

Psychosocial Interventions for Traumatized Youth in the Juvenile Justice System: Research, Evidence Base, and Clinical/Legal Challenges

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Abstract

Psychosocial interventions for posttraumatic stress reactions increasingly are recognized as a key component in the provision of juvenile justice services. This article provides an overview of the research; clinical and legal successes; and challenges emerging from the development, evaluation, and implementation of trauma-focused psychosocial therapeutic interventions (TF-PTI) in juvenile justice systems. Four TF-PTI models that have empirically demonstrated effectiveness with justice-involved youth are

described. Clinical and legal precautions are discussed to inform practitioners, policymakers, administrators, and the judiciary when utilizing or adopting these and other TF-PTIs as one component of trauma-informed juvenile justice programming. The review highlights potential benefits that may accrue to public safety, as well as to the health and positive development of youth and families when juvenile justice programs provide access to evidence-based TF-PTIs in a systematic, equitable, and culturally competent manner.

Introduction

Psychosocial interventions for posttraumatic stress reactions increasingly are recognized as a key component in the provision of services to youth involved in or at risk for involvement in the juvenile justice system (Danielson, Begle, Ayer, & Hanson, 2012; Ford, Chapman, Mack, & Pearson, 2006; Ford, Kerig, & Olafson, 2014; Kerig, 2012). Research has demonstrated that more than 80% of juvenile justice-involved youth report a history of exposure to at least one traumatic event at some point in their lives (e.g., childhood maltreatment, domestic or community violence, severe accidents, traumatic deaths of family or friends), and typically these youth have endured multiple types of traumatic exposure (Abram et al., 2004; Dierkhising et al., 2013; English, Widom, & Brandford, 2002; Ford, Hartman, Hawke, & Chapman, 2008; Ford, Grasso, Hawke, & Chapman, 2013; Stimmel, Cruise, Ford, & Weiss, 2014; see Kerig & Becker, 2010, 2012, 2014 for reviews). Such polyvictimization places youth at significant risk for ongoing emotional, developmental, academic, and behavioral problems. Persistent posttraumatic stress can lead to serious long-term mental health problems for youth, including posttraumatic stress disorder (PTSD), substance abuse, anxiety, disordered eating, depression, self-injury, conduct problems, and revictimization, all of which further increase the likelihood of involvement in delinquency, crime, and the justice system (Becker & Kerig, 2011; Ford, 2010; Ford et al., 2006; Ford, Elhai, Connor, & Frueh, 2010; Ford et al., 2013).

In addition to the preponderance of youth entering the justice system with histories of prior exposure to traumatic events, the juvenile justice system itself may expose youth to additional traumatic stressors, such as peer violence, abuse by staff, and shackling and restraints (Dierkhising, Lane, & Natsuaki, 2014; Mendel, 2011). Retraumatization of youth in justice settings increases their risk for PTSD and could also cause problem behaviors that may endanger other youth and adults (DeLisi et al., 2010; Ford &

Blaustein, 2013). Therefore, effective therapeutic interventions provided on a timely basis and matched to the specific needs and life circumstances of each traumatized youth are an essential component of a trauma-informed juvenile justice system. To this end, this article provides an overview of the state of the art in current research on the development and implementation of psychosocial interventions for traumatized youth who are involved in the juvenile justice system or are at risk due to delinquency.

Working With Traumatized Youth in the Juvenile Justice System: Six Challenges

A growing evidence base supports in general the effectiveness of therapeutic interventions for adolescent PTSD and the related psychosocial problems that follow from exposure to traumatic stress (e.g., Cary & McMillen, 2012; Connor, Ford, Arnsten, & Greene, 2014; de Arellano et al., 2014). However, there are several reasons why justice-involved youth might be considered a special population in need of services targeted specifically to their needs and characteristics. These youth and the professionals and staff who work with them face six key challenges: (a) the overrepresentation of youth of color and of lesbian, gay, bisexual, transgender, questioning, and gender nonconforming (LGBTQ/ GNC) youth in the juvenile justice system; (b) the high prevalence of traumatic exposure and polyvictimization among justice-involved youth; (c) the adverse impact that PTSD symptoms have on youth participation in and benefit from rehabilitative services; (d) the difficulty of involving family and other support system members in justice-involved youth services; (e) justice-involved youths' ongoing risk of exposure to violence, losses, and other threats that can reactivate or exacerbate PTSD symptoms; and (f) the potentially coercive context of involuntary rather than voluntary participation created by law enforcement and judicial mandates on youth. These six challenges' relevance to providing targeted services addressing youth PTSD and associated psychosocial and behavioral

problems are described in more detail in the paragraphs below.

First, the disproportionate minority contact with law enforcement has led youth from underserved communities of color to be overrepresented in U.S. juvenile justice systems and to receive disparate responses (e.g., more frequent arrests and confinement, harsher legal sanctions) at each level of that system. Additionally, LGBTQ/GNC youth are disproportionately represented in the juvenile justice system. It is estimated that about 5–7% of the national youth population identifies as LGBTQ (Office of Juvenile Justice and Delinquency Prevention [OJJDP], 2014), but about 20% of all youth in the juvenile justice system identify as LGBTQ/GNC (Brown, Canfield, & Irvine, 2014). Among girls in juvenile detention, an astonishing 40% identify as LGBTQ/GNC (Irvine, 2015). Researchers believe the true percentage of LGBTQ/GNC youth among justice-involved populations is even greater because many youth avoid disclosing their sexual orientation or gender identity to reduce the risk of discrimination or abuse (OJJDP, 2014). Given these overrepresentations, effective interventions for these youth and their families (who are frequently economically disadvantaged as well) need to be designed and implemented so as to mitigate the risks of disparate treatment (e.g., to reduce the likelihood of these youth being stigmatized or subjected to disproportionate sanctions), as well as to be culturally competent, relevant to diverse populations (e.g., subgroups of youth of color of different linguistic or cultural backgrounds and of LGBTQ youth based upon different forms of sexual identity), and accessible in ways that might challenge traditional methods of mental health service delivery.

Second, research suggests that youth in the justice system differ from their peers by virtue of the number, kinds, and multiplicity of traumatic exposure they have endured (Ford et al., 2010; Ford et al., 2013). For example, in one of the few studies to directly compare justice-involved and community youth, Wood and colleagues (2002)

found that detained youth had on average experienced twice as many traumatic events as their high school peers. In particular, justice-involved youth reported a significantly greater likelihood than community youth of having lost a loved one to a violent death, having witnessed someone being killed, having both witnessed and experienced sexual assault, and having someone threaten their lives with a knife or gun. Even higher rates of traumatic stressor exposure and posttraumatic stress reactions are found among the subset of youth in the justice system who are gang-involved (e.g., Harris et al., 2012), especially among gang-involved girls (e.g., Kerig, Chaplo, Bennett, & Modrowski, in press; Kerig & Ford, 2014). Thus, interventions for justice-involved youth must be prepared to respond to significant levels of polyvictimization and revictimization and the resulting complex developmental dysregulations that ensue from exposure to chronic interpersonal traumatic stressors among these youth (Ford & Cloitre, 2009; Ford, Chapman, Connor, & Cruise, 2012; Kerig, Vanderzee, Becker, & Ward, 2012).

Third, a growing body of work is emerging that suggests traumatic stress reactions may contribute to youths' involvement in the justice system through specific posttraumatic mechanisms. In particular, recent theory and research has emerged suggesting that, beyond symptoms such as reexperiencing and hyperarousal, which are commonly understood and readily recognized as posttraumatic reactions, many justice-involved youth display another constellation of symptoms that is more vulnerable to misidentification. Posttraumatic coping strategies involving experiential avoidance—including emotional numbing, acquired callousness, dissociation, and self-harming behavior—are frequently seen among youth in the justice system and have been implicated specifically in adolescent delinquency (Allwood, Bell, & Horan, 2011; Bennett, Kerig, Chaplo, McGee, & Baucom, 2014; Bennett & Kerig, 2014; Bennett, Modrowski, Kerig, & Chaplo, 2015; Ford et al., 2006; Kerig, Bennett,

Thompson, & Becker, 2012; Plattner et al., 2003). Research also shows that this spectrum of post-traumatic reactions may complicate treatment due to being disproportionately associated with difficult comorbid problems such as substance abuse (Carrion & Steiner, 2000) and suicidality (Bennett et al., 2014) and can interfere with the effectiveness of evidence-based traumatic stress interventions (Taylor et al., 2001). Therefore, these symptoms may require special attention in treatments for justice-involved adolescents.

Fourth, it may be challenging to include caregivers and other supportive adults in treatment, especially for youth with behavioral/emotional problems (Garfinkel, 2010) and those placed outside the home, particularly in facilities geographically distant from their home communities. Anecdotal reports suggest that this may be a particularly acute problem for girls: Because the number of system-involved girls tends to be low, some jurisdictions economize by closing small local girls' units to merge them into larger facilities that are miles, or even states, away from the girls' home communities, creating significant barriers to caregiver involvement (Smith, Leve, & Chamberlain, 2011). The inclusion of caregivers has been empirically demonstrated to enhance the effectiveness of traumatic stress treatment for youth (Cohen & Mannarino, 2000), but interventions targeting justice-involved youth may have to meet the challenge of achieving positive outcomes in their absence or with limited involvement on their part.

Fifth, whereas some therapy models advise clinicians to begin trauma-focused components only when a youth is in a position of safety, this may not be realistic when working with traumatized justice-involved youth. Many of these youth are living in, or are returning to, communities with high rates of violence, and youth in detention or secure care may be witnesses to or victims of recurring potentially traumatizing events while institutionalized. Moreover, incarceration itself may threaten youth safety (Aebi et al., 2015). For these youth, traumatic stress treatment must be designed and

delivered in order to assist them in therapeutic processing of traumatic memories from the distant past as well as intrusive memories, re-experiencing of recent traumatic events, and ongoing traumatic exposures (Ford & Cloitre, 2009).

And sixth, many of these youth may not perceive participation as—and it may not in actuality be—wholly voluntary. Research on informed assent shows that youth often do not believe they have the right to choose when participation is invited by an adult in authority (Bruzzese & Fisher, 2003), and some institutional programming is indeed compulsory. Further, in some jurisdictions, judges and probation officers mandate psychosocial interventions, including traumatic stress treatment, in disposition plans for youth (Kendall, 2007). Even when traumatic stress treatment is not technically mandatory, justice staff may expect, and youth may assume, that therapists will provide regular reports about youths' progress. This may undermine the perceived voluntariness of the treatment and may threaten youths' perceived or actual privacy, especially when traumatic stress treatment requires them to provide a detailed narrative account of their experiences. Although other kinds of psychosocial interventions for justice-involved youth have demonstrated that their effectiveness is not reduced when delivered in contexts of court-mandated treatment compared with voluntary treatment (e.g., Alexander, Robbins, Waldron, & Neeb, 2013), this issue may complicate traumatic stress treatment in ways that have not been assessed.

In summary, given these ways in which the juvenile justice system presents a distinctive context for traumatic stress treatment—both regarding the presenting problems of this population of traumatized youth and their families and the challenges of service delivery—it is important that interventions be tried, tested, and proven effective in this context. We therefore will review the evidence base for treatments targeting traumatic stress that have evidence of efficacy or effectiveness specifically in a juvenile justice context.

The Evidence Base Supporting Psychosocial Interventions for Traumatized Juvenile Justice-Involved or Delinquent Youth

We identified four therapeutic psychosocial interventions that have published peer review reports of randomized trial efficacy or quasirandomized design effectiveness studies with youth involved in juvenile justice systems. Each of these interventions provides a detailed manual with step-by-step instructions designed to guide training of interventionists, the delivery of each session and activity, and the monitoring of fidelity and competence of implementation.

Trauma Affect Regulation: Guide for Education and Therapy (TARGET)

TARGET (Ford, 2015) is a 4–12-session educational and therapeutic intervention for traumatized youth and adults designed to be provided in either a one-to-one or group format by behavioral health clinicians. Nonclinical line staff are trained to serve as coleaders in the group modality in juvenile justice settings, as well as to deliver TARGET on a 24-hour, 7-days a week basis as a milieu intervention in congregate programs (Ford & Blaustein, 2013; Ford & Hawke, 2012). When delivered in the group format, either one leader or two coleaders may conduct groups of 4 to 10 youth. TARGET groups are designed to be gender-specific, with discussion topics and activities tailored to boys' and girls' differing interests and experiences, but both genders receive the same core skills set.

TARGET teaches a seven-step sequence of self-regulation skills summarized by the acronym FREEDOM. The first skills, **F**ocusing and **R**ecognizing triggers, provide a foundation for shifting from stress reactions driven by hypervigilance to proactive emotion regulation. Four subsequent skills are designed to enable participants to differentiate **E**motions, **E**valuative cognitions, **D**eliberate goals, and **O**ptions for action, and to determine whether they are based on stress reactions or are grounded in the participants' core personal values. A final skill, **M**aking a contribution,

is intended to enhance participants' reflective mentalizing skill (Allen, Fonagy, & Bateman, 2008) by providing a practical approach to monitoring day-to-day applications of the first six FREEDOM steps and recognizing how this enriches the lives of participants and other people.

A randomized clinical trial with justice-involved girls with dual diagnosis PTSD, substance use, or other disorders (e.g., oppositional-defiant, depressive, panic) showed that a 10-session individual TARGET intervention was superior to relational psychotherapy in reducing PTSD and depression and improving emotion regulation (Ford, Steinberg, Hawke, Levine, & Zhang, 2012). Additional evidence for TARGET's effectiveness as a group and milieu therapeutic intervention with detained boys and girls was provided by two quasi experimental studies. These studies in secure juvenile detention facilities and locked inpatient units in juvenile justice mental health centers showed reductions in violent behavioral incidents and coercive restraints and in PTSD and depression symptoms, and increased hope/engagement in rehabilitation following TARGET's delivery (Ford & Hawke, 2012; Marrow, Knudsen, Olafson, & Bucher, 2012).

Trauma and Grief Components Therapy for Adolescents (TGCTA)

TGCTA (Layne, Saltzman, Pynoos, & Steinberg, 2002) is a four-module 8- to 24-session group psychosocial intervention first developed for, disseminated to, and evaluated in a randomized trial for adolescent war survivors in Bosnia in the 1990s (Layne et al., 2008). It has since been implemented successfully in open trials with detained youth in Ohio (Olafson et al., 2016), urban, gang-involved, and at-risk youth in California (Saltzman, Pynoos, Layne, Steinberg, & Aisenberg, 2001), and delinquent youth in Delaware schools (Grasseti et al., 2014). In both the randomized trial in Bosnia and the open trial research studies in the United States, TGCTA was associated with reduced PTSD, depression, and maladaptive grief reactions and improved

behavior (Layne et al., 2008; Olafson et al., 2016; Saltzman et al., 2001).

TGCTA's four modules address: (a) foundational knowledge and skills to enhance posttraumatic emotional, cognitive, and behavioral regulation and to improve interpersonal skills; (b) group sharing and processing of traumatic experiences; (c) group sharing and processing of grief and loss experiences; and (d) resumption of adaptive developmental progression and future orientation. Each session contains step-by-step instructions for implementation, including suggested scripts for the exact language to use while conducting groups. Groups of 8 to 10 youth are generally led by two coleaders. Although single gender groups are recommended, some implementers have reported successful implementation with mixed gender groups.

TGCTA is similar to TARGET in several respects, including educating youth about the role that traumatic experiences and posttraumatic stress reactions can play in behavioral, emotional, interpersonal, and legal problems; and providing youth with skills for recognizing, coping actively and nonavoidantly with, and reducing the distress associated with posttraumatic stress reactions. Where TARGET emphasizes processing of current episodes of posttraumatic stress reactions using the FREEDOM skills, TGCTA emphasizes processing memories of past traumatic experiences as a means to reduce the distress elicited by those memories and the self-defeating avoidance that occurs when traumatized youth feel unable to tolerate posttraumatic stress reactions. TGCTA also provides a unique module designed to enable youth to process grief associated with traumatic losses.

Cognitive Processing Therapy (CPT)

CPT is offered as both a one-to-one or group treatment that teaches cognitive restructuring skills designed to enable clients to examine and rework beliefs about their self/identity, relationships, the world, and their futures, which may

have become maladaptive as a result of traumatic experiences (Resick & Schnicke, 1993). Two versions of CPT have been developed and tested. The original CPT was designed to enable traumatized clients to create, with the supportive guidance of a therapist, a detailed spoken and written account (referred to as a narrative) of a specific traumatic event. Over the course of 16 to 20 sessions, the narrative is used as a basis for the client to revise core personal beliefs about the meaning of the traumatic experience in light of a new ability to recall the event without avoidance, hyperarousal, or intolerable emotional distress. An alternate form, CPT-C, involves creating what is referred to as an impact statement, a brief written summary describing the effect that the traumatic event has had on the client's life, without requiring a detailed narrative account. Research suggests that the two versions are equally effective and that CPT-C may be advantageous by facilitating more rapid treatment gains with fewer dropouts from therapy (Resick et al., 2008; Walter, Dickstein, Barnes, & Chard, 2014).

The efficacy of CPT with traumatized youth has been demonstrated in a randomized clinical trial that included adolescents (e.g., Chard, 2005), and a revised version of CPT has been developed specifically for youth (Matulis, Resick, Rosner, & Steil, 2014). This longer (31 session) developmentally adapted CPT includes emotion regulation and interpersonal effectiveness skills that are similar in intent—although different in actual practice—to those in TARGET. The adapted CPT showed evidence of reductions in PTSD and depression in an open trial with 10 female and 2 male adolescents who had child abuse-related PTSD (Matulis et al., 2014). Of particular relevance to the current review of evidence for the treatment's effectiveness with justice-involved youth, an 8-session group version of CPT with incarcerated boys was found to be superior in reducing PTSD and depression symptoms as compared to a control condition in which youths received the standard facility services while they waited to receive CPT (Ahrens & Rexford, 2002).

Trauma-Adapted Multidimensional Treatment Foster Care (TA-MTFC)

MTFC was developed to provide an alternative to residential care for youth with chronic and severe antisocial behavior and mental health problems that put them at high risk for future incarceration or hospitalization (Chamberlain, Saldana, Brown, & Leve, 2011). With the active support of a clinical team, therapeutic foster parents are trained to implement a highly structured behavioral program in the home that includes active adult monitoring, fair and consistent discipline, provision of a positive relationship with a caregiving adult, and redirection toward prosocial activities and away from antisocial peers. Randomized controlled trials have shown high levels of effectiveness in reducing youths' delinquent behaviors and mental health problems (Chamberlain, Leve, & DeGarmo, 2007; Chamberlain et al., 2011).

MTFC research also revealed gender differences related to girls' high rates of mental health disorders, family discord, and traumatic stress exposure (Chamberlain & Moore, 2002). Consequently, a gender-responsive version of the intervention was developed that was further enhanced by the inclusion of trauma-focused modules based on the principles of Trauma-Focused Cognitive Behavioral Therapy (Cohen, Mannarino, & Deblinger, 2006). The trauma-related components focus particularly on psychoeducation about traumatic stress exposure and reactions, and they affect regulation, healthy sexuality, and the development of adaptive skills for coping with traumatic stress. A small randomized clinical trial involving 30 adolescent girls with histories of justice involvement found that, at a 12-month follow-up session, girls who received the integrated MTFC plus traumatic stress treatment demonstrated significantly lower levels of trauma-related mental health problems and delinquent behavior when compared to girls assigned to standard juvenile justice programming (Smith, Chamberlain, & Deblinger, 2012).

Next Steps for TF-PTIs With Youth in Juvenile Justice Systems

TARGET, TGCTA, CPT, and TA-MTFC have shown evidence of success in enabling justice-involved and delinquent youth to cope effectively with and be less distressed by PTSD and related posttraumatic symptoms, as well as in improving their ability to regulate their emotions (TARGET), succeed in school (TGCTA), and safely and optimistically participate in juvenile justice detention and inpatient psychiatric programs (TARGET). Thus, psychosocial therapeutic interventions appear to provide a basis for helping traumatized justice-involved or high-risk youth to manage, and potentially overcome, posttraumatic stress problems. In so doing, the interventions also potentially enhance youths' ability to engage in rehabilitation, resume involvement in prosocial activities, and avoid reoffending (Ford & Hawke, 2012; Layne et al., 2008).

Although promising, in many respects the evidence-based TF-PTIs available for justice-involved youth are still at an early stage of development (Ford & Blaustein, 2013). Most have been subjected to a limited number of clinical trials, often conducted by the developers; thus, broader dissemination and replication showing evidence of effectiveness across diverse participants and contexts are needed. Most also are designed to be provided only to youth, despite evidence that supportive family involvement is an important protective factor mitigating against delinquency (Garfinkel, 2010). TA-MTFC is a positive exception in that it includes family therapy and services in the foster home. Other TF-PTIs that have been designed or adapted to provide family systems therapy (e.g., Ford & Saltzman, 2009) should be evaluated in the context of juvenile justice service planning—and specifically tested in conjunction with evidence-based, in-home family therapy models for delinquent youth, such as multisystemic therapy, multidimensional family therapy, and functional family therapy.

In addition, deeper research probes into the mechanisms underlying the treatments'

effectiveness will be important for revealing the critical ingredients and components that might be streamlined for greater efficiency and cost effectiveness. Dismantling studies that distinguish these factors might address questions, such as which presumed therapeutic components most significantly influence TF-PTI outcomes (e.g., psychoeducation, trauma memory processing, emotion regulation skills, self-monitoring, social support/modeling, presence of a caring adult role model/mentor). Clinical trials comparing the outcomes achieved by different forms of service delivery also would inform us of the relative benefits of group approaches compared with individual approaches for increasing engagement, preventing dropouts, and achieving positive outcomes. Such trials would also determine whether milieu reinforcement of TF-PTIs by juvenile justice staff (or by parents, teachers, mentors, or peers in home and community settings) is either a helpful catalyst or a requirement for sustained generalization of behavior change (Ford et al., 2012). Drawing on the TA-MTFC example, research is needed to determine whether and under what circumstances TF-PTIs can be an adjunct to, integrated with, or a prerequisite for other evidence-based interventions targeting youth problem behavior. For example, once youth who receive a TF-PTI are coping effectively with the aftermath of trauma, would they be more receptive to commonly offered juvenile justice programs targeting other noncriminogenic or criminogenic risk, need, or responsivity factors (Ford, Chapman, Connor, & Cruise, 2012)?

Clinical and Legal Challenges in Delivering TF-PTIs for Justice-Involved Youth

A long-standing problem for evidence-based practice is the gap between what is proven effective in the laboratory and what is available to clients in “real world” settings (Weisz, Ng, & Bearman, 2014). Advances in implementation science have made it clear that effective interventions for youth need to be not only developed

but also disseminated in ways that ensure fidelity and sustainability (Stirman et al., 2012; Weisz et al., 2014). This may prove particularly challenging in juvenile justice settings in which there are stakeholders at many levels of the system—legislators, judges, administrators, attorneys, probation officers, line staff—whose buy-in may prove essential for initial and sustained TF-PTI implementation. Further, ongoing fidelity monitoring is essential to the sustainability of evidence-based treatments (Scheirer & Dearing, 2011). Therefore, stakeholders in systems of care must be educated about the need for trauma-informed interventions as well as be willing to find strategies to bear the costs of investing in a high-quality, enduring, and accessible method for delivering TF-PTIs to justice-involved youth and families. Collaborative partnerships that cross the aisles traditionally separating the judicial, mental health, and correctional components of the justice system may be the key to success (Olafson, Goldman, & Gonzalez, 2016).

Crafting appropriate interventions for justice-involved youth requires an examination of broader questions of law and policy, including: (a) the social structures that lead youth into the justice system, particularly in light of the challenges to accessing high-quality, voluntary care outside the justice system; (b) the stage at which traumatic stress services are most likely to be effective for youth in the juvenile justice system; and (c) the potential legal risks of traumatic stress treatment and the relevant legal protections that should accompany such treatment.

Addressing Traumatic Stress Before Youth Become Embedded in the Juvenile Justice System

Although high-quality targeted interventions within juvenile facilities are essential, policymakers should begin their consideration of such services within the broader social and economic context leading young people into justice systems. Far too many youth who have mental health needs, particularly those of color or from poor

families, are referred into the juvenile justice system unnecessarily (Mallett, 2015). Many of these youth receive no mental health treatment, and others are involuntarily placed in mental health services when they could be better served by voluntary mental health treatment in the community (Garcia, Greeson, Kim, Thompson, & Denard, 2015). Youth incarceration rates in the United States are dramatically higher than in any other country in the world. The rate at which the United States holds young people in locked facilities is estimated to be five times that of South Africa, which has the second highest rate of incarcerated youth among all nations (Mendel, 2011). The most recent data available show that, despite a reduction of more than 40% over a 10-year period (from 96,531 incarcerated or detained youth in the United States in 2003 to 54,148 in 2013), thousands of youth still are confined in juvenile justice residential facilities every year in the United States (OJJDP, n.d.); many countries do not incarcerate children or adolescents at all (Mendel, 2011).

Juvenile justice systems in the United States also arrest, adjudicate, and confine young people of color at disproportionate rates, despite evidence of similar offending behavior among other racial groups (Lauritsen, 2005). In 2013, more than two-thirds of incarcerated youth were Black, Hispanic, American Indian, or of mixed racial background (OJJDP, n.d.). Moreover, at least one study found that “[t]he likelihood that disorders would be detected or treated was ... lower among racial/ethnic minorities” than among white peers (Teplin et al., 2013, p. 11). In addition to ensuring access to traumatic stress services in facilities, state and local policies should prioritize ensuring youth access to high-quality voluntary mental health services in the community, reducing racial disparities in the juvenile justice system, and permitting secure care placement only when necessary for public safety.

Thanks to successful reform efforts nationally, many juvenile justice systems have developed effective and efficient alternatives to incarcerating youth (Mendel, 2014).

As this juvenile detention reform has decreased the number of incarcerated juvenile justice youth, it has become increasingly important to explore avenues for providing traumatic stress interventions for nonincarcerated juvenile justice youth and for offering any needed treatment at the earliest possible juncture in the trajectory of a youth’s justice-system involvement (American Academy of Child and Adolescent Psychiatry, 2005). This may include offering voluntary traumatic stress treatment to youth who are in diversion programs or home on probation. It is also important to look even further upstream (e.g., troubled youth identified in school systems), particularly for the many youth who are at risk for becoming involved in both the juvenile justice and child welfare systems.

Addressing Traumatic Stress With Dual Status Youth

An overwhelming percentage of youth in the juvenile justice system have a history of childhood abuse and/or neglect; many of these youth also were involved with the child welfare system (Widom, 2003). Youth who become involved in both the child welfare and juvenile justice systems are often referred to as “dual status” youth. This is not a monolithic group. In fact, as awareness and research on dual status youth have grown, so too has the terminology used to describe them.

“Dually identified youth” refers to youth who are currently involved in the juvenile justice system following an arrest and were formerly involved in the child welfare system due to a report of parental neglect or maltreatment. Youth in juvenile detention facilities are more likely to have experienced abuse or neglect (and related types of victimization in their families and communities; Ford et al., 2013) than other youth in national samples (Ford et al., 2010). As a result, many of these justice-involved youth were involved in child protection investigations, and in some instances, they were placed in foster homes or congregate care facilities for their own safety prior to coming to the attention of the law enforcement and juvenile justice systems.

By contrast, “dually adjudicated youth” refers to youth who have formal (compared with informal involvement, such as diversionary), concurrent involvement with both systems (Herz et al., 2012; Wiig, Tuell, & Heldman, 2013). This refers to youth who were adjudicated dependent because of abuse or neglect and are also adjudicated delinquent. A third category, “dually involved youth,” includes youth who have concurrent involvement with both the child welfare and juvenile justice systems, though involvement with one or both systems may be informal (e.g., youth adjudicated dependent and placed in a group home, arrested by law enforcement but placed in a diversionary program by a probation officer) (Wiig et al., 2013). Thoughtful cross-system collaboration can support early and effective interventions before youth formally enter the juvenile justice system and can prevent or reduce juvenile justice system–involvement for youth with traumatic stress-related behavioral and emotional problems (Ford et al., 2006). Cross-system collaboration involves proactive sharing of information (within the bounds of legally mandated privacy regulations) and coordinated planning of services by personnel and agencies serving dual-involved youth (Marans, Berkowitz, & Cohen, 1998; Morrissey, Fagan, & Coccozza, 2009). The key systems with which youth in the juvenile justice system often are involved include (but are not limited to) law enforcement, child welfare, schools, developmental disabilities services, mental health services, pediatrics services, community recreational programs, homelessness services, and family/social services.

Juvenile justice and child welfare systems can take numerous steps to ensure that such cross-system collaboration occurs. First, when youth enter the juvenile justice system, stakeholders can commit to identifying whether youth have current or prior child welfare involvement. Early identification is a critical step forward, given that in most jurisdictions, this information is not identified or shared. Staff must exercise caution to ensure that this sensitive information is

appropriately shared (i.e., consistent with state and federal protections and ethical boundaries). Second, once a youth referred to the juvenile justice system is identified as having current or historical involvement with the child welfare system, both systems can work together to explore whether underlying traumatic stress problems can be addressed without the youth becoming more deeply embedded into the juvenile justice system. Third, both child welfare and juvenile justice systems can explore ways in which they can build high-quality TF-PTIs into the infrastructure of their response to dual-status youth. This will require a sustained, coordinated effort between the systems and a deep commitment to improving outcomes for dual-status youth.

Providing youth access to TF-PTIs is an important element of a broader strategy to disrupt the child welfare to juvenile justice pipeline. Indeed, an emphasis on earlier intervention may help persuade decision makers to invest in TF-PTIs and to sustain such methods. As efforts evolve to reform treatment for dual status youth, researchers should track data to highlight what common sense suggests: Earlier intervention is more effective and efficient than services or treatment provided after problems become chronic and severe. Such data will further support endeavors to develop thoughtful TF-PTI-related policies.

Addressing Traumatic Stress When Youth Are Intensively Involved in Juvenile Justice

Once youth formally enter the juvenile justice system, policymakers and practitioners face challenges related to the legal risks that can be posed by traumatic stress treatment; policies are needed to ensure that treatment can be provided to youth safely and without negative repercussions. A review of case law has revealed that judges may consider evidence of childhood trauma histories as aggravating factors in juvenile disposition, transfer decisions, and adult sentencing (Feierman & Fine, 2014). Moreover, treatment and screening that involve discussion

of a youth's trauma history may inadvertently elicit information about past incidents of juvenile or criminal offending. Therefore, policies are needed to ensure that youth can participate fully in TF-PTI without self-incrimination (National Juvenile Defender Center, 2014). Screening or treatment provided during detention or in a diversion program pose particular risks to a youth's delinquency adjudication hearing. However, even after adjudication, youth may reveal past actions that could lead to further adjudications or to a lengthier or more secure disposition. Protections in state law are the most effective way to protect confidential information (Rosado & Shah, 2007). Such policies protect young people from being penalized for full participation in treatment as well as protect the mental health providers and their relationships with the youth and capacity to provide effective treatment.

Additionally, policymakers and mental health providers can ensure that youth are not penalized for failing to comply with treatment or not benefitting from treatment. Except for the four methods described in this review, TF-PTIs have been developed and tested almost exclusively with youth who are voluntarily seeking therapy free from the chronic stress of juvenile justice sanctions, are living with parent(s) or other adult primary caregivers who can participate supportively, and are not currently exposed to additional traumatic stressors. In contrast, in secure facilities, youth who are mandated to participate in treatment are in restrictive settings, are detached from caregivers and family, have reduced protection from further traumatic exposures, and are at risk for punitive sanctions. Indeed, because many juvenile systems have indeterminate sentencing, with release granted when the young person demonstrates appropriate rehabilitation (Nurse, 2010), a youth's failure to comply with and show evidence of benefiting from treatment will often lead to additional time in the system and specifically in secure facilities. Even in the juvenile justice systems with determinate sentences or

guidelines, a youth's failure to comply can lead to "time adds" or can push a young person's disposition to the outer range of the guidelines. Although it is reasonable to encourage young people to participate in traumatic stress treatment, the treatments must be delivered in ways that avoid penalizing young people for whom coping with ongoing stressors—of both the traumatic and chronic day-to-day types—is a more pressing challenge than addressing the effects of past traumatic events.

Practitioners should also be aware of the requirements around mandatory reporting of child abuse, and policymakers should ensure that such requirements are carefully tailored to promote confidential communications between young people and mental health professionals. To effectuate these goals, policy makers can craft laws designed to protect young people from abuse so that these statutes are not used to impose juvenile or criminal sanctions on young people. Thus, for example, sexually active minors could be protected from being considered "offenders," and thus triggering mandatory reporting for the purposes of statutory rape or child abuse (Mallie, Viljoen, Mordell, Spice, & Roesch, 2012). It is particularly vital that young people have the opportunity for open dialogue with their mental health professionals about their own sexual activity without risk of punitive consequences. Legal statutes could also provide exceptions for the mandatory reporter requirement when mental health professionals are treating juvenile clients who are victims of sexual abuse, including statutory rape. These clients, especially, need the opportunity to seek counseling and pursue sanctions against abusers when they decide to do so.

Summary and Conclusion

Although there is a rapidly growing array of evidence-based and evidence-informed, gender sensitive, developmentally appropriate, and ethnoculturally acceptable therapeutic interventions for the treatment and rehabilitation of complexly

traumatized children and adolescents (Ford & Courtois, 2013), only four trauma-focused psychosocial therapeutic interventions have been adapted for and tested empirically with youth involved in the juvenile justice system. Because the potential benefits to youth and to juvenile justice systems of effective trauma-focused psychosocial therapeutic interventions are substantial, implementation and rigorous evaluation of the evidence-based models are a priority for the clinical and justice fields.

Therapeutic interventions that help to establish a safe milieu and prevent potentially traumatizing (or traumatic stress reactivating) sanctions (e.g., incarceration, physical restraints, seclusion) to enable young people to recover from emotional and behavioral problems caused by posttraumatic stress, are essential not only for youth but also their families and communities, and the law enforcement, court, and juvenile justice staff and professionals who work with them. When post-traumatic emotional and behavioral problems are effectively addressed in all services and programs within the juvenile justice system, everyone—troubled youth and their families, adults who are responsible for public safety, and entire communities—may become safer and healthier.

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