INVITED COMMENTARY

Toward a Trauma-Responsive Juvenile Justice System

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Childhood traumatic stress is predictive of delinquency in adolescence, the severity of delinquent offenses, and the likelihood of reoffending. Over the past decade, the Juvenile Justice Section of North Carolina’s Department of Public Safety has advanced from trauma-informed toward trauma-responsive care. Efforts taken and lessons learned are presented.

Adverse childhood experiences are commonplace. By the age of 17, more than 71% of all children experience a potentially traumatizing adverse event, such as physical abuse, sexual abuse, violence, or a serious accident [1]. Exposure to potentially traumatizing events in childhood has been linked to a host of adverse emotional, developmental, behavioral, and academic outcomes in childhood and adolescence, including developmental delays, school problems, substance abuse, and suicide [2], and it has been further linked to the onset of 28% of all psychiatric disorders in adolescents [3]. The landmark Adverse Childhood Experiences (ACE) Study further demonstrated that childhood trauma exposure is also associated with chronic physical and behavioral health problems across the lifespan, including heart disease, obesity, diabetes, emphysema, and premature death [4]. It is perhaps not surprising, then, that longitudinal studies have also established that childhood traumatic stress is predictive of delinquency in adolescence [5], the severity of the offenses that lead to justice system involvement, and the likelihood of reoffending [6, 7].

Rates of trauma exposure among youth involved in the juvenile justice system are even higher than those reported by their non-involved peers, with rates rising as involvement in the system increases [6]. The Northwestern Juvenile Project, a prospective longitudinal study of nearly 2,000 juvenile justice-involved youth in Cook County, Illinois, established that over 90% of detained youth had experienced at least one trauma, 84% had experienced more than one trauma, and over 55% had reported being exposed to trauma on 6 or more occasions [8]. Here in North Carolina, assessments of youth committed to a period of confinement in state-run youth development centers (YDCs) in 2016 revealed that 100% of girls and 67% of boys had histories of exposure to an average of 6 different potentially traumatizing events. Of these, 99.5% were experiencing associated mental health problems, and over half met the diagnostic criteria for post-traumatic stress disorder.

It is noteworthy that the types of trauma to which juvenile justice-involved youth are exposed are often chronic adversities suffered at the hands of people, typically their caretakers [9]. Researchers examining data on a national sample of juvenile justice-involved youth through the National Child Traumatic Stress Network’s Core Data Set report that the most frequently reported trauma types are loss and bereavement (ie, traumatic loss, separation from caregiver, or bereavement) (61.2%), living with an impaired caregiver (51.7%), domestic violence (51.6%), emotional abuse/psychological maltreatment (49.4%), physical maltreatment/abuse (38.6%), and community violence (34%) [10]. More than half (62.14%) of the youth were exposed to trauma during the first 5 years of life [10]. A growing body of research has been dedicated to identifying the pathways through which exposure to these types of trauma may contribute to youths’ involvement in the justice system [11-13]. Hyperarousal, a common symptom of post-traumatic stress disorder, may contribute to delinquent acts involving easily triggered and excessive anger, such as fighting or assaultive behavior. Emotional numbing may become entrenched as a form of acquired callousness in some youth as a means of squelching the overwhelming pain and fear that may be triggered by reminders of traumatic experiences [12, 13]. Others postulate that traumatic stress may result in altered emotion processing (eg, affect dysregulation, deficits in recognizing emotions in oneself or others); in altered cognitive processes (eg, seeing and attributing hostile intent to others where none exists, alienation from others); and in altered interpersonal processes (eg, difficulty getting attached to people, an affinity for antisocial peers) [13].

The journey of the Juvenile Justice Section of the North Carolina Department of Public Safety toward becoming trauma-informed began in earnest in 2007, with a request to the Juvenile Justice Section of North Carolina’s Department of Public Safety toward becoming trauma-informed began in earnest in 2007, with a request
for technical assistance from the Substance Abuse and Mental Health Services Administration’s National Center for Trauma-Informed Care (NCTIC). The NCTIC offers consultation, technical assistance, education, outreach, and resources to support a shift to trauma-informed care across a broad range of publicly funded service systems, including systems providing mental health and substance abuse services, housing and homelessness services, child welfare, criminal justice, and education. Experts from the NCTIC traveled to North Carolina to provide training to leaders from across sections of Juvenile Justice in the principles of trauma-informed care and continued to support our efforts to become better informed through ongoing assistance over the 3 years that followed. They delivered training to our executive management team, then visited each of our YDCs to conduct separate focus groups with staff and the youth confined there to get a sense of our culture. They made recommendations for changes in everything from our training, furnishings, and programming, to our daily operations. In looking back, many of these changes—designed to encourage safety and a culture aimed at healing while avoiding unnecessary power struggles—seem obvious: they advised us, for example, to approach each youth from a stance of “universal trauma precautions,” assuming each had a history of exposure to traumatizing experiences and viewing their emotional reactions and behavior through a “trauma lens.”
They suggested that, instead of relying on room confinement as a cooling off period, we work with youth at admission to create individualized crisis response plans and kits that would help youth cope with stressful events.

As we became more attuned to the unmet treatment needs of the YDC population, we recognized a need to provide enhanced trauma-specific mental health treatment services for confined youth. In 2010, Dana Hagele, MD, co-director of the NC Child Treatment Program (NC-CTP), invited us to send a team of licensed mental health clinicians from our YDCs to participate in a 9-month-long training program in the high-fidelity delivery of Trauma-focused Cognitive Behavior Therapy (TF-CBT), an evidence-based treatment for trauma-related problems. Using principles drawn from implementation science and the Institute for Healthcare Improvement’s Breakthrough Series (BTS) Collaboratives, the NC-CTP learning collaborative methodology incorporates in-person learning sessions, individual coaching calls, standardized performance metrics for trainees and clients, the coaching of agency clinical supervisors in how to maintain the fidelity of treatment implementation, and the training of a senior leader from the agency in implementation support. Trainees are coached by a clinical expert through the completion of 2 cases with acceptable fidelity. We have since sent 6 teams of YDC-based licensed mental health clinicians to be trained in the high-fidelity delivery of TF-CBT, and another 5 teams to learning collaboratives in a group intervention called Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS). This led us to change our policy to ensure that we screen all youth within a month of arrival at a YDC for problems related to trauma exposure using a standardized screening instrument and to refer them to high-quality treatment services to address needs when they arise.

In 2008, Juvenile Justice had shifted its practice in YDCs to a new model of care through which direct care staff—those with the most “face time” with committed youth—functioned as key agents of change responsible for teaching youth prosocial skills through structured, therapeutic interactions. Under this approach, staff undertake role plays with youth across settings and shifts to help them rehearse and master interpersonal and self-management skills. To ensure that direct care staff were trained to understand trauma and to recognize emotional distress and post-traumatic stress reactions, the agency received training underwritten by the MacArthur Foundation. In 2012, clinical staff were trained via a “Train the Trainer” protocol in the delivery of Think Trauma, a skills-based, interactive trauma-focused training curriculum for frontline staff and others who work with adolescents in juvenile justice residential settings. The curriculum provides basic education about trauma to those working with youth, teaches staff to reframe problematic behavior typically exhibited in justice-involved youth as survival coping skills/strategies, offers training in strategies that are most effective in working with youth with trauma, and encourages staff to understand and manage the impact that this work can have upon them. All YDC staff were trained in the day-long curriculum, which was subsequently incorporated into the basic training program that all direct care staff within Juvenile Justice must complete when they join the agency.

To date, Juvenile Justice has invested much of its energy toward trauma-informed care in our long-stay YDCs, where licensed mental health clinicians and other staff are agency employees guided by Juvenile Justice policies. Within our YDCs, we have managed to progress from being trauma-informed to becoming trauma-responsive, reflecting our knowledge about trauma within our policies and practices. This has happened because we have allocated the resources needed to enable staff to take the time to recognize need, and to then deliver high-fidelity, trauma-specific mental health treatment and support services. This can be more challenging in other agencies (eg, in those managing or delivering mental health services), where the demands of high-quality treatment can clash with productivity expectations (eg, limitations on the number of hours or sessions allowed per case).

We have learned several lessons as a function of our efforts over the past decade. First, we have learned that culture change takes years of sustained effort and the involvement of individuals drawn from a vertical slice of the agency. While it is vital to have executive-level leaders who understand and support the effort and who are willing to commit the resources (eg, manpower, time, equipment) required, it is equally important to identify local leadership teams consisting of both enthusiastic employees and those with the authority to effect change. We have also learned that universal screening using a psychometrically sound instrument is vital to ensure that the scope of need is correctly assessed. Within our agency, we learned that when we added a standardized screening measure to our clinical interview (and less specialized battery of assessment instruments) to diagnose trauma-related problems, the number of detected trauma-related problems rose by a factor of 10.

There is reason to be optimistic about North Carolina’s future as a trauma-responsive state. The General Assembly has continued to fund the North Carolina Child Treatment Program to ensure that mental health providers in the state are well-trained in the high-fidelity delivery of evidence-based treatments for trauma-related mental health and behavioral problems [14]. First Lady of North Carolina Kristin Cooper has recognized Adverse Childhood Experiences and trauma-informed care as central to the issues she champions: foster care, child abuse and neglect, childhood hunger, and literacy. There is also widespread interest in the recommendation found in the report from the 2016 Governor’s Task Force on Mental Health and Substance Abuse that North Carolina work across agencies to adopt a trauma-informed system of care [15]. Individuals within every child-and family-serving agency are eager to make this happen. We stand ready to assist.
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