Sponsored by The Iowa State Bar Association's Family Law and Juvenile Law Section

Juvenile Law Seminar

Trauma Informed Care/Adverse Childhood Experiences (ACE)

8:30 a.m.-10:00 a.m.

Presented by

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Thursday, April 3, 2014

Trauma Informed Care: Looking at Behaviors Through a Trauma Lens

Orchard Place/Child Guidance Center

Gladys Noll Alvarez, LISW, Trauma Informed Care Project Coordinator

Rebecca Sloan, LISW, Trauma Informed Care Project Consultant

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Trauma Informed Care: is a paradigm shift

Trauma Informed Care (TIC) is.....

Not a mental health intervention....it is....

- Organizational structure
- Treatment framework
- Understand, recognize, respond to trauma effects
- Emphasis on physical, psychological and emotional safety for both ***consumers*** and ***providers***
- Help survivors rebuild a sense of control and empowerment

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Trauma Informed Care

- Emerged out of multiple strains of research findings
- Pervasive long term impact of trauma
- *Large percentage* in human services & juvenile court system experienced severe trauma
- *Trauma is a central experience of symptoms presented*
- Fail to incorporate trauma knowledge
  - Existing explanations
  - Responses

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Why Trauma Informed Care?

- Designed to minimize re-victimization
- Validates the survivors' life experiences
- Problem behaviors may be attempts to cope with abusive experiences

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Essentials of TIC

- Connect – Focus on Relationships
- Protect – Promote Safety and Trustworthiness

Hummer, V., Crosland, K., Dollard, N., 2009

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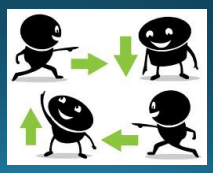
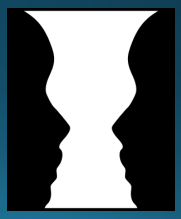
Essentials of TIC

- Respect – Engage in Choice and Collaboration
- Redirect (Teach and Reinforce) – Encourage Skill-Building and Competence



Trauma…

is something which threatens one's physical or psychological integrity.

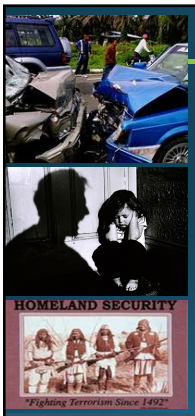


Traumatic Stress…

Results from exposure to traumatic experiences

- Physical/emotional responses-pounding heart
- Rapid breathing
- Trembling
- Dizziness
- Loss of bladder or bowel control
- Overwhelms ability to cope
- Elicit feelings of terror, powerlessness, and out-of-control physiological arousal

Marsenich, L. 2010, CA Institute of Mental Health



Trauma-Informed Care (TIC)

Types of Trauma

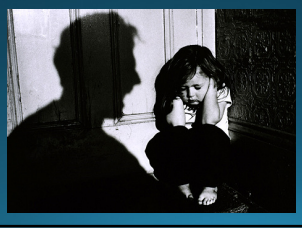
- Acute
- Chronic
- Complex
- Historical/Intergenerational

Acute trauma:

A *single* event that lasts for a limited time
•car accident
•witnessing a crime
•natural disaster

Chronic trauma:

The experience of ***multiple*** traumatic events, often over a long period of time



Complex Trauma…

Describes a specific kind of chronic trauma and its effects on children that include:

- Multiple traumatic events that begin at a very young age, typically under 5.
- Caused by adults who should have been caring for and protecting the child

Sources: Cook et al. (2005). *Psychiatric Annals,35* (5), 390-398; van Der Kolk, C. A., & Courtois, B. A. (2005). *Journal of Traumatic Stress*, *18*, 385-388.

Historical Trauma…

- Accumulative emotional and psychological pain over lifespan
- Across generations
- Result of massive group trauma

(Yellow-Horse Brave Heart, 1995)

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Historical Trauma can:

- Varied effects on individuals:
  - unsettled trauma or grief
  - depression, high mortality,
  - increase of alcohol abuse, child abuse and domestic violence
- Examples
  - Lakota and other American Indian
  - Jewish Holocaust survivors and descendants.

(Brave Heart, 2000)

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Interpersonal Violence

- ***Tends to be more traumatic than natural disasters***
- More disruptive to our sense of trust and attachment
- ***Experienced as intentional*** rather than as "an accident of nature"

(International Society for the Study of Trauma and Dissociation, 2009)

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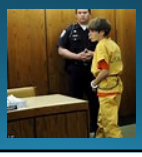
Prevalence of Trauma

- Children who experience child abuse and neglect are 59% more likely to be arrested as a juvenile, 28% more likely to be arrested as an adult, and 30% more likely to commit violent crime.

(Child Welfare Information Gateway, 2006)



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FACT: <u>One out of every 4</u> children attending school has been exposed to a traumatic event that can affect learning and/or behavior.

National Child Traumatic Stress Network Schools Committee. (October 2008). Child Trauma Toolkit for Educators. Los Angeles, CA & Durham, NC: National Center for Child Traumatic Stress.

FACT: Trauma can impact school performance.

- Lower GPA
- Higher rate of school absences
- Increased drop-out
- More suspensions and expulsions
- Decreased reading ability

National Child Traumatic Stress Network Schools Committee. (October 2008). Child Trauma Toolkit for Educators. Los Angeles, CA & Durham, NC: National Center for Child Traumatic Stress.

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Prevalence of Trauma

- More than *1 in 3 women* (35.6%) and more than *1 in 4 men* (28.5%) in the United States have experienced rape, physical violence, and/or stalking by an intimate partner. (CDC,2013)
- Nearly 80% of female offenders with a mental illness report having been physically and/or sexually abused. (Marcenich, 2009)
- 75% of women and men in treatment for substance abuse report trauma histories. (SAMSHA/CSAT, 2000)

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Adverse Childhood Experiences (ACE) Study

- Decade long study involving 17,000 people.
- Examines the health and social effects of ACEs throughout the lifespan.
- Largest study ever done on this subject.
- General Findings: Childhood experiences are powerful determinants of who we become as adults.

Dr. Vincent Felitti

Dr. Rob Anda

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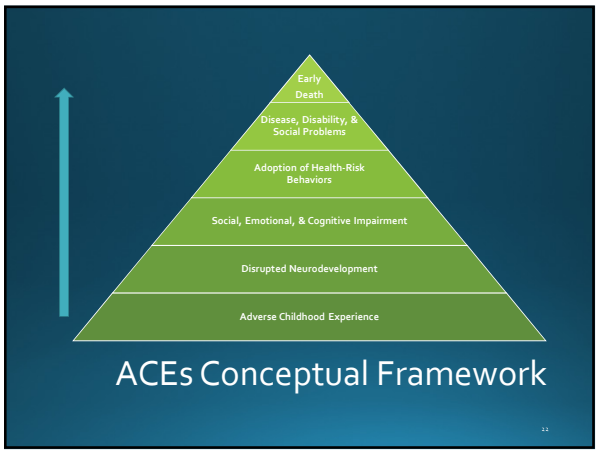
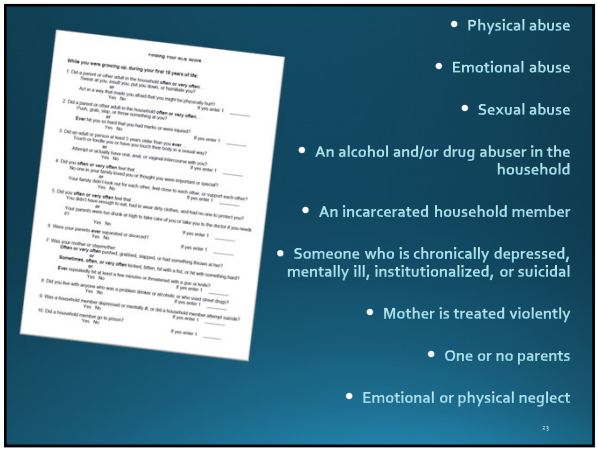




Probability of outcomes

Given 100 American Adults

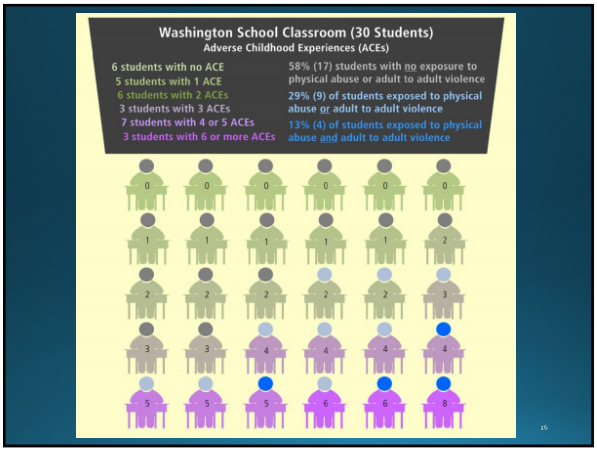
33	51	16
Report No ACEs	**Report 1-3 ACEs**	**Report 4-8 ACEs**
WITH 0 ACEs	**WITH 3 ACEs**	**WITH 7+ ACEs**
1 in 16 smokes	1 in 9 smokes	1 in 6 smokes
1 in 69 are alcoholic	1 in 9 are alcoholic	1 in 6 are alcoholic
1 in 480 uses IV drugs	1 in 43 uses IV drugs	1 in 30 use IV drugs
1 in 14 has heart disease	1 in 7 has heart disease	1 in 6 has heart disease
1 in 96 attempts suicide	1 in 10 attempts suicide	1 in 5 attempts suicide

Prevalence

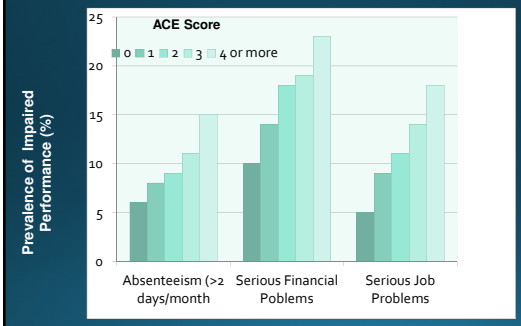
Adverse Childhood Experiences (ACE) Study
Centers for Disease Control & Prevention

Household dysfunction	
• Substance abuse	27%
• Parental separation/divorce	23%
• Mental illness	19%
• Battered mother	13%
• Incarcerated household member	5%
Abuse	
• Psychological	11%
• Physical	28%
• Sexual	21%
Neglect	
• Emotional	15%
• Physical	10%

Centers for Disease Control and Prevention



Impaired Worker Performance



Health risks associated with ACEs

Behaviors
- School Absenteeism — tardies & truancy
- Dysregulated eating (under & overeating)
- Smoking
- Suicide attempts
- Illicit drug use & substance abuse
- Multiple sexual partners
- Self-injurious behaviors (e.g., cutting)

Outcomes
- Autoimmune disorders
- Obesity & eating disorders
- Substance use disorders
- Chronic obstructive pulmonary disease (COPD)
- Depression
- Fetal death
- Health-related quality of life
- Ischemic heart disease (IHD)
- Liver disease
- Risk for intimate partner violence
- Sexually transmitted infections Unintended pregnancies

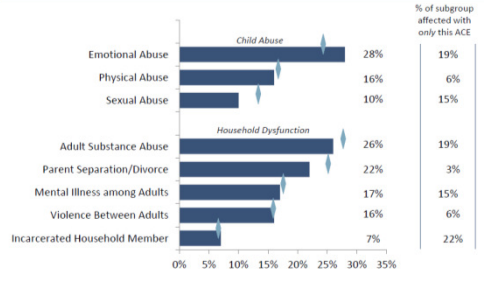
Adverse Childhood Experiences in Iowa: A New Way of Understanding Lifelong Health

Findings from the 2012 Behavioral Risk Factor Surveillance System

Commissioned by the Central Iowa ACEs Steering Committee

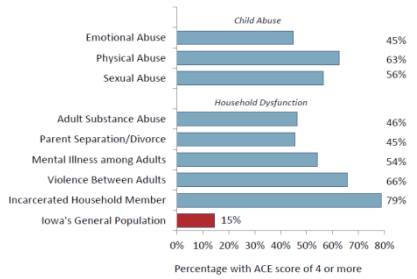
ACEs 360 IOWA

Prevalence of Individual ACEs in Iowa

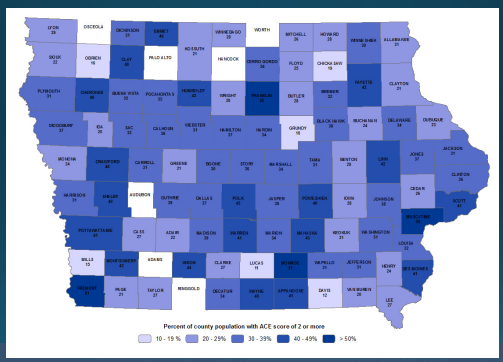


Average score across seven comparison states: (Arkansas, California, Louisiana, New Mexico, Tennessee, Washington & Wisconsin)

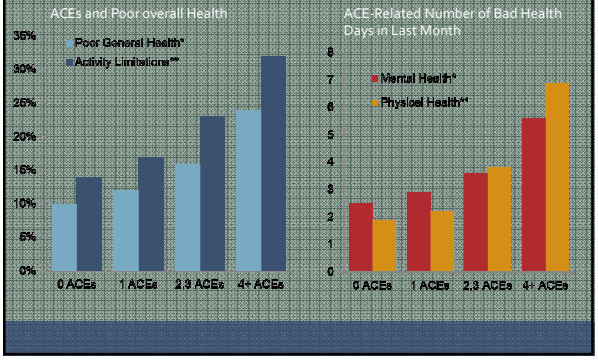
Co-Occurrence of High ACE Scores among Those Who Experienced Specific ACEs



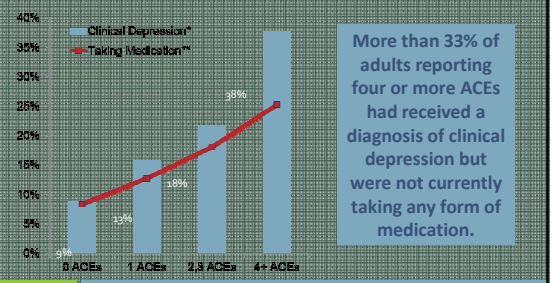
Where do Iowans with ACEs live now?



Impact on lifelong health

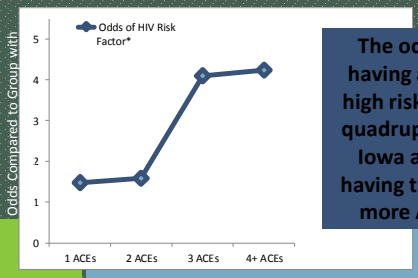


ACEs and depression



More than 33% of adults reporting four or more ACEs had received a diagnosis of clinical depression but were not currently taking any form of medication.

ACE-Related Odds of Certain High Risk Behaviors: Any Intravenous Drugs Use, STDs, Prostitution, or Risky Sex.



The odds of having an HIV high risk factor quadrupled for Iowa adults having three or more ACEs.

Odds of having serious health condition

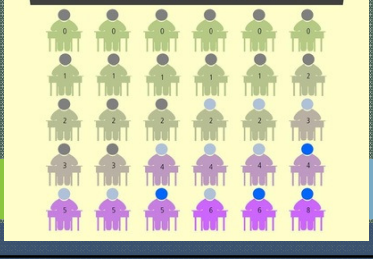
Health Condition	0 ACEs	1 ACEs	2 ACEs	3 ACEs	4+ ACEs
Arthritis	**100%**	**130%**	**145%**	**155%**	**236%**
Asthma	100%	115%	118%	**160%**	**231%**
Cancer	100%	112%	101%	111%	**157%**
COPD	100%	120%	**161%**	**220%**	**399%**
Diabetes	100%	128%	132%	115%	**201%**
Heart Attack	100%	148%	144%	**287%**	**232%**
Heart Disease	100%	123%	**149%**	**250%**	**285%**
Kidney Disease	100%	-17%	164%	179%	**263%**
Stroke	100%	114%	117%	180%	**281%**
Vision	100%	**167%**	**181%**	**199%**	**354%**

Impact on education

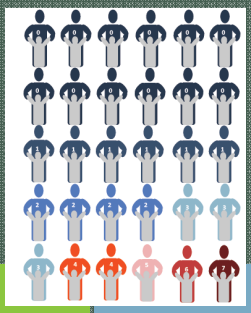
Washington School Classroom (30 Students)
Adverse Childhood Experiences (ACEs)

6 students with no ACE
5 students with 1 ACE
6 students with 2 ACEs
3 students with 3 ACEs
7 students with 4 or 5 ACEs
3 students with 6 or more ACEs

58% (17) students with no exposure to physical abuse or adult to adult violence
29% (9) of students exposed to physical abuse or adult to adult violence
13% (4) of students exposed to physical abuse and adult to adult violence



Impact on future children



On average, ***5 out of every 30 students*** in an Iowa school classroom will live with a parent who has a very high ACE score – a score of 4 or more.

Through Our Eyes

Trauma and the Brain

Three Core Concepts in Early Development

1 Experiences Build Brain Architecture

NATIONAL SCIENTIFIC COUNCIL ON THE DEVELOPING CHILD
Center on the Developing Child HARVARD UNIVERSITY

Three Core Concepts in Early Development

3 Toxic Stress Derails Healthy Development

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Center on the Developing Child
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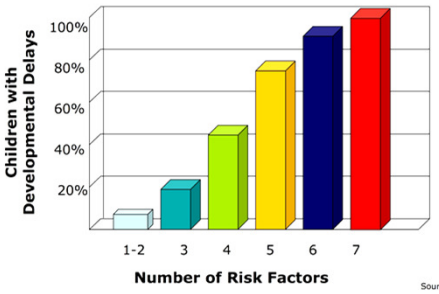
Significant Adversity Impairs Development in the First Three Years



Source: Barth et al. (2008)

How Individuals Respond to Trauma

Long-term trauma can interfere with healthy development and affect a individual's:

- Ability to trust others
- Sense of personal safety
- Ability to manage emotions
- Ability to navigate and adjust to life's changes
- Physical and emotional responses to stress

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How Individuals Respond to Trauma

A individual's reactions to trauma will vary depending on:

- Age and developmental stage
- Temperament
- Perception of the danger faced
- Trauma history (cumulative effects)
- Adversities faced following the trauma
- Availability of supportive adults who offer help, reassurance, and protection

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Arousal Continuum

State	Calm	Arousal	Alarm	Fear	Terror
Age equivalent	Adult	Adolescent	Child	Toddler	Infant
Heart Rate	70-90	90-100	100-110	110-135	135-160
Sense of Time	Extended Future	Days Hours	Hours minutes	Minutes seconds	No sense of time

Age	Normal Range (Resting)
Premature	120-170
0-3 months	100-150
3-6 months	90-120
6-12 months	80-120
1-3 years	70-110
3-6 years	65-110
6-12 years	60-95
Over age 12	55-85

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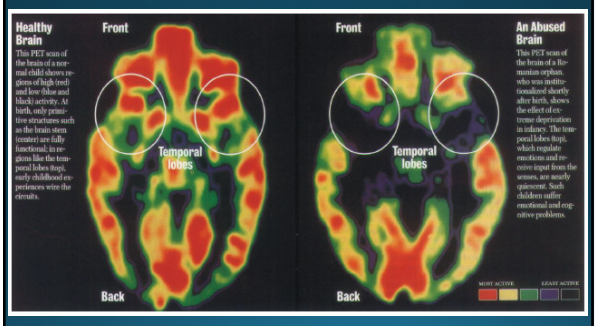
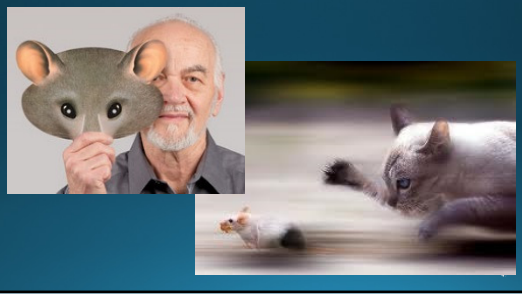
Brain Development in Early Childhood



What Is The Cat Hair?

Panksepp, J (1998)

Panksepp, Jaak. (1998). Affective Neuroscience: The Foundations of Human and Animal Emotions. New York: Oxford University Press.



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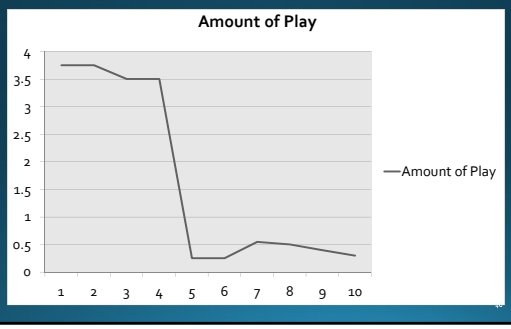
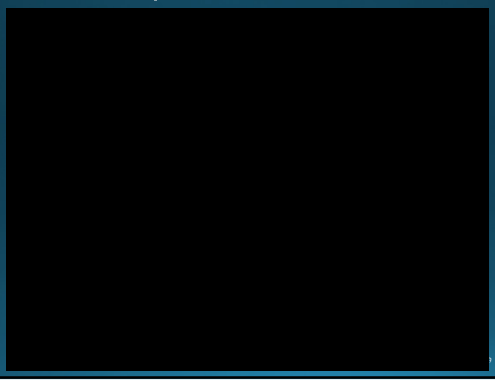


How Many Passes Do You Count?



Core Components of Trauma-Informed, Evidence-Based Treatment

- Therapeutic relationship
- Psychoeducation: normal responses to trauma
- Parent support, therapy, or training
- Emotional expression and regulation skills
- Anxiety management and relaxation skills
- Cognitive processing or reframing
- Construction of a coherent trauma narrative
- Gradual exposure to traumatic memories and feelings
- Personal safety training/empowerment activities
- Resilience and closure

How can *you* reduce effects of trauma?

- Encourage people to seek help
- Challenge others to consider the causes of behavior
- Be present with clients
- Encourage clients to explore
- Encourage self control
- Build self confidence

Recovering from Trauma: The Role of Resilience

- Resilience is the ability to recover from traumatic events.
- People who are resilient see themselves as:
  - Safe
  - Capable
  - Lovable

Resilience/Stress questionnaire

- 14 question survey
- Developed early childhood service providers, pediatricians, psychologists, and health advocates of Southern Kennebec Healthy Start, Augusta, Maine, in 2006, and updated in February 2013
- Scoring system modeled after ACE's

Secondary Traumatic Stress

WHAT IS IT?

- AKA: vicarious trauma, compassion fatigue
- It is the resulting effects of chronic exposure to traumatic material
- Symptoms are the same as those experienced by direct exposure
- First noticed in ER nurses who had "lost their ability to nurture" (Boyle, 2011)

Traumatic Stress Symptoms

- Hyper vigilance
- Intrusive thoughts
- Poor concentration/memory
- Avoidance of reminders, people, normal activity
- Detachment
- Anger
- Irritability
- Depression

Secondary Traumatic Stress

A direct result of frequent and repeated exposure to traumatic material:

- It is inevitable
- It is expected

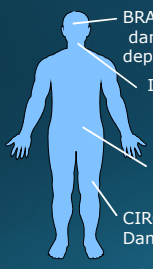
Secondary Traumatic Stress

Graphic images, narratives, testimony are traumatic material.

They are stressful.

Chronic stress is bad for your health.

Stress response: Chronic
Long-term impact of stress.



BRAIN: Cortisol becomes toxic to brain cells, damaging cognition. Fatigue, anger, & depression increase.

IMMUNE SYSTEM: Repeated suppression of disease-fighting cells ultimately weakens resistance to infection.

INTESTINES: Decreases in blood flow leave mucous lining vulnerable to ulcers.

CIRCULATORY SYSTEM: Elevated BP & heart rate Damage elasticity of blood vessels.

Nash,W. (*2sequelae of chronic exposure to child pornography: Protecting ourselves through knowledge, awareness and action* [PowerPoint slides].*a2o). Managing the psychological*

Caregivers Also Need Care

- We are all human
- Caring for family and friends can be difficult, draining, exhausting, and frustrating
- Daily/Weekly Self Care

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Court Interventions

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

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

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

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

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

4. Complex trauma is associated with risk of delinquency.

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

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

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

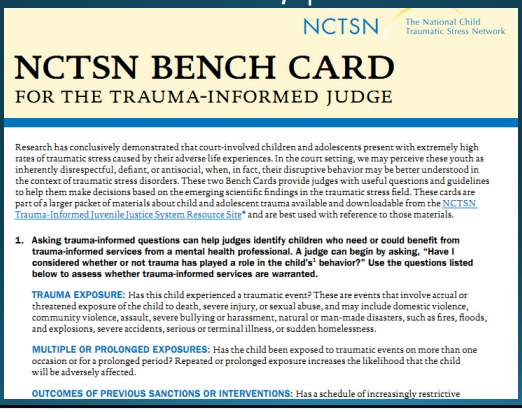
7. There are mental health treatments that are effective in helping youth who are experiencing child traumatic stress.

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

9. Youth are resilient.

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

NCTSN's Bench Card; questions to ask



NCTSN The National Child Traumatic Stress Network

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.

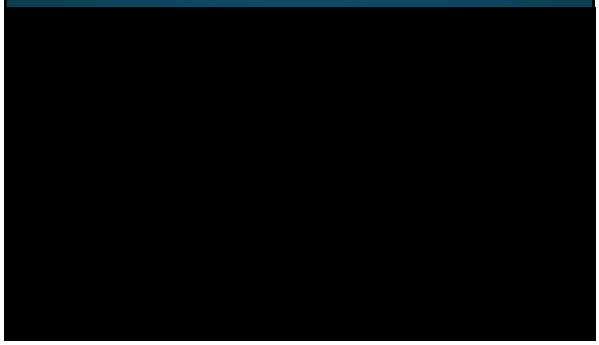
1. **Asking trauma-informed questions can help judges identify children who need or could benefit from trauma-informed services from a mental health professional. A judge can begin by asking, "Have I considered whether or not trauma has played a role in the child's' behavior?" Use the questions listed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

How TIC looks in the larger system…



RESOURCES

- www.traumainformedcareproject.org
- www.nctsn.org
- http://www.nctsn.org/products
- www.samhsa.gov/nctic/about.asp
- www.traumacenter.org/about/about_bessel.php
- www.sidran.org/
- www.iowaaces360.org/
- www.resiliencetrumpsaces.org

Contact Information

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THANK YOU!

NCTSN The National Child Traumatic Stress Network

NCJFCJ est. 1937 NATIONAL COUNCIL OF JUVENILE AND FAMILY COURT JUDGES WWW.NCJFCJ.ORG

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 NATIONAL COUNCIL OF JUVENILE AND FAMILY COURT JUDGES

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?

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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

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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)

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- 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

Adverse Childhood Experiences and Health and Well-Being Over the Lifespan

This chart shows the sequence of events that unaddressed childhood abuse and other early traumatic experiences set in motion. Without intervention, adverse childhood events (ACES) can result in long-term disease, disability, chronic social problems and early death. 90% of public mental health clients have been exposed to multiple physical or sexual abuse traumas. Importantly, intergenerational transmission that perpetuates ACES may continue without implementation of interventions to interrupt the cycle.

Adverse Childhood Experiences (Birth to 18) →	**Impact of Trauma and Adoption of Health Risk Behaviors to Ease Pain of Trauma** →	**Long-Term Consequences of Unaddressed Trauma**
Abuse of Child • Emotional abuse 11% * • Physical abuse 28% * • Contact sexual abuse 22% ***Trauma in Child's Household Environment*** • Alcohol or drug user by household member 27% • Chronically depressed, emotionally disturbed or suicidal household member 17% • Mother treated violently 13% • Imprisoned household Member 6% • Not raised by both biological parents 23% (Loss of parent by separation or divorce, natural death, suicide, abandonment) ***Neglect of Child*** • Physical neglect 19% • Emotional neglect 15% *Above types of ACEs are the "heavy end" of abuse. Eg. Emotional: recurrent threats, humiliation, chronic criticism Physical: beating vs spanking Neglect: Lack of basic needs for attachment, survival/growth **One ACE category = score of 1.** **List is limited to ACE study types.** Other trauma may include: combat, poverty, street violence, historical, racism, stigma, natural events, persecution etc.	***Neurobiologic Effects of Trauma*** • Disrupted neuro-development • Difficulty controlling Anger – Rage • Hallucinations • Depression *(and numerous other mental health problems – see below)* • Panic reactions • Anxiety • Multiple (6+) somatic problems • Sleep problems • Impaired memory • Flashbacks • Dissociation ***Health Risk Behaviors*** • Smoking • Severe obesity • Physical inactivity • Suicide attempts • Alcoholism • Drug abuse • 50+ sex partners • Repetition of original trauma • Self-injury • Eating disorders • Perpetrate interpersonal violence. aggression, bullying, etc.	***Disease and Disability*** • Ischemic heart disease • Cancer • Chronic lung disease • Chronic emphysema • Asthma • Liver disease • Skeletal fractures • Poor self rated health • Sexually transmitted disease • HIV/AIDS ***Social Problems*** • Homelessness • Prostitution • Delinquency, violence and criminal behavior • Inability to sustain employment • Re-victimization: by rape; DV, bullying, etc • Compromised ability to parent • Negative alterations in self-perception and relationships with others • Alterations in Systems of Meaning • Intergenerational transmission of abuse • Long-term use of multi human service systems, **At Annual Cost of: $103,754,017,492.00**

Multiple studies reveal the origin of many mental health disorders may be found in childhood trauma, including Borderline Personality Disorder BPD, Anti-Social Personality Disorder, PTSD, Schizophrenia, Bipolar Disorder, Dissociative Identity Disorder DID, Anxiety Disorders, Eating Disorders including severe obesity, Attention Deficit Hyperactivity Disorder ADHD, Oppositional Defiant Disorder ODD and others.

Sources: *Adverse Childhood Experiences Study* (CDC and Kaiser Permanente, see http:// www.ACEstudy.org) *The Damaging Consequences of Violence and Trauma* (see http://www.NASMHPD.org) and *Trauma and Recovery* (J Herman). Cost data: 2007 Economic Impact Study (PCAA). Chart created by Ann Jennings, PhD. http://www.TheAnnaInstitute.org Revision: April 6, 2010

Finding Your ACE Score

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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.

Resilience/Stress Questionnaire

Person completing Questionnaire: Mother Father Professional Other _____
Birth Year(s) of child(ren) 19__ 200_

Your answers are confidential. You do not need to share them with anyone but you may find it helpful to do so. If answering any of the questions is disturbing, you may answer them at another time if you prefer.

Please circle the most accurate answer <u>under</u> each statement:

1. I believe that my mother loved me when I was little.

Definitely True	Probably True	Not Sure	Probably Not True	Definitely Not True

2. I believe that my father loved me when I was little.

Definitely True	Probably True	Not Sure	Probably Not True	Definitely Not True

3. When I was little, other people helped my mother and father take care of me and they seemed to love me.

Definitely True	Probably True	Not Sure	Probably Not True	Definitely Not True

4. I've heard that when I was an infant someone in my family enjoyed playing with me, and I enjoyed it, too.

Definitely True	Probably True	Not Sure	Probably Not True	Definitely Not True

5. When I was a child, there were relatives in my family who made me feel better if I was sad or worried.

Definitely True	Probably True	Not Sure	Probably Not True	Definitely Not True

6. When I was a child, neighbors or my friends' parents seemed to like me.

Definitely True	Probably True	Not Sure	Probably Not True	Definitely Not True

7. When I was a child, teachers, coaches, youth leaders, or ministers were there to help me.

Definitely True	Probably True	Not Sure	Probably Not True	Definitely Not True

Resilience/Stress Questionnaire - page 2

8. Someone in my family cared about how I was doing in school.

Definitely True	Probably True	Not Sure	Probably Not True	Definitely Not True

9. My family, neighbors and friends talked often about making our lives better.

Definitely True	Probably True	Not Sure	Probably Not True	Definitely Not True

10. We had rules in our house and were expected to keep them.

Definitely True	Probably True	Not Sure	Probably Not True	Definitely Not True

11. When I felt really bad, I could almost always find someone I trusted to talk to

Definitely True	Probably True	Not Sure	Probably Not True	Definitely Not True

12. As a youth, people noticed that I was capable and could get things done.

Definitely True	Probably True	Not Sure	Probably Not True	Definitely Not True

13. I was independent and a go-getter.

Definitely True	Probably True	Not Sure	Probably Not True	Definitely Not True

14. I believed that life is what you make it.

Definitely True	Probably True	Not Sure	Probably Not True	Definitely Not True

****

___ How many of these Protective Factors did I have as a child and youth?

___ How many still help me now?

Comments on Resilience and Protective Factors:

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

Authored By:
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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).

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).

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).

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.

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.

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).

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.

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.

"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.

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.)

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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.

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.

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.

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.

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 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 t**raumatic 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.

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 jflinfo@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

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