Justice-Involved Youth and Trauma-Informed Interventions

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Abstract

Professionals working in the juvenile justice system must consider the impact of trauma on justice-involved youth when creating interventions and policies. Most youths involved with the justice system have a history of childhood adversity. Juvenile justice service systems should work to implement trauma-informed interventions that address the needs of youth with mental health and trauma-related disorders. The adoption of a trauma-informed approach throughout the juvenile justice system and the implementation of interventions for juvenile offenders with a history of trauma exposure has enormous potential benefits for justice-involved youth, the staff who work with them, their families, and the community at large.

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Introduction

The United States leads the industrialized world in the rate at which young people are incarcerated (Annie E. Casey Foundation [AECF], 2013). Approximately 45,000-60,000 youth under age 18 are incarcerated in juvenile correctional facilities and adult prisons on any given day (American Civil Liberties Union [ACLU], 2018; Hockenberry & Sladky, 2018). In 2014, an estimated one million children were arrested (Children's Defense Fund, 2018). In 2015, 48,043 children were detained overnight (Children's Defense Fund, 2018). Although the numbers were declining in 2016, an estimated 856,000 children were arrested that year (Children's Defense Fund, 2018). Incarcerating youth poses lifelong consequences by cutting them off from their families, compromising their education, disrupting their social relationships, possibly increasing their chance of recidivating, and often exposing them to further trauma and violence (AECF, 2013; OJJDP, 2016; Hancock, 2017; ACLU, 2018).

One out of every 14 children in the United States has had an incarcerated parent (Murphey & Cooper, 2015; Zoukis, 2017). Although a precise number is difficult to ascertain, it is estimated that half of justice-involved youth [JIY] in custody have or had a parent or close relative in custody (Butterfield, 1999). Delinquent behavior is often a learned behavior and an inherited consequence of their parent's incarceration. Research has shown that having a parent in jail or prison has produced severe trauma in some children, and parental incarceration is one of the ten primary adverse childhood experiences (ACEs) identified by the Centers for Disease Control (Skinner-Osei & Levenson, 2018). Exposure to parental incarceration has shown a significant relationship with delinquency and other maladaptive behaviors (Felitti, Anda, Nordenberg, Williamson, Spitz, Edwards, & Marks, 1998; Baglivio, Epps, Swartz, Huq, Sheer, & Hardt, 2014; Skinner-Osei, 2018). Parental incarceration can create profound shame and stigma for children and their families. When a parent is incarcerated, children are locked behind metaphorical bars, and they must cope with erroneous and damaging assumptions from their peers, teachers, and even other family members (Skinner-Osei & Levenson, 2018). For many children, parental incarceration is an intergenerational family legacy, mainly because they are at risk of repeating what has been modeled to them (Skinner-Osei & Levenson, 2018; Levenson, 2019).

Children in the justice system are often viewed as beyond hope and uncontrollable. They may appear angry and defiant when, in actuality, they are stricken with loneliness, depression, abandonment, powerlessness, and fear (Office of Juvenile Justice and Delinquency Prevention [OJJDP], 2012). What masquerades as intentional defiance and aggression is often a defense against the despair and

hopelessness that traumatic events have caused in their lives (Skinner-Osei & Levenson, 2018). These characteristics are exacerbated by the use of the outdated and harmful "training school" model that punishes JIY by placing them in remote prison-like settings (ACLU, 2018). Many youths are incarcerated for non-violent offenses; primarily low-level property offenses, public order offenses, and status offenses, such as possession of alcohol and truancy (OJJDP, 2012; AECF, 2013; Campaign for Youth Justice [CFYJ], 2016).

The consequences are far-reaching. Many of these youths are offending due to pre-existing trauma stemming from some form of maltreatment and/or family dysfunction. Moreover, abused or neglected children have an increased likelihood of running away from home (Kaufman & Widom, 1999). Many who run away are between the ages of 12-17 and have suffered some form physical, sexual, verbal, or emotional abuse inflicted by relatives or close family friends (Kaufman & Widom, 1999; Kunz, 2017; Dowshen, 2018; Bryan, 2019). Other reasons involve family conflict and dynamics, personal crisis, sexual orientation, divorce, death, school problems, and addiction (Dowshen, 2018; Congressional Research Service, 2019). Runaways are at increased risk for arrest, and when they are thrust into the juvenile justice system [JJS], it serves as further abuse and may re-trigger or worsen their trauma.

In nine states running away is considered a low-level status offense meaning that youth may be fined, given probation, have their driver license suspended, required to have a drug screening, or be forced to return to the chaotic home life that they were fleeing. The combination of running away and childhood victimization increases the likelihood that these youths will be arrested (Kaufman & Widom, 1999). Runaway and homeless youth have higher rates of involvement in the JJS (Youth.Gov, 2019). At least half of runaway and homeless youth had been arrested at least once since they first ran away, and many others had been arrested multiple times (National Conference of State Legislatures [NCLS], 2019; Youth.Gov, 2019). Many of their arrests can be attributed to the activities that they must endure to survive, such as survival sex, substance use, and physical abuse (NCLS, 2019).

Over the last decade, a significant amount of attention has been given to criminal justice reform, and notably, the reduction of juvenile offenses and the effectiveness of the front-line staff who work with them. However, there is still a substantial need for more evidenced-based trauma-informed interventions and rigorous training protocols for professionals working in juvenile correctional facilities. Also, other variables, such as trauma-informed understanding of criminality, mental health, and neurophysiological development, need to be

considered. The consideration of these variables has amplified the U.S. Department of Justice's mission to create and support more trauma-informed interventions (Branson, Baetz, Horwitz, & Hoagwood, 2017). This paper will outline a history of the JJS, provide evidence supporting trauma-informed interventions, and conclude with implications for education and training, policy, and advocacy, and prevention.

History of the Juvenile Justice System

The purpose of the JJS is to increase safety in the community, bring about justice for crimes committed, and rehabilitate troubled youth (McCord, Widom, & Crowell, 2001; Downey, 2011; Russell & Manske, 2017; Troutman, 2018). Over the last 170 years, the juvenile justice paradigm has shifted continuously concerning age, nature of the crime committed, punitive accountability, rehabilitation, and sustainable community safety (Russell & Manske, 2017). Before 1899, the United States operated under the old British system of justice, which considered the ages of seven to fourteen a gray zone (Dialogue on Youth and Justice, 2007). Although many presumed a child so young was incapable of knowingly committing a crime, if it was determined that the child understood the difference between right and wrong, they could receive the same punishment as an adult offender (McCord, Widom, & Crowell, 2001; Dialogue on Youth and Justice, 2007; Taylor & Fritsch, 2015).

During the nineteenth century, institutions such as the Chicago Reform School, Society for the Prevention of Juvenile Delinquency, and the New York House of Refuge were created to address the treatment of JIY (Dialogue on Youth and Justice, 2007; Troutman, 2018). This system of juvenile social reform led to the first juvenile justice court in Cook County, Illinois in 1899 (Mears, Pickett, & Mancini, 2014; Russell & Manske, 2017). The focus was on the child, the approach was informal, non-adversarial, flexible, and the cases were treated as civil actions instead of criminal (Dialogue on Youth and Justice, 2007).

Although the American JJS claimed to be rehabilitative, it actually became more punitive for several reasons: (1) Inconsistencies in policy and procedure. Initially, there were fifty-one individual JJS across the U.S. that operated independently of one another (McCord, Widom, & Crowell, 2001); (2) Out of consideration for victims, there was an increasing demand for JIY to be held accountable (McCord, Widom, & Crowell, 2001); and, (3) The number of violent crimes committed by juveniles consistently increased (McCord, Widom, & Crowell, 2001). Although the causes and consequences of crime seemed to justify increasingly punitive measures, the constitutional rights of JIY were violated for decades in the early part of the 20th

century. In the 1960s two controversial court cases, Kent v. the U.S. (1966), and *In re Gault* (1967), changed how juvenile cases proceeded through the court system (McCord, Widom, & Crowell, 2001; Downey, 2011). The outcomes led to increased constitutional protections for minors, and they were given the same due process rights as adults (Downey, 2011).

Following *In re Gault,* Congress passed the Juvenile Delinquency Prevention and Control Act in 1968. The premise of the act relied on emerging research that suggested that when pursuing punishment, courts should consider the social and behavioral environment of youth. Courts were encouraged to take into account a youth's history of abuse and trauma, family cohesiveness, social connections, education, and, more importantly, the likelihood of successful rehabilitation (Downey, 2011). The act sought to prevent juvenile delinquency, deinstitutionalize youth in the system, and keep JIY separate from adult offenders, which was significant because evidence had long shown that juvenile crimes became more extreme after they were confined with adults. Additionally, to better serve JIY, the act created three entities: 1) The Office of Juvenile Justice and Delinquency Prevention [OJJDP]; 2) The Runaway Youth Program; and, 3) The National Institute for Juvenile Justice and Delinquency Prevention [NIJJDP] (Impact Law, 2019).

The intentions of the act were short-lived and contradictory. The act was amended and abandoned its original goal of rehabilitation. Similar to the adult system, it reverted to punitive measures. It was amended to include provisions that allowed some states to try JIY as adults for some violent crimes and weapons violations (Impact Law, 2019). The new provisions were fueled by prison administrators, justice practitioners, policymakers, and the public. All parties cohesively insinuated that rehabilitative measures were not effective, mainly because juvenile crime continued to rise. A plethora of research about the needs and well-being of JIY was minimized or ignored, while the publication of Robert Martinson's 1974 study concluding that "*Nothing Works*" was used as evidence and reason to support increased punitive measures. The *Nothing Works Doctrine* analyzed programs that were designed to reduce recidivism to determine if they were effective, and furthered questioned if rehabilitation was possible (Martinson, 1974). The most detrimental consequence derived from the doctrine is that it inspired mandatory minimum sentences and the removal of judicial discretion (Levenson & Willis, 2018).

Even with the new extreme punitive measures, crime continued to rise in the juvenile and adult systems. From 1980-1994 there was a significant surge in the number of violent criminal offenses committed by JIY, which motivated states to adopt even more aggressive policing, which bled into the school system (McCord,

Widom, & Crowell, 2001; Wald & Losen, 2003; Backstrom & Walker, 2006; Bryer & Levin, 2013). This get-tough approach, including what became known as the “school to prison pipeline” (Wald & Losen, 2003), propelled more stringent legislation that immediately increased the number of youths incarcerated. Tens of thousands of youth were placed in correctional facilities that offered little if any rehabilitative programming (Bryer & Levin, 2013).

Although these increasingly punitive measures yielded results that illustrated the tough on crime tactics were ineffective, there was a reluctance to consider reasons why youth were committing crimes and how to intervene early and preventively. Instead, politicians used the media to support a tough-on-crime agenda, characterizing JIY as violent and irredeemable instilling fear in the public. In 1996 John Delulio informed policymakers and the public of a dire threat of super-predators, whom he defined and described as "radically impulsive, brutally remorseless, rapists, murders, burglars drug dealers, and gang members” (Kelly, 2016, p.1; Fair Punishment Project, 2016). Instantly, politicians and most notably First Lady Hillary Clinton, begin to use the label to help generate support for tougher crime policies (Fair Punishment Project, 2016). As labeling theory infers, the power of labels, particularly shaming and stigmatizing labels, further separates justice-involved persons from society and reinforces deviant identity and criminal behavior (Levenson & Willis, 2018). As Charles Cooley theorized, our impressions of ourselves are shaped by how others treat us, which in return helps to shape our constructions of social identity (Cooley, 1983 revision).

This cruel and unjust label helped to rapidly increase the number of JIY transferred into adult prisons. Moreover, the label made it easier for the public to endorse harsh policies such as the elimination of transfer restrictions and the ease of thrusting JIY into adult courts even if they were younger and accused of lesser offenses (Kelly, 2016). A study in Maryland found that the average sentence for a 17-year-old in adult court is approximately 41% longer than the 18-year-olds (Gulstad, 2016). In 1996, the Department of Justice found that JIY in adult court were more likely to be sentenced to prison (Gulstad, 2016).

Another culprit was racial disparities. Development Services Group, Inc. 2017 [OJJDP] stated that youths of color are more likely to be referred to the JJS than whites. Although Delulio (1996) was not specific about the race of the super-predators, society assumed that they were black and brown. In 1998 Frank Gilliam published the *Superpredator Script,* finding that when people were shown a mug shot of an African-American or Hispanic youth for just five seconds, they were more afraid and more likely to support harsher punishments for youth (Gilliam & Iyengar,

1998). Sadly, this was not surprising because the criminal justice system was idealized out of oppression and discrimination (Alexander, 2012).

In the late 1990s, the criminal justice pendulum swung back a bit, and policymakers agreed that reform was warranted. They encouraged research, evidence-based interventions, mental health evaluations, and education and training for professionals working with JIY (National Research Council, 2014). Although these goals were well-intentioned and pragmatic, many politicians ignored suggestions from research findings and continued to perpetuate fear even when their insinuations were falsified by empirical evidence. Although minimal changes were being made or suggested, many JIY were warehoused in horrific conditions that created or worsened their conditions (Shields, 2011). They were further abused and traumatized, and their mental health needs were ignored.

Mental health disorders are prevalent in the JJS (Development Service Group, Inc. [OJJDP], 2017). An estimated two-thirds of JIY have a diagnosable mental health disorder compared to an estimated 9 to 22 percent of the general youth population (Teplin et al., 2005; Schubert & Mulvey 2014; Development Service Group, Inc. [OJJDP], 2017; National Conference of State Legislatures [NCLS], 2019). In 2014 The National Survey on Drug Use and Health estimated that 11.4 percent of adolescents aged 11 to 17 had a major depressive episode in the past year (Center for Behavioral Health Statistics and Quality, 2015). Fazel, Doll, and Langstrom (2008) also found that youths in detention and correctional facilities were almost ten times more likely to suffer from psychosis than youths in the general population.

The Pathways to Desistance Study followed more than 1,300 youths for 7 years and found that the most common mental health problem was substance use disorder (76 percent), high anxiety (33 percent), ADHD (14 percent), depression (12 percent), PTSD (12 percent, and mania (7 percent) (Development Service Group, Inc. [OJJDP], 2017). As cited in Development Service Group, Inc. [OJJDP], (2017, p. 3) Wasserman et al. (2010) conducted a multisite study that analyzed system intake, detention, and secure post-adjudication and found that 51 percent of the youth met the criteria for one or more psychiatric disorders. Furthermore, the Northwestern Juvenile Project found that 46 percent of males and 57 percent of females had two or more psychiatric disorders (Development Service Group, Inc. [OJJDP], 2017). Also, a study in Texas, Louisiana, and Washington found that 79 percent of the youths diagnosed for one mental health disorder also met the criteria for two or more diagnoses (Teplin et al., 2005; Development Service Group, Inc. [OJJDP], 2017). Research shows that many of behavioral health disorders are related to, and symptomatic of, early childhood trauma such as abuse, neglect, family dysfunction, poverty, and violent communities (Fox, Perez, Cass, Baglivio, &

Epps, 2015; Baglivio, Wolff, Piquero, Greenwald, & Epps, 2017; Levenson & Willis, 2018).

Even with this knowledge, there is still a significant lack of services pre and post-release in correctional facilities and communities. Instead of receiving adequate treatment, many are warehoused in correctional facilities that lack psychotherapy and other health services (Shields, 2011). The lack of services, or in many cases, the non-existence of services, violates JIY's 8th and 14th Constitutional rights, which state that JIY with severe mental disorders must receive treatment while confined in a secure public or private state correctional facility (Grisso & Underwood, 2004; Teplin et al., 2005). The United States has a history of warehousing the mentally ill and favoring institutionalization over rehabilitation. An example is the California Youth Authority [CYA], who has a reputation for being dangerous for JIY (Kita, 2011). CYA once housed an estimated 10,000 JIY (Kita, 2011). CYA was not set up to house JIY, especially those with minor offenses (Kita, 2011). Like most correctional facilities, CYA was made with the perpetrator in mind, with strong potential for re-traumatization for youth with a history of childhood adversities (Levenson & Willis, 2018). At CYA, there was no separation of JIY based on age and severity of the crime (Ulloa, 2019). So those with non-violent, low-level offenses were housed with violent gang members, sexual offenders, and repeat offenders. Additionally, many endured 23-hour lockdowns, beatings by staff, and being caged (Ulloa, 2019). A Grand Jury found that the children received their schooling while in cages, and they were frequently drugged and improperly cared for (Kita, 2011). The Grand Jury also found that CYA used excessive chemical restraints (Kita, 2011). The CYA medical staff admitted to the Superintendent that their workload was too large, which prohibited them from adequately providing mental health care services (Kita, 2011). At the time, there was only one full-time psychologist and one part-time psychiatrist to serve 750 wards (Kita, 2011).

As with other components of the criminal justice system, racial disparities also exist when it comes down to those who receive mental health services (Baglivio et al., 2017). African American JIY are less likely to receive substance use or mental health treatment (Development Services Group, Inc. 2017, [OJJDP]). Spinney et al. (2016) completed a systematic review that analyzed articles published from 1995-2014 that examined racial disparities in the JJS and concluded that there was some race effect in deciding who received services. Aalsma et al. (2014) also concluded that whites were more likely to see a mental health clinician within the first 24 hours of detention intake and to receive a referral for mental health services after discharge.

Childhood Trauma and Justice-Involved Youth

At the turn of the millennium, the focus shifted again from confinement to understanding why youth commit crimes. This time around was different because some policymakers had expanded their views and were interested in discussing what reform would entail. Also, there was a surge of research on adolescent behavior, co-occurring disorders, and neurodevelopment. The research implied that many youths offended because they were faced with a multiplicity of psychosocial challenges, complicated family situations, and co-occurring mental health and substance use disorders (Thomas & Penn, 2002). Further research emerged concerning adolescent development and behavior, explicitly illustrating that neurodevelopment in the prefrontal cortex of the brain is not fully developed until people reach their mid-20s; these areas are responsible for cognitive processing as well as the ability to inhibit impulses and weigh consequences before acting (OJJDP, 2012). The way JIY internalize and externalize problems might be related to their deficient emotional and behavioral regulation skills, supporting the notion that children and adolescents may not be criminally responsible for their actions because developmentally they are different from adults (McCord, Widom, & Crowell, 2001; Marrow, Knudsen, Olafson, & Bucher, 2012).

Neurocognitive functioning is further compromised for children exposed to traumatic incidents, chronic abuse, or neglect. Cognitive processing and self-regulation can be under-developed when daily survival skills become prioritized in a traumagenic environment (van der Kolk, 2006). The quickly expanding research literature has informed the understanding of the impacts of chronic toxic stress on the developing brain, and the relationships between early trauma, self-regulation, and criminality (Wolff & Baglivio, 2016; Holley, Ewing, Stiver, & Bloch, 2017). Many JIY experienced trauma-related neurodevelopmental changes in the brain that manifest in disrupted cognitive and psychosocial development (Marrow et al., 2012). The threat of childhood trauma is so severe that it is considered a public health concern (Branson et al., 2017; Center for Disease Control and Prevention, 2018). More than half of young children ages 0-5 experience a traumatic event such as physical trauma, abuse or neglect, and exposure to domestic and or community violence (Marrow et al., 2012; Buss, Warren, & Horton, 2015). Traumatic events may include exposure to actual or threatened death, serious injury, sexual abuse, physical abuse, domestic violence, community and school violence, medical trauma, motor vehicle accidents, acts of terrorism, war experiences, natural and human-made disasters or the physical integrity of self or others (American Psychological Association, 2008; Diagnostic and Statistical Manual of Mental Disorders-IV and V, 2013; De Bellis & Zisk, 2014).

In the United States, approximately 50% to 80% of JIY report some form of victimization (Ford, Grasso, Hawke, & Chapman, 2013). The risk for posttraumatic stress and mental health disorders is increased by at least twofold and could be as far upward as tenfold for youth exposed to traumatic events such as emotional, physical, and sexual abuse, intimate partner, family, or community violence (OJJDP, 2012). In 2009, one in ten children experienced poly-victimization, which increases the risk of academic disengagement, gang affiliation, depression, suicidality, relationship volatility, substance abuse, and participation in behaviors that increase criminogenic risk (Finklehor, Turner, Ormrod, Hamby, & Kracke, 2009; OJJDP, 2012; National Center for Mental Health and Juvenile Justice [NCMHJJ], 2016).

A culmination of research indicates that between 75% and 93% of JIY are exposed to multiple types of violence and traumatic events before contact with the JJS (Ford, Chapmen, Hawke, & Albert, 2007; Ford et al., 2013; Listenbee & Torre, 2012; Marrow et al., 2012; NCMHJJ, 2016; National Child Traumatic Stress Network [NCTSN], 2016; Rapp, 2016; Branson et al., 2017). JIY have three times more adverse childhood experiences when compared to other youth (Baglivio et al., 2014; Yoder, Whitaker, & Quinn, 2017). Research has also shown that time spent in correctional facilities contributes to producing or exaggerating traumagenic experiences for most people (Levenson & Willis, 2018; National Alliance on Mental Illness, 2019). Sedlak and McPherson (2010) reported that more than a third of young people in juvenile placement feared attacks from staff or other youths. Using data collected from state agencies, researchers found that between 2004 and 2007 there was an average of 10 assaults a day and approximately 13,000 documented reports of physical, sexual, or emotional abuse by staff members (Mohr, 2008; White, Shi, Hirschfield, Mun, & Loeber, 2010). In correctional facilities, routine practices such as solitary confinement and use of restraints can be re-traumatizing for abused or neglected youngsters, causing additional harm and further compromising their mental and physical health (Hayes, 2004). Thus, recognizing the prevalence and impacts of ACEs is crucial in understanding the importance of evidence-based and trauma-informed juvenile justice practices.

Trauma-informed interventions with justice-involved youth

Developing a trauma-informed JJS involves cultivating an environment that recognizes the impact of traumatic childhood experiences while "striving for a physically and psychologically safe environment for both youth and staff in detention" (Pickens, 2016, p. 226). According to the Substance Abuse and Mental Health Services Administration [SAMHSA], trauma-informed care [TIC] is an evidence-based practice that teaches service providers and their organizations

about the triggers and vulnerabilities of trauma survivors and employs effective interventions to treat traumatic responses (2015). TIC "involves understanding, anticipating, and responding to peoples' expectations and needs, and minimizing the chances of re-traumatizing someone who is trying to heal" (SAMHSA, 2015). TIC provides an environment created on a foundation of safety, empowerment, collaboration, trust, and respect (Fallot & Harris, 2009; Bloom, 2013). More importantly, TIC is not intended to excuse delinquent behavior, but instead, its primary goal is to recognize, conceptualize and respond to symptoms of trauma such as behavioral and emotional dysregulation (Levenson, 2019).

In the late 1990s, the significance of ACEs garnered massive attention surrounding trauma-informed interventions. In juvenile justice programs, such models are designed to help advance coping strategies, improve problem-solving, and implement positive self-correction skills rather than simply punitive responses (Skinner-Osei & Levenson, 2018; Levenson, 2019). The Coalition for Juvenile Justice advocated for a continuum of care that catered to the specific needs of JIY, particularly mental health services and trauma-informed interventions (Thomas & Penn, 2002). However, over the last twenty years, the number of JIY has increased faster than those of adults, even as the need for trauma-informed interventions is being recognized (Demeter & Sibanda, 2017). Scarce funding, as well as inadequate training and lack of researcher-agency collaboration, may explain why the implementation of TIC has not kept pace with the need. A study conducted in 1998 found that only 71% of juvenile correctional centers reported that they screened for mental health issues (Desai, Goulet, Robbins, Chapman, Migdole, & Hoge, 2006). The same study on PTSD in incarcerated adolescents reported that only 55.8% of juvenile correctional settings offer psychiatric evaluation beyond mental health screenings (Ulzen & Hamilton, 2003).

Assessments of childhood trauma and related mental health needs are essential in providing appropriate care for JIY and potentially increasing the success of the JJS in preventing recidivism. Although research has shown that early screenings are significant, there is still a disconnect with policymakers providing adequate funding and resources. In 2005 Gallagher and Dobrin utilized data from the 2000 Juvenile Residential Facility Census (n = 3,690) and found that if every child and adolescent that entered a correctional facility was screened within the first 24 hours, the risks of serious suicide attempts may be reduced. Furthermore, Grisso and Underwood (2004) concluded that, 1) Screening should be performed for all JIY at the earliest point of contact with the JJS; 2) Assessments should be performed for JIY who require further evaluation; 3) Care should be taken to identify the most appropriate instruments.

A lack of instruments designed specifically for identifying trauma in JIY is a concern, as is the debate that is centered on nothing works versus what works and what works well. The task at hand begins with appropriate trauma screening, and also requires adoption of intervention models that provide more than the bare minimum of services. TIC works from the top-down and the bottom-up and begins with stakeholder buy-in to achieve policy changes, provide more funding, and help change the perception of those who still view JIY as super-predators. Then, training for all clinical, correctional, and other staff coming in contact with JIY need to be trained in understanding trauma, so that behaviors can be conceptualized within a TIC framework and correctional environments can be modified to become less traumagenic.

Some of the most common trauma-informed interventions, instruments, and curriculums utilized in the JJS are the Trauma and Grief Components Therapy for Adolescents (TGCTA), Cognitive Processing Therapy (CPT), Trauma-Adapted Multidimensional Treatment Foster Care (TA-MTFC), the Attitudes Related to Trauma-Informed Care [ARTIC] questionnaire, and the Think Trauma Curriculum. For this review, the Sanctuary Model and Trauma Affect Regulation Guide for Education and Therapy [TARGET] were selected as prime examples. Both are considered effective psycho-educational programs for JIY and correctional staff. When used correctly, these interventions highlight characteristics that address trauma, build skills, create healing relationships, and reduce criminogenic risks.

Sanctuary Model. The primary objective of the Sanctuary Model is to create a culture within an organization that provides "a trauma-informed, evidence-supported template for system change based on the active creation and maintenance of a nonviolent, democratic, productive community to help people heal from trauma" (NCTSN, 2008). The model provides a universal language that is accessible to staff, clients, and other stakeholders. It is not rigid and can be adapted to many settings and populations. The model also involves creating a culture of nonviolence, emotional intelligence, inquiry, social learning, and shared governance, facilitating "open communication, social responsibility, as well as growth and change" (NCTSN, 2008). These goals are accomplished using three key components: a shared language of Safety, Emotion management, Loss, and Future [SELF], development of a core implementation team, and concrete intervention tools. The success of the Sanctuary Model requires implementation across all levels of an organization or institution (Pickens, 2016).

Some of the strengths of the model are its easy adaptability across many cultures, its recognition of the stigma of mental illness, its demonstrated reduction in the use of restraints in residential facilities, and its track record in improving staff

retention (NCTSN, 2008). The drawbacks to this model include the time it can take to implement (up to 2.5 years) fully and the cost of implementation ($65,000), which can make it difficult for many organizations to obtain the funding needed to incorporate the model efficiently (NCTSN, 2008).

TARGET. TARGET is appropriate for intervention in cases of complicated poly-victimization as well as traumatic loss, for anyone over the age of ten years (NCTSN, 2012). TARGET is designed to be successfully implemented concurrently with other evidence-based interventions, in conjunction with any work with families, and with substance abuse treatment (NCTSN, 2012). TARGET is comprised of seven skills-based steps taught over ten sessions: self-regulation via *Focusing*; trauma processing via *Recognizing* current triggers; *Emotions* and cognitive *Evaluations*; strengths-based reintegration by *Defining* core goals; identifying currently effective *Options*; and affirming core values by *Making* positive contributions [FREEDOM] (Marrow, et al., 2012). These skills are based on three primary therapeutic components. A psycho-educational component helps individuals understand the effects of PTSD on neurobiology and how PTSD is an adaptive response to a perceived threat that can be triggered in the absence of an actual threat. This component helps children understand why they feel and react in the ways they do and shows them how they can regain control of their symptoms. The second component consists of the teaching and guided practice of the FREEDOM skills, and the third is an experiential component in which youth create a timeline of their lives to help organize autobiographical memory, which can often be fragmented in traumatized youth (Marrow et al., 2012).

The strengths of the TARGET intervention are plentiful, beginning with the extensive psycho-educational component for both youth and staff, which helps to explain the effects of trauma on the brain, body, emotions, behavior, and relationships in everyday language that de-stigmatizes trauma. TARGET also provides instruction and modeling of skills for symptom management and emotion regulation, and with training and materials for reinforcement of new skills by non-professional workers (NCTSN, 2012). As with the Sanctuary Model, a significant drawback is the cost of training and maintaining fidelity and quality of implementation, which is higher than with other, less comprehensive intervention models. Despite the financial and time challenges associated with both interventions, evidence-based TIC programming within juvenile justice facilities has the potential to improve outcomes for both JIY and staff.

Implications for Practice, Policy, Advocacy, and Prevention

With an estimated 200,000 JIY transitioning back into their homes each year after residential programs, there are significant implications for practice, policy, and advocacy (Hancock, 2017). There are also important implications for prevention for at-risk children. When correctional staff, probation officers, social workers, judges, attorneys, advocates, clinicians, and teachers are trained in neurobiological and psychosocial impacts of trauma, the futures of JIY can be drastically changed.

Front-line practice

Practitioners working directly with JIY should be continuously educated and trained about the impact of trauma on neurocognitive functioning and mental health. Specifically, staff should be aware of how traumatic stress reactions can manifest in dysregulation and respond with effective trauma-informed methods of managing problem behaviors (Pickens, 2016). Levenson (2019) states that there are two primary goals when deploying TIC: (1) View maladaptive, problematic behavior and presenting problems through the lens of trauma (case conceptualization), and (2) Avoid disempowering dynamics in the helping relationship, which can re-traumatize clients (trauma-informed responding). Justice-involved practitioners should also be trained to understand the role of trauma exposure in the development of youth criminogenic risk factors, so that they can successfully create, revise, and implement effective interventions (Pyle, Flower, Fall, & Williams, 2016). Creating safe spaces for youth to trust others and practice self-regulation and self-correction skills can reduce risk factors for recidivism.

Policy

Recently, the Juvenile Justice Reform Act of 2018 was passed. This legislation is momentous because it incorporates decades of research and practice about criminogenic risks and needs of JIY in correctional systems and best practices for responding to juvenile crime. The most significant piece of this legislation is that it recognizes the role trauma play in offending, rehabilitation, and recidivism. The act has incorporated programs to reduce juvenile delinquency, assist runaway youth, and locate missing children (Congress.gov, 2017). The act also requires states to update their plans to include alternatives to detention, transitional services, screening for victims of human trafficking, appropriate accommodations for pregnant JIY, and requires administrators to focus on reentry, mental, and behavioral health (Congress.gov, 2017). The act aims to achieve this by including (1)

more evidenced-based trauma-informed interventions, (2) revision of policies regarding dangerous and inhumane confinement practices, (3) improvements in the quality of educational services, (4) more attention and services for special youth populations, and (5) more accountability for practitioners and youth (AECF, 2018). Policies and procedures should continue to be revised throughout the entire criminal justice system. The revisions should specifically address how trauma-related behavioral problems can adversely impact juvenile justice staff and youth. Policy and procedures should empower JIY and staff to develop a real ability to assist each other in rehabilitative efforts. This is vital because program management, health care services, facility security, and intervention management have significant inverse relationships with recidivism (Hancock, 2017).

Advocacy and Prevention

There are more than 180 agencies that advocate for JIY (AECF, 2018). Juvenile Justice advocates goals are: (1) work towards deinstitutionalization, (2) provide direct service, (3) teach JIY and their families how to become self-advocates, and (4) encourage JIY to be active in their treatment (Youth Advocate Programs, 2018). Although advocates in the past were confident that there were opportunities for effective treatment, rehabilitation, and intervention, the question of "what works" has been consistently raised (Russell & Manske, 2017). In an attempt to figure out what works, many advocates educated policymakers about the need for more federal and state legislation, funding, awareness of trauma and mental health, justice programs and services, and the prospect of positive outcomes for youth and public safety (AECF, 2018).

Advocates are also asking for more evidenced-based interventions not only for JIY but also for juvenile justice practitioners. Front-line workers such as correction officers, probation officers, social workers, and attorneys experience vicarious traumatization when working with JIY (Branson et al., 2017). The high rates of traumatic stress in front line staff play a critical role in performance, treatment of JIY, and outcomes (Branson et al., 2017). Practitioners can be most effective when provided with the training and resources to facilitate best practices and appropriate outcomes for the youth they serve.

Finally, TIC has important implications for prevention using a public health model (Khanlou & Wray, 2014; Larkin, Felitti, & Anda, 2014). Primary prevention puts universal precautions in place, while secondary prevention targets at-risk populations, and tertiary prevention provides services to ameliorate the problem after it has occurred (German, Horan, Milstein, Pertowski, & Waller, 2001). When we

recognize early adversity as a risk factor for delinquent behavior, we can advocate for primary prevention services such as parenting assistance for at-risk families, safety nets for impoverished and marginalized communities, early educational opportunities like Head Start known to facilitate resilience in children, programs that enhance positive role modeling for disadvantaged youth, and access to affordable health and mental health services. Attending to the traumagenic conditions that contribute to delinquent behavior can mitigate risk while offering more cost-effective ways to improve desired outcomes such as reduced recidivism and community safety.

Conclusion

The JJS has made significant strides; however, a substantial amount of work remains. This work should be inclusive of more evidenced-based trauma-responsive programs, awareness of the impact of trauma, increased mental health screenings and services, and the creation of trauma-informed federal and state legislation. Attention should also be paid to modifying correctional facility environments to offer a physical and psychological milieu that provides safety, trust, empowerment, and hope through corrective relationships with staff and other adult role models. As illustrated, TIC can help reduce behavioral and security concerns within juvenile justice facilities and improve overall youth outcomes by reducing recidivism, improving mental health outcomes, and increasing self-esteem and sense of self-efficacy among JIY. TIC initiatives "lay the groundwork for developing a system of care for youth that supports collaboration within the juvenile justice system" and between various social service systems (Pickens, 2016, p. 226). This foundation, if laid correctly, could potentially change the lives of hundreds of thousands of youth involved in the justice system, making our communities safer for everyone.

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