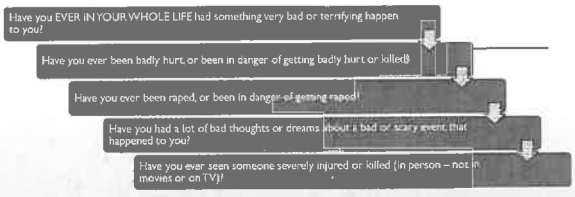
Positive Achievement Change Tool

Includes ACE scores

03

Psychological Evaluation (required prior to residential placement)

Includes Trauma Checklist



MAYSI QUESTIONS ASSESSING IF A YOUTH HAS EXPERIENCED PAST TRAUMATIC EVENTS

JUVENILE CODE LAW; FAMILY CODE SECTIONS – WHAT DO THEY SAY THAT WILL HELP ME HERE?

- Texas Family Code Section 51.20 – the court can order child to be examined by a professional, disinterested party to assess for mental health illness.
- Texas Family Code Section 51.21 – the court can order child to be further assessed by the Local Mental Health Authority (LMHA) if screening indicates need for further assessment.
- Texas Human Resource Code (HRC) 221.003 – the juvenile department must use a validated risk and needs assessment before the disposition of the child's case cannot be used against the child at adjudication hearing

A CULTURE SHIFT

- What approach am I taking in my job?
- What approach are we taking in our organization?
- What are our outcomes?
- Are we having restorative, rehabilitative impact on our youth?
- How do I get buy-in from key stakeholders in my work?

CASE STUDY: WILLIAMSON COUNTY

- 2012 – Trauma Informed Care Curriculum out for Staff in Juvenile Justice Residential Settings (Think Trauma) – National Child Traumatic Stress Network
- 2013 -- All WCJS Counselors trained in Trauma Focused – Cognitive Behavioral Therapy (TF-CBT) through a grant with local mental health authority – Bluebonnet Trails Community Services
- 2013 – All Juvenile Supervision Officers (JSOs) and Juvenile Probation Officers (JPOs) trained using National Child Traumatic Stress Network (NCTSN) Trauma Informed Care curriculum for JJ system professionals

CASE STUDY: WILLIAMSON COUNTY

- 2014 – 2016 – Continued to train all staff in further trauma informed care (equine therapy, relationship building, Paper Tigers, Resilience, etc.). Continued to train therapists (DBT, EMDR)
- 2016 – Adopted the Trust Based Relational Intervention® (TBRI®) as the new treatment framework for residential services. All department staff were trained in TBRI® and a new partnership formed with Karyn Purvis Institute for Child Development. WCJS is the first juvenile justice agency in the world seeking to implement TBRI® as an intervention framework.
- 2017 – Opened new residential treatment program: eliminated military residential program.
- 2017 – Trained select staff as TBRI® Practitioners and they further trained staff themselves.

CASE STUDY: WILLIAMSON COUNTY

Since opening the CORE Program

- Grievances: 83% decrease
- Suicide Watches (Moderate & High) : 93% decrease
- Restraints: 31% decrease
  - Note: Academy's practice was to remove all youth who were restrained due to the inability to seclude residents. CORE will have multiple restraints on the same resident due to working through trauma.
- Removals/Unsuccessful Completions:
  - CORE removal rate - 20%
  - Academy removal rate- 45%

Based on 2016 Academy statistics and 2017 CORE statistics

CASE STUDY: WILLIAMSON COUNTY

Challenges and unexpected ripple affects

- Resistance to the new philosophy (training, coaching, terminating)
- Military staff? How do they fit in? (repurposing, creating new niches for them)
- Confusion with the accountability/correction piece
- How does this translate to field probation?
- Recruiting/interviewing – what characteristics and assets are you now looking for?
- Parent/family involvement in this process
- Relationships with attorneys can change
- And we are confident there will be continued challenges for quite some time ..... ☺

PRACTICAL INTERVENTIONS FOR ALL OF US

- Relate
- Regulate
- Reason
- Ask, "what do you need?"
- Give full attention, good eye contact
- Use a clam, authoritative voice
- Use playful engagement and humor
- Help with transition
- Offer choices where you can
- Offer compromises when you can
- Share power, "what do you think/"

BACK TO RELATIONSHIP – WHY IS THIS IMPORTANT

- What broke down was relationship in their lives; what will heal them will be through relationships
- They can't control their impulses, they can't calm down enough to listen to you, they are in an almost constant state of flight fight or freeze, they need nurture, balance of nurture and structure, and need to feel safe
- So we can have reduced rates of restraints, grievances, suicide watches, crisis interventions and increased rates of success in school, self-regulation, ability to connect with healthy adults, ability to trust and reason

ANGEL'S VIDEO – 5 MINUTES

WHAT CAN PROBATION DEPTS. DO?

- TJJD has been ahead of the game…started TIC training a good 6+ years ago
- Already training all staff on TIC for certification, so maybe look at how to make it practical and useful in staff's day to day practice.
- Look at training more on TIC and ACEs…staff, youth themselves, parents, other community stakeholders…schools, youth groups, law enforcement
- Family intervention programs? SNDP?
- More training on how to engage with youth…moving from the correctional approach to a relational approach; Motivational Interviewing: Developmental Relationships and SPARK (Search Institute), explore LMHA training and ask to be invited; invite attorneys to trainings
- Explore well researched interventions that support your approach - TBRI
- Ask, what does this kid need?

WHAT CAN ATTORNEYS DO

- Help the youth understand the court process, step by step, including in court hold and in the court room.
- Be available for your client, be approachable, be an advocate, help teach them, be one of the healthy adults in his/her life.
- Offer choices where you can
- Attend trainings on trauma, ACEs, Motivational Interviewing, TBRI, etc.
- Know your own ACE score and how you may react to these kids' responses.
- Have coping tools available for your client to help calm him/her (you will have had to learn what works in advance).

WHAT JUDGES CAN DO

- You have a huge amount of power – what a wonderful place to be in regards to being able to help this necessary societal education and cultural shift.
- Schedule further training on trauma, ACEs, resiliency, relationship building, TBRI for your teams (attorneys and judges).
- Have a basket of fidgets available in the court room for your kids; have water available.
- Consider private settings where appropriate.
- Ask for successes and strengths on each case from your probation departments. Ask what does this youth need?
- Educate parents/handouts.

COLLABORATIONS: SYSTEM OF CARE CHANGES

- Participate in task forces that may exist in your county on youth behavioral health.
- Work in collaboration with schools in your county.
- Work in collaboration with other entities serving youth: CAC, law enforcement, churches, LMHAs, etc.
- Section in your resource document with helpful materials.

FINAL THOUGHTS

MY CHALLENGE AND ENCOURAGEMENT:

- LEARN MORE ABOUT TRAUMA/ACEs AND HOW IT IMPACTS THE YOUTH WE SERVE
- SHARE YOUR KNOWLEDGE AND EXPERIENCES WITH OTHERS
- IN THE STATE OF TEXAS, LET'S TRULY BECOME A TRAUMA-INFORMED, RESILIENCY FOCUSED YOUTH AND FAMILY SERVICE SYSTEM
- THANK YOU!

31st ANNUAL JUVENILE LAW CONFERENCE

MENTAL HEALTH RESOURCES/REFERENCES

- **Adverse Childhood Experiences (ACEs)**
  1. ACE assessment
  2. The ACE Study
  3. The Truth about ACEs
  4. Websites for further perusal:
     a. http://.acestoohigh.com/aces-101/
     b. www.cdc.gov/violenceprevention/acestudy/
     c. www.resilencetrumpsACEs.org
     d. https://www.youtube.com/watch?v=95ovIJ3dsNk (Dr. Nadine Burke Harris on ACEs)
  5. Papers/Articles for further research:
     a. *The Prevalence of Adverse Childhood Experiences (ACEs) in the Lives of Juvenile Offenders*, OJJDP Journal of Juvenile Justice, Volume 3, Issue 2, Spring 2014.
     b. *Trauma Changes Everything: Examining the Relationship Between Adverse Childhood Experiences and Serious, Violent and Chronic Juvenile Offenders*, Elsevier Ltd., 2015.
     c. *The Interrelatedness of Adverse Childhood Experiences Among High-Risk Juvenile Offenders*, Michael T. Baglivio and Nathan Epps, Sage Publications, 2015.

- **Probation Departments**
  1. Essential Elements of a Trauma-Informed Juvenile Justice System
  2. Empowering Direct Care Workers Who Work with Children and Youth in Institutional Care
  3. The NCTSN National Juvenile Probation Officer Survey
  4. Trauma-Informed Juvenile Justice Roundtable: Current Issues and New Directions in Creating Trauma-Informed Juvenile Justice systems
  5. Trauma and the Environment of Care in Juvenile Institutions
  6. Papers for further research:
     a. *Strengthening our Future: Key Elements to Developing a Trauma-Informed Juvenile Justice Diversion Program for Youth with Behavioral Health Conditions*, National Center for Mental Health and Juvenile Justice and the Texas Assistance Collaborative, 2014-2015.
     b. *The Role of Family Engagement in Creating Trauma-Informed Juvenile Justice Systems*, Liane Rozzell, Families and Allies of Virginia Youth, 2013; found on NCTSN website.
     c. *Trauma among Girls in the Juvenile Justice System*, 2014, National Child Traumatic Stress Network (NCTSN).

- **Attorneys**
  1. Trauma: What Child Welfare Attorneys Should Know

- **Judges**
  1. NCTSN Bench Card for the Trauma-Informed Judge
  2. Helping Traumatized Children: Tips for Judges
  3. Service Systems Brief
  4. Ten Things Every Juvenile Court Judge Should Know about Trauma and Delinquency

- **Websites for further perusal:**
  a. www.nctsn.org (ample resources on trauma-informed care)
  b. http://www.txsystemofcare.org/
  c. http://sites.utexas.edu/mental-health-institute/texas-children-recovering-from-trauma-2/
  d. http://kpjrfilms.co/resilience/ (ACEs and resiliency)
  e. http://kpjrfilms.co/paper-tigers/ (film about a trauma-informed high school in Washington/ACEs)
  f. https://child.tcu.edu/about-us/tbri (TBRI)
  g. http://www.dshs.texas.gov/mhsa/lmha-list/ (list of all local mental health authorities in Texas)
  h. https://ncjtc.fvtc.edu/ (for training opportunities)
  i. https://www.mentalhealthfirstaid.org (training)
  j. https://www.search-institute.org/developmental-relationships/
  k. https://www.texaslawyersforchildren.org/ (free legal resources and tools for Texas judges and attorneys handling child abuse cases)
  l. https://www.youtube.com/watch?v=60EWsfWvKI8 (video on Judge Byrne on her TBRI courtroom)

- **Papers for further research:**
  1. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach, 2014: https://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf
  2. Motivational Interviewing for Probation Officers: Tipping the Balance toward Change, 2006: http://www.buildmotivation.com/images/28%20mi-2%20federal%20probation.pdf

- **Resources for Collaboration**
  1. Cross-System Collaboration
  2. This website address will provide you with 1) Toolkit for Agencies in Organizing a Mental Health in Schools Conference, and 2) Youth Behavioral health Subcommittee Overview: http://www.wilco.org/Departments/Juvenile-Services/MH-Training-Resources-Handouts

Adverse Childhood Experiences (ACEs)

Finding Your ACE Score

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?
   Yes No 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?
   Yes No If yes enter 1 _____

3. Did an adult or 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?
   Yes No 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 didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often or very often** feel that ...
   You didn't 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?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No 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?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score.

The Adverse Childhood Experiences (ACE) Study

ABOUT THE STUDY: What everyone should know!

Over 17,000 Kaiser Permanente members voluntarily participated in a study to find out about how stressful or traumatic experiences during childhood affect adult health. After all the identifying information about the patients was removed, the Centers for Disease Control and Prevention processed the information the patients provided in their questionnaires,

Here's What We Learned:

Many people experience harsh events in their childhood. 63% of the people who participated in the study had experienced at least one category of childhood trauma. Over 20% experienced 3 or more categories of trauma which we call Adverse Childhood Experiences (ACEs).

- 11% experienced emotional abuse.
- 28% experienced physical abuse.
- 21% experienced sexual abuse.
- 15% experienced emotional neglect.
- 10% experienced physical neglect.
- 13% witnessed their mothers being treated violently.
- 27% grew up with someone in the household using alcohol and/or drugs.
- 19% grew up with a mentally-ill person in the household.
- 23% lost a parent due to separation or divorce.
- 5% grew up with a household member in jail or prison.

ACEs seem to account for one-half to two-thirds of the serious problems with drug use. They increase the likelihood that girls will have sex before reaching 15 years of age, and that boys or young men will be more likely to impregnate a teenage girl.

Adversity in childhood causes mental health disorders such as depression, hallucinations and post-traumatic stress disorders.

The more categories of trauma experienced in childhood, the greater the likelihood of experiencing:

- alcoholism and alcohol abuse
- chronic obstructive pulmonary disease (COPD)
- depression
- fetal death
- poor health-related quality of life
- illicit drug use
- ischemic heart disease (IHD)
- liver disease
- risk for intimate partner violence
- multiple sexual partners
- sexually transmitted diseases (STDs)
- smoking
- obesity
- suicide attempts
- unintended pregnancies

If you experienced childhood trauma, you're not alone.

Talk with your family health practitioner about what happened to you when you were a child. Ask for help.

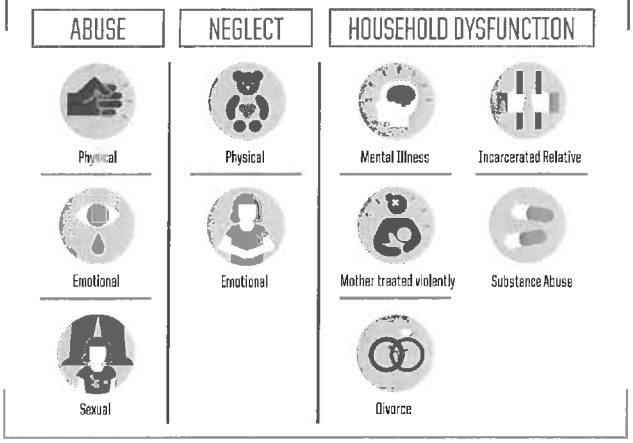
For more information about the ACE Study, email carolredding@acestudy.org, visit www.acestudy.org, or the Centers for Disease Control and Prevention at: http://www.cdc.gov/NCCDPHP/ACE/

THE TRUTH ABOUT ACEs

WHAT ARE THEY?

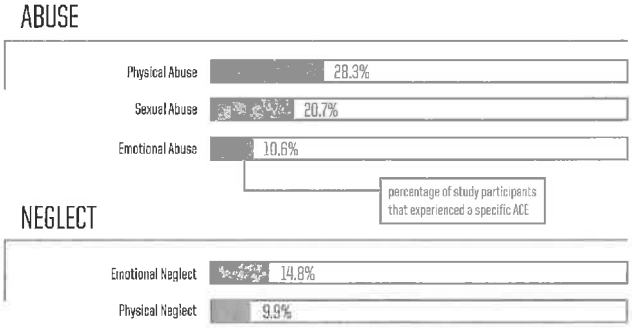
ACEs are ADVERSE CHILDHOOD EXPERIENCES

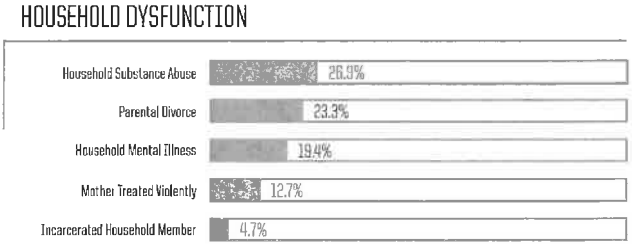
The three types of ACEs include

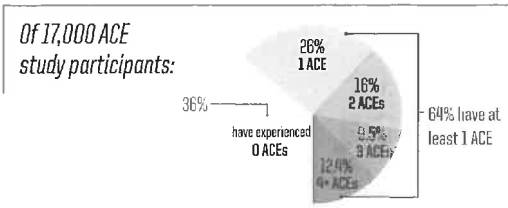


HOW PREVALENT ARE ACEs?

The ACE study revealed the following estimates:*

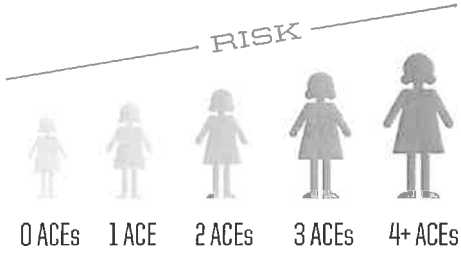




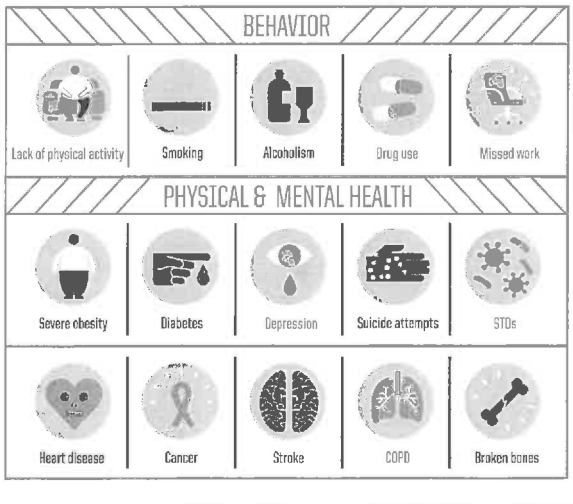


WHAT IMPACT DO ACEs HAVE?

As the number of ACEs increases, so does the risk for negative health outcomes



Possible Risk Outcomes:



rwjf.org/aces

Robert Wood Johnson Foundation

*Source: http://www.cdc.gov/ace/prevalence.htm

Probation Departments

NCTSN The National Child Traumatic Stress Network

Essential Elements
of a Trauma-Informed Juvenile Justice System

1 TRAUMA-INFORMED POLICIES AND PROCEDURES
Trauma-informed policies and procedures make juvenile justice organizations safer and more effective by ensuring the physical and psychological safety of all youth, family members, and staff and promoting their recovery from the adverse effects of trauma.

2 IDENTIFICATION/SCREENING OF YOUTH WHO HAVE BEEN TRAUMATIZED
Carefully timed traumatic stress screening is the standard of care for youth in the juvenile justice system.

3 CLINICAL ASSESSMENT/INTERVENTION FOR TRAUMA-IMPAIRED YOUTH
Trauma-specific clinical assessment and treatment and trauma-informed prevention and behavioral health services are the standard of care for all youth identified as impaired by posttraumatic stress reactions in the screening process.

4 TRAUMA-INFORMED PROGRAMMING AND STAFF EDUCATION
Trauma-informed education, resources, and programs are the standard of care across all stages of the juvenile justice system.

5 PREVENTION AND MANAGEMENT OF SECONDARY TRAUMATIC STRESS (STS)
Juvenile justice administrators and staff at all levels recognize and respond to the adverse effects of secondary traumatic stress in the workplace in order to support workforce safety, effectiveness, and resilience.

6 TRAUMA-INFORMED PARTNERING WITH YOUTH AND FAMILIES
Trauma-informed juvenile justice systems ensure that youth and families engage as partners in all juvenile justice programming and therapeutic services.

7 TRAUMA-INFORMED CROSS SYSTEM COLLABORATION
Cross system collaboration enables the provision of continuous integrated services to justice-involved youth who are experiencing posttraumatic stress problems.

8 TRAUMA-INFORMED APPROACHES TO ADDRESS DISPARITIES AND DIVERSITY
Trauma-informed juvenile justice systems ensure that their practices and policies do address the diverse and unique needs of all groups of youth and do not result in disparities related to race, ethnicity, gender, gender-identity, sexual orientation, age, intellectual and developmental level, or socioeconomic background.

1

TRAUMA-INFORMED POLICIES AND PROCEDURES

Trauma-informed policies and procedures make juvenile justice organizations safer and more effective by ensuring the physical and psychological safety of all youth, family members, and staff and promoting their recovery from the adverse effects of trauma.

Juvenile justice policies and procedures are trauma-informed when they establish—at every level in the organization—a culture that (1) recognizes the adverse effects of trauma on youth, families, and staff; (2) that requires and supports operational practices that consistently prevent further traumatization; and (3) that supports healing and recovery of all trauma-affected individuals in the organization.

Specifically, trauma-informed organizations establish policies and procedures that do the following:

- Protect the current safety of youth, families, and staff by preventing threats or physical or psychological harm to them, including by eliminating the use of coercive or harsh practices (e.g., restraints, seclusion, shackling) or by limiting such practices to circumstances in which they are demonstrably necessary and effective.
- Mandate a trauma-informed safety plan that includes effective, individualized coping strategies for each youth who identifies traumatic reminders.
- Mandate psychoeducation for all staff on the adverse effects of traumatic events on youth and on the appropriate responses to youth that prevent further traumatization and minimize the re-activation or exacerbation of youths' posttraumatic stress reactions.
- Increase youths and families' opportunities to make their lives and environments safe from trauma and to develop knowledge, practices, and skills that promote recovery from traumatic events and posttraumatic stress disorders.
- Counteract the powerlessness and disenfranchisement inherent in trauma by ensuring adequate legal representation for all youth by attorneys who understand the effects of trauma on youth and families.
- Create safe spaces where youth and families can re-group when they experience posttraumatic stress reactions that interfere with their responsible participation in the legal process, while assisting them in (and holding them accountable for) fulfilling their responsibilities pertaining to their participation in judicial processes.
- Provide both trauma-specific clinical services *(see Elements 2 and 3)* and trauma-informed programming *(see Element 4)*.
- Address the effect of secondary traumatic stress on all staff *(see Element 5)*.
- Promote partnering with youth and families *(see Element 6)*.
- Promote cross-system collaboration and facilitate diversion of youth to the least restrictive level of involvement in order to increase coordination, effectiveness, and timeliness of services for court-involved youth *(see Element 7)*.
- Address the needs of diverse populations of youth and reduce disparities based on race, ethnicity, gender, gender-identity, sexual orientation, age, intellectual and developmental level, or socioeconomic background *(see Element 8)*.

2

IDENTIFICATION/SCREENING OF YOUTH WHO HAVE BEEN TRAUMATIZED

Carefully timed traumatic stress screening is the standard of care for youth in the juvenile justice system. Traumatic stress screening should take place as early as possible to identify traumatized youth who have emotional, behavioral, learning, or relationship difficulties due to persistent post-traumatic stress reactions.

Universal implementation of a brief, valid, and reliable screening tool is the first step in identifying youth who have traumatic stress symptoms that may have contributed to their offending and may interfere with their success in court-ordered programming. Screeners must be able to (1) sensitively, correctly, and appropriately administer the items of the screening tool and (2) accurately interpret the results. Non-clinicians may conduct screenings if they receive training and have access to consultation/support by trauma-trained mental health professionals.

Screeners should use the following guidelines:

Begin screening after the youth—at least minimally—trusts the person and wants to participate. The screening should complement, rather than replicate, the content of other screenings or assessments.

Obtain informed assent from the youth and informed consent from the parents/caregivers unless participation is court or legally mandated (which should be explained clearly).

Explain the purpose of the screening to the youth and caregivers, including how the information will help the youth and how you will protect her/his legal rights and best interests. Specifically, inform the youth (1) whether the purpose of the evaluation is to inform adjudication decisions or to determine needs for services and (2) whether you will keep his or her responses private or need to release them to court and/or juvenile justice staff.

Explain the results of the screening to the youth and family in non-technical terms that inform them about the effects of trauma. Collaborate in setting goals to promote the youth's safety from future traumatic events and (when indicated) recovery from posttraumatic stress reactions.

Arrange for a follow-up comprehensive trauma-informed assessment if the screening indicates a likelihood of clinically significant traumatic stress problems.

Ensure that the screen is designed and administered in a manner that is sensitive to diversity, including the youth's and family's language, culture, gender, identity, and ability (e.g., religion, sexual orientation, disability).

Make certain that screening tools are reliable and valid for youth involved in juvenile justice.

If the youth has experienced trauma but the screening process does not indicate any clinically significant current trauma-related symptoms, inform the youth and family about the effects of traumatic stress and ways to cope effectively. This is an appropriate universal precaution based on the prevalence of trauma-related impairment in the juvenile justice population.

If the screening does not provide evidence of past or current exposure to traumatic events but risk factors or collateral information indicates the likelihood of possible past trauma or the presence of trauma reactions or traumatic stress, arrange for a clinical assessment by a mental health professional.

Policies and procedures must protect against misuse of the screening results (including self-incrimination or violation of the youth's rights or safety).

3

CLINICAL ASSESSMENT/INTERVENTION FOR TRAUMA-IMPAIRED YOUTH

Trauma-specific clinical assessment and treatment and trauma-informed prevention and behavioral health services are the standard of care for all youth identified as impaired by posttraumatic stress reactions in the screening process.

Effective assessment, treatment, and prevention services for trauma-exposed youth include those that are trauma-specific and directly address post-traumatic symptoms, as well as those that are trauma-informed and address other mental health or behavioral problems (e.g., substance abuse, depression, impulsivity, aggression, school or learning problems) that traumatic stress reactions may exacerbate.

Trauma-specific clinical assessment should follow these guidelines:

Assessment instruments must be reliable and valid for justice-involved youth.

Assessment should identify past and current exposure to traumatic events.

Assessment should identify current posttraumatic stress symptoms and related behavioral health (psychiatric, substance misuse, and behavioral) problems that cause impairment in the youth's psychosocial adjustment and legal status.

Assessment should determine the potential relationship of posttraumatic stress and related behavioral health symptoms to criminogenic risks/needs and responsivity factors related to recidivism.

Assessment should identify strengths possessed by the youth and family that can positively influence the legal and treatment process.

Trauma-specific interventions should follow these guidelines:

Only behavioral health providers who have expertise in treatment interventions for posttraumatic stress (and related behavioral health problems) proven effective with justice-involved youth should administer the interventions.

Intervention must be tailored and responsive to youth/family preferences and personal or cultural characteristics (e.g., age, gender, race/ethnicity, language, sexual orientation, intellectual ability, and community and socioeconomic resources).

Trauma-informed services should follow these guidelines:

Services should include a continuum of clinical or preventive interventions (e.g., for substance abuse, depression/anxiety, anger/aggression, negative peer group affiliation, school/learning problems, and impulsivity) designed to address the effects of posttraumatic stress symptoms and related behavioral health problems on youths' criminogenic risk/needs.

Services should include juvenile justice programming (e.g., probation, diversion, parole, detention, incarceration, residential treatment, community service/school and vocational programs) that addresses the effects of posttraumatic stress symptoms and behavioral health problems on youths' criminogenic risk/needs.

Services should aim to prevent re-traumatization, re-activation, or exacerbation of posttraumatic stress symptoms and behavioral health problems, as well as to enhance youth and family resilience and positive development.

4

TRAUMA-INFORMED PROGRAMMING AND STAFF EDUCATION

Trauma-informed education, resources, and programs are the standard of care across all stages of the juvenile justice system.

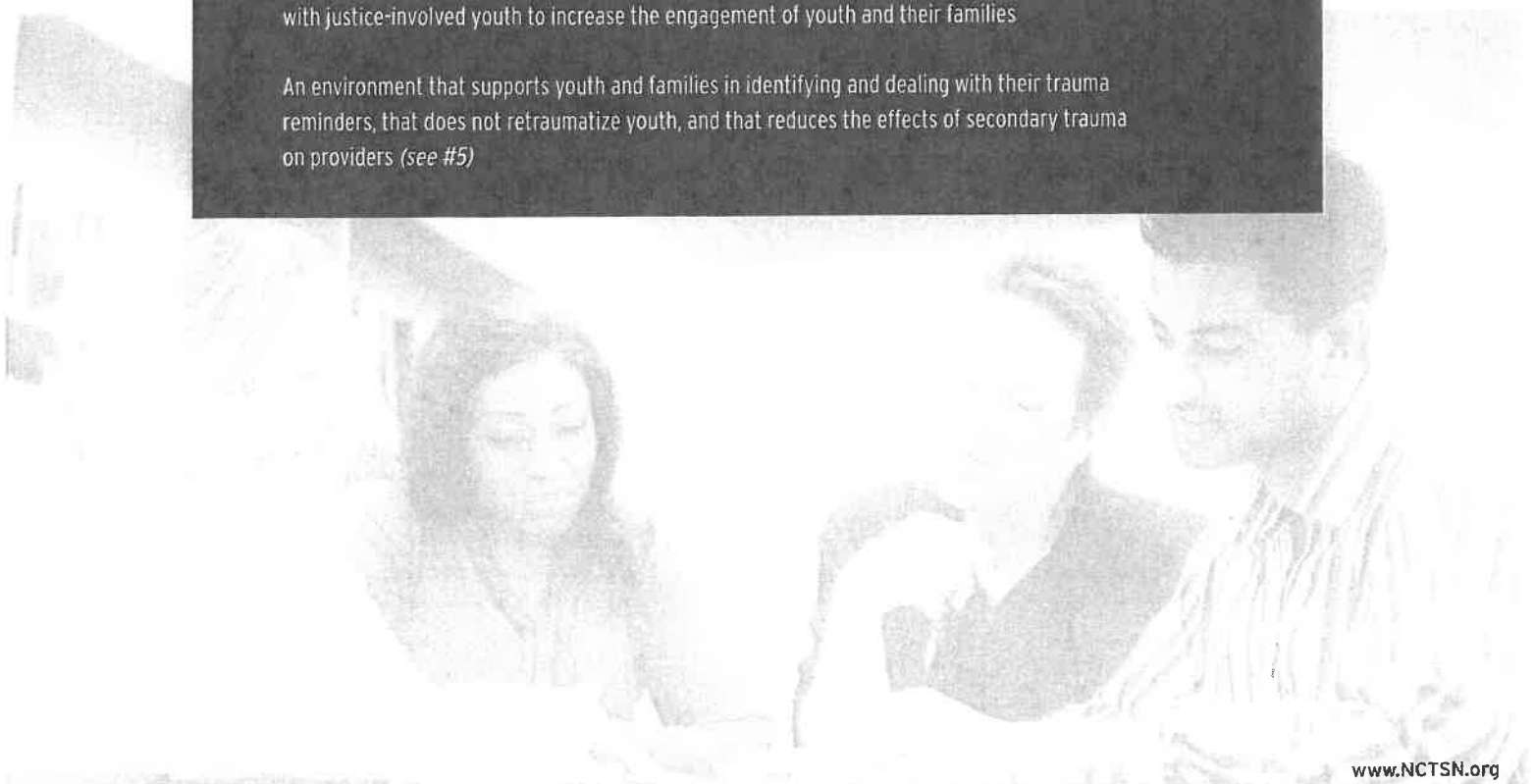
The juvenile justice system should offer resources and training about the effects of trauma exposure on youth and families, the nature of traumatic stress reactions, and recognition of the signs of their own secondary traumatic stress to staff at all levels and stages of youth involvement. This training should enable juvenile justice staff to provide trauma-informed programming with an emphasis on strengthening resilience in youth, families, themselves, and their work environment.

All juvenile justice system staff, administrators, professionals, volunteers, and other service providers must have research-based knowledge of the effects that exposure to traumatic stress has on youths' physical, psychological, and social development and on their behavioral and legal problems. Trauma-informed training for juvenile justice staff should begin at the onset of employment and continue regularly, providing skills relevant to the individual's role (e.g., judge, attorney, probation officer, law enforcement, detention officer) and setting (e.g., court, detention, incarceration, community-based probation, parole, diversion).

These efforts must include the following:

Skills that non-clinical—as well as clinical—service providers can utilize in interacting with justice-involved youth to increase the engagement of youth and their families

An environment that supports youth and families in identifying and dealing with their trauma reminders, that does not retraumatize youth, and that reduces the effects of secondary trauma on providers *(see #5)*



5

PREVENTION AND MANAGEMENT OF SECONDARY TRAUMATIC STRESS (STS)

Juvenile justice administrators and staff at all levels recognize and respond to the adverse effects of secondary traumatic stress in the workplace in order to support workforce safety, effectiveness, and resilience.

All judicial and law enforcement personnel are affected personally by knowing about the traumas experienced by the youth to whom they provide supervision and services. STS is the emotional duress that results from learning about another person's traumatic experiences and from observing firsthand the traumatized person's posttraumatic stress reactions. STS may involve feelings of sadness, irritability, anxiety, distrust, guilt, depression, or worry that can impair work functioning and can spill over into one's personal life outside of work. STS may result in problems interacting with youth, families, or other staff that can result in a conflictual and unhealthy workplace, absenteeism, burnout, health problems, and turnover.

Juvenile courts and juvenile justice systems should proactively mitigate the adverse effects of STS on personnel at all levels using the following guidelines:

Provide educational resources to staff so that they can readily (1) identify when they or their co-workers or supervisors are experiencing STS, (2) recognize STS as a normative reaction, and (3) use effective coping strategies to respond to STS.

Establish policies and procedures that enable staff experiencing STS to access help privately (e.g., through an EAP) while not adversely affecting employment.

Provide consistent modeling and messaging by organizational leadership that encourages and supports recognition and prevention or recovery from STS.

Support supervisory staff in developing skills that increase supervisor ability to recognize STS and to respond with appropriate support and resources.

Develop and sustain programs to provide timely, systematic, and effective stress management (including but not limited to team debriefings) after critical incidents (e.g., violent assaults, self-harm or suicide attempts, ODs, acute psychiatric crises).

6

TRAUMA-INFORMED PARTNERING WITH YOUTH AND FAMILIES

Trauma-informed juvenile justice systems ensure that youth and families engage as partners in all juvenile justice programming and therapeutic services.

Trauma involves experiences of powerlessness and isolation that can make youth and families reluctant to trust and cooperate with persons or institutions in authority. Trauma-informed juvenile justice systems seek to reverse this dynamic by empowering youth and their families as partners rather than as adversaries, while maintaining the legal system's regulations and authority. Youth and families are more likely to cooperate and fulfill their responsibilities when treated as collaborators in decision-making and partners in planning and implementing services.

Traumatized youth and families working as partners are less likely to resort to breaking the law or ignoring court orders. Having meaningful control reduces their reliance on posttraumatic coping strategies such as avoidance, defiance, blaming, withdrawal, deception, aggression, recklessness, indifference, or exploitation. Collaborating with traumatized youth helps them engage in learning how to manage posttraumatic stress reactions and work toward re-entering the community as responsible and productive citizens.

Trauma-informed partnering with youth and families involves the establishment and monitoring of adherence to policies and procedures designed to ensure the following:

Legal mandates and service planning include input from the youth and participating family members concerning their needs in order to mitigate the adverse effects of posttraumatic stress symptoms and related behavioral health problems.

Youth and families obtain tangible resources/assistance that reduce obstacles to engagement and partnering (e.g., language interpreters, bus passes, consideration of family preferences and constraints when scheduling family meetings, referrals to services that are physically accessible and culturally acceptable to the youth and family).

Adults valued by the youth and family participate in maintaining or building a strong support network.

7

TRAUMA-INFORMED CROSS SYSTEM COLLABORATION

Cross system collaboration facilitates the provision of continuous integrated services to justice-involved youth who are experiencing posttraumatic stress problems.

Organizations and service systems that serve youth and families should use trauma-informed policies and programming to build and maintain partnerships with schools, law enforcement, child welfare, healthcare, courts, community-based organizations, and adult and peer opinion leaders and advocates.

These partnerships should do the following:

Strive to prevent youth from entering the juvenile justice system, thereby reducing their risk of further exposure to traumatic stressors and exacerbation of traumatic stress reactions.

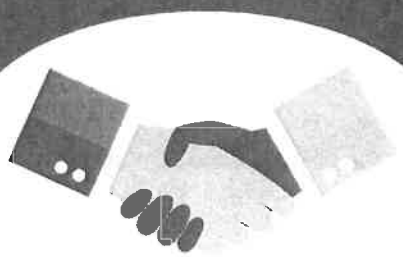
Identify youth who are involved in multiple systems to offer them efficient and timely trauma-informed screening, assessment, and collaborative case and service planning.

Support traumatized youth and families' successful transitioning across systems, settings, and developmental phases (e.g., completing adjudication mandates; returning to family, school, or community; aging into adulthood).

Develop communication systems that allow for the sharing of information among systems while appropriately maintaining confidentiality of youth.

Improve understanding and coordination of the care of youth involved (or likely to be involved) in multiple systems.

Implement trauma-informed approaches to assist youths and families to achieve prosocial goals.



8

TRAUMA-INFORMED APPROACHES TO ADDRESS DISPARITIES AND DIVERSITY

Trauma-informed juvenile justice systems ensure that their practices and policies do address the diverse and unique needs of all groups of youth and do not result in disparities related to race, ethnicity, gender, gender-identity, sexual orientation, age, intellectual and developmental level, or socioeconomic background.

Juvenile justice organizations should review and reform system-, program-, and workforce-level policies and practices that contribute to racial, ethnic, gender, gender-identity, sexual orientation, intellectual or developmental level, or economic disparities in the treatment of youth, in order to protect them from further traumatization or exacerbation of pre-existing traumatic stress reactions.

Youth of color continue to be overrepresented at each stage of the juvenile justice system. Youth stigmatized due to their cultural, ethnic, sexual, or religious beliefs, practices, backgrounds, or orientations or due to socioeconomic, intellectual, developmental, physical, or psychological disadvantage evidence high rates of exposure to traumatic stress. Therefore, choices regarding traumatic stress-related service needs and access to services should be offered in such a way as to reduce disparities and address each youth's specific needs.

Knowledge about and responsiveness to the needs of diverse youth is essential for creating truly effective trauma-informed services. Organizations should recognize that traumatized youth may have specific needs (related to their gender and sexual orientation; socioeconomic, cognitive, and developmental level) and should deliver services that assist highly vulnerable sub-groups of justice-involved youth. This includes eliminating or minimizing procedures that may re-traumatize them or exacerbate their pre-existing traumatic stress reactions (e.g., strip-searches, physical takedowns, restraints, shackling, isolation, deprivation of privacy).

Trauma-responsive services for these youth should incorporate practices that are beneficial for all youth but essential for those whose gender, sexual orientation, or developmental level increases their risk of being traumatized:

- Ensure that peers and adults with whom they interact or reside—in both informal settings and mandatory activities or sanctions—while involved in the juvenile justice system do not stigmatize, exclude, or re-traumatize them.
- Provide opportunities to receive prosocial support from youth and adults of similar gender, sexual identity, age, and developmental status.
- Ensure that youths are able to comprehend and engage meaningfully and voluntarily in services and in decisions related to their legal disposition and planning to the best of their ability.
- Ensure that language barriers or cognitive limitations do not effect traumatic stress screening and assessment or treatment practices and that appropriate trauma-informed and trauma-specific services are accessible to all youth.
- Utilize validated and trauma-responsive risk assessment instruments and interventions at key decision points (e.g., detention, disposition, case planning), so as to reduce the unnecessary use of sanctions that may traumatize youth or exacerbate pre-existing traumatic reactions to reminders (e.g., restraints, shackling, detention, isolation, denial of privileges or access to educational or rehabilitative resources).

Gordon R. Hodas MD

EMPOWERING DIRECT CARE WORKERS WHO WORK WITH CHILDREN AND YOUTH IN INSTITUTIONAL CARE

INTRODUCTION:

This paper offers a vision and a framework to support the efforts of administrators, program directors and supervisors to empower direct care workers who work with children and youth (*children*) in institutional care. There is increasing recognition that many children have "serious emotional disturbance " (SED) as well as exposure to severe, chronic trauma, even though many of these children have not been identified as such (NASMHPD and NTAC, 2004). The ultimate goal is for direct care workers to maximize their effectiveness with children in their care, so that the children can address the challenges that led to their admission and successfully return to the community. This involves efforts by the direct care worker to address the child's mental health needs, promote skill building and prosocial conduct, work with the child's family and community based resources, and help child and family prepare for the child's discharge. When the above tasks are actively pursued respectfully and collaboratively, with the worker seeking to understand the perspectives of the child and family and building on strengths, then the process will likely promote the child's resiliency in response to adversity as well (Coatsworth and Duncan, 2003).

The discussion to follow is, in reality, applicable to all staff working with children, including therapists, educators, psychologists, and child psychiatrists. It is, however, especially relevant to direct care workers, given their central role with children in institutional care, whether in Mental Health, Child Protection, or Juvenile Justice. The ideas are also applicable to direct care workers working in community settings, including Special Education, in-home services, and community-based activities.

Direct care workers, sometimes referred to within Mental Health as "mental health workers" and "mental health techs" and by other terms in other systems, are typically individuals with a high school diploma, although some may have a higher terminal degree, and a specified amount of experience working with children in human services. Despite their limited formal training (and, at times, limited clinical experience), direct care workers typically have the most frequent contact with children and, often, the greatest influence. These individuals frequently enter the field with a strong sense of purpose and the desire to make a difference for children. Yet they often receive insufficient training and supervision, and may experience themselves as unsupported. In addition, understanding the concept of a therapeutic boundary – which guides the direct care worker to serve as a caring professional and not a friend to the child, thereby reducing the possibility of a conflict of interest or inappropriate conduct – requires orientation and training. No program can effectively meet the needs of its children without an effective, well-trained cadre of direct care staff. This, in turn, requires a strong commitment by program leadership to promote the professional development of its workforce.

THE CONTEXT THAT SHAPES DIRECT CARE STAFF FUNCTIONING:

We begin with the recognition that a program cannot help children without effectively trained and guided direct care workers. There are, in addition, other prerequisites for an effective program that meets of the needs of its identified population of children. Ten key parameters are identified below:

1. The agency's organizational culture and leadership, from the top down. This involves a well formulated, written treatment philosophy that guides the treatment milieu and all interpersonal relationships, which is actively promoted and modeled by agency leaders.

2. The agency's commitment to strengths based treatment, including respect for each child and his/her family and openness to input from them.

3. The agency's commitment to prevention (primary, secondary, and tertiary), and to what is known as "trauma informed care" (a systematic effort to identify childhood trauma and help the child understand its impact and begin to heal) (NETI, 2003).

4. The agency's ability to remain child-centered, so that implementation of policies, procedures and "rules" is flexible enough to address the child's needs and does not become the primary goal in itself.

5. The agency's openness to input from staff at all levels, as the basis for information gathering, collaborative problem solving, and program improvement. Staff need to feel "safe" and valued in providing input, since concern for losing their job keeps many quiet.

6. The degree of individualized information about the child that is initially obtained from child, family and referral source and then updated on a regular, routine basis and shared among staff. This includes obtaining a trauma history and the collaborative development of a safety plan with the child (also known as a de-escalation preference survey).

7. The agency's ability to empower the child, by helping the child understand the connection between one's life experience, including past trauma exposure, and current coping efforts.

8. The agency's commitment to the training, supervision, and professional development of its staff.

9. The agencies commitment to, and ongoing implementation of, an ongoing quality improvement process (CQI), based on the premise that the program needs to adapt to the needs of children, rather than children adapting to an unchanging program.

10. The cultural competency and diversity of staff, which should reflect the diversity of the resident population. It is helpful for all staff to appreciate that each child and family, regardless of religion, ethnicity, and race, has its own unique culture.

THE VISION FOR EFFECTIVE DIRECT CARE WORKERS – CREATING THERAPEUTIC RELATIONSHIPS THAT CONVEY RESPECT AND HOPE:

An agency's identified protocols, interventions and usual practices notwithstanding, it is staff relationships with children, conveying respect and hope (Frank and Frank, 1991), that constitute the primary basis for therapeutic change. Therefore, the agency vision needs to promote the development and maintenance of such relationships.

Direct care workers need to understand that relationship building with children with SED, prior traumatic experiences, multiple losses, drug and alcohol problems, and/or externalized behavior is far from easy. Guardedness is typical and may actually be protective for the child. Relationship building requires time, patience, use of relevant individualized information, and a readiness to follow the lead of the child. An ability to listen and withhold judgment is indispensable. The relationship needs to be person-to-person, not just worker-to-client. This means that the direct care worker relates to the child first as a human being, and only then as someone with identified problems or challenges. Genuine caring is essential, since the child can readily surmise when a staff person is feigning interest and "going through the motions." A respectful relationship is collaborative rather than primarily hierarchical in nature. A child learns respect not through lectures but through repeated experiences of being respected. In some manner, verbal or otherwise, the direct care worker conveys the idea that "we need to work together to understand what is going on and how to help you out – I don't have all the answers myself."

The direct care worker is not a therapist to the child, but their relationship should certainly be "therapeutic" in nature – e.g. organized around clearly identified efforts to implement the child's treatment or service plan, and to promote the child's adaptation, coping, and capacity for self-expression and self-advocacy. The direct care worker constantly seeks to expand individualized information about each child – the child's strengths, vulnerabilities, triggers, sources of coping and de-escalation, etc. In order to develop and maintain strong connections with children, the direct care worker must present him/herself in a warm, accepting, non-intimidating way, always using the relationship to meet the child's needs rather than to have personal needs met. Since children learn more from actions than from words, the direct care worker needs to serve as a role model for the child. Above all, the direct care worker must avoid shaming and humiliation, since such interventions lead individuals toward revenge and violence, not constructive change (Gilligan, 2001).

FROM SOUP TO NUTS – INTRODUCING AND MAINTAINING THE VISION:

While a few staff may intuitively understand and implement the above vision (these individuals are sometimes referred to as "naturals"), it is important to recognize that the ability to cultivate and maintain therapeutic relationships with children represents a set of values and skills *that can be taught*. The following constitute some of the opportunities and settings to embed the values and promote the skills.

1. The written agency Mission and Philosophy statements.

2. The written job description of staff worker expectations, including skills that maintain a therapeutic culture, promote the resiliency and recovery of children in care, and enable the avoidance of restraint and coercion.

3. The initial job interview with, and screening of, the applicant, so that appropriate individuals are hired and inappropriate ones turned away.

4. The initial orientation of newly hired staff, encompassing general program operations and specific approaches to prevention, de-escalation, and safe crisis management.

5. Ongoing staff training throughout the calendar year.

6. Ongoing staff supervision and mentoring.

7. Periodic performance evaluations.

8. Linking of relationship building with children to the data system and the Quality Improvement process.

THE FRAMEWORK TO EMPOWER DIRECT CARE WORKERS – THREE KEY DOMAINS:

We propose 3 key domains of functioning that – strategically used within an agency in such settings as identified above – can ultimately empower direct care staff and thereby improve the quality of care for children. These domains broaden the perspective and skill sets of direct care staff, and involve the following: 1) values and beliefs; 2) job-specific expectations and competencies; and 3) professional self-awareness and self-control. We suggest that Human Resource and program staff that interview job applicants ascertain the extent to which each individual brings *therapeutically based values and beliefs*, *appropriate competencies*, and *the capacity for self-awareness and self-control*. Based on these factors, in association with the individual's overall profile (professional qualifications, work history, references, manner of self-presentation, and personal characteristics), appropriate hiring decisions can be made. Thereafter, it becomes the responsibility of the agency to embed therapeutically based values, skills, and capacities in direct care staff through comprehensive hiring, orientation, training, supervision, and performance evaluation criteria that incorporate the above elements.

VALUES AND BELIEFS:

The first key domain, which can either empower or handicap direct care workers, involves their values and beliefs. In general, values and beliefs organize our perceptions of children and their families, and therefore greatly influence our subsequent interactions and interventions with them. While a person is free in their private life to maintain any values and beliefs they choose, the direct care worker's role involves being "therapeutic," and therefore their values and beliefs need to be therapeutically based. Fortunately, considerable consensus

has been achieved as a result of the national system of care movement and the formulation of CASSP (Child and Adolescent Service System Program) Principles, based on ground-breaking work in the 1980's at the National Institute of Mental Health in Washington D.C.

CASSP Principles, as affirmed in Pennsylvania by multiple stakeholders (OMHSAS, 1995) stipulate that services to children and their families need to maintain certain characteristics that grant them legitimacy and promote the vision of shared relationships and hopefulness. In summarized form offered here, CASSP Principles involve the following:

1. child-centered (organized around the actual strengths and needs of the child, and individualized in nature),

2. family-focused (recognizing the central role of parents and the family in raising children, and building upon family participation and leadership for both a specific child and in overall policy development),

3. community-based (supporting the child's remaining in the home and community, whenever possible, or returning to the community as soon as possible when in placement, and using services and resources convenient to the family, within the community),

4. multi-system (collaborative efforts at meeting the child's needs by all involved child-serving system representatives and stakeholders),

5. culturally competent (recognizing the unique cultural characteristics of each child and family, and ensuring that services support and build upon this culture),

6. least restrictive/least intrusive services and interventions (ensuring that services effectively address the needs of the child without involving unnecessary restriction of movement or intrusion into child and family living).

Consistent with CASSP Principles and such related concepts as "strengths based treatment" (an ongoing commitment to identify the multiple strengths of the child, family, community and service system, and to build upon them while providing services), there are certain values and beliefs on the part of direct care staff that predispose toward therapeutic relationships. These relate to the worker's view of the following: 1. children, 2. families, 3. treatment, and 4. personal motivation to serve as a direct care worker.

1. Values and Beliefs About Children:

Direct care workers need to understand that children are different from adults, in that they possess less knowledge and fewer skills and are engaged in a very critical process of physical and psychosocial development, with brain maturation in fact continuing into the mid-20's. Given the fluidity of child development and the potential resilience of children, it is important that staff avoid labeling or stereotyping children negatively, based on their behavior and conduct.

A partial list of therapeutic values and beliefs for direct care staff regarding children includes the following. Children should be viewed as:

a. Significantly different than adults, due in part to an extensive, rapid developmental process, which staff need to recognize and promote.

b. Doing the best they can, given current circumstances and limitations (limitations typically involve knowledge, skills, stability, and support).

d. Survivors, whose behavior reflects adaptation to adverse circumstances, limited skills, and physiological imbalances. Children therefore should not to be viewed as "bad," "manipulative," or "attention seeking."

e. In need of understanding, respect, support, and redirection – not control, "management," coercion, or shaming.

f. In need of encouragement to recognize and build on their strengths and competencies.

g. Possessing a capacity for resilience and positive change, when offered appropriate treatment and support.

h. Capable of active participation in their own treatment, when offered the opportunity for meaningful partnership with staff.

2) Values and Beliefs About Families:

Direct care workers ideally recognize the many challenges that families (broadly defined to include the nuclear family, extended family, and highly committed others) face in trying to raise a child, particularly one with special needs. When there is also poverty and scarcity of services, the challenges multiply. With such considerations in mind, and consistent also with a commitment to remain strengths-based, the direct care worker needs to disavow such concepts as "the dysfunctional family."

A partial list of therapeutic values and beliefs for direct care staff regarding the family includes the following. Families should be viewed as:

a. Caring and competent.

b. Experts in relation to their child – and therefore key sources of information.

c. Partners in treatment, not individuals to be blamed.

d. Allies to professional staff.

3) Values and Beliefs About the Nature of Treatment:

Direct care staff cannot be effective if, in reality, they do not believe that mental health treatment and/or therapeutically based interventions in child welfare and juvenile justice can make a positive difference in the lives of children. While it may be naive to assume that all mental health treatment is beneficial, direct care workers should not view services as a "waste of time" or the children being served as being "beyond help." Stigma cannot be effectively challenged when those entrusted with the care of children privately endorse these same beliefs.

A partial list of therapeutic values and beliefs for direct care staff regarding the nature of treatment includes the following. Mental health treatment, along with therapeutic interventions in related child-serving systems, should be viewed as:

a. Viable and meaningful.

b. Mediated through relationships and the restoration of hope.

c. Facilitated by a team process in which team members collaborate together.

d. Focused on accountability and natural consequences, not on punishment.

e. Involving the absence of violence, threats, and coercion towards children.

f. Respecting the integrity of the child's body and avoiding use of restraint, except in an extreme emergency as a last resort to maintain safety.

g. Involving ongoing efforts to help the child identify constructive choices.

4) Values and Beliefs Underlying Personal Motivation:

It is important that individuals seeking to work with children in placement be motivated to work in such settings for appropriate reasons. A key involves being committed to the job and the children, not just "passing through." Gratification for the direct care worker should come from helping children, not controlling or using them.

What follows is a partial list of therapeutically based rationales for an individual seeking employment as a direct care worker:

a. A desire to help children, not control or exploit them.

b. A desire to "give back" to the community and to others.

c. A desire to provide children the positive experiences they deserve.

d. A desire to learn and grow as a professional and not just "pass through."

JOB-SPECIFIC EXPECTATIONS AND COMPETENCIES:

The second key domain to empowering direct care staff involves identifying and promoting job-specific expectations and related competencies. Typically, job-specific expectations and competencies are based on concepts of "professionalism," which include such elements as timeliness, reliability, attentiveness, honesty, personal appearance, judgment, documentation and record keeping, and the maintenance of respectful, non-abusive relationships. Such expectations are fundamentally sound and appropriate. Especially important are the personal characteristics of the individual. An effective worker is one who seeks influence through relationships rather than coercion. Such an individual tends to be flexible and curious, recognizing the need to listen rather than judge the child, and has a readiness to function as part of a team. There is a sense of ease in the presence of others, whether involving the child or families and outside professionals (see Hansen et al, 1996, for a broad discussion of family and community competences).

Despite the importance of relationship building in the work of direct care workers, the search for job competencies does not always preferentially explore this dimension. The discussion below considers the skills involved in relationship building and in the subsequent use of therapeutic relationships to benefit the child.

1. Relationship Building:

Relationship building begins with the direct care worker's assuming a therapeutic persona, which involves a consistent manner of presenting oneself to children. Whether intuitively chosen or the result of careful reflection, a persona that is therapeutic is one in which the direct care worker is warm, accepting, and non-intimidating. This manner of presentation creates a welcoming environment that offers interpersonal safety to the child. The goal is for the child to view the direct care worker as being committed to the child's wellbeing, such that the child would respond affirmatively if asked "The Cardinal Question" (The Cardinal Question for the direct care worker involves the following: "Given the totality of my relationship with this child, does the child view me as being on his/her side?" [Hodas, 2003, 2004b]).

Once formed, therapeutic relationships can be used at all times to promote the child's wellbeing.

2. Use of Therapeutic Relationships:

A therapeutic relationship should be used to help the child implement the individualized treatment plan and to promote the child's coping and adaptation. On a routine basis and in the absence of a particular crisis or concern, this involves the direct care worker's being regularly available to the child, offering input, support, and feedback as appropriate. Efforts to be strengths based and to proactively anticipate the needs of the child constitute the essence of *primary prevention*, which aims to promote the child's overall wellbeing and avoid crisis. The direct care worker can help the child learn to cope effectively by being familiar with, and implementing, the child's treatment or care plan, and by making use of information provided

by the child that has been incorporated in the development of an individualized safety (prevention) plan for the child.

When a crisis does occur or appears imminent, the direct care worker offers quick intervention in order to address the problem early and prevent further escalation. Sometimes, supportive statements and low-key redirection suffice and the situation can be resolved uneventfully. At other times, however, the direct care worker needs to intervene more intensively by using a variety of de-escalation approaches, with the goal of defusing the situation, avoiding need for restrictive physical procedures such as physical restraint, and restoring safety and calm. Efforts to address and resolve crisis in the least restrictive and intrusive manner are part of what is known as *secondary prevention*. All effective primary and secondary prevention efforts build upon pre-existing relationships between the direct care worker and the child.

Unfortunately, in some instances, primary and secondary prevention efforts fall short, and the child may require application of a restrictive procedure on an emergency basis to maintain his/her safety or that of others. The decision to use physical restraint should never be made lightly, since being restrained is not therapeutic and in fact often traumatizes or re-traumatizes the child. *Tertiary prevention*, once a restraint is terminated as quickly as clinically appropriate, involves efforts to learn from the experience so that future restraints become less likely. Key elements of tertiary prevention involve processing with the child, once safety and stability have been restored. Informal processing takes place shortly after the restraint is discontinued. A more formal processing (known as formal debriefment) should occur the next day, involving the child, program leaders, and others working with the child, including the family whenever possible.

3. Importance of De-Escalation Skills for Staff – Staff Core Competencies:

Given the importance of de-escalation as a skill set to soothe and settle a distressed child and as a tool to avoid the need for physical restraint, it is important that direct care workers have extensive training in a range of de-escalation approaches and interventions. Staff untrained in relationship building and in de-escalation may conclude that they possess few if any alternatives other than physical force, when a child is out of control. In addition, de-escalation cannot be implemented solely as a "technique" in the absence of a caring relationship and a strong commitment on the part of involved staff to guide the process to a non-violent resolution.

Below are some useful approaches to de-escalation. While not inclusive, the list can serve as a guide to administrators, program directors, supervisors, and direct care workers themselves. It should be appreciated that many of these same skills, identified here as de-escalation methods, also constitute appropriate primary interventions for staff as they get to know the child and work on developing a trusting relationship. De-escalation core competencies include the following:

1. Listening.

2. Remaining calm and non-judgmental.

3. Offering support and concern.

4. Being soothing through voice and manner.

5. Having a non-stressful "conversation" with the child.

6. Acknowledging the legitimacy of some aspect of the child's concern or grievance.

7. Highlighting current evidence of child's coping, despite distress.

8. Avoiding shaming and humiliation.

9. Using previously obtained information and previously completed tools.

10. Asking questions.

11. Expanding one's knowledge base about the child.

12. Reminding the child of own goals, strengths, and past accomplishments.

13. Helping the child understand the current crisis in terms of past trauma experiences.

14. Asking directly, "How can I help?"

15. Asking the child for help – "Help me to help you."

16. Providing space, and time, as indicated.

17. Judicious use of humor (always avoiding sarcasm and put-downs).

18. Redirection, ensuring the child opportunity to save face.

19. Openness of staff person to input from other staff, as indicated.

20. Other.

PROFESSIONAL SELF-AWARENESS & SELF-CONTROL:

The third key domain to empowering direct care staff involves assessing and promoting *professional self-awareness and self-control.* This constitutes an area infrequently targeted in training, supervision, and especially performance evaluations. Direct care staff soon enough learn that intensive contact with troubled, challenging children can be highly stressful. It is preferable that staff be oriented to this dynamic from the outset. They also need to understand that, no matter how professional and "objective" they may try to be, the actions and behavior of some children will nevertheless provoke negative personal reactions – anger, anxiety, hurt, and

other emotions that should not be expressed or acted upon. In the absence of self-awareness and the capacity for self-control, the direct care worker may engage in counter-aggression toward the child, destabilizing both the child and the milieu. In fact, there is increasing awareness that counter-aggression and over-control by staff underlie many episodes of physical restraint (NETI 2003, Hughes 2002).

The following constitutes a partial list of the kind of knowledge and capacities needed by the direct care worker in order to remain therapeutic despite negative personal reactions:

1. Awareness of the stressful nature of working with troubled children and in institutional settings.

2. Awareness of one's own strengths and vulnerabilities as a person and professional.

3. The ability and desire to identify areas in need of professional development.

4. The ability to recognize angry and other negative personal reactions, when they arise.

5. The ability to manage and control angry and other negative personal reactions, when they arise, so they are not acted upon against the child.

6. The consistent use of one's supervisor and the supervisory structure, and one's peers.

STAFF RETENTION AND MORALE:

At a time when there is a significant manpower shortage in human services, it is important for agencies to retain their staff and maintain staff morale. It is also important that the need to fill staff positions not lead to the indiscriminate hiring of available applicants, irrespective of their qualifications and suitability to work with troubled children.

One issue frequently identified by direct care staff as a source of considerable concern involves the insufficiency of salary. Direct care staff justifiably argue that their salary structure in no way reflects their level of responsibility, or the degree of impact that they typically have on children in their care. Many staff find it necessary to hold two or more jobs in order to continue to work with children. Maintaining two or more jobs creates fatigue, and takes staff away from time with their own families. It thus becomes difficult for the individual to maintain the personal balance so necessary for effective direct care work. Related to the need for a realistic salary structure is the need for opportunities for direct care staff for advancement within the agency. When direct care positions are essentially dead-end jobs, it becomes difficult for talented staff to carve out a career for themselves doing such work. As a result, dedicated staff may leave prematurely, and new staff may look upon their position as time-limited, until something more remunerative comes along. Morale is difficult to achieve when staff feel underpaid and undervalued.

In addition to addressing salary-related issues, there are many ways that facilities can promote staff retention and morale. Staff morale tends to be high when staff feel competent, respected, and supported. Staff need to understand in advance the stressful nature of working with children, so that they can remain child-centered and not "take it personally." Hence, the importance of the intensive level of orientation, training, supervision, and mentoring described earlier. Staff also want to make a difference, so supervisors need to help their supervisee identify their positive reasons for entering the field and then reinforce, over time, the worker's personal sense of mission. It is important for an agency to identify and celebrate success, whenever it occurs. Similarly, the agency should endeavor to help the worker learn from mistakes. Staff also need to feel safe at the job. This encompasses both physical and emotional safety. Staff do not want to be subjected to constant physical aggression from children, some of which might cause considerable physical harm. Similarly, staff do not want to feel as though they are out there alone, and that they will be blamed when something goes wrong.

Agencies committed to staff empowerment through appropriate hiring, orientation, training, supervision, mentoring, and performance evaluation increase the likelihood of positive staff morale and staff retention. In particular, staff with the knowledge, belief and values, and core competencies to create a therapeutic environment, recognize and address trauma, and provide alternatives to use of restraint are likely to find substantial satisfaction from their work. In fact, recent research provides solid evidence of many positive benefits of restraint reduction, not only for children but also for staff. LeBel and Goldstein found that reduction of restraint in child and adolescent Inpatient hospitals in Massachusetts resulted in better clinical outcomes and significant cost savings for the facilities. In addition, there were fewer injuries to children and staff, and lower staff turnover (2005). For example, staff turnover decreased by 80%, and the number of workdays missed due to restraint-related injury decreased by 98%. The use of worker sick time decreased by 53%, and the use of replacement staff decreased by 78%. These changes were associated with increased staff availability to address the treatment needs of the children and, in general, improved staff work conditions.

CAVEATS:

There are potential roadblocks to the empowerment of direct care workers and the provision of effective care and treatment to troubled children, and well-meaning programs should recognize and address these. First, staff empowerment, in association with restraint reduction, cannot be viewed as just "one more agency activity." It must be seen as a priority and receive the intensive planning and monitoring that it requires. There is need for concern toward those facilities that assert that they are "doing it already" without first undertaking a review of its culture and practices. There is need for similar concern toward those facilities that assert that they "cannot afford" to undertake the necessary changes.

It is important that facilities and staff appreciate that restraint reduction is part of a larger commitment, which involves supporting the dignity and wellbeing of each child, individually and within the context of family and community. Coercive practices, whether physical or psychological, need to be avoided. Intimidation and violence, or the threat of these, cannot be tolerated or overlooked.

Facilities need to understand what the child needs and does not need. In association with individualized care, some generalizations can be made. For example, children can be assumed to *need* the following:

1. Therapeutic relationships.

2. Active treatment that addresses the child's needs and promotes wellness.

3. Understanding about one's life and the likely sources of one's problems.

4. Family involvement, to the extent possible.

5. Community connections.

6. Voice.

7. Choice, with opportunities for active participation.

In like manner, it can be assumed that there are certain experiences that children *do not need*, which include the following:

1. Intimidation.

2. Threats.

3. Violence.

4. Abuse and neglect.

5. Shaming and humiliation.

6. Breaches of confidentiality that have not been previously agreed upon.

Finally, it is important that an agency identify and disseminate a clear philosophy of treatment or care, to guide staff interventions at all levels. Without a unifying philosophy, staff will likely over-focus on the child's surface behaviors, with insufficient attention to the underlying forces that drive the child.

CONCLUSION – A TIME OF OPPORTUNITY:

Now is a time of opportunity to improve the treatment and interventions offered to children with challenging problems, whether it involves SED, drug and alcohol use, antisocial and disturbing behaviors, or the consequences of neglect, abuse or other trauma. There is an increasing emergence of evidence-based interventions for children, and a consensus that programs should collect data related to both individual and aggregate outcomes (President's New

Freedom Commission on Mental Health, 2003). The new field of trauma-informed care (NETI 2003) highlights the seriousness of trauma in the lives of children and reinforces our recognition that effective interventions begin with meaningful relationships. Staff with a trauma informed orientation understand that coercion and restrictive procedures are counter-therapeutic and reflect treatment failure at the program level (Hodas 2004a). Physical interventions, or their threat, create instability and often traumatize and re-traumatize children (NETI 2003). It is therefore imperative that all programs working with children and youth work to reduce the use of restraint and other coercive practices. Fortunately, there is increasing evidence that such reductions can be achieved meaningfully and safely (Rivard et al, 2005, Rivard, 2004, LeBel et al, 2004, LeBel and Goldstein, 2005), with benefit to staff as well as children.

The stigmatizing of children, by both the lay public and some professionals, is a source of concern. Children are stigmatized not just for "mental illness" but also for disruptive behavior, without regard to the circumstances and life experiences underlying such behavior. Too often, it is presumed that the child is nothing more than the sum of his behaviors, even though these behaviors may be grounded in significant maltreatment and consequent neurobiological abnormalities (Perry et al, 1995, Perry, 2004). Trauma informed care tells us that the child does not always choose his behaviors, but can be assisted in making better choices (Hodas 2005).

Three domains – values and beliefs, professionalism that includes competency in relationship building, and self-awareness and self-control – represent critical starting points for programs committed to enhancing the quality, competence, morale, and sense of mission of its direct care staff. With the appropriate training, supervision, mentoring, and performance evaluation process, direct care workers can be assisted in addressing the treatment needs and promoting the wellbeing, resilience, and recovery of children. It is important not to under-estimate the level of commitment and infrastructure needed to effectively train staff.

Children can experience a sense of wellbeing when they feel safe, their symptoms are being addressed, they begin to understand what has happened to them, and they are assisted in finding their voice and participating in their treatment. Specific wellness strategies include attention to diet, exercise, relaxation, pursuit of interests, and the maintenance of healthy relationships. Resiliency is promoted when the child develops new skills, modifies behaviors that are maladaptive, and learns how to accept help from others. Recovery, a concept most often applied to the adult population, is also of relevance to children and youth and their families. Children subjected to chronic maltreatment, and those dealing with other psychiatric disorders as well, must learn to function effectively and find purpose in their lives despite the persistence of some level of disability. A core element of recovery, and of a satisfying life, involves the development of a sense of personal meaning and a positive identity (Torry et al, 2005).

Many direct care staff bring desire and energy to the table. These assets must then be supported and channeled through training, supervision, and mentoring. Regardless of care setting, positive relationships and the offer of hope constitute the core elements of all effective helping (Frank and Frank, 1991). The message to the child, as suggested by Canada (1998), should be one of "salvation and forgiveness," with reassurance that change is possible. Staff need to help children understand that we will not give up on them, so they in turn do not give up on themselves.

SUGGESTED READING

Allen, L. (1998, October). Deadly restraint. *Hartford Courant.*

Anderson, E. (1999): Code of the street: Decency, violence, and the moral life of the inner city. New York: Norton.

Bloom, S. (2003): The Sanctuary Model: A trauma-informed systems approach to the residential treatment of children. In *Residential Group Care Quarterly, 4* (2). Washington DC: Child Welfare League of America, pp. 1, 4-5.

Bryant, R. (2003): Acute stress reactions: Can biological responses predict Posttraumatic Stress Disorder? In *CNS Spectrums: The International Journal of Neuropsychiatric Medicine, 8* (9), 668-674.

Burns, B. and Hoagwood, K. (2002): Community treatment for youth: Evidence-based interventions for severe emotional and behavioral disorders. New York: Oxford University Press.

Canada, G. (1998). Reaching up for manhood: Transforming the lives of boys in America. Boston: Beacon Press.

Child Welfare League of American (2004): CWLA Best practice guidelines: Behavior support and intervention training. Washington DC: Child Welfare League of America.

Child Welfare League of American (2004): Achieving better outcomes for children and families: Reducing restraint and seclusion. Washington DC: Child Welfare League of America.

Coatsworth, J. D. and Duncan, L. (2003): Fostering resilience: A strengths-based approach to mental health – a CASSP discussion paper. Harrisburg: Pennsylvania CASSP Training and Technical Assistance Institute.

Curie, C. (2005): Commentary: SAMHSA's commitment to eliminating the use of seclusion and restraint. *Psychiatric Services, 56* (9), 1139-1140.

Donnelly, C. (2003): Pharmacologic treatment approaches for children and adolescents with posttraumatic stress disorder. Laor, N. and Wolmer, L. (guest editors): *Child and Adolescent Psychiatric Clinics of North America: Posttraumatic Stress Disorder, 12* (2). Philadelphia: W.B. Saunders, 251-269.

Eth, S. (ed.), (2001). PTSD in children and adolescents. Washington DC: American Psychiatric Association Press.

Flannery, D., Singer, M., Wester, K. (2001): Violence exposure, psychological trauma, and suicide risk in a community sample of dangerously violent adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry, 40*, 435-442.

Frank, J.D, and Frank, J.B. (1991): Persuasion and healing: A comparative study of psychotherapy. Baltimore: Johns Hopkins.

Garbarino, J. (1999). Lost boys: Why our sons turn violent and how we can save them. New York: Free Press.

Garbarino. J. and deLara, E. (2002): And words can hurt forever: How to protect adolescents from bullying, harassment, and emotional violence. New York: Free Press.

Gilligan, J. (2001). Preventing violence. New York: Thames and Hudson.

Glod, C. and Teicher, M. (1996): Relationship between early abuse, PTSD, and activity levels in prepubertal children. *Journal of the American Academy of Child and Adolescent Psychiatry, 35*, 1384-1393.

Goleman, D. (1995): Emotional intelligence: Why it can matter more than IQ. New York: Bantam Books.

Greene, R. (1998). The explosive child: A new approach for understanding and parenting easily frustrated, "chronically inflexible" children. New York: HarperCollins.

Groves, B. (2002): Children who see too much: Lessons from the Child Witness to Violence Project. Boston: Beacon.

Hansen, M., Anderson, C., Gray, C., Harbaugh, S., Lindbald-Goldberg, M., Marsh, D. (1996): Child, family, and community core competencies. Harrisburg: PA CAASP Training and Technical Assistance Institute.

Hardenstine, B. (2001): Leading the way toward a seclusion and restraint-free environment: Pennsylvania's success story. Harrisburg: Department of Public Welfare, Commonwealth of Pennsylvania.

Harris, M. and Fallot, R. (issue editors) (2001): Using trauma theory to design service systems. *New Directions in Mental Services, 89*. San Francisco: Jossey-Bass.

Herman, J. (1992). Trauma and recovery: The aftermath of violence – from domestic abuse to political terror. New York: Basic Books.

Hodas, G. (2001a). "Presuming the positive" as part of strengths based treatment in working with children and families, in Guidelines to best practice in child and adolescent mental health services. Harrisburg: PA Department of Public Welfare, 51-56.

Hodas, G. (2001b): Working with children and adolescents who are defiant: Unconditional respect comes first, in Guidelines to best practice in child and adolescent mental health services. Harrisburg: PA Department of Public Welfare, 63-68.

Hodas, G. (2003): Building relationships: The role of the direct care worker and the use of self in reducing seclusion and restraint. In Training curriculum for the reduction of seclusion and restraint. Alexandria, VA: NTAC.

Hodas, G. (2004a): Restraint and seclusion are therapeutic failures. *Residential Group Care Quarterly, 1*, Winter 2004, 11, 12-13.

Hodas, G. (2004b): Strengths based treatment for juveniles. Presentation to staff working at Pennsylvania's Youth Development and Youth Forestry Centers. Unpublished.

Hodas, G. (2005): Understanding and responding to childhood trauma: Creating trauma informed care. Alexandria, VA: NTAC (publication pending).

Huckshorn, K, (2003, revised 3/27/04): A snapshot of core interventions for S/R reduction. Alexandria, VA: National Executive Training Institute (NETI) and National Technical Assistance Center for State Mental Health Planning.

Hughes, W. (2002): Replacing control with empowerment is a proven solution. *Networks*, Summer and Fall. Alexandria, VA: NTAC.

Isaacs, M. (1992). Violence: The impact of community violence on African American children and families. Arlington, Va. National Center for Education in Maternal and Child Health.

Isaacs-Shockley, M., Cross, T., Bazron, B., Dennis, K., Benjamin, M. (1996): Framework for a culturally competent system of care. In Stroul, B (ed): Children's mental health: Creating system of care in a changing society. Baltimore: Brookes. 23-39.

Joint Commission on Accreditation on Healthcare Organizations (JCAHO) (2003): Restraint and seclusion standards for behavioral health. *2003 Comprehensive Accreditation Manual for Behavioral Health Care.*

Kaplan, S. and Pelcovitz, D. (issue editors) (1994): Child abuse. *Child and Adolescent Psychiatric Clinics of North America, 3*:4. Philadelphia: W.B. Saunders.

LeBel, J., Stromberg, N., Duckworth, K., Kerzner, J., Goldstein, R., Weeks, M., Harper, G., LaFlair, L., Sudders, M. (2004): Child and adolescent restraint reduction: A state initiative to promote strengths-based care. *Journal of the American Academy of Child and Adolescent Psychiatry, 43* (1), 37-45.

LeBel, J. and Goldstein, R. (2005): The economic cost of using restraint and the value added by restraint reduction or elimination. *Psychiatric Services, 56* (9), 1109-1114.

Lewis, D. (1998). Guilty by reason of insanity: A psychiatrist explores the mind of killers. New York: Fawcett Columbine.

Mahoney, K., Ford, J., Ko, S., Siegfried, C. (2004): Trauma-focused interventions for youth in the juvenile justice center. Washington, DC: Juvenile Justice Working Group of the National Child Traumatic Stress Network, www.NCTSNet.org.

National Association of State Mental Health Program Directors (NASMHPD) and National Technical Assistance Center for State Mental Health Planning (NTAC) (2004): The damaging consequences of violence and trauma: Facts, discussion points, and recommendations for the behavioral health system. Washington, D.C.: U.S. Department of Health and Human Services (HHS).

National Executive Training Institute (NETI) (2003):Training curriculum for the reduction of seclusion and restraint. Alexandria, VA: National Technical Assistance Center for State Mental Health Planning.

National Executive Training Institute (NETI) (Draft, 2004): Core intervention fidelity measures. Alexandria, VA: National Technical Assistance Center for State Mental Health Planning.

National Institute on Drug Abuse (NIDA) (1997): Preventing drug use among children and adolescents: A research-based guide. NIH Publication No. 02-4212.

Office of the Surgeon General (2001): The Surgeon General's Report on Children's Mental Health. Washington, D.C: Department of Health and Human Services.

Office of the Surgeon General (2001): Youth violence: A report of the Surgeon General. Washington, D.C: Department of Health and Human Services.

Perrin, S., Smith, P., Yule, W. (2000): Practitioner review: The assessment and treatment of Post-traumatic Stress Disorder in children and adolescents. *J. Clin. Psychol. Psychiat.*, 41, 277-289.

Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS) (1995): Child and Adolescent Service System Program (CASSP) Principles.

President's New Freedom Commission on Mental Health (2003): Achieving the promise: Transforming Mental Health Care in America, Available at the following website: http://www.mentalhealthcommission.gov/reports/FinalReport/FullReport.htm

Perry, B., Pollard, R., Blakeley, T., Baker, W., Vigiliante, D (1995): Childhood trauma, the neurobiology of adaptation and use-dependent development of the brain: How 'states' becomes 'traits.' *Infant Mental Health Journal, 16* (4): 271-291.

Perry, B. (2004): Understanding traumatized and maltreated children: The core concepts – Living and working with traumatized children. The ChildTrauma Academy, www.ChildTrauma.org.

Prothrow-Stith, D. (1991): Deadly Consequences: How violence is destroying our teenage population and a plan to begin solving the problem. New York: HarperPerennial.

Rasmussen, A., Vythilingam, M., Morgan III, C. (2003): The neuroendocrinology of Posttraumatic Stress Disorder: New directions, in *CNS Spectrums: The International Journal of Neuropsychiatric Medicine, 8* (9), 651-667.

Rivard, J., Bloom, S., McCorkle, D., Abramowitz, R. (2005): Preliminary results of a study examining the implementation and effects of a trauma recovery framework for youths in residential treatment. *Therapeutic Community: The International Journal for Therapeutic and Supportive Organizations*, 1-12.

Rivard, J. (2004): Initial findings of an evaluation of a trauma recovery framework in residential treatment. *Residential Group Care Quarterly, 5*, Winter 2004, 3-5.

Substance Abuse and Mental Health Services Administration (SAMHSA). See the website: www.mentlhealth.samhsa.gov/child/childhealth.asp

Torry, W., Rapp, C., Van Tosh, L., McNabb, C., Ralph, R. (2005): Recovery principles and evidence-based practice: Essential ingredients of service improvement. *Community Mental Health Journal, 41* (1), 91-100.

Van der Kolk, B. (2003): The neurobiology of childhood trauma and abuse. Laor, N. and Wolmer, L. (guest editors): *Child and Adolescent Psychiatric Clinics of North America: Posttraumatic Stress Disorder, 12* (2). Philadelphia: W.B. Saunders, 293-317.

Wolpaw, J. and Ford, J. (2004): Assessing exposure to psychological and post-traumatic stress in the juvenile justice population. Washington, DC: Juvenile Justice Working Group of the National Child Traumatic Stress Network, www.NCTSNet.org.

Gordon R. Hodas MD is Statewide Child Psychiatric Consultant with the Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS) and Children's Bureau in Harrisburg. He collaborates with multiple program offices within the Department of Public Welfare, with the Department of Health, and with counties, managed care programs, provider agencies, families and advocates, and others. Dr. Hodas is Clinical Professor of Psychiatry at the University of Pennsylvania School of Medicine. He has served as faculty member for the National Executive Training Institute (NETI) in developing and disseminating its "Training Curriculum for the Reduction of Seclusion and Restraint" and has presented nationally on trauma informed care.

NCTSN The National Child Traumatic Stress Network

INSTITUTE FOR TRANSLATIONAL RESEARCH in Children's Mental Health
UNIVERSITY OF MINNESOTA
INNOVATE. INFORM. IGNITE.

The NCTSN National Juvenile Probation Officer Survey

Youth on Probation

The court system is a common entry point for youth who have experienced trauma and are in need of treatment services. Youth going through the court system are often ordered by the court to participate in juvenile probation. In 2013, of the 716,000 justice involved youth, 54% (383,600) received court-ordered probation and 12% received out-of-home placement such as correctional facilities, group homes, and residential treatment facilities.

The Office of Juvenile Justice Delinquency and Prevention refers to juvenile probation as the "work horse of the juvenile justice system." Probation is the most frequently used community-based court order for lower level offenders and is used to keep justice-involved youth living in their communities, attending their schools, and working at their jobs, with the intent of preventing more serious delinquent behavior and the use of harsher consequences, e.g., out-of-home placement. Probation involves regular meetings with a probation officer as well as attending to other conditions of probation such as chemical dependency and mental health treatment, community service, and restitution. In essence, the probation officer serves as the court's eyes and ears while the youth is involved in the justice system.

Child Traumatic Stress in Justice Involved Youth

Risk behaviors and delinquency take place within a larger social context which often times is the result of exposure to chronic and complex traumatic events. The evidence suggests that between 70 to 96% of justice-involved youth have been exposed to at least one traumatic event (Abram et al., 2002). In fact, justice-involved youth are twice as likely to meet the criteria for PTSD, similar to service members returning from deployment in Operation Iraqi Freedom (Ford et al 2012).

This project was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services (HHS). The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

Background

According to the Center for Juvenile Justice Reform, interagency collaboration is critical to removing barriers for justice-involved youth as they integrate into the community (CJJR). Therefore, exploring the role of a probation officer, the "eyes and ears of the court," is vital to developing and maintaining interagency collaboration between probation and mental health treatment.

To be a group focused on making a service system more trauma-informed, it is essential to include partners that are key members of that service system. The NCTSN Justice Consortium consists of child trauma clinicians, researchers, federal juvenile justice partners, national organizations, and local court officials (judges and attorneys) across the country. Through a collaborative process we created the publication Ten Things Every Judge Should Know About Child Trauma, Judges Benchcards, and several joint national conference presentations and webinars.

Because probation officers are so crucial in supporting youth and recommending court decisions, in 2013 we decided to reach out to probation officers nationwide via a survey to find out what they know about trauma, how best we could collaborate with them, and what products they would like the NCTSN to produce to meet their needs with respect to trauma-informed practices.

Survey Development

To develop an effective survey with appropriate language, we needed first to conduct meetings with a subset of our target population. Meetings were conducted with personnel from two Juvenile/Family Court systems in Ohio in order to determine which topic areas might be most useful to approach within the survey. Probation Officers, Court Administrators, and Hearing Officers from these Courts provided their views regarding the ways in which information on the trauma history of a youth may be gathered, assessed, and utilized within the context of the Juvenile Justice System. The areas of inquiry selected by participating Court personnel also produced sample questions that were refined gradually as the survey was developed.

Survey Results

Information About the Survey

With the NCTSN being a network founded and maintained in the art of collaboration, the Justice Consortium asked our over 200 Network members to help outreach to juvenile probation departments across the country. This survey dissemination approach is called relationship-based dissemination, asking probation departments with existing relationships to complete the survey and help disseminate it to other departments in an effort to help us learn more about their role within the juvenile justice system. Following outreach through members across the network, the survey was distributed to state and local juvenile probation administrators who further disseminated the survey throughout their state. Forty-five states participated with at least one response. In total, 2,320 juvenile probation officers (JPOs) started the survey, 2,284 provided consent to participate, and 1,875 indicated that they currently carried a youth caseload making them eligible. After removing surveys with excessive missing data, the final sample size was 1,747. Seventy-six percent of the respondents indicated their job title as a Juvenile Probation Officer with evenly divided across urban (36%), suburban (26%), and rural (38%) settings. The sample contained more female (56%) than male (44%) respondents with the majority of the sample identifying as White/Caucasian (70%). Respondents indicated an average of 10 years of experience working in juvenile justice.

Survey Results

The first part of the collaboration process was to understand how the other partners view their role in the lives of the children on their probation caseload. With this in mind, respondents were surveyed about what they identified as their job roles and primary goals.

Enforcing court orders was the most frequent endorsed job role (87%); however, the roles of advocate and social work were also endorsed by over 50% of respondents, reflecting that JPOs view their role as both supervisory and supportive in nature. Similarly, their probation goals for youth on their caseloads were evenly distributed between reducing recidivism (48%) and improving youth functioning (49%).

A majority of JPOs (68%) indicated having received formal training in trauma through a workshop. Despite many respondents having received trauma training, many respondents indicated wanting more training on specific trauma topics including: identifying trauma-related needs (62%), survival strategies of traumatized youth (60%), the impact of trauma on youth (59%), developing an effective case plan (52%), and how to engage in self-care as a JPO (47%). JPO self-care emerged as an important training element; about 50% of the sample identified one or more job stressors related to managing their caseloads, including the needs of the youth/families exceeding available resources (63%), youth/family motivation (72%), and case complexity (52%).

In terms of daily trauma-informed practices, 55% of the respondents indicated that their office routinely screens for trauma. However, less than 40% indicated that this screening occurs through a standard trauma screening tool. Instead, a variety of structured and unstructured methods are used with youth in their caseloads. Almost all respondents (94%) indicated some attempt to obtain information about youth exposure to traumatic events from youth caregivers/legal guardians. Similar to screening, 56% of respondents indicated awareness of trauma-specific interventions, but when asked to list interventions, only one-third of respondents listed common trauma-specific interventions, such as Trauma Focused-Cognitive Behavioral Therapy. Instead of relying on screening results to inform referral decisions, over 70% of respondents indicated that referrals for treatment are based on either youth or caregiver disclosure of a traumatic event disclosure or youth disclosure of trauma symptoms.

Summary and Conclusion

Juvenile probation officers have widespread interest in understanding the impact of trauma on the youth they supervise. NCTSN and our partners can support JPO's by widely disseminating the information they want about trauma and youth in formats they most frequently access.

Suggested Citation
Bray, C., Cruise, K., Tener, R., Blackshear, K., and Olafson, E. (2017). *The NCTSN National Juvenile Probation Officer Survey.* Los Angeles, CA, and Durham, NC: National Center for Child Traumatic Stress.

About the National Child Traumatic Stress Network
Established by Congress in 2000, the National Child Traumatic Stress Network (NCTSN) is a unique collaboration of academic and community-based service centers whose mission is to raise the standard of care and increase access to services for traumatized children and their families across the United States. Combining knowledge of child development, expertise in the full range of child traumatic experiences, and attention to cultural perspectives, the NCTSN serves as a national resource for developing and disseminating evidence-based interventions, trauma-informed services, and public and professional education.

NCTSN The National Child Traumatic Stress Network

Trauma-Informed Juvenile Justice Roundtable: Current Issues and New Directions in Creating Trauma-Informed Juvenile Justice Systems

Carly B. Dierkhising, Susan Ko, and Jane Halladay Goldman

National Center for Child Traumatic Stress

Background

Creating trauma-informed service systems has been an integral focus of the National Child Traumatic Stress Network (NCTSN) since its inception in 2001. Consequently, a primary objective of the Service Systems Program at the National Center for Child Traumatic Stress (NCCTS) has been to educate stakeholders and provide skills-based training on how to become a trauma-informed service system. The juvenile justice system, specifically, has been an essential service system to target in light of the strikingly high prevalence of trauma exposure and traumatic stress among justice-involved youth.

Exciting advances in research, practice, and policy have occurred in the past decade that have elevated the importance of this work. One can no longer question whether youth in the juvenile justice system are experiencing trauma, due to rigorous replication studies on the prevalence rates of trauma and traumatic stress among justice-involved youth across the country. These findings have provided the impetus for juvenile courts, detention facilities, and other stakeholders to implement trauma-informed screening, assessments, and treatments in their settings. Due to these key research findings and the initiative of early adopters, policymakers are also now advocating for trauma-informed care within juvenile justice systems. This is best evidenced by the Report of the Attorney General's Task Force on Children Exposed to Violence, which included a section on improving the juvenile justice system, with key recommendations that support trauma-informed practices (see Report of the Attorney General's Task Force on Children Exposed to Violence, 2012).

These advances are encouraging; however, there is more work to be done. An essential step in creating trauma-informed juvenile justice systems is to further understand the key elements of a trauma-informed juvenile justice system and to identify specific practice examples that speak to these elements. The NCCTS took this step by convening the Trauma-Informed Juvenile Justice Roundtable, which included trauma experts and key stakeholders, as well as clinicians, supervisors, and juvenile justice staff that provide services to youth in juvenile justice systems across the country.

The Juvenile Justice Roundtable

The Juvenile Justice Roundtable was a two-day meeting exploring current issues and new directions in creating trauma-informed juvenile justice systems. Forty participants representing a rich array of backgrounds and expertise attended this meeting, including NCTSN members and affiliates, front-line juvenile justice staff, system administrators, mental health clinicians and supervisors, and partners from the National Council of Juvenile and Family Court Judges (NCJFCJ) and the Center for Juvenile Justice Reform (CJJR). Additionally, five national experts on key issues in juvenile justice were invited in

order to advance our discussion of the key elements of a trauma-informed juvenile justice system.
Each expert addressed a specific element of a trauma-informed juvenile justice system; these included: disproportionate minority contact, environment of care, trauma-informed assessment and interventions, cross-system collaboration, and family partnerships. These elements are discussed in depth in the collection of briefs that accompanies this report. Two young adults who had been involved in the juvenile justice system as youth were also present. These presenters highlighted their experiences with childhood trauma and the juvenile justice system, and what types of practices and people were both harmful and helpful during their journey.

Throughout the meeting participants worked in small groups to discuss the important aspects of a trauma-informed juvenile justice system and the current challenges of this work. They evaluated the current state of the field in terms of resources, practices, and interventions, and identified gaps in the existing knowledge and resource base. Organizational trauma, the environment of care for staff, and the need to change the underlying correctional culture were also explored.

Current Issues and Essential Elements

A primary issue in this work is furthering our understanding of what a trauma-informed juvenile justice system entails. In framing this discussion, we utilized the definition of a trauma-informed child and family serving system that was developed by the NCTSN Trauma-Informed Service Systems Working Group. This definition includes the following elements:

> A service system with a trauma-informed perspective is one in which programs, agencies, and service providers: (1) routinely screen for trauma exposure and related symptoms; (2) use culturally appropriate evidence-based assessment and treatment for traumatic stress and associated mental health symptoms; (3) make resources available to children, families, and providers on trauma exposure, its impact, and treatment; (4) engage in efforts to strengthen the resilience and protective factors of children and families impacted by and vulnerable to trauma; (5) address parent and caregiver trauma and its impact on the family system; (6) emphasize continuity of care and collaboration across child-service systems; and (7) maintain an environment of care for staff that addresses, minimizes, and treats secondary traumatic stress, and that increases staff resilience. (The National Child Traumatic Stress Network)

The goal of the Roundtable was to use this definition as the basis for identifying the essential elements of a trauma-informed juvenile justice system and the practices that result in implementation of these elements. Although our discussion was not exhaustive in highlighting all potential elements of a trauma-informed juvenile justice system, the following elements emerged as important starting points and are briefly discussed below and in the briefs that accompany this report:

- Utilize trauma screening and assessment and evidence-based trauma treatments designed for justice settings
- Partner with families to reduce the potential traumatic experience of justice involvement
- Collaborate across systems to enhance continuity of care
- Create a trauma-responsive environment of care
- Reduce disproportionate minority contact and address disparate treatment of minority youth

Trauma-informed screening and assessment and evidence-based trauma treatments are essential to a trauma-informed juvenile justice system. In *Trauma-Informed Assessment and Intervention*, Patricia Kerig, Professor at the University of Utah, discusses how these practices play an integral role in supporting traumatized youth as well as the challenges to implementing and sustaining these practices. She also highlights practice examples for how trauma-informed screening and assessment can be integrated into a justice setting.

Partnering with families is essential for children's well-being and an important part of a trauma-informed juvenile justice system. Caregivers and families need to be supported in order to support their children, and this includes considering the effect of caregiver trauma on parenting practices and ways of making justice involvement less trauma-inducing for caregivers and families. In *The Role of Family Engagement in Creating Trauma-Informed Juvenile Justice Systems*, Liane Rozzell, founder of Families and Allies of Virginia Youth, provides an eloquent discussion of the importance of partnering with families and ways in which to do so. For instance, she emphasizes that justice settings expand their outreach to supportive caregivers by

broadening their definition of family to include non-traditional caregivers and adults.

Continuity of care and collaboration across systems for justice-involved youth is vital because many youth who come in contact with the justice system also have contact with other service systems such as child welfare, school, and mental health systems. If these systems do not communicate with each other, resources are wasted and youth suffer. In *Cross-System Collaboration*, Macon Stewart, faculty at the Center for Juvenile Justice Reform, outlines practice examples for collaborating across systems, drawing from the Crossover Youth Practice Model from the Center for Juvenile Justice Reform. In this model, an initial step in collaboration is identifying whether youth are involved in multiple systems at the initial point of contact.

Providing a safe environment of care for youth that reduces re-traumatization is essential. This element is somewhat unique to the juvenile justice system, as youth reside in justice facilities for varying lengths of time. This is also a challenging element because of the correctional mindset that many juvenile facilities were built upon. In *Trauma and the Environment of Care in Juvenile Institutions*, Sue Burrell, staff attorney at the Youth Law Center, outlines specific areas to target in order to effectively implement this essential element. Important target areas for trauma-informed practice are discussed, such as creating a safe environment, protecting against re-traumatization, and behavior management.

Reducing disproportionate minority contact in the juvenile justice system is essential to best serve youth. In *Racial Disparities in the Juvenile Justice System: A Legacy of Trauma*, Clinton Lacey, Deputy Commissioner of the New York City Department of Probation, outlines the historical context of racial disparities and highlights how systems can move forward to reduce these racial disparities. An initial first step to address disparity, he outlines, is framing the issue so that practical and proactive discussion can move beyond assigning blame.

In addition to highlighting trauma-informed practices at the Roundtable, we learned the importance of community partnerships and providers in this work from the invited consumer panelists. The panelists identified community partners as having a great impact on their lives, as they were able to be consistently available throughout the youth's life, and some remained involved in their lives even as the youth transferred to different residential placements. This included community organization volunteers and staff, mentors, clergy, faith-based organizations, and coaches. Steve Avalos, one of the consumer panelists and a youth mentor at Homeboy Industries, a community-based organization, emphasized this point when he remarked, "It all started with education and believing in myself. And it took someone else to believe in me for me to believe in myself." (Avalos, 2013)

New Directions

The current issues and key elements provided above lay the foundation for continued work in defining and creating trauma-informed juvenile justice systems. Importantly, creating trauma-informed juvenile justice systems does not rely solely on informing and educating systems about trauma and its impact. Trauma-informed systems also utilize trauma-informed practices, skills, and strategies that directly affect the youth in their care.

While the Roundtable cultivated a rich discussion surrounding key elements of a trauma-informed juvenile justice system, participants also provided the field with important new directions and challenges for future work. An overarching theme in our work is creating a cultural shift in juvenile justice from the correctional mindset to one that embraces trauma-informed practices that support social and emotional health, successful community reentry, and resilience, and family-oriented approaches that support youth in becoming effective adults, while still holding them accountable for their actions. Collaboration across the various domains of the juvenile justice system (e.g., juvenile courts, residential facilities, probations, mental health, etc.) is essential to moving this work forward, establishing safe and effective work and residential environments, and perhaps most importantly, to recognizing that all stakeholders — youth, families, and staff — have important roles in creating a trauma-informed juvenile justice system.

Suggested Citation

Dierkhising, C.B., Ko, S., and Halladay Goldman, J. (2013). *Trauma-Informed Juvenile Justice Roundtable: Current Issues and Directions in Creating Trauma-Informed Juvenile Justice Systems.* Los Angeles, CA & Durham, NC: National Center for Child Traumatic Stress.

NCTSN The National Child Traumatic Stress Network

Trauma and the Environment of Care in Juvenile Institutions

Sue Burrell

Youth Law Center

"Youth...'is a moment and condition of life when a person may be most susceptible to influence and to psychological damage.'" *Eddings v. Oklahoma*, 455 U.S. 104, 115 (1982)

Every day, thousands of young people in the juvenile justice system are incarcerated or held in out-of-home settings. They are among the most vulnerable youth in our society. Almost all have experienced trauma in some form, and many suffer from Post Traumatic Stress Disorder.[1] Trauma exposure may occur in family settings in the form of physical or sexual abuse. These young people may experience additional trauma as they witness or are victims of violent crime, often in neighborhoods where this is a staple of daily life. Still other forms of trauma are a result of disruption — the loss of family members to death, abandonment, or imprisonment — or because of removal from home by the child welfare or juvenile justice systems. Although traumatic events occur in all communities, their impact is most heavily borne by youth from neighborhoods that are impoverished and racially marginalized.[2]

Research has established the relationship between trauma exposure, traumatic stress, and behavior. We now understand that youth who have experienced trauma at home or in their communities may resort to self-help methods in an effort to feel safe — carrying weapons, engaging in physical conflict in situations they perceive as calling for "self-defense," joining gangs, and self-medication with drugs or alcohol.[3] We also know that the effects of trauma do not end with arrest. Trauma continues to affect behavior in day-to-day interactions, as youth respond to painful experiences and loss, exhibited in depression, fear, and anxiety; low self-esteem; self-destructive behavior; combative self-preservation; mistrust of adults; perceptions of unfairness; uncontrolled anger; deep sadness; and extreme sensitivity to rejection.[4]

As someone who has spent her career in juvenile justice — first representing young people in court and later working as a litigator and consultant on conditions of confinement — I am grateful for this body of information. It offers a way to more fully understand behavior in relation to the other vulnerabilities of the youth we work with, such as age and immaturity; disability and mental illness; and belonging to groups experiencing disparate treatment based on race, class, gender, sexual preference, or gender identity. Although its origins were in other contexts, the empirical work on trauma exposure and PTSD holds great potential for juvenile system professionals as a tool to inform our decisions about the use of incarceration and institutional practices. This brief offers some beginning thoughts about the intersection of trauma and institutional confinement.

Recent evidence of institutional abuses confirms the need for attention to trauma-informed care. Investigations leading to the Prison Rape Elimination Act have established that sexual abuse and harassment of institutionalized youth are common.[5] Research on solitary confinement of detained youth has found that it is routinely used and extremely damaging.[6] Researchers and advocates have confirmed troubling abuse and harassment of LGBTQ youth in institutional settings.[7] Studies of girls in juvenile justice have found a high incidence of unaddressed physical, sexual, and emotional abuse, and deficits in gender-specific treatment.[8]

These specific issues are symptomatic of a larger problem. Our system has lost touch with its well-intentioned origin as a means to care for young people. In the "get tough" era of juvenile justice toward the end of the last century, we built and

began to operate juvenile facilities that are indistinguishable from adult jails and prisons — heavy on hardware, custody, and control. All too often our attention has been focused on how to efficiently run these institutions, rather than on the impact of what we are doing to the young people we serve. We have been slow to recognize that subjecting children to detention in such facilities is inherently traumatic, and counterproductive to producing good outcomes.[9]

Viewing the use of confinement and the institutional environment of care through a trauma lens provides a useful framework for self-examination. The trauma-informed model calls for us to consider the impact of incarceration itself, and the ways youth may be served without locking them up. For those who are appropriately confined, it gives us an approach for examining how we are treating youth from the moment of intake through reentry into the community. It gives us a meaningful way to understand why youth who have experienced trauma act the way they do, and to develop practices that make their situation better, not worse.

Incarceration is a Traumatic Event

Removal of a child from the home, even for a brief period, is itself a traumatic event. Loss of liberty, personal identity, and the familiar landscape of daily life is a frightening, disorienting, and life-changing event for a person of any age, but it is especially so for young people. Institutional placement deprives youth of the moorings in their lives — support from family and friends, school, sports, and other activities that would otherwise help them to cope with anxiety and uncertainty. It subjects youth to a complete loss of control and forced exposure to a negative peer culture.

Those who work in juvenile facilities know only too well that youth with mental health issues (including a history of trauma) emotionally deteriorate in custody, and their conditions often worsen.[10] Incarceration also makes it more difficult to address past trauma and, as we have seen, many youth arrive at the front door with significant trauma-related challenges. Detention centers are not designed for treatment, and many facilities struggle to provide even basic mental health services. Resource issues, and the failure to recognize and properly address complex behavior stemming from trauma, create an environment in which some youth are punished, isolated, or restrained for behavior that is trauma-related.

The best way to prevent systemic traumatization is not to incarcerate youth in the first place. Accordingly, the first step in developing a trauma-informed environment of care is to examine the use of secure confinement.[11] Detention should be reserved for the few youth who pose a danger to the community pending the outcome of their case, or who are unlikely to appear for their court appearances. Youth who may be appropriately supervised in the community should be maintained at home, with services in the community. Systems should also be on guard to protect against incarceration that is well-intentioned but still unnecessary and traumatic. Thus, youth should never be incarcerated for assessment or simply to receive treatment. It should also be recognized that "non-secure" placement is in many ways just as traumatic to youth as being held in a locked facility. Alternatives to detention should be developed and utilized to the maximum extent possible.

Trauma-Informed Care in Institutions

Even if we succeed in reducing unnecessary confinement, some youth will still be held in institutions or residential confinement, so our efforts need to be directed at preventing and reducing the impact of institutional trauma. The prospect of developing a comprehensive trauma-informed environment may seem overwhelming, but a great deal of thinking about trauma-informed organizations has already occurred. The work of Dr. Sandra Bloom's Sanctuary Model[12] on these issues has resulted in a comprehensive approach to making organizational change, and jurisdictions around the country are using the Sanctuary Model in facilities for youth in juvenile justice.[13] The National Child Traumatic Stress Network also offers a national clearinghouse of research and training materials, including a curriculum specifically designed for juvenile justice professionals working with youth in custody.[14]

Some of the areas that have good potential to reduce trauma in juvenile institutions are: front door screening and orientation, institutional values, staff training, housing policies, physical environment, behavioral interventions, and use of force. This section briefly highlights these issues. Assessment, treatment, family engagement, and racial disproportionality are also core concerns in trauma-informed care, and they are addressed in other briefs in this series.

Creating a Safe Environment

Youth who have experienced chronic trauma do not believe that the adults around them can or will protect them, and sometimes they are right. What is interpreted as delinquent behavior or pointless acting out is often their attempt to assume the burden of taking care of themselves. Accordingly, a fundamental goal in developing trauma-informed care in juvenile custodial situations is to provide an environment in which youth are safe and perceive themselves to be safe.

Creating a safe environment should be the primary focus of formal principles that set the tone for how youth and staff are treated in the facility. The first principle, for example, might be a statement about shared responsibility for maintaining a safe and supportive environment; a process for informing staff and youth of the principles; and a process for addressing violations of the principles. In addition, there should be a values statement specifying that all individuals must be treated with respect; that no harassment or abuse of any kind will be tolerated; and that youth will not be subjected to categorical treatment based on actual or perceived race, ethnic group identification, national origin, religion, gender, sexual orientation, gender identity, mental or physical disability, or HIV status. When new employees are hired, these principles should be used to bring in staff who support the values of the organization.

Implementing trauma-informed care also requires attention to adequacy of resources. Having a safe environment depends on having adequate staff (including mental health or other specialty care) to engage youth, head off violence or other abuse, and provide support for youth and staff in relation to traumatic events. As part of creating a safe environment, staff in a trauma-informed juvenile facility should be trained on what trauma is; how it is exacerbated by immaturity and disabilities; what kinds of things may cause re-traumatization; how to recognize and respond to trauma-related behavior in the institutional setting; and how staff can deal with their own experiences of trauma.[15] Also, staff should receive training to help them to work more effectively with particular groups of youth likely to have experienced specific forms of trauma — youth crossing over from the child welfare system, girls, LGBTQ youth, and youth from neighborhoods with high levels of violence and gang activity.

Facilities moving toward trauma-informed practice will want to carefully scrutinize what happens from the moment youth enter the front door, and how well detention intake policies and procedures create an environment of safety. Some of the issues to consider are whether:

- Staff are sensitive and alert to whether a young person is in distress, and appropriate steps are taken to address concerns
- Youth are informed that their needs will be recognized; for example, that "safe zone" signs are posted to help LGBTQ youth feel more at ease, and youth are informed of non-discrimination policies
- Interviews about sensitive information occur in private areas
- Youth are informed about safety in the facility, for example, how gang issues are handled, what protections there are to assure safety, and how to confidentially report any problems
- Searches are no more intrusive than needed for intake and in compliance with Prison Rape Elimination Act standards (no cross-gender pat downs, and cross-gender strip searches or body cavity searches only in exigent circumstances)[16]
- Youth are screened for trauma, and further assessment occurs where needed
- Youth receive all of the information they need about their rights and the institutional rules in a form they can understand
- Youth receive information about how to register complaints or to speak confidentially to someone who can help them if problems arise

Also, facilities working toward trauma-informed care should scrutinize their policies to determine whether trauma is unintentionally inflicted through policies that single out members of some groups for disparate treatment. For example, in the not-too-distant past, some facilities automatically segregated gay or lesbian youth, and would not allow them to have roommates, resulting in unnecessary humiliation and separation. Procedures in trauma-informed facilities should afford flexibility in housing to permit individualized decisions when truly needed for the safety or well-being of youth. To the extent possible, youth themselves should be a part of those decisions; they may be the best source of information about creating a safe environment.

Protecting Against Re-Traumatization

In addition to the trauma inherently experienced as a result of incarceration, youth may suffer re-traumatization in the custodial setting. Following are a few of the areas that bear careful consideration in moving toward a trauma-informed environment of care.

Use of Force and Solitary Confinement

Perhaps the most potentially damaging way youth may be re-traumatized is in the use of force or solitary confinement.[17] In our work at the Youth Law Center, we have encountered many examples of this. In one facility, male staff subjected girls with a history of sexual abuse to five-point restraint, sometimes cutting off their clothing. In another, gay and lesbian youth were "protected" by being held in protracted solitary confinement after being victimized by other youth. In still another, youth considered to be out of control were held in "safety rooms" with their hands and ankles cuffed and affixed to bolts in the floor to prevent them from damaging the expensive surfacing of the walls. In a number of facilities, youth considered to be at risk for suicide were held in isolation cells stripped of all furnishings, and were forced to wear degrading suicide smocks, sometimes for days at a time. For the many youth who have already experienced traumatic events, such practices vividly reawaken painful feelings of being powerless, worthless, fearful, and alone.

Facilities with trauma-informed practices can substantially reduce their use of force and solitary confinement, and employ interventions that reduce re-traumatization. Achieving such a reduction begins with the recognition that existing practices, even when they are used with the best of intentions, are harming youth. Then, attention can be directed at creating an environment in which these practices can be more closely examined and changed. At the outset, an assessment of resources is essential — for example, whether the facility has adequate staffing and programming to keep youth engaged and active. In active programs, there is less time for boredom or depression, which contribute to fighting and self-harming behavior, which in turn result in the use of force or solitary confinement. In developing trauma-informed practices, facilities can then turn to assuring that staff are trained and empowered to de-escalate potentially violent situations; that there is good back-up from others on staff as well as clinical staff; that youth are involved in learning to self-manage their behavior; that staff receive feedback and support that help them to use trauma-informed skills; and that families are included as a resource in behavior management. The guiding principle in this work is that when physical intervention is needed, the intervention that is the least restrictive method is used, and that youth are not subjected to hardware that produces additional trauma.[18]

Behavior Management/Disciplinary Confinement

Juvenile facilities in many jurisdictions employ punitive disciplinary systems that take away points for various programmatic deficiencies or rule breaking, followed by imposition of solitary confinement. Sometimes the punishments are wildly out of proportion to the offense. In one facility I visited, for example, staff imposed five days of locked room time for possession of a pencil (considered contraband).

This kind of disciplinary system cries out for trauma-informed analysis, because it heaps additional disapproval on youth who already feel rejected, abandoned, and unfairly treated. Also, as we have discussed, the behavior that prompts discipline may itself be a product of untreated trauma. There is increased evidence that the imposition of solitary confinement is extremely damaging for juveniles, even when it is for brief periods. A national study of suicides in juvenile facilities found that fully half of those who died were on disciplinary lockdown.[19]

Facilities moving to a less trauma-inducing form of behavior management can find guidance in an increasing body of work on positive behavior management.[20] The idea is that youth are supported and reinforced for doing things right, rather than punished for doing things wrong. Although this work began as an offshoot of behavior management work in special education, it has been successfully adapted to youth in juvenile facilities in a number of states. Using positive behavior interventions helps these jurisdictions avoid the no-win scenario of placing the young person in more and more restrictive settings (with attendant compounding of trauma), and helps youth to demonstrate mastery and skill.

Physical Environment

Although there is a huge range of management styles among juvenile facilities, it is fair to say that many look very much like jails for children. The clanging metal doors; paucity of natural light; modular plastic furniture bolted to the floor; cramped cement spaces offered for recreation; scratched metal mirrors; concrete slab beds; stripped isolation rooms; and sterile sleeping cells all contribute to an unfriendly, surreal environment for youth at a critically vulnerable point in their lives.[21] Although it is common to hear that these prison-like settings are required because of the high-risk population held in them, a few pioneering systems are proving that assumption to be wrong.[22]

Ideally, a trauma-informed approach to physical environment should begin from scratch, designing every aspect of these facilities to produce a supportive environment for youth, staff, and families. But even when planning a new facility is not an option, a great deal can be done to make existing facilities less trauma-inducing. Thus, staff in one facility implementing trauma-informed care were allowed to paint the walls in warm soothing colors, purchase comfortable furniture to encourage social interaction between staff and youth, install carpet and sound panels to reduce noise, and create a "comfort room" or "Zen space" that could be used to practice self-calming and relaxation skills.[23]

Challenges to Creating a Trauma-Informed Environment of Care

As this brief is being written, more and more systems are expressing an interest in trauma-informed approaches to institutional environments and care. But let's consider for a moment what might cause a system not to move in this direction. One potential impediment is the presence of misperceptions about what works to stem delinquency. It has been suggested to me, in more than one facility, that facilities should treat youth harshly so they will not want to engage in future delinquency. It has also been suggested, more than once, that we shouldn't make things too comfortable for detained youth because they will not want to leave, or will want to commit another act to get back into detention.

These beliefs have been soundly trounced by science[24] and by the less than stellar record of juvenile corrections in many jurisdictions. Over the past decade, research has established that adolescents are biologically and developmentally different from adults, and that their immaturity causes them to act impulsively, without considering future consequences. The United States Supreme Court has embraced these findings and repeatedly rejected the notion that punitive measures deter young people from criminality.[25] Beyond the scientific reasons for rejecting a deterrence model, the track record of punitive juvenile facilities is troubling because it simply doesn't work.[26]

Although the belief that harsh practices are needed persists in some places, it can be changed through education about the impact of trauma, and exposure to systems that have successfully moved toward a trauma-informed model. In my experience, once those working in juvenile systems see the benefits of this kind of change, they embrace it and often become the standard bearers for the work. And while this brief has focused on the benefits of trauma-informed care in relation to its impact on youth in custody, there are equally significant benefits for institutional staff and administrators. In fact, helping staff to recognize and address the impact of past trauma in their lives and secondary trauma experienced on the job is an essential part of the trauma-informed model of care.

Staff in facilities where trauma-informed care has been adopted report being better able to regulate their own emotions and behaviors, thus resorting to use of restraint and seclusion less often. They report finding their work more rewarding as they apply new skills in helping youth to regulate their own behavior. They report spending less time writing incident reports for restraint and seclusion, and more time in activities with the youth.[27] This is not surprising; many of the core elements of trauma-informed care address the importance of creating an environment in which everyone feels safe, supported, respected, and engaged.

Best Practices and Support for a Trauma-Informed Environment

Practitioners seeking further information about how to develop a trauma-informed environment of care can find support both in trauma-specific work, and in other conditions work that addresses trauma-related issues without formally being designated as trauma work. Following are a few sources to help you get started.

Center for Nonviolence and Social Justice, Drexel University School of Public Health: The Center has been a pioneer in working on trauma and juvenile justice from the perspective of public health, and they have written an excellent monograph on these issues. See, for example, John Rich et al., Healing the Hurt: Trauma-Informed Approaches to the Health of Young Boys and Men of Color, Center for Nonviolence and Social Justice, Drexel University Schools of Public Health and Medicine, funded by The California Endowment (2012). Website: http://www.nonviolenceandsocialjustice.org/

The Equity Project: A national project that works to ensure that lesbian, gay, bisexual, and transgender youth in juvenile delinquency courts are treated with dignity, respect, and fairness. Its materials examine issues of sexual orientation, gender identity, and gender expression that impact youth during the entire delinquency process, ranging from arrest through post-disposition. Several of the Project's publications specifically address the treatment of youth in custody. Website: http://equityproject.org/

Juvenile Detention Alternatives Initiative (JDAI): The Annie E. Casey Foundation's JDAI has been implemented in more than 100 sites and serves as a national leader in reducing unnecessary incarceration. Their materials help jurisdictions to analyze their use of incarceration, develop a consensus about the use of detention, create risk assessment tools, and implement alternatives that may prevent youth from experiencing the trauma and the other ill-effects of detention. JDAI also provides standards for operating safe, humane conditions in juvenile detention facilities, and a guide to facility assessment. The JDAI resources may be accessed through http://www.aecf.org/MajorInitiatives/JuvenileDetentionAlternativesInitiative.aspx.

National Child Traumatic Stress Network (NCTSN): This is the pre-eminent clearinghouse for research and training materials about child trauma. The Network was created through a Congressional initiative in 2000, and is funded by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services. It has developed a substantial body of materials about trauma and juvenile justice, including this brief. Website: http://www.nctsn.org/

Prison Rape Elimination Act of 2003 (PREA): This groundbreaking law is a result of extensive national efforts to set standards to prevent and address sexual assault in correctional facilities, including juvenile facilities. There is substantial overlap in the concerns addressed in PREA and what we would expect in trauma-informed institutional care. PREA was enacted as 42 U.S. Code § 15601 et seq., and the implementing regulations can be found at 28 Code of Federal Regulations, part 115, available at http://www.ojp.usdoj.gov/programs/pdfs/prea_final_rule.pdf

The Sanctuary Model: This is a comprehensive organizational model developed by Dr. Sandra Bloom designed to facilitate the development of trauma-informed structures, processes, and behaviors on the part of staff, clients, and the organizational community. Organizations, including juvenile justice programs and facilities, can become certified in the Sanctuary Model.
Website: http://www.sanctuaryweb.com/

The W. Haywood Burns Institute: A national nonprofit that helps protect and improve the lives of youth of color and poor youth by promoting and ensuring fairness and equity in youth-serving systems. The Burns Institute works to eliminate racial and ethnic disparity by building a community-centered response to youthful misbehavior that is equitable and restorative.

References

[1]Julian D. Ford et al. (2007), Trauma Among Youth in the Juvenile Justice System: Critical Issues and New Directions, Research and Program Brief, National Center for Mental Health and Juvenile Justice, pp. 1-2; Erica Adams (July 2010), Healing Invisible Wounds: Why Investing in Trauma-Informed Care for Children Makes Sense, Justice Policy Institute, pp. 1, 5.

[2]Defending Childhood: Report of the Attorney General's National Task Force on Children Exposed to Violence (2012), pp. iv-v, 2-7.

[3]Linh Vuong, Fabiana Silva, and Susan Marchionna (2009), Children Exposed to Violence, National Council on Crime and Delinquency, pp. 1-3.

[4]Marty Beyer (2011), A Developmental View of Youth in the Juvenile Justice System. Chapter 1 in Juvenile Justice: Advancing Research, Policy, and Practice, Francine Sherman and Francine Jacobs, (Eds.), pp. 3-23, 9-11 Wiley.

[5]Keeping Youth Safe While in Custody: Sexual Assault in Adult and Juvenile Facilities, Hearing before the Subcommittee on Crime, terrorism, and Homeland Security of the Committee on the Judiciary, House of Representatives, 111th Congress, Second Session (Feb. 23, 2010), Serial No. 111-100.

[8]See, generally, Human Rights Watch and American Civil Liberties Union (2012), Growing up Locked Down: Youth in Solitary Confinement in Jails and Prisons Across the United States, pp. 20-46.

[7]Katayoon Majd, Jody Marksamer, and Carolyn Reyes (2009), Hidden Injustice: Lesbian, Gay, Bisexual and Transgender Youth in Juvenile Courts, Legal Services for Children, National Juvenile Defender Center, and National Center for Lesbian Rights, pp. 101-112.

[8]Marianne Hennessey et al. (2004), Trauma Among Girls in the Juvenile Justice System, NCTSN Juvenile Justice Working Group, pp. 3-4; 100 Girls: A Preliminary Look at the Lives and Outcomes of Young Women Incarcerated in San Francisco Juvenile Hall (Early Release Version), Youth Justice Institute (2012), pp. 1-2.

[9]Richard A. Mendel (2011), No Place for Kids: The Case for Reducing Juvenile Incarceration, Annie E. Casey Foundation, pp. 5-12.

[10]Edward Cohen and Jane Pfeifer (2008), Costs of Incarcerating Youth with Mental Illness: Final Report, prepared for the Chief Probation Officers of California and California Mental Health Directors Association, pp. vi, 13-17, 31; Sue Burrell and Alice Bussiere (2005), Difficult to Place: Youth with Mental Health Needs in California Juvenile Justice, Youth Law Center, p. 9.

[11]For example, Cook County, Illinois, incorporates trauma-informed practice into its efforts to reduce incarceration, expedite services, and provide a coordinated multidisciplinary approach to services for youth. Its Probation Department has its own clinical services unit, with clinicians who have been trained in trauma-informed practice and incorporate it into their daily work. Youth are assessed for trauma in the community, and the clinician develops an individualized treatment plan, often using trauma-informed cognitive behavioral therapy. A primary goal of this work is to maintain youth in a community-based setting. (Electronic communication from Amanda Halawa-Mahdi, Supervisor, Clinical Interventions Division, to Sue Burrell, Jan. 8, 2013.)

[12]Information about the Sanctuary Model and certification are available at http://www.sanctuaryweb.com/

[13]For example, programs in the Children's Home of Reading in Pennsylvania have undergone a multi-year process of becoming a trauma-informed system using the Sanctuary Model. Administrators had wanted to consciously examine the system's underlying philosophy and approach to working with youth, and the Sanctuary Model provided a helpful vehicle for that work. The Model has helped the system to establish good values by which to guide its work with youth, and provided a much-needed framework for supporting staff in working with youth who have experienced trauma. (Telephone interview with Ron Spitz, Vice President of Programs, Children's Home of Reading, Jan. 14, 2013.)

[14]National Child Traumatic Stress Network, http://www.nctsn.org/. The curriculum is Think Trauma: A Training for Staff in Juvenile Justice Residential Settings, available at http://www.nctsn.org/products/think-trauma-training-staff-juvenile-justice-residential-settings. First-time users need to register on the site to access its extensive library of resources.

[15]Again, the National Child Traumatic Stress Network has developed Think Trauma, a comprehensive training specifically designed for juvenile justice professionals working with youth in residential settings, supra, note 14.

[16]Prison Rape Elimination Act of 2003, 42 U.S. Code § 15601 et seq, and regulations promulgated at 28 Code of Federal Regulations, part 115, available at http://www.ojp.usdoj.gov/programs/pdfs/prea_final_rule.pdf.

[17]The terms "seclusion", "solitary confinement," and "isolation" are used interchangeably in this brief to refer to the imposition of locked room time for mental health, protection, or disciplinary reasons.

[18]See Sue Burrell (2009), Moving Away from Hardware: The JDAI Standards on Fixed Restraint, prepared for the Annie E. Casey Foundation Juvenile Detention Alternatives Initiative, pp. 1-2, 8-10.

[19]Lindsay M. Hayes (Feb. 2009), Characteristics of Juvenile Suicide in Confinement Facilities, OJJDP Juvenile Justice Bulletin, p. 6.

[20]National Center for Positive Behavior Interventions and Supports, U.S. Department of Education, Office of Special Education Programs, at http://www.pbis.org/community/juvenile_justice/default.aspx.

[21]The stark, punitive character of many juvenile facilities is effectively reflected back to us in the work of photographer Richard Ross, whose Juvenile-In-Justice project can be found here: http://www.juvenile-in-justice.com/

[22]In Missouri, for example, state facilities have wooden bunk beds, plush sofas, stuffed animals, microwaves, musical instruments, cats, and a variety of sharp objects that would produce apoplexy in staff working in more traditional punitive environments.

[23]Monique T. Marrow, Kraig J. Knudsen, Erna Olafson, and Sarah E. Bucher (2012), The Value of Implementing TARGET within a Trauma-Informed Juvenile Justice Setting, Journal of Child & Adolescent Trauma, 5(3), pp. 257-270, 261.

[24]See, for example, materials developed through the MacArthur Foundation Research Network on Adolescent Development at http://www.adjj.org/content/index.php

[25]In Roper v. Simmons, 543 U. S. 551, 577 (2005), the Court recognized that, because of their lack of maturity and underdeveloped sense of responsibility, juveniles make "impetuous and ill-considered actions and decisions," and are unlikely to consider the possible punishment before acting; see also Graham v. Florida, 130 S. Ct. 2011, 2028 (2010); Miller v. Alabama, 132 S.Ct. 2455, 2465 (2012).

[26]Richard A. Mendel, No Place for Kids, supra, note 9; Barry Holman and Jason Ziedenberg (2006), The Dangers of Detention: The Impact of Incarcerating Youth in Detention and Other Secure Facilities, A Justice Policy Institute Report.

[27]Monique T. Marrow, Kraig J. Knudsen, Erna Olafson, and Sarah E. Bucher, "The Value of Implementing TARGET within a Trauma-Informed Juvenile Justice Setting," supra, note 23, p. 267.

Suggested Citation

Burrell, S. (2013). *Trauma and the Environment of Care in Juvenile Institutions.* Los Angeles, CA & Durham, NC: National Center forChild Traumatic Stress.

Attorneys

NCTSN The National Child Traumatic Stress Network

ABA Center on Children and the Law
AMERICAN BAR ASSOCIATION

TRAUMA:
What Child Welfare Attorneys Should Know

EXECUTIVE SUMMARY

Each year, over 45 million children in the United States are affected by violence, crime, abuse, or psychological trauma.[1] Trauma exposure can significantly interfere with the way children's brains assess threat, which in turn can affect how they respond to stress. The negative impact of trauma exposure is particularly relevant for children and families in the child welfare system, as the majority of child welfare-involved clients have experienced multiple traumas, including abuse, neglect, and exposure to domestic violence. By understanding the impact of trauma on youth and families, and incorporating trauma-informed skills into legal advocacy, attorneys representing children or parents in child welfare cases can improve outcomes for their clients.

This document is intended to provide you with knowledge about the impact of trauma, practice tips for incorporating trauma-informed practices into legal representation, and resources to assist in the representation of clients with histories of trauma. Its intent is to guide you in your representation of clients, with the understanding that not all suggestions will be applicable or appropriate in all cases.

Trauma-informed legal practice can strengthen legal advocacy, improve attorney-client relationships, and ensure appropriate screening, in-depth assessment, and evidence-based treatment. In addition, awareness of secondary traumatic stress can improve prevention, identification, and self-care among legal professionals.

Below is a summary of tips that may assist you in incorporating trauma-informed skills and principles into your everyday practice. More detailed information about each of these tips can be found in the document that follows.

TABLE OF CONTENTS

PRACTICE TIPS

General Tips for Representing Clients in Child Welfare Cases

- Identify known or suspected trauma the client may have experienced.
- Consider the role trauma exposure may play in a client's behaviors, including refusal to engage in treatment, missing court appearances or appointments, as well as exhibiting hostility, apathy, or defiance during court proceedings. These behaviors could be misinterpreted signs of an alarm reaction or trauma response.
- Provide structure, predictability, and opportunities for the client to exert control over decisions as appropriate.
- Provide adequate explanation to the client about his case, including your role as the attorney, a reasonable understanding of the purpose of court proceedings, and a realistic expectation of the potential outcome of court proceedings.
- Advocate for placement stability for children. When placement change is necessary, advocate for a planned transition that occurs gradually rather than abruptly.
- Advocate for visitation to begin immediately between child and parent, unless this poses a threat to the child's physical or psychological safety or the child does not want visitation.
- Support visitation that is intentional, well-planned, and held in a neutral location away from where the trauma occurred. Make every effort to prepare the child for visitation.
- Encourage continuity of treatment after transitions and collaboration among professionals providing services for the client.
- Promote client resilience by leveraging existing social supports, advocating for client involvement in services and activities that increase a sense of mastery and competence, and making referrals for trauma-informed mental health treatment when appropriate.

Trauma Screening, Assessment, and Treatment

- Advocate for universal screening of trauma exposure and related symptoms.
- Provide universal in-depth assessment for those children and parents for whom a screening identifies a history of trauma.
- Make referrals or advocate for appropriate trauma treatment for clients affected by trauma exposure. Not all mental health providers are trained to provide evidence-based trauma treatment, so it is important to identify the type of treatment offered.
- Coordinate with a client's existing therapist to ascertain information about trauma triggers, suggested steps for ameliorating trauma triggers, the treatment being provided, and any other relevant information, such as risk for self-harm.

Attorney-Client Relationship

- Consider issues of physical and psychological safety when advocating for clients and resist practices that may re-traumatize children and parents.
- Meet in a quiet space with minimal distractions and outside the presence of other parties who may contribute to the client feeling threatened.
- Provide adequate information about the attorney-client meeting, including the purpose of the meeting, expectations for the meeting, and length of the meeting.
- Provide a thorough explanation about the court process, including the purpose of each court hearing, the information that you will present in court, and potential questions that the judge or attorneys may ask of the client. Allow the client time to practice and role-play responses.
- Be alert for signs of a trauma reaction, which typically present as some variation of the fight, flight, or freeze response. These signs may include lashing out, shutting down or withdrawing, or regressive, defiant, or disrespectful behaviors.
- Try to avoid startling the client with loud noises, sudden movements, or unexpected news without adequate explanation or preparation.
- Minimize touching the client, which can trigger a reaction in individuals with histories of physical or sexual abuse.
- Avoid overpromising or telling the client that "everything will be fine." Clients may be triggered by feeling let down or misled by their attorney.

Secondary Traumatic Stress

- Maintain work environments for staff that increase resilience and acknowledge, reduce, and treat vicarious or secondary traumatic stress.
- Identify and engage in self-care on an individual and organizational basis.

TRAUMA:
What Child Welfare Attorneys Should Know

1 Defining Trauma-Informed Legal Advocacy

In 2014, more than 700,000 children in the United States were exposed to child maltreatment and more than 400,000 children were residing in foster care.[1] Children in foster care are likely to have been exposed to multiple forms of trauma, such as physical or sexual abuse, neglect, family and/or community violence, trafficking or commercial sexual exploitation, bullying, or loss of loved ones. [2] In addition to situations of abuse or neglect that lead to their removal from their homes, children in care may experience further stresses after entering the system. Separation from family, friends, and community is often referred to as system-induced trauma.

The majority of parents or caregivers involved in the child welfare system have also experienced trauma and many were maltreated or placed in foster care as children. Addressing trauma among families involved in child welfare is essential to stopping this cycle of maltreatment. Without proper intervention, the negative effects of childhood trauma may persist into adulthood, and can result in higher rates of psychiatric or medical illness, substance use, criminal offending, and early death.[3]

The Attorney General's National Task Force on Children Exposed to Violence1 recommends that all professionals serving children exposed to violence and psychological trauma learn about and provide for trauma-informed care and trauma-focused services. Similarly, the American Bar Association has called for integrating trauma knowledge into daily legal practice and integrating and sustaining trauma awareness and skills in practice and policies.[4]

Trauma-informed systems are structured with an understanding of the causes and effects of traumatic experiences, and incorporate practices that support recovery. [5] A system-wide approach requires involvement by all stakeholders working with children and their families, including caseworkers, attorneys for all parties, judges, service providers, birth parents, and caregivers such as foster parents and kinship caregivers.

By enhancing the ability to recognize the impact of trauma, respond appropriately, and avoid legal practices that may re-traumatize children or parents, trauma-informed legal representation can support recovery and enhance resilience, thus improving outcomes for children and families. Incorporating trauma-informed skills into legal practice can also improve attorney-client relationships, increase opportunities to advocate for appropriate services, and enhance prevention, recognition, and mitigation of secondary traumatic stress (STS; see Section Eight).

Trauma-informed legal representation may include:

1. Identifying all known and suspected trauma the client may have experienced
2. Understanding parent and caregiver trauma and its impact on the family
3. Considering the legal implications of routine screening for trauma exposure and related symptoms, particularly for parents and dual-system involved youth (see Glossary)
4. Making appropriate referrals for culturally sensitive, evidence-based assessment and treatment for traumatic stress and associated mental health symptoms
5. Advocating for provision of resources (e.g., psychoeducational books, victim assistance information) about trauma exposure, its impact, and treatment for children, families, and stakeholders
6. Understanding and promoting resilience and protective factors for children and their families
7. Encouraging continuity of care and collaboration across child-serving systems
8. Maintaining work environments for staff that increase staff resilience and address, reduce, and treat vicarious or secondary traumatic stress
9. Considering issues of physical and psychological safety when advocating for clients and resisting practices that may re-traumatize children and parents
10. Maintaining awareness of one's own behaviors, tone of voice, body language, and approach when engaging and questioning clients who may have a history of trauma
11. Taking steps to make clients more comfortable and to recognize when clients are having a trauma reaction
12. Engaging in continuing education about trauma to learn new and developing information that can benefit clients

These suggestions identify actions you can take to promote a trauma-informed response to your clients, *with the understanding that the confines of professional conduct, including confidentiality and ethical considerations as well as strategic case planning, may affect one's ability to act on these recommendations in individual cases.* In addition, advocates should always clearly explain their role to child clients, whether they are representing the client's expressed wishes as an attorney, best interest as *guardian ad litem*, or taking a hybrid approach.

By keeping these principles in mind, you can build more effective relationships with your clients to serve their legal interests, work to ensure necessary service needs are met, and support clients' current and future well-being.

2 The Impact of Trauma Exposure on Child Development

Approximately 80 to 90 percent of youth involved in the child welfare system have experienced at least one traumatic event.[6] Trauma may result from either direct experiences, such as being neglected or abused, or witnessed experiences including domestic violence between caregivers. Children may also be traumatized by hearing about something that happened to their parent or caregiver (e.g., serious injury, incarceration).[7]

Traumatic experiences early in life may alter how the brain assesses threat and how clients respond to stress. A fight or flight response may be "triggered" by anything that reminds a client of past traumatic events, causing a perception of immediate danger. A triggered youth or adult may engage in aggressive or avoidant behaviors in an effort to feel safe; behave defiantly or aggressively to keep others at a distance; or attempt to escape the situation. Common responses include running away from home or school; avoiding attorneys or court hearings perceived as threatening; shutting down; or "spacing out."

There are a range of potential reactions to traumatic events. Most trauma survivors, including youth in the juvenile justice system or parents accused of maltreatment, will recover from their experiences and thus should not be viewed as "damaged" or beyond help. Trauma's impact on the brain and normal child development can be reversed with appropriate treatment and other supports (see Section Six). Recovery is related to resilience; and attorneys can promote clients' resilience in a number of ways, listed below.

PRACTICE TIPS: PROMOTING CLIENT RESILIENCE

Leverage existing social supports – immediate and extended family, fictive kin (see Glossary Terms, page 7), **community and religious leaders, school staff, coaches, etc.**

Advocate for clients' involvement in services or activities that increase their sense of mastery or competence, such as parenting classes/training for caregivers, or afterschool activities for children and youth.

Support clients in developing effective coping skills by referring them to trauma-informed treatment as indicated, and helping them cope with potentially distressing court proceedings or transitions by adequately explaining them in advance.

While many youth and adults who experience trauma are able to work through subsequent challenges without professional intervention, some will develop symptoms of Posttraumatic Stress Disorder, or PTSD (see Glossary Terms, page 6, for definition). PTSD increases the risk for negative outcomes across the lifespan, including academic challenges and peer problems in childhood and criminal justice involvement in adolescence and adulthood. (See Appendix, Section Two, for additional resources on how trauma may affect clients in different age groups.) Some clients may experience partial symptoms of PTSD or develop other disorders such as substance use, depression, or anxiety.

Many trauma survivors will not meet criteria for a PTSD diagnosis but will experience significant trauma-related impairment in daily living. Youth or adults with more chronic or pervasive exposure to traumatic events, termed complex trauma, may suffer additional challenges that are not captured by the PTSD diagnosis (see Glossary Terms). Whenever possible, clients should be screened. If a trauma screen reveals trauma exposure, a further in-depth assessment for trauma exposure and related symptoms to determine the impact of their traumatic experiences and need for appropriate treatment is warranted (see Section Five).

3 The Impact of Trauma Exposure on Parents

Approximately 90 percent of parents or caregivers involved in the child welfare system have histories of trauma exposure, including high rates of childhood abuse and neglect, and a significant number were involved in the system as children.[8,9,10] Additionally, families may be affected by historical trauma resulting from societal racism and oppression towards ethnic minorities, particularly African-American, Native American, and immigrant communities. The impact of these traumatic experiences on both caregivers and their children can be inadvertently intensified by institutional practices within systems such as child welfare or juvenile justice.[11]

Exposure to trauma does not always determine adverse outcomes for parents and their children. However, for some parents, prior trauma exposure may negatively impact the manner in which they interact with their children, thereby placing children at higher risk for traumatic stress. This is also known as intergenerational trauma. For example, parents with histories of repeated exposure to violence may have greater difficulty recognizing the adverse effects of violence exposure for children. Untreated PTSD can also interfere with a parent's ability to use safe and effective parenting strategies and protect their children from abuse by others.[12,13] In turn, without effective intervention, children exposed to neglect or abuse are significantly more likely to perpetrate violence against dating partners, enter into abusive relationships in adolescence and adulthood, and perpetrate abuse of their own children when they become parents.[14,15,16] Consequently, addressing traumatic stress within families in the child welfare system is essential for reducing rates of child maltreatment and interrupting the intergenerational transmission of trauma. Further, recognition of these risks can position attorneys to recommend resources to clients that lessen the impact of risks and bolster clients' resiliency.

Trauma can affect a parent's approach to discipline and child-rearing.

Parents with trauma histories who abuse or neglect their children may view their parenting behavior as normal, and may not understand that there are alternative ways of interacting with their children. Additionally, a traumatized parent may be hypervigilant or overly focused on identifying potential threats to his or her child. Hypervigilant parents may react harshly to child misbehavior because they fear consequences or reactions from others if their children continue to misbehave. Parents with trauma histories may also place extreme restrictions on their children, such as requiring them to spend all free time at home to avoid potential danger. Trauma can also deplete a parent's psychological and physical energy as well as the financial and social resources necessary to accomplish parenting tasks.

After a client-centered decision-making process that includes legal counseling of the client, parent attorneys can advocate for participation in trauma-informed parenting workshops and treatment *(see Section Six)*. Since reunifi-

GLOSSARY OF TERMS

Trauma
Exposure to actual or threatened death, serious injury or violence in one of the following ways: 1) direct experience; 2) witnessing a traumatic event; 3) learning that a loved one experienced trauma; or 4) repeated or extreme exposure to aversive details of traumatic events (e.g., child welfare attorneys who develop secondary traumatic stress after repeated exposure to their clients' trauma stories).

Child Traumatic Stress
Occurs when a child experiences a traumatic event or situation that upsets and overwhelms his or her ability to cope; and the signs and symptoms interfere with the child's daily life.

The Body's Alarm System
Function of the brain that scans the environment for potential danger and prepares us to act. When triggered, the alarm system sets off a cascade of immediate physiological changes that prepare one for Fight-Flight-Freeze response in order to stay safe. This is a complex response that involves multiple areas of the brain, including the sympathetic nervous system and the amygdala.

Trigger
A reminder of a past traumatic event that sets off the body's alarm system, so that the person feels in imminent danger once again. A "trigger" can be anything connected to a traumatic event, including an event, situation, place, physical sensation, or even a person.

Posttraumatic Stress Disorder
A mental health disorder most commonly associated with trauma exposure. PTSD is characterized by problems in four areas: re-experiencing (i.e., flashbacks or nightmares of traumatic event); avoidance of thoughts or reminders of past trauma;

cation is the ultimate goal in most child welfare cases, and most children in the child welfare system reunify with their biological families[17], it is essential that parents and caregivers receive needed trauma-informed services in order to begin the healing process and improve their capacity to provide safe and stable home environments.

Trauma can affect parental reactions to court proceedings and an attorney's working relationship with the parent.

For parents or caregivers with histories of trauma, child welfare proceedings may present particular challenges that can significantly interfere with their ability to effectively manage court proceedings and relationships with court and child welfare professionals. Parents who have experienced trauma may exhibit difficult behaviors such as angry outbursts, lateness, refusal to return phone calls, and missed appointments or court appearances. One study of child welfare-involved mothers also found that those who had previous involvement with the system as children were significantly less engaged with services provided through child welfare agencies.[18] These behaviors may be interpreted as hostility or apathy, but may in fact be symptoms of traumatic stress. Traumatic stress pushes the brain into a hypervigilant mode that may cause individuals to be highly sensitive to power differentials, perceived attacks, and a perceived loss of control. This may result in a parent's distrust of, and irritability toward, those who appear more powerful and in control, such as attorneys, judges, and child welfare caseworkers.[a] In such cases, parents may need additional support to help them understand those reactions, and the impact of those reactions on the overall case. Lifelong traumas may also teach ineffective ways to assert power in the world. It is understandable for parents to exhibit distrust of a system that may have been unhelpful, even harmful, in the past, especially if they have lived in poverty and have dealt with structural racism in the very systems designed to help them. Understanding these reactions can help you develop a more effective attorney-client relationship.

[a]*Traumatic stress may decrease a parent's ability to perceive the world accurately, process information, remain organized due to executive function deficits, and increase risk of substance use. In turn, this may contribute to an increased risk of maltreating their children.*

negative changes in thought or mood (i.e., persistent negative emotions, persistent or exaggerated negative beliefs about oneself, others, or the world); and hyperarousal (angry outbursts, being constantly "on guard" against potential threats). Some people may also experience dissociation. (See Appendix Section Two for additional information).

Complex Trauma
Refers to exposure to multiple or prolonged forms of traumatic experiences in childhood and the wide-ranging, long-term impact of this exposure. Complex trauma disrupts normal child development and may lead to difficulties with attachment (i.e., ability to form trusting, meaningful relationships); managing emotions and behavior; and executive functioning (i.e., ability to focus attention, solve problems, plan or pursue long-term goals).

Kinship Foster Care
Refers to the placement of youth in foster care that is provided by grandparents, aunts, uncles, or other family members.

Fictive Kin
Individuals who play an important role in a youth's life but are not related through marriage or birth.

Dual-System Involved Youth
Refers to youth who are involved in both the child welfare and juvenile justice systems.

Psychological Safety
The belief that one is safe from emotional harm and has the ability to manage threats to safety. Psychologically safe environments encourage respect for others' feelings, even when there is disagreement. Individuals can also increase their own sense of psychological safety in stressful situations by learning and using coping skills.

Dual-System Involved Youth
Youth involved in both the child welfare and juvenile justice systems)

4 The Impact of Trauma on the Attorney-Client Relationship

Trauma can interfere with the formation of strong client-attorney relationships by impairing the client's capacity to trust others, process information, communicate, and respond to stressful situations. Understanding trauma's impact on behavior can help you modify your approach with traumatized clients, prepare clients for court proceedings in a way that reduces their likelihood of a traumatic response, and advocate for clients in a way that empowers them and helps build a sense of safety and resiliency. With adequate preparation, clients may feel empowered by the opportunity to tell their stories and receive empathy and effective support from the professionals involved.

To establish an effective working relationship with traumatized clients, you should focus on physical and psychological safety, communication, and client support.

Physical and psychological safety:

When a client is reminded, either consciously or unconsciously, of a past trauma, that trigger may cause the client to feel as if she is in imminent danger. When traumatized clients feel physically or psychologically unsafe, they may become focused on protecting themselves and avoiding the perceived danger. As a result, they may not listen to or process information accurately, may refuse to talk, or simply agree to anything in order to leave. You can assist your client and establish a safe environment by providing structure and predictability, allowing the client to make informed decisions about his or her case whenever possible.

Court hearings and other procedures in the child welfare system may inadvertently trigger or re-traumatize clients with trauma histories. For example, clients are frequently triggered by a perceived loss of control or power, such as court decisions made about placement or visitation. Therefore, you should give clients a clear voice in decisions related to their representation, elicit their views, and seek active, age-appropriate involvement.

When triggered, clients may react in ways that are misinterpreted by the court. For example, a child may withdraw emotionally or physically *(often described as freezing or shutting down)* in response to questions about desire for contact with a parent. Or, a parent with a trauma history may shut down or react defiantly during cross-examination. A child placed in foster care, particularly an adolescent, may run away or act out in response to conflict with a foster parent or group home staff member. Judges, attorneys, and other professionals may view such a client as uncooperative or disinterested rather than as someone who is having a trauma response. You can advocate for clients by explaining to the court and the other parties that the client's behavior is a reflection of underlying trauma. Decisions regarding such disclosures should be case-specific and within the bounds of attorney-client privilege and your specific attorney role.

Some suggestions for increasing physical and psychological safety include:

- Meet in a quiet space where there are minimal distractions, away from other parties who may make your client feel threatened.
- Inform the client of the purpose of that day's meeting, what to expect during the meeting, and how long the meeting will last. Several shorter meetings can build familiarity and be more productive than a single, longer meeting. Make sure to ask what questions the client may have.
- Explain the court process. Let the client know what you are going to say in court, questions you may ask the client, and questions the judge or opposing attorney may ask (particularly when you anticipate an adversarial cross-examination). Knowing what to expect can help your client feel less anxious during a hearing. Allowing the client time to practice responding and role-playing can increase a sense of control and safety.

As part of explaining the court process to child clients, it is also important to provide a realistic understanding of the potential outcomes of a court hearing. It can be empowering for child clients to know that their attorney is listening to them and will express their wishes in court, but it is also important for them to be prepared for the possibility that those wishes may or may not be granted or taken into consideration.

Additionally, when child clients are not present for court hearings, it can be triggering for them to know there was a court date but not be informed about what happened at that hearing. Children and youth should attend their own hearings whenever possible. When their presence is not possible, it is important to provide information about what happened or some type of update in an age-appropriate manner.

Communication:

Clients who have experienced trauma may experience greater difficulty forming trusting relationships with their attorneys. Many youth in the child welfare system have been hurt by a caretaker or authority figure they trusted, and many parents distrust "the system." Such clients may not believe that you will actually advocate for them. Clients also may be slow to share emotionally-charged information, or may not feel safe expressing preferences regarding their desired outcomes, such as visitation or placement. Developing an effective attorney-client relationship takes time and patience.

You can learn to recognize signs that a client may be experiencing a trauma reaction so that you do not misinterpret or exacerbate the client's response. Trauma reactions typically represent some version of fight, flight, or freeze. A client who suddenly becomes loud or combative may be going into "fight mode" in order to keep herself safe by pushing others away. Clients may go into "flight mode" and try to avoid a triggering situation by refusing to answer sensitive questions or attempting to leave a meeting or court hearing. Clients may also "freeze" by shutting down or dissociating *(a common response to trauma when a person mentally shuts down or "goes elsewhere")*. She may sit quietly but will no longer be paying attention. Do not assume that silence means the client understands or consents. *(Appendix Section Four includes information about identifying signs of trauma reactions in clients.)*

PRACTICE TIPS TO AVOID TRIGGERING CLIENTS WITH PRIOR TRAUMA

Look for signs of trauma reactions. As discussed in this section, clients may exhibit variations of the fight, flight, or freeze response.

Try not to startle the client. Loud noises *(including yelling)*, sudden movements *(jumping up from a chair)*, or unexpected news can all trigger trauma responses.

Prepare the client for what is ahead. Predictability is important to establishing a trusting relationship. Preparation can help minimize your client's hypervigilance to threats from unfamiliar or unexpected sources.

Minimize touching the client. You may intend to be supportive when you put your arm around a child or touch a parent's shoulder, but that can trigger a reaction in people who have been physically or sexually abused. By respecting your client's personal space, you can help build the client's sense of control and safety.

Do not overpromise or tell the client "everything will be fine." This includes promising clients you will always be there for them. Attorneys frequently change. Be honest in your communications because clients may be triggered by feeling let down or misled by their attorney. Remember that clients' behaviors may also be influenced by the expectation that you will inevitably disappoint them, so be honest and forthright from the start.

[b] *Child participation in the court process is considered a best practice by national organizations such as the American Bar Association, National Council of Juvenile and Family Court Judges, and National Association of Counsel for Children. A study in Nebraska found that children's anxiety levels related to court participation were low overall and even lower for children who had attended court. The children who attended court also viewed the judgments as more fair. A recent New Jersey study showed that court participation is not upsetting for youth, but can provide an opportunity for them to be heard. It also provides better information to both the youth and the court.*[19]

Client support:

Parents and children who are involved in the child welfare system may still have strong attachments to and pleasant memories of family members. In fact, a child can remain emotionally attached to a dysfunctional family and may be further traumatized by complete loss of contact with relatives. Family members can offer the best source of long-term support for a traumatized child. It is essential that a child stay connected with siblings, relatives and extended family (as defined by the client), and friends. In cases in which ongoing family contact is not feasible or is contraindicated for safety reasons, you can look for ways to involve other people trusted by your client, such as a family friend, coach, teacher, or pastor.

Finally, you should be aware that some clients may find the experience of court involvement traumatizing, whether from memories of past involvement, interactions with or observations of others in the courthouse, and especially the intensity of the courtroom environment itself. Trauma triggers might include an attorney's behaviors, tone of voice, body language or approach to questioning. You can take steps to make your clients more comfortable and to recognize when clients are having a trauma reaction.

POSSIBLE SIGNS THAT YOUR CLIENT HAS BEEN "TRIGGERED"

Lashes out verbally or physically

Becomes defiant, disrespectful
(fight response meant to keep potential threats at a distance)

Has difficulty tracking the attorney's questions

Shuts down, stops talking

Becomes jumpy, fidgety, starts pacing

Has sudden, dramatic shifts in mood

Looks spaced out, gets lost in conversation, or appears to have "gone somewhere else"

Speech grows louder, faster

Suddenly tries to leave situation
(flight response)

Adopts regressive behaviors
(thumb sucking, rocking)

Client Resiliency:

It should be noted that despite trauma histories and traumatic stress reactions, clients are often resilient. Your actions during the course of legal proceedings can further bolster resiliency. Whether through advocacy for treatment *(Section Six: Effective Treatments for Traumatic Stress)* or facilitating a client-attorney relationship that conveys awareness of traumatic stress reactions, promoting a psychologically safe environment using the above strategies can support your clients' improved management of traumatic stress reactions.

5 Screening and Assessment

Clients involved in child welfare proceedings should be routinely screened for exposure to trauma and related mental health conditions in order to determine their need for therapy and other services. In this section we distinguish between screening, assessment, and neuropsychological evaluations.

Screening refers to a brief set of questions administered to children, parents or caregivers to identify clients who likely suffer from trauma-related impairment. Screening can be conducted by attorneys using validated assessment instruments. Any client who screens positive for likely trauma exposure or symptoms can be referred to a qualified mental health professional for a full assessment. Various trauma-informed screening instruments and questionnaires are available for use *(see NCTSN Measures Review Database).*[20]

A ***trauma-informed mental health assessment*** refers to a comprehensive evaluation conducted by a trained mental health provider such as a social worker, psychologist, or psychiatrist. The goal is to determine if the client is suffering from traumatic stress or other mental health problems and to generate recommendations for treatment or other social services. The provider conducting the assessment gathers information on trauma experiences or symptoms along with other mental health symptoms, medical issues, academic and employment history, and family dynamics, as well as strengths exhibited by the child, parent, family, and community. A thorough assessment should include information from several sources, including clinical interviews with the child, caregivers, and collateral informants; review of client records (school, medical, and mental health treatment); and behavioral observations.

Neuropsychological evaluation *(also referred to as cognitive evaluation)* is used to assess a child's current level of intellectual and academic functioning. Such evaluations may be warranted for clients who are experiencing significant academic or vocational problems or are suspected of having undiagnosed learning disorders or developmental delays. The latter are quite common among children with prior trauma exposure. You may need to make the case that such an assessment is required by reasonable efforts and request that the court order the assessment and approve payment by the child welfare agency.

Integrating trauma screening and assessment findings into court reports is a key element of a trauma-informed child welfare court system. Including these findings will assist the court to understand the impact of trauma on the child and parent, develop plans that support their resilience, and avoid decisions that may re-traumatize the child and parent. Screenings, assessments, and evaluations may need to be court-ordered. Depending on local law, the results are generally made available to all parties or may be obtained by one party or the other for use as an advocacy tool.

PRACTICE TIPS: CONSIDERATIONS FOR TRAUMA SCREENING AND ASSESSMENT

A trauma assessment is very different from a mental health assessment conducted as part of a custody evaluation. The former is not designed to provide recommendations regarding placement and visitation within the child welfare context.

Although it is recommended that you advocate for trauma-informed assessments of clients who screen positive for trauma exposure or symptoms, this may not always be possible within the confines of your particular role. Parents' attorneys in particular may resist trauma assessments if the parent client is not amenable to an assessment or if the attorney has concern that the parent may be viewed by courts as too "damaged" to be rehabilitated. In this case, one option is to consider whether this concern is outweighed by the potential benefits. Trauma screening and assessment will help ensure that parents with traumatic stress receive appropriate services to help facilitate their healing and address mental health issues that potentially impact their legal cases. While it is ultimately the client's decision, parents' attorneys can also engage in client-centered counseling to present both the potential benefits and potential risks of a trauma-informed assessment.

You should be aware of potential legal consequences related to information shared during court-ordered assessments. For example, an accused parent may report information on trauma history that could be used against him in court proceedings. Likewise, acknowledgment of living with an abusive spouse could be used as evidence that the parent is providing an unfit home environment for the child.

Whenever possible, each child and parent involved in child welfare proceedings should be screened for traumatic events and related symptoms as long as the jurisdiction has sufficient legal protections to ensure the information will not be used in ways that will further harm the youth or family.

Not all mental health agencies routinely ask about trauma exposure or symptoms during their assessments. You should make efforts to ensure that the child welfare agency arranges for trauma-informed assessments.

6 Effective Treatments for Traumatic Stress

Even severely traumatized youth and adults can recover from trauma with the right supports, including effective mental health treatment. The terms trauma-informed or trauma-focused treatment refer to mental health interventions designed to help people recover from traumatic stress. There are evidence-based trauma-informed or -focused interventions for every age group, ranging from infants to adults *(see NCTSN Empirically Supported Treatments and Promising Practices)*.[21]

There are individual treatments for a traumatized child or parent as well as treatments designed for the parent and child to work together. Trauma-focused treatments can support client resilience by helping the client develop effective coping and problem-solving skills, build on strengths, reduce trauma-related symptoms, and improve social, academic, and developmental functioning. Trauma-informed treatment has been shown to improve mental health and behavioral outcomes among children and parents and to reduce the likelihood of future abuse or neglect.[22, 23]

Whenever a client undergoes a comprehensive assessment *(see Section Five)* and is found to suffer from trauma-related impairment, you should advocate for trauma-informed treatment. A core principle of trauma-informed practice is to provide clients with a sense of control over the process. Thus, you should ask about and advocate for client preferences about treatment modality *(e.g., individual, family, or group treatment)* and therapist gender. Regarding the latter, some youth have an aversion to or may be triggered by a clinician of the same gender as their abuser.

Not all treatments are trauma-informed, including many of the treatments commonly recommended in family courts, such as parenting groups, substance abuse treatment, or anger management. Clients with traumatic stress are less likely to benefit from such interventions and more likely to end treatment prematurely. A negative treatment outcome may be used against the client (particularly a parent) as evidence he is unwilling or too damaged to change behaviors. Therefore, you should advocate that your clients are referred to trauma-informed treatment when indicated.

Many mental health providers have not been trained in trauma-informed treatment. In order to identify trained providers, you can search through relevant online directories. You can also interview prospective treatment providers to determine whether they offer trauma-informed treatment *(see Appendix Section Six)*.

CORE ELEMENTS OF TRAUMA-INFORMED/FOCUSED TREATMENT

Educating clients regarding trauma and its impact

Increasing client sense of physical & psychological safety

Identifying triggers for trauma reactions

Developing emotional regulation skills
(i.e., skills to help control and express strong feelings)

Developing trauma-informed parenting skills

Addressing grief and loss *(when appropriate)*

Processing traumatic memories

7 Placement Decisions, Transitions, and Visitation

The child welfare court system has historically focused on physical safety. More recently, however, there has been increased attention on ensuring psychological safety for children and families. Psychological safety is the ability to feel safe within one's self as well as safe from external harm. The inability to feel safe can impact an individual's interactions with others, can lead to a variety of maladaptive coping strategies, and can result in anxiety.

Removing a child from a home where there is neglect or abuse may improve his or her physical safety, but at the same time may impair the sense of psychological safety for both the child and the parents. Research shows that frequent placement changes are associated with poor outcomes for children involved in the child welfare system.[24,25] You may not have the power to alleviate your clients' distress, but you can minimize trauma caused to families involved in the child welfare system and improve their sense of safety by becoming an advocate for them during the following critical junctures:

Placement Decisions:

In jurisdictions with client-directed representation, you should advocate for a child client's stated interests. Giving a child a voice in the proceedings will help the child feel that she has some control in a process that can otherwise be overwhelming and even traumatic. Attorneys advocating for the child's best interest should also consider the child's wishes in making the best-interest determination. You should first consider whether the child can safely remain in the home with any needed supports to minimize disruptions. When children must be removed from their homes, you should advocate that they be placed with a relative who is willing and able to provide a physically and psychologically safe home environment.

You should seek the input of your client, whether this is a child or parent, regarding relatives who may be able to provide a safe home for the child. You should also advocate for siblings to be placed together except in cases of suspected sibling abuse or other safety concerns. Research shows that youth who are initially placed in kinship foster care and with all their siblings are significantly more likely to achieve stable placement and exit the system.[26]

In cases when an out-of-home placement is unavoidable, you should consider advocating for a placement close to the child's home community. This will allow the child to maintain connections with his or her support systems including extended family, church, school, teachers, mentors, and coaches. When a child is placed outside his community, you should advocate that he remain in the same school, unless it is in his best interest to move to a new school. This can also provide the stability, continuity, and connections with adults that are needed. One positive relationship with an adult can make all the difference for a child! Having a stable, nurturing relationship with an adult can facilitate tremendous healing and develop resilience for a child who has experienced trauma.

Transitions:

You can help with transitions through thoughtful and planned decisions regarding placements, visitation, and reunification. You can:

- Advocate for a minimal number of moves and placement changes
- Assess the appropriateness of any placement based on the child's emotional, social, developmental, and medical needs
- Advocate for allowing both the child and caregiver time to prepare for visits with a parent
- Request time to say goodbye to a foster family by planning for reunification or a placement change in advance.

Visitation:

Children involved in the child welfare system often strongly voice a desire for contact with their parent(s), even in cases when the parent was abusive or neglectful. Thus, attorneys representing children or parents should advocate for visitation to begin as soon as possible except when it threatens the physical or psychological safety of the child or the child expressly does not want visitation with a parent.

Visitation should be intentional and well planned. It should be held in a neutral location away from any environment where a child may have experienced trauma. When appropriate, encourage and facilitate positive relationships and communication between birth parents and caregivers about the child's routines, habits, triggers, and coping skills. *(See Appendix Section Seven: "Working with Parents Involved in the Child Welfare System – Visitation.")*

Visits may trigger trauma reactions, so you can prepare your client *(child or parent)* in advance. It may be beneficial to communicate with the client's therapist to understand potential reactions to visits or when considering advocating for a change in visitation. Ask child clients how they feel about visits and try to determine what might trigger them *(sights, sounds, smells, places, voices, etc.)*. You should communicate with the therapist regarding a client's reactions to visits before requesting changes in visitation. You can also encourage parent clients to use visits as an opportunity to practice certain skills and demonstrate their ability to parent safely.

8 Secondary Traumatic Stress and Attorneys

The terms vicarious trauma or secondary traumatic stress *(STS)* describe the negative physical and psychological health consequences resulting from repeated exposure to the stories and experiences of traumatized clients. Attorneys handling child welfare cases are at high risk for developing secondary traumatic stress reactions due to frequent exposure to trauma survivors and their stories of maltreatment. Furthermore, research suggests that a substantial number of attorneys, particularly attorneys practicing specialties such as criminal law and family law, will be threatened with violence at least once in their careers.[27] One study of public defenders found that 34 percent of attorneys reported symptoms of STS while 11 percent met criteria for a diagnosis of PTSD.[28,29]

STS reactions range from decreased empathy towards clients and changes in a sense of personal safety to the onset of PTSD symptoms *(see Section Two)*. STS can lead to impairment in your mental or physical health, job performance, and personal relationships.[30] Those affected by STS may engage in risky or unhealthy behaviors to cope with STS. These behaviors may include increased substance use, experiencing feelings of estrangement from loved ones, or being overly focused on protecting one's own children from danger.

Risk Factors for Secondary Traumatic Stress:

Both individual and job-related or organizational factors may increase your risk for developing STS. Individual factors include a prior history of trauma exposure, such as attorneys who were themselves abused as children, and unhealthy strategies for coping with distress.[29] Job and organizational factors that influence risk for STS include the number of trauma survivors in your caseload, level of coworker and supervisor support, and education and training about STS.[31] In a study on the incidence of STS among attorneys, participants attributed their traumatic stress reactions to a lack of education about understanding clients with trauma histories and the absence of a regular forum for discussing the stress of working with such clients.[32]

Preventing Secondary Traumatic Stress:

There are several strategies that individual attorneys and agencies can adopt to help prevent STS. Training on working with trauma survivors has been shown to increase empathy and confidence in working with this population among mental health providers.[33] Recommended areas of focus for training with attorneys include:[31]

- Understanding the impact of trauma on children and adults
- Acquiring skills for working with trauma survivors
- Recognizing the signs and risks for secondary trauma and
- Practicing stress reduction and management skills such as mindfulness techniques

Formal supervision and peer support groups can also help prevent STS by providing support and a forum for discussing the challenges of working with trauma survivors. Agencies should also offer employee assistance programs or referrals to outside mental health providers for attorneys who develop symptoms of STS.

STRATEGIES FOR SELF-CARE

- Exercise regularly and maintain a consistent sleep schedule
- Eat healthy food and reward yourself with your favorite food occasionally
- Build breaks into your schedule—even if just a few minutes
- Connect daily with others who recharge your emotional state
- Practice mindful activities that can include meditation, yoga, or spiritual practices
- Set and maintain boundaries with clients: clarify that your role as attorney differs from those of social workers, case managers, or other service providers
- Reduce your caseload or diversify your practice, if possible
- Monitor your risk for STS by periodically completing a STS self-assessment tool such as the ProQOL or the Secondary Traumatic Stress Scale (see Appendix Section Eight for links)
- Connect clients with appropriate service providers—use a team approach for clients who have experienced trauma and need a high level of support
- Create a go-to list of local resources for clients
- Access state bar legal assistance programs or confidential support services when available or seek counseling services as needed

SIGNS OF VICARIOUS OR SECONDARY TRAUMATIC STRESS

- Disruption in perceptions of safety, trust, and independence
- Sleeping difficulties or nightmares
- Exhaustion
- Alcohol or drug use to self-medicate
- Anger or cynicism towards "the system"
- Difficulty controlling emotions
- Hyper-sensitivity to danger
- Increased fear and anxiety
- Intrusive thoughts or images of client trauma stories
- Social withdrawal
- Minimizing the impact of trauma
- Illness, increase in sick days at work
- Diminished self-care and depletion of personal resources
- Reduced sense of self-efficacy

POTENTIAL IMPACT OF SECONDARY TRAUMATIC STRESS ON JOB PERFORMANCE

- Reduced empathy towards clients
- Inability to listen to, or active avoidance of, clients
- Over-identification with clients, or conversely, shutting down emotionally *(both responses interfere with effective legal representation)*
- Distancing oneself from exposure to key aspects of a client's history and ongoing trauma, thereby potentially missing events with high probative value in litigation
- Overreaction by displaying hypervigilance through angry outbursts in court, or unduly questioning the credibility of witnesses when emotional legal issues become triggers
- Excessive anger or irritability, as a result of STS, may be masked as zealous advocacy in a trial setting, but may in fact be damaging to the attorney and client.
- Compromised quality of legal service due to emotional depletion or cognitive effects of STS. Some traumatized professionals, believing they can no longer be of service to their clients, end up leaving their jobs or the serving field altogether. Several studies indicate that the development of secondary traumatic stress often predicts that a helping professional will eventually leave the field for another type of work.

The Importance of Collaboration

Collaboration and coordination among service providers and systems comprise a key principle of trauma-informed practice.[5] Therefore, it is important for attorneys and other providers working on a case to both collect and share information to support their clients as appropriate within legal and ethical confines. Benefits of information-sharing include:

- Preventing clients from having to repeat their trauma histories to multiple agencies or providers
- Ensuring that all involved parties understand trauma's impact on the client and tailor their services accordingly
- Increased ability to make sense of the client's behaviors or difficulties

The following section lists the roles played by professionals most often involved in child welfare cases, their scope of practice, and recommendations regarding how to work with each.

Children's Attorneys and Guardians ad Litem:

Many children do not immediately disclose traumatic events, like sexual abuse. Such children are frequently misdiagnosed, based on their behavior, with emotional disturbance, oppositional defiance, bipolar disorder, attention deficit hyperactivity disorder *(ADHD)* or other physical or developmental disabilities. Children may not understand why they engage in these behaviors, and may be afraid to tell the truth because it would require disclosure of the trauma. Collaboration with other parties is key to determining whether another assessment might be warranted. Foster parents and other caregivers often have a wealth of information that can be helpful. Has the child experienced known or suspected abuse or other trauma? If the child is engaging in conduct at home, could that conduct be caused by neurological responses to trauma? Unprovoked anger may be a manifestation of the fight response; running out of school or from home, the flight response; and tuning out, the freeze response. Sleep disturbances *(losing sleep at night, and sleeping during the day)*, inability to focus, and depression may all be caused by trauma. Are there situations that trigger these behaviors? Does the child engage in self-harm, or appear depressed? What helps the child calm down? Conducting a thorough and independent investigation by collecting information from others can help you better understand the child's situation.

Sharing information *(as allowed under ethics rules and privacy statutes)* with parent attorneys, the treating therapist, school personnel, and court staff may benefit the child as well.

Parent Attorneys:

Parents may also have information that can help. However, there are important considerations related to confidentiality and other barriers that a parent attorney must consider. When it can benefit the parent and facilitate help for the child, a parent's attorney can encourage the parent to consider sharing this information. Parent attorneys can also ask their clients about how trauma may affect their parenting ability and discuss with their client the benefits and drawbacks of sharing this information.

Child Welfare Agency Case Worker:

Child services workers are required to regularly check on the child. They see children interact with their parents, foster parents, or kinship caregivers, often in the home. Much of the information case workers discover is incorporated into case planning and reports to the court. They often have additional information that may shed light on the child's experiences.[34,35,36]

School Personnel:

Knowledge and incorporation of trauma-informed practices varies widely among different school systems. It is important that providers involved with the child's case, after obtaining the appropriate releases, inform the school about the child's special trauma needs. A child's case file will often contain information about the child's history, experiences, and family background that the school does not need in order to provide services. However, not all schools have comprehensive policies to protect children's privacy. You should ensure that only the information needed to serve the child is provided to the school, and that such information is provided only to individuals who have been trained to ensure and protect the child's confidentiality.

Many children who are experiencing neurological responses to trauma require accommodations in school to access their education. Common accommodations often provided in an Individual Education Plan *(IEP)* or 504 plan, include:

- Permitting the child to leave class early *(to avoid the hustle and bustle of busy pass times in the hall)*
- Permitting the child to leave class at any time to speak to a counselor
- Providing trigger warnings of materials in the curriculum that might trigger the student, and furnishing alternative assignments *(for example, doing an independent study in English when the class is studying a book that will likely trigger the student)*
- Adjusting the child's class schedule so the child can sleep later in the morning

The school may also have information that will help with understanding the child's needs. For this reason, ongoing dialogue with the school is essential.

Court staff:

Children's attorneys should take the lead to make sure that the child's needs are met in court and that court staff are aware of potential concerns. Important questions to consider include: Will the child or caregiver need accommodations in court? Will the client be triggered if the abuser *(i.e., abusive parent or partner)* will be in the courtroom? Do special arrangements need to be made?

Treating therapist:

With regular collaboration, the treating therapist can play a key role in making sure that a client's needs are met at school, at home, and in court. Attorneys and therapists alike must be mindful of their respective ethical duties to their clients. Treating therapists can generally opine about a client's needs and what would be helpful without violating client confidentiality. You should advise the therapist of upcoming court hearings so the therapist can help the client process the information, address potential triggers, and prepare for court. It is also helpful to obtain information from the treating therapist about a client's potential trauma triggers and strategies for preventing, addressing, or mitigating those triggers. Likewise, if a client is at risk for self-harm, you should speak to the therapist and inquire about steps or strategies that have been discussed with the client or put into place to reduce this risk.

10 Systems-Level Advocacy and Resources

The current guide was developed with two goals. The first goal is to increase the knowledge and skills of individual attorneys who work with clients who have survived trauma. The second, broader goal is to create trauma-informed child welfare and family court systems, in which all professionals, consumers, and stakeholders are educated about the impact of trauma and trauma-informed practices and policies. Creating trauma-informed service systems is a time- and resource-intensive effort that will require the involvement of a variety of stakeholders in child welfare and other service systems. In the list below, we have included specific resources that may assist attorneys and other system stakeholders in beginning to implement trauma-informed care in their local child welfare and family court systems. The Appendix to this document also includes additional resources to assist attorneys in both individual and systems-wide advocacy and practice.

Resources for educating other stakeholders on trauma-informed care

American Bar Association Center on Children and the Law's website on *Polyvictimization and Trauma-informed Legal Advocacy* http://www.americanbar.org/groups/child_law/what_we_do/projects/child-and-adolescent-health/polyvictimization.html

National Child Traumatic Stress Network and National Council of Juvenile & Family Court Judges. (2013). *Bench card for the trauma-informed judge*. Los Angeles, CA and Durham, NC: Authors. http://www.nctsn.org/products/nctsn-bench-card-trauma-informed-judge

National Child Traumatic Stress Network (2005). *Helping children in the child welfare system heal from trauma: A systems integration approach.* http://www.trauma-informed-california.org/wp-content/uploads/2012/02/A_Systems_Integration_Approach.pdf

National Council of Juvenile & Family Court Judges (2014). *Trauma court audit.* http://www.ncjfcj.org/sites/default/files/Trauma%20Audit%20-%20Snapshot.pdf

Aces too High (2014). https://acestoohigh.com/2014/09/24/trauma-informed-judges-take-gentler-approach-administer-problem-solving-justice-to-stop-cycle-of-aces/

REFERENCES

[1]Attorney General's National Task Force on Children Exposed to Violence. (2012). *Defending childhood: Report of the Attorney General's National Task Force on Children Exposed to Violence.* Washington, DC: US Department of Justice.

[2]Klain, E. J., & White, A. R. (2013). Implementing trauma-informed practices in child welfare. CITY: State Policy Advocacy Reform Center. Retrieved from http://www.centerforchildwelfare.org/kb/TraumaInformedCare/ImplementingTraumaInformedPracticesNov13.pdf

[3]Bellis, M. A., Lowey, H., Leckenby, N., Hughes, K., & Harrison, D. (2014). Adverse childhood experiences: retrospective study to determine their impact on adult health behaviours and health outcomes in a UK population. *Journal of Public Health*, 36, 81-91.

[4]American Bar Association. (2014). ABA Policy on Trauma-Informed Advocacy for Children and Youth. Retrieved from http://www.americanbar.org/content/dam/aba/administrative/child_law/ABA Policy on Trauma-Informed Advocacy.authcheckdam.pdf

[5]National Child Traumatic Stress Network. (2007). *Creating Trauma-Informed Child-Serving Systems. Service Systems Brief.* Los Angeles, CA and Durham, NC: National Center for Child Traumatic Stress. Retrieved from http://www.nctsn.org/resources/topics/creating-trauma-informed-systems

[6]Miller, E. A., Green, A. E., Fettes, D. L., & Aarons, G. A. (2011). Prevalence of maltreatment among youths in public sectors of care. *Child Maltreatment*, 16, 196–204.

[7]American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (5th Edition): DSM-5*. Washington, DC: American Psychiatric Publishing.

[8]Chemtob, C. M., Griffing, S., Tullberg, E., Roberts, E., & Ellis, P. (2011). Screening for trauma exposure, and post-traumatic stress disorder and depression symptoms among mothers receiving child welfare preventive services. *Child Welfare*, 90, 109–128

[9]Grella, C. E., Hser, Y. I., & Huang, Y. C. (2006). Mothers in substance abuse treatment: Differences in characteristics based on involvement with child welfare services. *Child Abuse and Neglect*, 30(1), 55–73. doi:10.1016/j.chiabu.2005.07.005

[10]Marcenko, M. O., Lyons, S. J., & Courtney, M. (2011). Mothers' experiences, resources, and needs: The context for reunification. *Children and Youth Services Review*, 33, 431-438.

[11]Evans-Campbell, T. (2008). Historical trauma in American Indian/Native Alaska communities: A multilevel framework for exploring impacts on individuals, families, and communities. *Journal of Interpersonal Violence*, 23, 316–338.

[12]Banyard, V. L., Williams, L. M., & Siegel, J. A. (2003). The impact of complex trauma and depression on parenting: An exploration of mediating risk and protective factors. *Child Maltreatment*, 8(4), 334–349.

[13]Cohen, L. R., Hien, D. A., & Batchelder, S. (2008). The impact of cumulative maternal trauma and diagnosis on parenting behavior. *Child Maltreat*, 13, 27–38.

[14]Libby, A. M., Orton, H. D., Beals, J., Buchwald, D., & Manson, S. M. (2008). Childhood abuse and later parenting outcomes in two American Indian tribes. *Child Abuse and Neglect*, 32(2), 195–211.

[15]Thornberry, T. P., Henry, K. L., Smith, C. A., Ireland, T. O., Greenman, S. J., & Lee, R. D. (2013). Breaking the cycle of maltreatment: the role of safe, stable, and nurturing relationships. *The Journal of Adolescent Health : Official Publication of the Society for Adolescent Medicine*, 53(4 Suppl), S25–31.

[16]Widom, C. S., Czaja, S., & Dutton, M. A. (2014). Child abuse and neglect and intimate partner violence victimization and perpetration: a prospective investigation. *Child Abuse & Neglect*, 38, 650–63.

[17]Child Welfare Information Gateway. (2011). Family reunification: What the evidence shows. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. Retrieved from https://www.childwelfare.gov/pubPDFs/family_reunification.pdf#page=6&view=Research%20on%20Family%20Reunification

[18]Fusco, R. (2015). Second generation mothers in the child welfare system: Factors that predict engagement. *Child and Adolescent Social Work Journal*, 32, 545-554.

[19]American Bar Association. (2014). Youth participation in court: Protocol pilot project. Retrieved from: http://www.americanbar.org/content/dam/aba/administrative/child_law/youthengagement/NJYoutinCourtPilotSummary.authcheckdam.pdf

[20]National Child Traumatic Stress Network *Measures Review Database*. Retrieved from http://nctsn.org/resources/online-research/measures-review

[21]National Child Traumatic Stress Network. Empirically Supported Treatments and Promising Practices. Retrieved from http://www.nctsn.org/resources/topics/treatments-that-work/promising-practices

[22]Shipman, K., & Taussig, H. (2009). Mental health treatment of child abuse and neglect: the promise of evidence-based practice. *Pediatric Clinics of North America*, 56(2), 417–28.

[23]Silverman, W. K., Ortiz, C. D., Viswesvaran, C., Burns, B. J., Kolko, D. J., Putnam, F. W., & Amaya-Jackson, L. (2008). Evidence-based psychosocial treatments for children and adolescents exposed to traumatic events. *Journal of Clinical Child & Adolescent Psychology*, 37(1), 156-183.

[24]Rubin, D. M., O'Reilly, A., Luan, X., & Localio, R. A. (2007). The impact of placement stability on behavioral well-being for children in foster care. *Pediatrics*, 119, 336–344.

[25]Ryan, J. P., & Testa, M. F. (2005). Child maltreatment and juvenile delinquency: Investigating the role of placement and placement instability. *Children and Youth Services Review,* 27(3), 227–249.

[26]Akin, B. A. (2011). Predictors of foster care exits to permanency: A competing risks analysis of reunification, guardianship, and adoption. *Children and Youth Services Review*, 33(6), 999–1011.

[27]Brown, K. N., & MacAlister, D. (2006). Violence and Threats against Lawyers Practising in Vancouver, Canada. *Canadian Journal of Criminology and Criminal Justice*, 48, 543–571.

[28]Levin, A. P., Albert, L., Besser, A., Smith, D., Zelenski, A., Rosenkranz, S., & Neria, Y. (2011). Secondary traumatic stress in attorneys and their administrative support staff working with trauma-exposed clients. *The Journal of Nervous & Mental Disease*, 199, 946–955.

[29]Vrklevski, L. P., & Franklin, J. (2008). Vicarious trauma: The impact on solicitors of exposure to traumatic material. *Traumatology*, 14, 106–118.

[30]Levin, A., Besser, A., Albert, L., Smith, D., & Neria, Y. (2012). The effect of attorneys' work with trauma-exposed clients on PTSD symptoms, depression, and functional impairment: A cross-lagged longitudinal study. *Law & Human Behavior*, 36, 538–547.

[31]Branson, C. E., Meskunas, H., & Baetz, C. (2016). Work-related traumatic stress among professionals in juvenile and criminal justice: A systematic review of the literature. *Manuscript in preparation*.

[32]Levin, A. P. & Greisberg, S. (2003). *Vicarious Trauma in Attorneys*, 24 Pace L. Rev. 245. Retrieved from http://digitalcommons.pace.edu/plr/vol24/iss1/11

[33]Greenwald, R., Maguin, E., Smyth, N. J., Greenwald, H., Johnston, K. G., & Weiss, R. L. (2008). Teaching trauma-related insight improves attitudes and behaviors toward challenging clients. *Traumatology*, 14, 1–11.

[34]U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth, and Families, Children's Bureau. (2016). *Child maltreatment 2014*. Retrieved from http://www.acf.hhs.gov/sites/default/files/cb/cm2014.pdf.

[35]U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth, and Families, Children's Bureau. (2015). *The AFCARS report.* Retrieved from http://www.acf.hhs.gov/sites/default/files/cb/afcarsreport22.pdf.

[36]Miller, E. A., Green, A. E., Fettes, D. L., & Aarons, G. A. (2011). Prevalence of maltreatment among youths in public sectors of care. *Child Maltreatment*, 16, 196–204.

APPENDIX

Section One: Defining Trauma-Informed Legal Advocacy

American Bar Association's Policy on Trauma-Informed Advocacy for Children and Youth (2014) http://www.americanbar.org/content/dam/aba/administrative/child_law/ABA%20Policy%20on%20Trauma-Informed%20Advocacy.authcheckdam.pdf

National Council of Juvenile & Family Court Judges (NCJFCJ) site on Trauma-Informed Systems of Care http://www.ncjfcj.org/our-work/trauma-informed-system-care

Section Two: The Impact of Trauma Exposure on Child Development

Conradi, L. Supporting the Mental Health of Trauma-Exposed Children in the Child Welfare System, ABA Child Law Practice, Volume 34, Number 1 (January 2015). Available from http://www.americanbar.org/groups/child_law/what_we_do/projects/child-and-adolescent-health/polyvictimization/supporting-the-mental-health-of-trauma-exposed-children-in-the-c.html

Forkey, H. Medical Effects of Trauma: A Guide for Lawyers, ABA Child Law Practice, Volume 34, Number 7 (July 2015). Available from http://www.americanbar.org/groups/child_law/what_we_do/projects/child-and-adolescent-health/polyvictimization/medical-effects-of-trauma–a-guide-for-lawyers.html

Klain, E. J. (2014). Understanding trauma and its impact on child clients. *Child Law Practice*, 33. Available from http://www.americanbar.org/publications/child_law_practice/vol-33/september-2014/understanding-trauma-and-its-impact-on-child-clients.html

Osofsky, J., Maze, C., Lederman, J. C., Grace, J. M., & Dicker, S. (2002). *Questions every judge and lawyer should ask about infants and toddlers in the child welfare system*. Reno, NV: National Council of Juvenile & Family Court Judges. Available from http://www.ncjfcj.org/resource-library/publications/questions-every-judge-and-lawyer-should-ask-about-infants-and-toddlers

Section Three: The Impact of Trauma Exposure on Parents

NCTSN Fact Sheet: *Birth Parents with Trauma Histories and the Child Welfare System*
This factsheet series from the Birth Parent Subcommittee of the Child Welfare Committee highlights the importance of understanding the serious consequences that trauma histories can have for birth parents and the subsequent potential impact on their parenting.

- For Parents (2012)
- For Child Welfare Staff (2011)
- For Judges and Attorneys (2011)
- For Mental Health Professionals (2012)
- For Resource Parents (2011)
- For Court-Based Child Advocates and Guardians ad Litem (2013)

Section Four: The Impact of Trauma on the Attorney-Client Relationship

Kraemer, T., & Patten, E. (2014). Establishing a trauma-informed lawyer-client relationship (Part one). *Child Law Practice*, 33. Available from http://www.americanbar.org/groups/child_law/what_we_do/projects/child-and-adolescent-health/polyvictimization/establishing-a-trauma-informed-lawyer-client-relationship.html

Kraemer, T., & Patten, E. (2014). Communicating with youth who have experienced trauma (Part two). *Child Law Practice*, 33. Available from http://www.americanbar.org/groups/child_law/what_we_do/projects/child-and-adolescent-health/polyvictimization/communicating-with-youth-who-have-experienced-trauma–part-2-.html

Reitman, K. A. (2011). *Attorneys for children guide to interviewing clients: Integrating trauma informed care and solution focused strategies*. Utica, NY: Child Welfare Court Improvement Project, New York State Unified Court System. Available from http://www.nycourts.gov/ip/cwcip/Publications/attorneyGuide.pdf

Section Five: Screening and Assessment

Vandervort, F. E. (2015). Using screening and assessment evidence of trauma in child welfare cases. *Child Law Practice, 34.* Available from http://www.americanbar.org/publications/child_law_practice/vol-34/may-2015/using-screening-and-assessment-evidence-of-trauma-in-child-welfa.html

Pilnik, L., & Kendall, J. R. (2012). *Identifying polyvictimization and trauma among court-involved children and youth: A checklist and resource guide for attorneys and other court-appointed advocates.* North Bethesda, MD: Safe Start Center, Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice. Available from http://www.americanbar.org/content/dam/aba/administrative/child_law/IdentifyingPolyvictimization.pdf

Section Six: Effective Treatments for Traumatic Stress

Finding Effective Trauma-Informed Treatment for Children, Teens, & Families
http://www.nctsn.org/resources/topics/treatments-that-work/promising-practices
The National Child Traumatic Stress Network's website includes a comprehensive list of the most effective and widely used trauma-informed treatments for children, adolescents, and families. This site includes a description of the core components of trauma-informed treatments and a list of trauma-informed interventions for children, adolescents, and families, with fact sheets summarizing the key components of each treatment and the research evidence that shows its effectiveness.

Finding a Trauma-Informed Therapist or Expert in Your Area
http://www.nctsn.org/about-us/network-members
The National Child Traumatic Stress Network is comprised of more than 100 federally-funded and affiliated academic and treatment centers around the US that provide trauma-informed mental health services and training/consultation on child traumatic stress. To find a trauma expert in your area, search the NCTSN's list of network members by state

http://www.istss.org/find-a-clinician.aspx
The International Society for Traumatic Stress Studies offers a searchable online database of mental health professionals that offer trauma-informed treatment across the globe.

http://www.nctsn.org/resources/get-help-now
The NCTSN's *Get Help Now* site offers information on finding help for children who have experienced abuse or neglect.

NCTSN Fact Sheet: *List of Questions to Ask Mental Health Professionals*

1. Does the individual/agency that provides therapy conduct a comprehensive trauma assessment?
   If so: What specific standardized measures are given? What did your assessment show? What were some of the major strengths and/or areas of concern?
2. Is the clinician/agency familiar with evidenced-based treatment models?
3. Have clinicians had specific training in an evidenced-based model *(when, where, by whom, how much)*?
4. Does the individual/agency provide ongoing clinical supervision and consultation to its staff, including how model fidelity is monitored?
5. Which approach(es) does the clinician/agency use with children and families?
6. How are parent support, conjoint therapy, parent training, and/or psychoeducation offered?
7. Which techniques are used for assisting with the following: Building a strong therapeutic relationship; affect expression and regulation skills; anxiety management; relaxation skills; cognitive processing/ reframing; construction of a coherent trauma narrative; strategies that allow exposure to traumatic memories and feelings in tolerable doses so that they can be mastered and integrated into the child's experience; personal safety/empowerment activities; resiliency and closure
8. How are cultural competency and special needs issues addressed?
9. Is the clinician or agency willing to participate in the multidisciplinary team *(MDT)* meetings and in the court process, as appropriate?

Section Seven: Placement Decisions, Transitions, and Visitation

ReMoved – video about the experience of children in foster care system http://vimeo.com/73172036

NCTSN Presentation: *Working with Parents Involved in the Child Welfare System - Visitation*
http://www.nctsn.org/nctsn_assets/anc16_new/visitation/presentation_html5.html

ACS-NYU Children's Trauma Institute. (2012). *Easing foster care placement: A practice brief.* New York: NYU Langone Medical Center. Available from http://www.nctsn.org/sites/default/files/assets/pdfs/easing_foster_care_placement_practice_brief.pdf

Smariga, M. (2007). Visitation with infants and toddlers in foster care: What judges and attorneys need to know. Washington, DC: American Bar Association. Available from http://www.americanbar.org/groups/child_law/what_we_do/projects/child-and-adolescent-health/infants-and-young-children.html

Section Eight: Secondary Traumatic Stress and Attorneys

Rainville, C. Understanding Secondary Trauma: A Guide for Lawyers Working with Child Victims, ABA Child Law Practice, Volume 34, Number 9 (September 2015). Available from http://www.americanbar.org/groups/child_law/what_we_do/projects/child-and-adolescent-health/polyvictimization/understanding-secondary-trauma–a-guide-for-lawyers-working-with.html

Institute for Redress & Recovery, Santa Clara Law. (n.d.) *Secondary trauma and the legal process: A primer & literature review*. Santa Clara, CA: Author. Available from http://law.scu.edu/redress#5

van Dernoot Lipsky, L., & Burk, C. (2009). *Trauma stewardship: An everyday guide to caring for self while caring for others*. San Francisco, CA: Berrett-Koehler Publishers. http://traumastewardship.com/inside-the-book/

The Professional Quality of Life Scale (ProQOL) is a 30 question assessment of secondary traumatic stress, burnout, and compassion satisfaction that is intended for use by a wide range of helping professionals. To download a free copy of the ProQOL, including instructions on how to complete and score the questionnaire, visit http://www.proqol.org/ProQol_Test.html. Mental health counseling or other supports can be helpful for addressing high scores on the secondary trauma or burnout scales of the ProQOL. Refer to Section 6 of this Appendix for additional information on locating a trauma-informed therapist in your area.

Section Nine: The Importance of Collaboration

Stewart, M. (2013). Cross-system collaboration. Los Angeles, CA & Durham, NC: National Center for Child Traumatic Stress. http://www.nctsn.org/sites/default/files/assets/pdfs/jj_trauma_brief_crosssystem_stewart_final.pdf

The Juvenile Law Center and Robert F. Kennedy National Resource Center for Juvenile Justice have developed the *Models for Change Information Sharing Toolkit*. Available from www.infosharetoolkit.org/

This project was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services (HHS). The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS. They have not been approved by the House of Delegates or the Board of Governors of the American Bar Association, and accordingly, should not be construed as representing the policy of the American Bar Association.

Suggested Citation:

National Child Traumatic Stress Network, Justice Consortium Attorney Workgroup Subcommittee (2017). Trauma: What child welfare attorneys should know. Los Angeles, CA, and Durham, NC: National Center for Child Traumatic Stress.

Judges

NCTSN The National Child Traumatic Stress Network

NCJFCJ

Dear Judge:

We are pleased to share the NCTSN Bench Card for the Trauma Informed Judge—an official product of the National Child Traumatic Stress Network's Justice Consortium in cooperation with the National Council of Juvenile and Family Court Judges. Designed by judges, lawyers, and behavioral health professionals, this card will assist you in your work with youth who struggle with traumatic stress.

Many court-involved youth have been exposed to traumatic events. They present with problems that require professional assistance to modify their behavior and protect the community. Strong connections have been made between early exposure to trauma and "derailed" child development. Traumatic experiences change the brain in ways that cause youth to think, feel and behave differently.

Trauma impacts many important court decisions, among them:

- temporary placement or custody,
- detention or hospitalization,
- residential or community based treatment,
- treatment and referrals to health and behavioral health services,
- transfers to adult criminal court,
- termination of parental rights and adoption,
- restoration and treatment for child victims,
- visitation with maltreating adults or jail/prison visitation.

For many traumatized children, the judge serves as the crucial professional to direct them to proper treatment. The good news is that, when properly treated through trauma-informed, evidence-based treatment, children can recover.

As a judge, we know you must balance your responsibilities to protect the public and restore victims while also trying to change the destructive life course of a struggling child or an offending teen. Judges know that failure to make such changes can lead to youths who become adults involved in the justice system. Judges often see those adults raise new generations who also appear in court—the outcome of the uninterrupted, intergenerational transmission of traumatic stress.

Enclosed are two bench cards. The first offers a series of questions to help you, as a judge, gather information necessary to make good decisions for children at risk of traumatic stress disorders. The second is a sample addendum designed to be copied or scanned and attached to your orders for behavioral health assessments. It will help mental health professionals develop reports that are trauma informed, admissible into evidence, and informative to you.

We hope that you find the bench cards to be helpful in your work with youth. For additional information and other trauma resources for judges and attorneys, please see http://www.nctsn.org/resources/topics/juvenile-justice-system

Should you have questions regarding the information contained in the cards, please contact Dr. James Clark at clark2j9@UCMAIL.UC.EDU or the NCTSN at help@nctsn.org

Sincerely,
The NCTSN Justice Consortium

NCTSN The National Child Traumatic Stress Network

NCJFCJ

NCTSN BENCH CARD

FOR THE TRAUMA-INFORMED JUDGE

Research has conclusively demonstrated that court-involved children and adolescents present with extremely high rates of traumatic stress caused by their adverse life experiences. In the court setting, we may perceive these youth as inherently disrespectful, defiant, or antisocial, when, in fact, their disruptive behavior may be better understood in the context of traumatic stress disorders. These two Bench Cards provide judges with useful questions and guidelines to help them make decisions based on the emerging scientific findings in the traumatic stress field. These cards are part of a larger packet of materials about child and adolescent trauma available and downloadable from the NCTSN Trauma-Informed Juvenile Justice System Resource Site* and are best used with reference to those materials.

1. **Asking trauma-informed questions can help judges identify children who need or could benefit from trauma-informed services from a mental health professional. A judge can begin by asking, "Have I considered whether or not trauma has played a role in the child's[1] behavior?" Use the questions listed below to assess whether trauma-informed services are warranted.**

   TRAUMA EXPOSURE: Has this child experienced a traumatic event? These are events that involve actual or threatened exposure of the child to death, severe injury, or sexual abuse, and may include domestic violence, community violence, assault, severe bullying or harassment, natural or man-made disasters, such as fires, floods, and explosions, severe accidents, serious or terminal illness, or sudden homelessness.

   MULTIPLE OR PROLONGED EXPOSURES: Has the child been exposed to traumatic events on more than one occasion or for a prolonged period? Repeated or prolonged exposure increases the likelihood that the child will be adversely affected.

   OUTCOMES OF PREVIOUS SANCTIONS OR INTERVENTIONS: Has a schedule of increasingly restrictive sanctions or higher levels of care proven ineffective in this case? Traumatized children may be operating in "survival mode," trying to cope by behaving in a defiant or superficially indifferent manner. As a result, they might respond poorly to traditional sanctions, treatments, and placements.

   CAREGIVERS' ROLES: How are the child's caregivers or other significant people helping this child feel safe or preventing (either intentionally or unintentionally) this child from feeling safe? Has the caregiver been a consistent presence in the child's life? Does the caregiver acknowledge and protect the child? Are caregivers themselves operating in survival mode due to their own history of exposure to trauma?

   SAFETY ISSUES FOR THE CHILD: Where, when and with whom does this child feel safest? Where, when and with whom does he or she feel unsafe and distrustful? Is the home chaotic or dangerous? Does a caregiver in the household have a restraining order against another person? Is school a safe or unsafe place? Is the child being bullied at school or does the child believe that he or she is being bullied?

   TRAUMA TRIGGERS IN CURRENT PLACEMENT: Is the child currently in a home, out-of-home placement, school, or institution where the child is being re-exposed to danger or being "triggered" by reminders of traumatic experiences?

   UNUSUAL COURTROOM BEHAVIORS: Is this child behaving in a highly anxious or hypervigilant manner that suggests an inability to effectively participate in court proceedings? (Such behaviors include inappropriate smiling or laughter, extreme passivity, quickness to anger, and non-responsiveness to simple questions.) Is there anything I, as a judge, can do to lower anxiety, increase trust, and enhance participation?

CONTINUED ON BACK →

This project was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services (HHS). The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

2. **It is crucial to have complete information from all the systems that are working with the child and family. Asking the questions referenced below can help develop a clearer picture of the child's trauma and assess needs for additional information.**

   COMPLETENESS OF DATA FOR DECISIONS: Has all the relevant information about this child's history been made available to the court, including child welfare and out-of-jurisdiction or out-of-state juvenile justice information?

   INTER-PROFESSIONAL COOPERATION: Who are the professionals who work with this child and family? Are they communicating with each other and working as a team?

   UNUSUAL BEHAVIORS IN THE COMMUNITY: Does this child's behavior make sense in light of currently available information about the child's life? Has the child exhibited extreme or paradoxical reactions to previous assistance or sanctions? Could those reactions be the result of trauma?

   DEVELOPMENT: Is this child experiencing or suffering from emotional or psychological delays? Does the child need to be assessed developmentally?

   PREVIOUS COURT CONTACTS: Has this child been the subject of other court proceedings? (Dependency/ Neglect/Abuse; Divorce/Custody; Juvenile Court; Criminal; Other)

   OUT-OF-HOME PLACEMENT HISTORY: How many placements has this child experienced? Have previous placements been disrupted? Were the disruptions caused by reactions related to the child's trauma history? How did child welfare and other relevant professionals manage these disruptions?

   BEHAVIORAL HEALTH HISTORY: Has this child ever received trauma-informed, evidence-based evaluation and treatment? (Well-intentioned psychiatric, psychological, or substance abuse interventions are sometimes ineffective because they overlook the impact of traumatic stress on youth and families.)

3. **Am I sufficiently considering trauma as I decide where this child is going to live and with whom?**

   PLACEMENT OUTCOMES: How might the various placement options affect this child? Will they help the child feel safe and secure and to successfully recover from traumatic stress or loss?

   PLACEMENT RISKS: Is an out-of-home placement or detention truly necessary? Does the benefit outweigh the potential harm of exposing the child to peers who encourage aggression, substance use, and criminal behavior that may possibly lead to further trauma?

   PREVENTION: If placement, detention or hospitalization is required, what can be done to ensure that the child's traumatic stress responses will not be "triggered?" (For example, if placed in isolation or physical restraints, the child may be reminded of previous traumatic experiences.)

   DISCLOSURE: Are there reasons for not informing caregivers or staff at the proposed placement about the child's trauma history? (Will this enhance care or create stigma and re-victimization?)

   TRAUMA-INFORMED APPROACHES: How does the programming at the planned placement employ trauma-informed approaches to monitoring, rehabilitation and treatment? Are staff knowledgeable about recognizing and managing traumatic stress reactions? Are they trained to help children cope with their traumatic reactions?

   POSITIVE RELATIONSHIPS: How does the planned placement enable the child to maintain continuous relationships with supportive adults, siblings or peers?

4. **If you do not have enough information, it may be useful to have a trauma assessment done by a trauma-informed professional. Utilizing the NCTSN BENCH CARD FOR COURT-ORDERED TRAUMA-INFORMED MENTAL HEALTH EVALUATION OF CHILD, you can request information that will assist you in making trauma-informed decisions.**

[1] The use of "child" on this bench card refers to any youth who comes under jurisdiction of the juvenile court.
*http://learn.nctsn.org/course/view.php?id=74

NCTSN The National Child Traumatic Stress Network

NCJFCJ

NCTSN BENCH CARD

FOR COURT-ORDERED TRAUMA-INFORMED MENTAL HEALTH EVALUATION OF CHILD: SAMPLE ADDENDUM

This Court has referred this child[1] for mental health assessment. Your report will assist the judge in making important decisions. Please be sure the Court is aware of your professional training and credentials. In addition to your standard psychosocial report, we are seeking trauma-specific information. Please include your opinion regarding the child's current level of danger and risk of harm. The Court is also interested in information about the child's history of prescribed psychiatric medications. We realize that you may be unable to address every issue raised below, but the domains listed below are provided as an evidence-based approach to trauma-informed assessment.

1. SCREENING AND ASSESSMENT OF THE CHILD AND CAREGIVERS

Please describe the interview approaches (structured as well as unstructured) used for the evaluation. Describe the evidence supporting the validity, reliability, and accuracy of these methods for children or adolescents. For screens or tests, please report their validity and reliability, and if they were designed for the population to which this child belongs. If feasible, please report standardized norms.

Discuss any other data that contributed to your picture of this child. Please describe how the perspectives of key adults have been obtained. Are the child's caregivers or other significant adults intentionally or unintentionally preventing this child from feeling safe, worthy of respect, and effective? Are caregivers capable of protecting and fostering the healthy development of the child? Are caregivers operating in "survival mode" (such as interacting with the child in a generally anxious, indifferent, hopeless, or angry way) due to their own history of exposure to trauma? What additional support/resources might help these adults help this child?

2. STRENGTHS, COPING APPROACHES, AND RESILIENCE FACTORS

Please discuss the child's existing strengths and coping approaches that can be reinforced to assist in the recovery or rehabilitation process. Strengths might include perseverance, patience, assertiveness, organization, creativity, and empathy, but coping might take distorted forms. Consider how the child's inherent strengths might have been converted into "survival strategies" that present as non-cooperative or even antisocial behaviors that have brought this child to the attention of the Court.

Please report perspectives voiced by the child, as well as by caregivers and other significant adults, that highlight areas of hope and recovery.

3. DIAGNOSIS (POST TRAUMATIC STRESS DISORDER [PTSD])

Acknowledging that child and adolescent presentations of PTSD symptoms will differ from adult presentations, please "rule-in" or "rule-out" specific DSM-V criteria for PTSD for adolescents and children older than six years, which include the following criteria:

- Exposure to actual or threatened death, serious injury, or sexual violence, either experienced directly, witnessed, or learning that the event occurred to a close family member or friend (Criteria A)
- Presence of intrusion symptoms such as intrusive memories, distressing dreams, flashbacks, physical reactions, trauma-specific re-enactment through play, psychological distress at exposure to cues (Criteria B)
- Avoidance of stimuli or reminders associated with the traumatic event, including avoidance of internal thoughts and feelings related to the event, as well as external activities, places, people, or situations that arouse recollections of the event (Criteria C)

CONTINUED ON BACK →

This project was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services (HHS). The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

- Negative changes in cognition, mood, and expectations; diminished interest in, detachment, and estrangement from others; guilt and shame; socially withdrawn behavior; reduction in positive emotions (Criteria D)
- Alterations in arousal and reactivity, including irritable or aggressive behavior, angry outbursts, reckless or self-destructive behavior, hypervigilance, exaggerated startle response, concentration problems, and sleep disturbance (Criteria E)
- Exhibiting these disturbances in behavior, thoughts and mood for over a month (Criteria F)
- Significant distress or impairment in relationships with parents, siblings, peers, or other caregivers or with school behavior (Criteria G)
- The disturbed behavior and mood cannot be attributed to the effects of a medication, street drug, or other medical condition (Criteria H)

PTSD can also be present for children ages six and younger. Criteria include exposure; intrusive symptoms, including distressing memories or play re-enactment and physiological reactions to reminders; avoidance of people, conversations or situations; negative emotional states such as fear, sadness, or confusion, sometimes resulting in constriction of play; irritable behavior and hypervigilance; and impairment in relationships with parents, siblings, peers or other caregivers.

Even if an official DSM-V diagnosis of PTSD is not warranted, traumatic stress reactions can definitely or potentially contribute to the child's behavioral, emotional, interpersonal, or attitudinal problems. Traumatic stress reactions may contribute to problems with aggression, defiance, avoidance, impulsivity, rule-breaking, school failure or truancy, running away, substance abuse, and an inability to trust or maintain cooperative and respectful relationships with peers or adults.

4. TRAUMA-INFORMED SERVICES

Has this child ever received Trauma-Focused, Evidence-Based Treatment?*** Sometimes well-intentioned psychiatric, psychological, social work, or substance abuse evaluations and treatment are incomplete and of limited effectiveness because they do not systematically address the impact of children's traumatic stress reactions.

The Court is interested in potential sources of trauma-informed services in your area and your thoughts about the likelihood that the child can receive those services.

In the meantime, what can be done immediately for and with the family, school, and community to enhance safety, build on the child's strengths, and to provide support and guidance? How can this child best develop alternative coping skills that will help with emotional and behavioral self-regulation?

5. SUGGESTIONS FOR STRUCTURING PROBATION, COMMUNITY SUPERVISION AND/OR PLACEMENT OPTIONS.

Structured case plans for probation, community supervision, and/or placement should consider the ability of the setting and the people involved to assist the child in feeling safe, valued, and respected. This is especially important for traumatized children. Similarly, the plan for returning home, for continuing school and education, and for additional court or probationary monitoring should also clearly address each child's unique concerns about safety, personal effectiveness, self-worth, and respect. Please consider where, when, and with whom this child feels most safe, effective, valued and respected. Where, when, and with whom does the child feel unsafe, ineffective, or not respected? What out-of-home placements are available that can better provide for this child's health and safety, as well as for the community's safety? What placements might encourage success in school, relationships, and personal development?

[1] The use of "child" on this bench card refers to any youth who comes under jurisdiction of the juvenile court.

*** Trauma-Focused, Evidence-Based (TF-EB) Treatment is science-based, often requires training in a specific protocol with careful clinical supervision, and emphasizes the treatment relationship, personal/psychological safety, emotional and behavioral self-regulation, development of coping skills, specific treatment of child traumatic experiences, and development of self-enhancing/pro-social thinking, feeling, decision-making, and behaving. TF-EB treatments include: Trauma-Focused Cognitive Behavioral Therapy, Parent-Child Interaction Therapy, Trauma Affect Regulation: Guidelines for Education and Therapy, Child Parent Psychotherapy and more. See website: http://www.nctsn.org/resources/topics/treatments-that-work/promising-practices

NCTSN The National Child Traumatic Stress Network

Helping Traumatized Children: Tips for Judges

A majority of children involved in the juvenile justice system have a history of trauma.[1] Children and adolescents who come into the court system frequently have experienced not only chronic abuse and neglect, but also exposure to substance abuse, domestic violence, and community violence.[2]

The psychological, emotional, and behavioral consequences of these experiences can be profound, but may go unrecognized if judges and related personnel do not delve more deeply into the backgrounds of children and adolescents who come before the court.[2,3] By understanding the impact of trauma on children's development, beliefs, and behaviors, judges can become more effective in addressing the unique needs and challenges of traumatized children and adolescents involved in the juvenile and family court system.

Effects of Trauma on Children and Adolescents

Child abuse and neglect have been shown to adversely affect the growth of the brain, nervous, and endocrine systems and to impair many aspects of psychosocial development, including the acquisition of social skills, emotional regulation, and respect for societal institutions and mores.[4] Although a significant proportion of traumatized children seen in court meet the diagnostic criteria for posttraumatic stress disorder (PTSD),[5,6] many others suffer from traumatic stress responses that do not meet the clinical definition of PTSD. Traumatic stress may manifest differently in children of different ages. **Table 1** lists some of the most common traumatic stress reactions seen in children of various ages.

Table 1. Child Traumatic Stress Reactions (By Age Group)

Age Group	Common Traumatic Stress Reactions
Young children (Birth–5 y)	▪ Withdrawal and passivity ▪ Exaggerated startle response ▪ Aggressive outbursts ▪ Sleep difficulties (including night terrors) ▪ Separation anxiety ▪ Fear of new situations ▪ Difficulty assessing threats and finding protection (especially in cases where a parent or caretaker was aggressor) ▪ Regression to previous behaviors (e.g., baby talk, bed-wetting, crying)
School-age children (6–12 y)	▪ Abrupt and unpredictable shifts between withdrawn and aggressive behaviors ▪ Social isolation and withdrawal (may be an attempt to avoid further trauma or reminders of past trauma) ▪ Sleep disturbances that interfere with daytime concentration and attention ▪ Preoccupation with the traumatic experience(s) ▪ Intense, specific fears related to the traumatic event(s)
Adolescents (13–18 y)	▪ Increased risk taking (substance abuse, truancy, risky sexual behaviors) ▪ Heightened sensitivity to perceived threats (may respond to seemingly neutral stimuli with aggression or hostility) ▪ Social isolation (belief that they are unique and alone in their pain) ▪ Withdrawal and emotional numbing ▪ Low self esteem (may manifest as a sense of helplessness or hopelessness)

This project was funded by the Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services.

Assessing the Effects of Trauma

Formal trauma assessment is critical to identifying children and adolescents in the courtroom who are suffering from traumatic stress.[2,3] Well-validated trauma screening tools include:

- UCLA PTSD Reaction Index[7]
- Trauma Symptom Checklist for Children (TSCC)[8]
- Trauma Symptom Checklist for Young Children (TSCYC)[9, 10]
- Child Sexual Behavior Inventory[11, 12]

Judges should use professionals experienced in administering and interpreting these assessments to make recommendations to the court.

> In Stark County, the court now understands that when children have been affected by trauma, they are "stuck" in a hypervigilant response. Being constantly on alert to danger decreases the ability of a youth to study and learn. . . They lose their temper and fight with little or no provocation.
>
> For years our court treated these cases as "bad behavior" and "lack of self control." It is only in the last several years that we, as a court, have educated ourselves about trauma. As a result, we now know that it is important to ask about trauma. Indeed, we often discover a history of trauma that has gone undetected, despite attempts to help the child through traditional counseling services.[3]
>
> Judge Michael L. Howard & Robin R. Tener, PhD.

Choosing Appropriate Service Providers

When referring traumatized children and families for care, courts have the unique opportunity to choose practitioners or agencies that understand the impact of trauma on children and can provide evidence-based treatment appropriate to the child's needs.[2]

While treatment needs to be individualized depending on the nature of the trauma a child has experienced, clinicians should use treatments that have clinical research supporting their use. Evidence-based treatment practices are those that have been rigorously studied and found to be effective in treating child or adolescent trauma. Information on specific evidence-based treatments for child traumatic stress is available from:

- The California Evidence-Based Clearinghouse for Child Welfare (http://www.cachildwelfareclearinghouse.org)
- The National Child Traumatic Stress Network– *Empirically Supported Treatments And Promising Practices* (http://www.nctsnet.org/nccts/nav.do?pid=ctr_top_trmnt_prom)
- The National Crime Victims Research and Treatment Center– *Child Physical and Sexual Abuse: Guidelines for Treatment* (http://academicdepartments.musc.edu/ncvc/resources_prof/OVC_guidelines04-26-04.pdf)

Judges may want to develop a list of community providers who have training and experience in delivering evidence-based trauma practices. If the community lacks trained trauma professionals, creating an advisory group that can increase community awareness of evidence-based practices and necessary training requirements might be helpful. It is important to remember that trauma treatment may need to be combined with treatment for other conditions as well, such as substance abuse or learning disabilities. By becoming trauma-informed and encouraging the development and mobilization of trauma-focused interventions, judges can "make the difference between recovery and continued struggle"[3] for traumatized youth and their families.

For More Information On Child Trauma in the Court

The *Juvenile and Family Court Journal* has published two special editions (Winter 2006 and Fall 2008) on child trauma as it relates to dependency and delinquency issues that come before the court. They are available at http://www.ncjfcj.org/content/blogcategory/364/433/.

References

1. Abram, K. M., Teplin, L. A., Charles, D. R., Longworth, S. L., McClelland, G. M., & Dulcan, M. K. (2004). Posttraumatic stress disorder and trauma in youth in juvenile detention. *Arch Gen Psychiatry, 61*(4), 403-410.
2. Igelman, R. S., Ryan, B. E., Gilbert, A. M., Bashant, C., & North, K. (2008). Best practices for serving traumatized children and families. *Juvenile and Family Court Journal, 59*(4), 35-47.
3. Howard, M. L., & Tener, R. R. (2008). Children who have been traumatized: One court's response. *Juvenile and Family Court Journal, 59*(4), 21-34.
4. Putnam, F. W. (2006). The impact of trauma on child development. *Juvenile and Family Court Journal, Winter*, 1-11.
5. Arroyo, W. (2001). PTSD in children and adolescents in the juvenile justice system. In S. Eth (Ed.), *PTSD in Children and Adolescents* (Vol. 20, pp. 59-86). Arlington, VA: American Psychiatric Publishing, Inc.
6. Steiner, H., Garcia, I. G., & Matthews, Z. (1997). Posttraumatic stress disorder in incarcerated juvenile delinquents. *J Am Acad Child Adolesc Psychiatry, 36*(3), 357-365.
7. Steinberg, A. M., Brymer, M. J., Decker, K. B., & Pynoos, R. S. (2004). The University of California at Los Angeles Post-traumatic Stress Disorder Reaction Index. *Curr Psychiatry Rep, 6*(2), 96-100.
8. Briere, J. (N.D.). *Trauma Symptom Checklist for Children™ (TSCC™).* Available from Psychological Assessment Resources, Inc., Luz, FL: http://www3.parinc.com/products/product.aspx?Productid=TSCC
9. Briere, J. (N.D.). *Trauma Symptom Checklist for Young Children™ (TSCYC™).* Available from Psychological Assessment Resources, Inc., Luz, FL: http://www3.parinc.com/products/product.aspx?Productid=TSCYC
10. Briere, J., Johnson, K., Bissada, A., Damon, L., Crouch, J., Gil, E., et al. (2001). The Trauma Symptom Checklist for Young Children (TSCYC): Reliability and association with abuse exposure in a multi-site study. *Child Abuse Negl, 25*(8), 1001-1014.
11. Friedrich, W. N., Fisher, J. L., Dittner, C. A., Acton, R., Berliner, L., Butler, J., et al. (2001). Child Sexual Behavior Inventory: Normative, psychiatric, and sexual abuse comparisons. *Child Maltreat, 6*(1), 37-49.
12. Friedrich, W. N. (N.D.). *Child Sexual Behavior Inventory (CSBI™).* Available from Psychological Assessment Resources, Inc., Luz, FL: http://www3.parinc.com/products/product.aspx?Productid=CSBI

This product was developed by the Justice System Consortium of the National Child Traumatic Stress Network, comprised of mental health, child welfare, and legal professionals with expertise in the field of child traumatic stress.

This project was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health & Human Services (HHS). The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

National Child Traumatic Stress Network

Established by Congress in 2000, the National Child Traumatic Stress Network (NCTSN) is a unique collaboration of academic and community-based service centers whose mission is to raise the standard of care and increase access to services for traumatized children and their families across the United States. Combining knowledge of child development, expertise in the full range of child traumatic experiences, and attention to cultural perspectives, the NCTSN serves as a national resource for developing and disseminating evidence-based interventions, trauma-informed services, and public and professional education.

Suggested Citation: National Child Traumatic Stress Network, Justice System Consortium. (2009). *Helping Traumatized Children: Tips for Judges*. Los Angeles, CA & Durham, NC: National Center for Child Traumatic Stress.

NCTSN The National Child Traumatic Stress Network

Service Systems Brief

v2 n2 August 2008

Judges and Child Trauma: Findings from the National Child Traumatic Stress Network/National Council of Juvenile and Family Court Judges Focus Groups

Child Trauma in the Juvenile Justice System

Child trauma is endemic in the juvenile justice system. At least 75% of youth involved in the juvenile delinquency system have experienced traumatic victimization,[1, 2] and 11–50% have developed posttraumatic stress disorder (PTSD).[1, 3-6] Many of these young people are involved in the family court system due to victimization.[7] For example, children involved in dependency cases generally have experienced at least one major traumatic event in their lifetime, and many have long and complex trauma histories.[7] Furthermore, abuse and neglect often are associated with concurrent exposure to domestic violence, substance abuse, and community violence.[8-11]

Background of Project

The National Council of Juvenile and Family Court Judges (NCJFCJ) is an organization dedicated to improving the effectiveness of the nation's juvenile courts. The mission of NCJFCJ is to improve courts and systems practice and to raise awareness of the core issues that touch the lives of many of our nation's children and families.

The juvenile justice system is composed of many interconnected organizations that vary widely in their level of training and expertise with regard to child trauma. Many members of the juvenile justice system are well aware of this knowledge gap and have expressed strong interest in becoming more informed about child trauma.

In 2004 the National Council of Juvenile and Family Court Judges (NCJFCJ) and the National Child Traumatic Stress Network (NCTSN) established a partnership to explore the issue of trauma-informed care within the juvenile justice system. As part of this effort, the NCTSN conducted focus groups with juvenile and family court judges at the NCJFCJ's annual conferences in 2005 and 2007 (see **Table 1** for more detailed information on these participants).

The primary objectives of these focus groups were to:

- Understand how knowledgeable juvenile and family court judges are about child trauma; and
- Identify ways to effectively collaborate with NCJFCJ to promote education on child trauma.

The level of involvement and interest shown by the judges demonstrated that child trauma is a significant issue for juvenile and family court judges in their courtrooms. Based on a survey given to participating judges, the NCTSN found that 53% of the participants had not received training about the assessment and treatment of child trauma prior to these focus groups. This statistic emphasizes the pressing need to develop ways to educate this population about both assessment and treatment of child trauma.

Table 1: 2007 Focus Group Demographics

Court jurisdiction	
Urban	53.3%
Suburban	40.0%
Rural	26.7%
Years in juvenile/family court*	
>10 yrs	40.0%
6-10 yrs	33.3%
< 5 yrs	20.0%
Case load†	
Child abuse/neglect; dependency cases	59.0%
Juvenile delinquency cases	30.0%
Domestic violence cases	19.0%
Divorce; child custody cases	23.0%
Other	25.5%

* Some respondents chose not to answer.
†Some respondents chose more than one answer.

53% of the participants had not received training about the assessment and treatment of child trauma prior to these focus groups

Child Trauma in the Juvenile Court System: Issues Judges Raise

During the focus groups, juvenile and family court judges repeatedly stressed the struggles they face when they encounter a child who has experienced trauma, and they identified the following issues:

- **Prevalence of trauma in the courtroom.** Judges can feel overwhelmed by the trauma-affected children they see in the courtroom. Many such children have had ongoing trauma and/or losses, and the magnitude of need can often seem daunting and insurmountable.
- **Placement concerns.** Judges are in a unique position to make significant decisions regarding placement. However, many judges have a difficult time selecting where to place a child. One judge described his fear that removing a child from the home might exacerbate a trauma the child has already experienced. Others stressed the difficulty of making placement decisions where removing a child from the home might prove more traumatic than the experiences that initially brought the child to the attention of child welfare or juvenile justice authorities.
- **Lack of resources.** Even when it is clearly acknowledged that a particular child has experienced trauma, the community may not have the appropriate resources to address the trauma and the chronic instability in that child's life. In some communities, it is hard to find evidence-based treatments for trauma. Mental health professionals themselves may be in the process of learning more about effective ways to treat child trauma.

- **Lack of understanding about child trauma.** Many judges are not aware of psychological diagnoses, symptoms, causes, and treatment. Furthermore, judges often do not know the right questions to ask service providers in order to make informed decisions about treatment choices for children.

- **Coordination with other service systems.** Various systems (e.g., school, medical) may not have a complete understanding about child trauma and its effects. Mental health or other professionals may not be aware of—or may not have access to—evidence-based, trauma-focused practice. Judges need more transparency with regard to who the "experts" are (e.g., social workers, psychologists, domestic violence advocates, etc.).

- **Confidentiality issues.** While many dependency cases turn into delinquency cases, confidentiality issues keep judges from knowing the extent of trauma a child may have experienced prior to committing the delinquent offense. Furthermore, due to tight deadlines, some psychiatrists may have to evaluate a child without having sufficient information about the child's trauma history.

64.3% of judges thought that a document describing the effects of trauma both immediately and over the long-term would be most helpful in their work with traumatized children

- **Secondary traumatic stress.** Just as there is a threat of burnout for mental health professionals who work with severely traumatized children, it is very stressful for judges to deal with child victims of trauma. One judge noted that often there is no process in place for talking about trauma with other judicial officers (e.g., when a child on probation is shot and killed). Judges related that they frequently are working nonstop and don't even have five minutes by themselves to deal with their emotions about a particularly difficult case. They also expressed reluctance to convey their true feelings about a child's trauma because of a lack of trust in one another. For example, a judge in one jurisdiction spoke about a fellow judge who committed suicide. When a group of judges were given the opportunity to meet together with a mental health professional to talk about their colleague's death, many did not take advantage of this help due to political distrust among them. As a result of such distrust, judges often keep their feelings to themselves.

Providing Resources for Judges

The vast majority of judges (76.9%) participating in the 2007 focus groups said that they get most of their information from judicial journals and continuing education sessions. Only 23.1% reported that they get information from psychology journals. As mental health professionals create public education campaigns for judges, they need to disseminate information about child trauma in places where judges will actually see it.

During the focus groups, 64.3% of judges said that a document describing the effects of trauma both immediately and over the long term would be most helpful in their

work with traumatized children. They also suggested that resources should include information on risk and resilience factors in children as well as actions that judges can take immediately and over the long term to help children who have been traumatized.

The NCTSN is partnering with the NCJFCJ to produce a special issue of the Juvenile and Family Court Journal focusing on child trauma, which will be published in the winter of 2008. The goal of this issue will be to present information on the impact of trauma on children as related to cases judges might expect to see in their courtroom, and to address the topics that judges raised during the focus groups.

The NCTSN continues to look for ways to partner with the NCJFCJ and other national organizations to raise the standard of care and to increase access to services for traumatized children and their families throughout the United States.

References

1. Abram, K. M., Teplin, L. A., Charles, D. R., Longworth, S. L., McClelland, G. M., & Dulcan, M. K. (2004). Posttraumatic stress disorder and trauma in youth in juvenile detention. *Arch Gen Psychiatry, 61*(4), 403-410.

2. Cauffman, E., Feldman, S. S., Waterman, J., & Steiner, H. (1998). Posttraumatic stress disorder among female juvenile offenders. *J Am Acad Child Adolesc Psychiatry, 37*(11), 1209-1216.

3. Arroyo, W. (2001). PTSD in children and adolescents in the juvenile justice system. In S. Eth (Ed.), *PTSD in Children and Adolescents* (Vol. 20, pp. 59-86). Arlington, VA: American Psychiatric Publishing.

4. Garland, A. F., Hough, R. L., McCabe, K. M., Yeh, M., Wood, P. A., & Aarons, G. A. (2001). Prevalence of psychiatric disorders in youths across five sectors of care. *J Am Acad Child Adolesc Psychiatry, 40*(4), 409-418.

5. Teplin, L. A., Abram, K. M., McClelland, G. M., Dulcan, M. K., & Mericle, A. A. (2002). Psychiatric disorders in youth in juvenile detention. *Arch Gen Psychiatry, 59*(12), 1133-1143.

6. Wasserman, G. A., McReynolds, L. S., Lucas, C. P., Fisher, P., & Santos, L. (2002). The voice DISC-IV with incarcerated male youths: prevalence of disorder. *J Am Acad Child Adolesc Psychiatry, 41*(3), 314-321.

7. Barth, R. P. (1996). The juvenile court and dependency cases. *The Future of Children, 6*(3), 100-110. Los Altos, CA: Center for the Future of Children, David and Lucile Packard Foundation.

8. Graham-Bermann, S. A. (2002). Child abuse in the context of domestic violence. In J. E. B. Myers, L. Berliner, J. N. Briere, C. T. Hendrix, T. A. Reid & C. A. Jenny (Eds.), *APSAC Handbook on Child Maltreatment* (pp. 119-130). Thousand Oaks, CA: Sage Publications.

9. Guterman, N. B., Cameron, M., & Hahm, H. C. (2003). Community violence exposure and associated behavior problems among children and adolescents in residential treatment. *Journal of Aggression, Maltreatment & Trauma, 6*(2), 111-135.

10. Hartley, C. C. (2002). The co-occurrence of child maltreatment and domestic violence: examining both neglect and child physical abuse. *Child Maltreat, 7*(4), 349-358.

11. Kelley, S. J. (2002). Child maltreatment in the context of substance abuse. In J. E. B. Myers, L. Berliner, J. N. Briere, C. T. Hendrix, T. A. Reid & C. A. Jenny (Eds.), *APSAC Handbook on Child Maltreatment* (pp. 105-118). Thousand Oaks, CA: Sage Publications.

This Service Systems Brief was written by Cally Sprague, MA, Program Coordinator at the National Center for Child Traumatic Stress.

TECHNICAL ASSISTANCE BULLETIN

Ten Things Every Juvenile Court Judge Should Know About Trauma and Delinquency

Authored By:
Kristine Buffington, MSW
Carly B. Dierkhising, MA
Shawn C. Marsh, Ph.D.

NCJFCJ
NATIONAL COUNCIL OF JUVENILE AND FAMILY COURT JUDGES

NCTSN The National Child Traumatic Stress Network

OJJDP
Office of Juvenile Justice and Delinquency Prevention

Introduction

Studies also demonstrate that youth who have multiple exposures to violence or victimization are at higher risk for mental health problems, behavioral problems, substance abuse, and delinquent behaviors.

The majority of youth who develop a pattern of delinquent behaviors and experience subsequent juvenile court involvement have faced both serious adversities and traumatic experiences. Research continues to show that most youth who are detained in juvenile detention centers have been exposed to both community and family violence and many have been threatened with, or been the direct target of, such violence (Abram et al., 2004; Wiig, Widom, & Tuell, 2003). Studies also demonstrate that youth who have multiple exposures to violence or victimization are at higher risk for mental health problems, behavioral problems, substance abuse, and delinquent behaviors (Ford, Chapman, Hawke, & Albert, 2007; Ford, Elhai, Connor, & Frueh, in press; Saunders, Williams, Smith, & Hanson, 2005; Tuell, 2008).

The mission of the juvenile court is complex. The court is tasked with protecting society, safeguarding the youth and families that come to its attention, and holding delinquent youth accountable while supporting their rehabilitation. In order to successfully meet these sometimes contradictory goals, the courts, and especially the juvenile court judge, are asked to understand the myriad underlying factors that affect the lives of juveniles and their families. One of the most pervasive of these factors is exposure to trauma. To be most effective in achieving its mission, the juvenile court must both understand the role of traumatic exposure in the lives of children and engage resources and interventions that address child traumatic stress. Accordingly, the purpose of this technical assistance bulletin is to highlight ten crucial areas that judges need to be familiar with in order to best assist traumatized youth who enter the juvenile justice system.

1. A traumatic experience is an event that threatens someone's life, safety, or well-being.

Trauma can include a direct encounter with a dangerous or threatening event, or it can involve witnessing the endangerment or suffering of another living being. A key condition that makes these events traumatic is that they can overwhelm a person's capacity to cope, and elicit intense feelings such as fear, terror, helplessness, hopelessness, and despair. Traumatic events include: emotional, physical, and sexual abuse; neglect; physical assaults; witnessing family, school, or community violence; war; racism; bullying; acts of terrorism; fires; serious accidents; serious injuries; intrusive or painful medical procedures; loss of loved ones; abandonment; and separation.

KEY DEFINITIONS

Acute Trauma: "A single traumatic event that is limited in time. An earthquake, dog bite, or motor vehicle accident are all examples of acute traumas" (Child Welfare Committee (CWC)/ National Center for Child Traumatic Stress Network (NCTSN) 2008, p. 6).

Chronic Trauma: "Chronic trauma may refer to multiple and varied (traumatic) events such as a child who is exposed to domestic violence at home, is involved in a car accident, and then becomes a victim of community violence, or longstanding trauma such as physical abuse or war." (CWC/NCTSN, 2008, p. 6).

Complex Trauma: "Complex trauma is a term used by some experts to describe both exposure to chronic trauma—usually caused by adults entrusted with the child's care, such as parents or caregivers—and the immediate and long-term impact of such exposure on the child." (CWC/ NCTSN, 2008, p. 7).

Hypervigilance: "Abnormally increased arousal, responsiveness to stimuli, and scanning of the environment for threats" (Dorland's Medical Dictionary for Health Consumers, 2007). Hypervigilance is a symptom that adults and youth can develop after exposure to dangerous and life-threatening events (Ford et al., 2000; Sipprelle, 1992). The American Psychiatric Association's diagnostic criteria manual (DSM-IV-TR) identifies it as a symptom related to Post Traumatic Stress Disorder (American Psychiatric Association, 2000).

Resiliency: "A pattern of positive adaptation in the context of past or present adversity" (Wright & Masten, 2005, p. 18).

Traumatic Reminders: "A traumatic reminder is any person, situation, sensation, feeling, or thing that reminds a child of a traumatic event. When faced with these reminders, a child may re-experience the intense and disturbing feelings tied to the original trauma." (CWC/NCTSN, 2008, p. 12).

A key condition that makes these events traumatic is that they can overwhelm a person's capacity to cope, and elicit intense feelings such as fear, terror, helplessness, hopelessness, and despair.

2. Child traumatic stress can lead to Post Traumatic Stress Disorder (PTSD).

While many youth who experience trauma are able to work through subsequent challenges, some display traumatic stress reactions. The impact of a potentially traumatic event is determined, not only by the objective nature of the event, but also by the child's subjective response to the event; something that is traumatic for one child may not be for another. The degree to which a child is impacted by trauma is influenced by his or her temperament; the way the child interprets what has happened; his or her basic coping skills; the level of traumatic exposure; home and community environments; and the degree to which a child has access to strong and healthy support systems.

Rates of PTSD in juvenile justice-involved youth are estimated between 3%-50% (Wolpaw & Ford, 2004) making it comparable to the PTSD rates (12%-20%) of soldiers returning from deployment in Iraq (Roehr, 2007). PTSD is a psychiatric disorder defined in the DSM-IV-TR, and several conditions or criteria must be met for an individual to receive the diagnosis. These criteria include: having been exposed to a threatening event, experiencing an overwhelming emotional reaction, and developing symptoms causing severe distress and interference with daily life. Further, individuals also must experience a sufficient number of the following three symptoms for more than one month: *avoidance* (i.e., avoiding reminders of the trauma); *hyperarousal* (i.e., being emotionally or behaviorally agitated); and *re-experiencing* (e.g., nightmares or intrusive memories). Since the PTSD diagnosis was developed initially to describe an adult condition, the definition is not a perfect fit for what professionals often see with children and youth who have experienced trauma. It is also important to understand that not all youth who are impacted severely by traumatic stress develop PTSD. Some youth may experience partial symptoms of PTSD, other forms of anxiety or depression, or other significant impairments in their ability to meet the demands of daily life (e.g., emotional numbness or apathy).

Rates of PTSD in juvenile justice-involved youth are estimated between 3%-50% (Wolpaw & Ford, 2004) making it comparable to the PTSD rates (12%-20%) of soldiers returning from deployment in Iraq (Roehr, 2007).

3. Trauma impacts a child's development and health throughout his or her life.

Traumatic experiences have the potential to impact children in all areas of social, cognitive, and emotional development throughout their lives. Trauma that occurs early in life, such as infancy or toddlerhood, strikes during a critical developmental period. The most significant amount of brain growth occurs between birth and two years of age. Exposure to child abuse and neglect can restrict brain growth especially in the areas of the brain that control learning and self regulation (DeBellis, 1999). Exposure to domestic violence has also been linked to lower IQ scores for children (Koenen, Moffitt, Avshalom, Taylor, & Purcell, 2003). In addition to critical periods of brain development, it is during early childhood that children develop the foundations for their future relationships. When young children are cared for by parents who protect them, interact with them, and nurture them, they can learn to trust others, develop empathy, and have a greater capacity for identification with social norms (Putnam, 2006). Loss of a caregiver or being parented by a significantly impaired caregiver can disrupt children's abilities to manage their emotions, behaviors, and relationships. Youth who experience traumatic events may have mental and physical health challenges, problems developing and maintaining healthy relationships, difficulties learning, behavioral problems, and substance abuse issues (Ford et al., 2007; Saunders et al., 2005). In other words, what occurs in the lives of infants and young children matters a great deal and can set the stage for a child's entire life trajectory.

Exposure to child abuse and neglect can restrict brain growth especially in the areas of the brain that control learning and self regulation (DeBellis, 1999).

The experience of either **acute trauma** (a single traumatic event limited in time), or **chronic trauma** (multiple traumatic events) can derail a child's development if proper supports or treatment are not accessed (Garbarino, 2000). It is not likely just one traumatic event will lead a youth to become violent or antisocial, rather it is both a series and pattern of traumatic events – occurring with no protection, no support, and no opportunities for healing – that places youth at the highest risk (Garbarino, 2000). It is this pattern of chronic trauma that affects many youth who come before the juvenile court system. Research also suggests that the impact of trauma can persist into adulthood and can increase risk of serious diseases, health problems, and early mortality (Felitti et al., 1998). Given that child traumatic stress can impact brain development and have such a profound influence throughout a person's lifespan, it is essential for courts and communities to work together to prevent traumatic events where possible (such as child abuse and neglect) and to provide early interventions to treat traumatic stress before a youth becomes entrenched in a pattern of maladaptive and problematic behavior.

4. Complex trauma is associated with risk of delinquency.

By recognizing and addressing the role of trauma in the lives of youth, the court and other systems can become more effective in meeting the needs of the justice-involved youth and the needs of the community.

The effect of trauma is cumulative: the greater the number of traumatic events that a child experiences, the greater the risks to a child's development and his or her emotional and physical health. Youth who experience **complex trauma** have been exposed to a series of traumatic events that include interpersonal abuse and violence, often perpetrated by those who are meant to protect them. This level of traumatic exposure has extremely high potential to derail a child's development on a number of levels. Youth who are victimized by abuse, and are exposed to other forms of violence, often lose their trust in the adults who are either responsible for perpetrating the abuse or who fail to protect them. Victimization, particularly victimization that goes unaddressed, is a violation of our social contract with youth and can create a deep disregard both for adults in general and the rules that adults have set (Cook, Blaustein, Spinazzola, & van der Kolk, 2003; Cook et al., 2005). Distrust and disregard for adults, rules, and laws place youth at a much greater risk for delinquency and other inappropriate behaviors.

Danny, a runaway who was interviewed in a residential treatment program, expressed anger and frustration with the fact that the juvenile court's first response was to quickly issue punitive consequences for his delinquent behavior, while being very slow to act and protect him from the physical abuse that he was suffering at the hands of his parent. He asserted that courts need to ask the questions, "Why is this kid running away? Why is he acting out like this?" It does not go unnoticed by youth when their safety and well-being is not addressed but their delinquent behavior is. These kinds of paradoxes and frustrations can increase the likelihood that youth will respond defiantly and with hostility to court and other professionals who are in positions of authority. System professionals would benefit from recognizing that imposing only negative or punitive consequences will likely do little to change the youth's patterns of aggression, rule breaking, and risky behaviors because such a response does not address the impact of traumatic stress on the child. By recognizing and addressing the role of trauma in the lives of youth, the court and other systems can become more effective in meeting the needs of the justice-involved youth and the needs of the community.

5. Traumatic exposure, delinquency, and school failure are related.

Academic failure, poor school attendance, and dropping out of school are factors that increase the risk of delinquency. Success in school requires confidence, the ability to focus and concentrate, the discipline to complete assignments, the ability to regulate emotions and behaviors, and the skills to understand and negotiate social relationships. When youth live in unpredictable and dangerous environments they often, in order to survive, operate in a state of **hypervigilance**. Clinical dictionaries typically describe hypervigilance as abnormally increased physiological arousal and responsiveness to stimuli, and scanning of the environment for threats. Individuals who experience hypervigilance often have difficulty sleeping and managing their emotions, and because they often see people or situations as a threat they are more likely to react in aggressive or defensive ways. The mindset and skills involved in hypervigilance fundamentally conflict with the skills and focus needed to succeed in school academically, socially, and behaviorally.

Unfortunately, school performance and attendance issues (whether trauma related or not), can be exacerbated by involvement in the juvenile justice or child protections systems. Studies in New York City and the State of Kentucky found that after being released from juvenile justice facilities, between 66%-95% of youth either did not return to school or dropped out (Brock & Keegan, 2007). Youth may experience absences while waiting for records to transfer, a delay in specialized services, inadequate educational planning, and poor service coordination between school systems, child welfare agencies, and juvenile justice systems. Also, it may be easier for youth to act out or give up than to continue failing in school. It is essential that the juvenile justice system work with other community partners to ensure that youth have the supports they need to attend and succeed in school. Without these supports and resources, uneducated youth face further adversities such as poverty, unemployment, and ongoing justice system involvement.

When youth live in unpredictable and dangerous environments they often, in order to survive, operate in a state of hypervigilance.

6. Trauma assessments can reduce misdiagnosis, promote positive outcomes, and maximize resources.

"Sixty-percent of youth involved in the juvenile justice system suffer from diagnosable mental health disorders" (Wood, Foy, Layne, Pynoos, & James, 2002, p. 129). Many of these youth have extensive histories of mental health treatment that may also include the use of psychotropic medication. Often youth who are exposed to chronic or complex trauma receive a diagnosis of Attention Deficit Disorder, Oppositional Defiant Disorder, Conduct Disorder, or other mental health disorders. These diagnoses are predominantly based on observable behaviors and symptoms. When there is a lack of thorough assessment, youth are provided treatment based on these behavioral diagnoses, without addressing the traumatic experiences that are contributing to the symptoms. In order to avoid this disconnect, trauma screenings and standardized assessments should be implemented at intake and at other points of contact. There are a number of assessments that assist in both identifying and tracking trauma histories, such as the Traumatic Events Screening Inventory (Daviss et al., 2000; Ford et al., 2000) and the Child Welfare Trauma Screening Tool (Igelman et al., 2007). There are also validated, standardized assessment tools that assist with identifying both mental health and behavioral symptoms and disorders related to traumatic experiences such as the UCLA Posttraumatic Stress Disorder Reaction Index (Steinberg, Brymer, Decker, & Pynoos, 2004) and the Trauma Symptom Checklist for Children (Briere, 1996). With such a strong body of knowledge and tools available, and so much at stake for youth and society, it makes good sense and is also ethically imperative to use evidence-based assessment tools to make accurate diagnoses that can inform appropriate responses and treatment for trauma-exposed youth.

When there is a lack of thorough assessment, youth are provided treatment based on these behavioral diagnoses, without addressing the traumatic experiences that are contributing to the symptoms.

7. There are mental health treatments that are effective in helping youth who are experiencing child traumatic stress.

A number of evidence-based practices (EBPs) are available to courts and communities for treating youth who are impacted by trauma. EBPs are practices that have been evaluated through rigorous scientific studies and have been found to be effective. It is a service provider's ethical responsibility to provide the highest standard of care and to use evidence-based practices whenever possible. It is also imperative that referrals for treatment be made to service providers that use trauma-focused EBPs, so that youth may receive both the best care and the most positive outcomes. The Centers for Disease Control indicates that the most highly effective treatments for traumatic stress are cognitive behavioral treatment models (Centers for Disease Control, 2008). Typically, trauma-focused, evidence-based treatments include the following components: psychoeducation, caregiver involvement and support, emotional regulation skills, anxiety management, cognitive processing, construction of a trauma narrative, and personal empowerment training. Judges can and should discuss the availability of EBPs with their treatment providers and advocate for the development of trauma-specific programming. (Please visit www.nctsnet.org for a list of evidence-based trauma treatments and respective evidence, treatment components, and target populations.)

It is also imperative that referrals for treatment be made to service providers that use trauma-focused EBPs, so that youth may receive both the best care and the most positive outcomes.

EVIDENCE-BASED TREATMENTS FOR WORKING WITH YOUTH WHO HAVE EXPERIENCED TRAUMA

There are a variety of treatments that research suggests are effective in working with youth who have experienced trauma. A comprehensive list of such treatments and supporting documentation is available at http://www.nctsn.org/nctsn_assets/pdfs/CCG_Book.pdf. Some of the more common evidence-based treatments, however, include (in no particular order):

Cognitive Behavioral Intervention for Trauma in Schools (CBITS): Tested with youth who have experienced violence and complex trauma. CBITS is provided in a group format in schools, residential programs, and other similar environments.

Trauma Affect Regulation: Guide for Education and Therapy (TARGET-A): TARGET-A shows evidence of effectiveness with youth who are in correctional facilities, residential settings, and community-based programs. This model can be practiced in group, individual, and family formats, which helps both youth and families to better understand trauma and stress, and to develop skills that help them to think through, and regulate, their emotional, cognitive, and behavioral responses to stress triggers.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT): Youth (and their parents, possibly) are taught to process the trauma; manage distressful thoughts, feelings, and behaviors; and enhance both personal safety and family communication. It can be provided over a relatively short period of time in virtually any setting.

Sanctuary Model: The Sanctuary Model promotes system change based on the creation and maintenance of a nonviolent, democratic, productive community to help individuals heal from trauma. The model provides a common language for staff, clients, and other stakeholders, and can be adapted to several settings and populations.

8. There is a compelling need for effective family involvement.

Youth who do not have helpful and consistent family support are at higher risk of violence and prolonged involvement in the court system (Garbarino, 2000). If juvenile courts are to enhance their success in rehabilitating juveniles who commit delinquent acts, they need to maximize opportunities to engage and partner with their caregivers. This means working to develop meaningful involvement of biological parents, extended family members, kinship caregivers, adoptive families, foster parents, and others.

Families may need education about traumatic stress and treatments that work so they can be more supportive of their children, and for some families, this education will help them address their own traumatic experiences. Kinship caregivers, foster parents, and adoptive families often regret not being involved sooner in a child's life so they could have prevented earlier traumatic events. Often out-of-home caregivers need more information about what specific traumatic events or adversities a child may have experienced prior to becoming part of their family so they can make sense out of the child's behaviors and find helpful ways to respond.

Families may need education about traumatic stress and treatments that work so they can be more supportive of their children, and for some families, this education will help them address their own traumatic experiences.

There can be obstacles and challenges to achieving successful family involvement. Sometimes families avoid interactions with the court system because of feelings of shame and fears of being criticized. Therefore, courts might wish to engage families in ways that can help them feel more valued, respected, and invited to participate in the court processes and their child's rehabilitation. Practical and economic issues can also play a significant role in limiting family involvement, including: too much distance from the child's home to the juvenile correction center, lack of reliable transportation, language and cultural barriers, and feelings of being overwhelmed and intimidated about interacting with a large public institution. When courts collaborate with community organizations and families, they may be able to find some practical ways to locate the resources that enable increased family participation. The best strategy to improve family involvement and partnerships is for the courts to take the time to ask them for guidance and solutions.

9. Youth are resilient.

Resiliency is the capacity for human beings to thrive in the face of adversity – such as traumatic experiences. Research suggests that the degree to which one is resilient is influenced by a complex interaction of risk and protective factors that exist across various domains, such as individual, family, community and school. Accordingly, most practitioners approach enhancing resiliency by seeking both to reduce risk (e.g., exposure to violence) and increase protection (e.g., educational engagement) in the lives of the youth and families with whom they work. Research on resiliency suggests that youth are more likely to overcome adversities when they have caring adults in their lives. Through positive relationships with adults, youth experience a safe and supportive connection that fosters self-efficacy, increases coping skills, and enhances natural talents. Parents and other important familial adults can help increase their children's ability to heal from trauma and promote prosocial behaviors by spending time at home together, talking, sharing meals, and "setting clear boundaries for behavior and reasonable disciplinary actions" (National Youth Violence Prevention Resource Center, 2007). Further, schools, courts, and communities can enhance resiliency by providing opportunities for youth to make meaningful decisions about their lives and environment, as well as investing in recreational programs, arts, mentorship, and vocational programs. The Search Institute, in Minneapolis, Minnesota, has developed a variety of tools to identify and promote developmental assets (www.search-institute.org).

Research on resiliency suggests that youth are more likely to overcome adversities when they have caring adults in their lives.

10. Next steps: The juvenile justice system needs to be trauma-informed at all levels.

Trauma-informed systems of care understand the impact of traumatic stress both on youth and families, and provide services and supports that prevent, address, and ameliorate the impact of trauma. It is essential that juvenile courts work to provide environments that are safe and services that do not increase the level of trauma that youth and families experience. For example, a trauma-informed juvenile justice system understands that youth who are chronically exposed to trauma are often hypervigilant and can be easily triggered into a defensive or aggressive response toward adults and peers. Such a juvenile justice system makes system-level changes to improve a youth's feelings of safety, reduce exposure to **traumatic reminders**, and help equip youth with supports and tools to cope with traumatic stress reactions. The provision of or referral to evidence-based trauma-informed treatment is essential within a trauma-informed system, as youth are less likely to benefit from rehabilitation services if the system they are involved in does not respond to their issues of safety and victimization.

To help sustain and ensure effectiveness of a trauma-informed juvenile justice system, data needs to be collected, evaluated, and used to determine the quality, fidelity, and effectiveness of the system changes.

Trauma-informed systems require successful and respectful partnerships between youth, families, professionals, and other stakeholders. To help sustain and ensure effectiveness of a trauma-informed juvenile justice system, data needs to be collected, evaluated, and used to determine the quality, fidelity, and effectiveness of the system changes. For example, there needs to be supervision and evaluation to ensure that trauma-informed interventions are being practiced the way they were designed in the particular evidence-based treatment model. Clinical outcome measures need to be used at least pre- and post-treatment to determine if a decrease in symptoms and/or increase in healthy coping have occurred during and after completion of the therapy model. Often juvenile detention centers have looked at rates of aggression, self-injury, and restraint and seclusion as data to help determine if the trauma-informed treatments are effective or in need of modification. All stakeholders need to be regularly informed on the status and quality of the outcomes of the system change efforts (Fixsen, Blase, Naoom, & Wallace, 2007). There are many resources that describe trauma-informed care in various service systems, such as juvenile justice, that can help guide interested systems through a transformation process.

Summary

Juvenile courts can benefit from understanding trauma, its impact on youth, and its relationship to delinquency. Research has repeatedly shown that the majority of youth in the juvenile justice system have experienced traumatic events; the juvenile court is disadvantaged if this fact is overlooked. By becoming trauma-informed, juvenile justice personnel aid the juvenile court in its mission of protecting and rehabilitating traumatized youth while holding them responsible for their actions. Rehabilitation resources also can be maximized by utilizing effective assessment and treatment strategies that reduce or ameliorate the impact of childhood trauma. Ultimately, such efforts will help promote improved outcomes for youth, families, and communities most in need of our help.

Research has repeatedly shown that the majority of youth in the juvenile justice system have experienced traumatic events; the juvenile court is disadvantaged if this fact is overlooked.

Resources

For more information about trauma, delinquency, or other issues of interest to juvenile and family courts, please contact the National Child Traumatic Stress Network (NCTSN) at info@nctsn.org or the National Council of Juvenile and Family Court Judges (NCJFCJ) at (775) 784-6012; e-mail jfinfo@ncjfcj.org. Other resources are available online at:

www.safestartcenter.org/cev/index.php

www.ojjdp.ncjrs.gov

www.search-institute.org

www.nctsnet.org

www.ncjfcj.org

About the Authors

Kristine Buffington, MSW, is the Vice President of Mental Health Services for A Renewed Mind, an outreach and community-based agency in Toledo, Ohio, that serves youth with mental health and substance abuse problems. Much of her 24-year career as a clinical social worker has been spent serving youth, adults, and families who have experienced traumatic stress. [kbuffington46@hotmail.com]

Carly B. Dierkhising, MA, is the Program Coordinator for the Service Systems Program at the National Center for Child Traumatic Stress (NCCTS), which seeks to improve access and raise the standard of care for traumatized children and families. Her primary focus is on the assessment and treatment of trauma-exposed youth involved in the juvenile justice system. [cdierkhising@mednet.ucla.edu]

Shawn C. Marsh, Ph.D., is the Director of the Juvenile and Family Law Department of the National Council of Juvenile and Family Court Judges. His research and teaching interests include adolescent development, delinquency, and resiliency. [smarsh@ncjfcj.org]

Note: The authors would like to thank the judicial officers, clinical experts, staff, and system consumers who reviewed this bulletin for their time and thoughtful input that made this a better product.

References

Abram, K. M., Teplin, L. A., Charles, D. R., Longworth, S. L., McClelland, G. M., & Dulcan, M. K. (2004). Posttraumatic stress disorder and trauma in youth in juvenile detention. *Archives of General Psychiatry, 61*, 403-410.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (Revised 4th ed.). Washington, DC: Author.

Briere, J. (1996). *Trauma symptom checklist for children professional manual*. Odessa, FL: Psychological Assessment Resources.

Brock, L., & Keegan, N. (2007). *Students highly at risk of dropping out: Returning to school after incarceration*. Retrieved from http://www.neglected-delinquent.org/nd/resources/library/atrisk.asp#issue

Centers for Disease Control. (2008). Reducing psychological harm from traumatic events: Cognitive behavior therapy for children and adolescents (individual & group). *Guide to Community Preventive Services*. Retrieved from http://www.thecommunityguide.org/violence/behaviortherapy.html

Child Welfare Committee, National Child Traumatic Stress Network [CWC/NCTSN]. (2008). *Child welfare trauma training tool kit: Comprehensive guide* (2nd ed.). Los Angeles, CA: National Center for Child Traumatic Stress.

Cook, A., Blaustein, M., Spinazzola, J., & van der Kolk, B. (Eds.). (2003). *Complex trauma in children & adolescents* [White paper]. U.S. Department of Health & Human Services. Retrieved from http://www.nctsnet.org/nctsn_assets/pdfs/edu_materials/ComplexTrauma_All.pdf

Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M., Cloitre, M., DeRosa, R., Hubbard, R., Kagan, R., Mallah, K., Olafson, E., & van der Kolk, B. (2005). Complex trauma in children and adolescents. *Psychiatric Annual, 35*(5), 390-398.

Daviss, W. B., Mooney, D., Racusin, R., Ford, J. D., Fleischer, A., & McHugo, G. J. (2000). Predicting posttraumatic stress after hospitalization for pediatric injury. *Journal of the American Academy of Child & Adolescent Psychiatry, 39*(5), 576-583.

De Bellis, M. D. (1999). Outcomes of child abuse part II: Brain development. *Biological Psychiatry, 45*(10), 1271-84.

Dorland's Medical Dictionary for Health Consumers. (2007). Retrieved from http://www.dorlands.com.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of household dysfunction to many of the leading causes of death in adults. *American Journal of Preventive Medicine, 14*(4), 245-258.

Fixsen, D. L., Blase, K. A., Naoom, S. F., & Wallace, F. (2007). *Lessons learned from research on implementation*. Retrieved from http://www.nwrel.org/nwrcc/images/rti2007/fixsen1.pdf

Ford, J. D., Chapman, J. F., Hawke, J., & Albert, D. (2007). *Trauma among youth in the juvenile justice systems: Critical issues and new directions*. Retrieved from http://www.ncmhjj.com/pdfs/Trauma_and_Youth.pdf

Ford, J. D., Elhai, J. D., Connor, D. F., & Frueh, B. C. (in press). Poly-victimization and risk of posttraumatic, depressive, and substance use disorders and involvement in delinquency in a national sample of adolescents. *Journal of Adolescent Health*.

Ford, J. D., Racusin, R., Ellis, C. G., Daviss, W. B., Reiser, J., Fleisher, A., & Thomas, J. (2000). Child maltreatment, other trauma exposure and posttraumatic symptomatology among children with oppositional defiant and attention deficit hyperactivity disorders. *Child Maltreatment, 5*(3), 205-217.

Garbarino, J. (2000). Lost boys: *Why our sons turn violent and how to save them*. Norwell, MA: Anchor.

Igelman, R., Taylor, N., Gilbert, A., Ryan, B., Steinberg, A., Wilson, C., & Mann, G. (2007). Creating more trauma-informed services for children using assessment-focused tools. *Child Welfare, 86*(5), 15-33.

References

Koenen, K., Moffitt, T., Avshalom, C., Taylor, A., & Purcell, S. (2003). Domestic violence is associated with environmental suppression of IQ in young children. *Development and Psychopathology, 15*, 297-311.

National Youth Violence Prevention Resource Center. (2007). *Risk and protective factors for youth violence fact sheet*. Retrieved from http://www.safeyouth.org/scripts/facts/risk.asp

Putnam, F. (2006). The impact of trauma on child development. *Juvenile and Family Court Journal, 57*(1), 1-11.

Roehr, B. (2007). *High rate of PTSD in returning Iraq war veterans*. Retrieved from http://www.medscape.com/viewarticle/565407

Saunders, B. E., Williams, L. M., Smith, D. W., & Hanson, R. F. (2005). *The Navy's future: Issues related to children living in families reported to the family advocacy program* (Contract No. N00140-01-C-N662). Retrieved from http://www.wcwonline.org/proj/NSF/NFSFinalChildReport.pdf

Sipprelle, R. C. (1992). A vet center experience: Multievent trauma, delayed treatment type. In D. Foy (Ed.), *Treating PTSD: Cognitive–behavioral strategies* (pp. 13-38). New York: Guilford Press.

Steinberg, A. M., Brymer, M. J., Decker, K. B., & Pynoos, R. S. (2004). The University of California at Los Angeles post-traumatic stress disorder reaction index. *Current Psychiatry Reports, 6*, 96-100.

Tuell, J. A. (2008). Child Welfare and Juvenile Justice Systems Integration Initiative: A Promising Progress Report. Washington, DC: Child Welfare League of America.

Wiig, J. K., Widom, C. S., & Tuell, J. A. (2003). *Understanding child maltreatment and juvenile delinquency: From research to effective programs, practice & systematic solutions*. Retrieved from http://www.cwla.org /programs/juvenilejustice/ucmjd.htm

Wolpaw, J. M., & Ford, J. (2004). *Assessing exposure to psychological trauma and post-traumatic stress in the juvenile justice population*. Retrieved from http://www.nctsnet.org/nccts/asset.do?id=515

Wood, J., Foy, D. W., Layne, C., Pynoos, R., & James, C. B. (2002). An examination of the relationships between violence exposure, posttraumatic stress symptomatology, and delinquent activity: An "ecopathological" model of delinquent behavior among incarcerated adolescents. *Journal of Aggression, Maltreatment, & Trauma, 6*, 127-147.

Wright, M. O., & Masten, A. S. (2005). Resilience processes in development: Fostering positive adaptation in the context of adversity. In S. Goldstein & R. B. Brooks (Eds.), *Handbook of resilience in children* (pp. 17–37). New York: Kluwer Academic/Plenum Publishers.

Suggested citation: Buffington, K., Dierkhising, C. B., & Marsh, S. C. (2010). *Ten things every juvenile court judge should know about trauma and delinquency*. Reno, NV: National Council of Juvenile and Family Court Judges.

National Council of Juvenile and Family Court Judges
P.O. Box 8970
Reno, NV 89507
www.ncjfcj.org

This project was supported by Grant No. 2007-JL-FX-0007 awarded by the Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice. Points of view or opinions in this document or program are those of the authors and do not necessarily represent the official position or policies of the U.S. Department of Justice or the National Council of Juvenile and Family Court Judges.

Resources for Collaboration

NCTSN The National Child Traumatic Stress Network

Cross-System Collaboration

Macon Stewart

Center for Juvenile Justice Reform

Youth develop within the context of their families and communities. To promote healthy growth and a strong sense of well-being for all youth, we must develop service systems that are able to manage the diverse needs of youth and families. This requires various partnerships across multiple service systems to attend to the needs of our most vulnerable youth who face significant risk factors. This level of partnership is the crux of collaboration. Cross-system collaboration enhances the strengths of partnering agencies/programs to promote a continuous system of services for youth and families.

There is a strong connection between trauma and the need for cross-system collaboration, in that a large percentage of youth involved with any system of care has experienced some degree of trauma. Research has shown that up to 34% of youth in the United States have experienced at least one traumatic event (Craig & Sprang, 2007). Among youth served by a system of care, research often speaks to the trauma that children and youth involved in the child welfare system experience as a result of being removed from their families and placed in a system that creates a degree of uncertainty about their future. A study of youth involved in the child welfare system in Maine found that one-third of females and more than two-thirds of males had a trauma-related diagnosis or were involved in child welfare as a result of a traumatic event (Cooper, Masi, Dababnah, Aratani, & Knitzer, 2007). In addition, between 75-93% of youth entering the juvenile justice system have experienced a traumatic event (Adams, 2010).

The need to address trauma from a cross-system perspective is further enhanced by the fact that child maltreatment (i.e., abuse — physical or sexual — and/or neglect) is a risk factor for delinquency. The experience of maltreatment increases a youth's likelihood to engage in delinquency by 47-55% (Ryan & Testa, 2005). The high percentage of youth involved in child welfare who experience trauma, coupled with the increased likelihood that these same youth will come into contact with the juvenile justice system — added in that these two systems are not traditionally service providers — highlights the need to address trauma in the context of cross-system collaboration.

Cross-system collaboration is a key element of a trauma-informed juvenile justice system, because youth who enter the delinquency system have challenges that cannot be addressed solely through punitive measures. These young people have been strongly influenced by their familial context and the communities in which they live. Therefore, in an effort to ensure public safety and rehabilitate youth, the juvenile justice system must be equipped to work with other systems and community partners that can assist youth in other domains of their life.

To support a trauma-informed juvenile justice system, it is important for the delinquency system to understand who these youth are and be aware of existing systems that are currently serving them at the earliest point possible. This requires the establishment of a mechanism for communication with those systems at the point of arrest or juvenile justice intake. This early communication allows for a foundation for the juvenile justice system to better understand the individual youth's psychosocial history, and presents an immediate opportunity to appropriately support youth. Early communication also impacts the systems' ability to work as a team and collectively respond to the youth's needs. This includes the gathering of assessment information and historical case planning data to assist in understanding the youth's history of trauma and how their current arrest may have further exacerbated internal triggers. Early communication sets a clear path that can dramatically impact the youth's trajectory for the better. It can impact their release from detention (and to the appropriate person), connect the juvenile justice intake worker with the current case manager for consultation and recommendations

for the initial hearing, and provide an opportunity for immediate case planning and acquisition of new services or the enhancement of existing services.

Historically cross-system collaboration has presented a challenge because of the siloed nature in which systems of care have operated. Child serving systems have been guided by statutory mandates, restrictive funding appropriations, mission/vision statements, and service plans that did not promote collaboration (Wiig & Tuell, 2008). This has had negative repercussions for the countless youth who find themselves on the receiving end of services. The recommendations for addressing these challenges are that:

a. Agencies must acknowledge the inherent connection to other existing systems

b. Systems must begin to cultivate relationships that focus on serving the best interests of the youth they have in common, and

c. Systems and agencies must make a commitment (through formalized agreements) to partner/collaborate

An eye-opening experience is when agencies finally see how many youth they actually have in common and begin to understand the level of duplication that is occurring in services. Understanding the fiscal impact of failing to collaborate, and the human impact of re-traumatization (as a result of system involvement), should serve as an impetus for restructuring, reorganizing, and committing to collaborate in the creation of a trauma-informed juvenile justice system.

Through our work in implementing the Crossover Youth Practice Model (CYPM) at the Georgetown University Public Policy Institutes Center for Juvenile Justice Reform, we work with jurisdictions to develop strong collaborative relationships between child-serving agencies that lead to improvements in youth outcomes and system functioning. For more information, go to http://cjjr.georgetown.edu.

In the CYPM, we require that each jurisdiction has the following agencies as part of their cross-system collaboration: child welfare, juvenile justice, family court, education, and behavioral health. Each of these systems has a vital role in the life of all youth who are involved with a system of care. An initial goal in our work is identification. Identification of a youth at the time of arrest or intake is critical to addressing their needs from the onset of the case. We have found that, in many jurisdictions, there is no formalized process for identifying a youth's involvement with other agencies. In many instances this lack of an identification mechanism leads to youth being held in detention for longer periods of time, and failure to provide the appropriate services due to a lack of information sharing between systems.

In all designated CYPM sites, a process for identifying a youth's involvement in other systems is created at the point of juvenile justice intake. In most instances this process confirms the youth's involvement with other systems within 24-48 hours and enacts the immediate notification of a cross-systems team to begin collaborating in the case planning process. In an effort to create a trauma-informed juvenile justice system, the immediate identification process will not only alert all relevant parties of a youth's arrest, but will allow for the exchange of assessment information to inform the decision-making process going forward. This exchange of information is protected through information sharing agreements that ensure that information acquired about a youth is only used for case planning purposes, and cannot be utilized at the charging phase or during any type of delinquency court proceeding. This level of collaboration is also required of the attorneys working on these cases. Providing the prosecutors, state's attorneys, and public defenders a vivid picture of youth and the experiences and hardships they have faced has challenged many of them to take a different approach when reviewing and filing on the pending charges. In many communities, the attorneys have established a team meeting structure to collectively review a youth's file and current charges to make a joint decision on how to move forward. In our CYPM work, cross-system collaboration is also impacting diversion opportunities to a large degree. We have found that, in several communities, foster care bias was limiting the opportunity for youth in child welfare to be offered diversion when deemed appropriate. This bias was predicated on the assumption that no one in child welfare would ensure the

youth's compliance with services, thereby pushing youth further into the juvenile justice system. Through our work, we are ensuring that all youth are offered an opportunity to participate in diversion services and, through cross-system collaboration, we are increasing the likelihood of success for all youth.

The necessity of cross-system collaboration in the creation of a trauma-informed juvenile justice system can't be overstated. Youth who enter the juvenile justice system come from various walks of life and very diverse communities. Having a system that is understanding of those dynamics and flexible enough to engage whoever those additional partners are is key to best serving youth and improving outcomes. No youth is an island unto themselves; neither is one system. Therefore it is incumbent upon us to maximize our ability to share resources and partner, because we all want to see our youth achieve in the best manner possible.

References

Adams, E. (2010). Healing invisible wounds: Why investing in trauma-informed care for children makes sense. Washington, DC: Justice Policy Institute.

Cooper, J. L., Masi, R., Dababnah, S., Aratani, Y., & Knitzer, J. (2007). Strengthening policies to support children, youth, and families who experience trauma. New York, NY: Columbia University, National Center for Children in Poverty.

Craig C.D., & Sprang G. (2007). Trauma exposure and child abuse potential: investigating the cycle of violence. American Journal of Orthopsychiatry, 77(2), 296-305.

Ryan, J.P., & Testa, M.K. (2005). Child maltreatment and juvenile delinquency: Investigating the role of placement and placement instability. Children and Youth Services Review, 27, 227-249.

Wiig, J.K., & Tuell, J.A. (2004, rev. 2008). Guidebook for juvenile justice and child welfare system coordination and integration: A framework for improved outcomes. Washington, D.C.: Child Welfare League of America Press.

Suggested Citation

Stewart, M. (2013). *Cross-System Collaboration.* Los Angeles, CA & Durham, NC: National Center for Child Traumatic Stress.