Adversity, Trauma, and Behavioral Health Needs among Justice Involved Youth

Nearly 1 million youth under the age of 18 are arrested each year in the United States.[1] These youth disproportionately have trauma-related and behavioral health conditions that have not been sufficiently identified or addressed in the community. As a result, they are at elevated risk of entanglement in the juvenile justice system.

Youth in contact with the juvenile justice system disproportionately experience mental and substance use conditions, and bear the burden of exposures to violence and traumatic stress. More than 90% of these youth experience at least one trauma in their lifetime, and the average youth has experienced 4.9 different types of trauma exposures.[2,3] Exposure to traumatic violence in childhood increases the risk for drug and alcohol use, depression, and anxiety, and has numerous additional long-term consequences including increased likelihood of stroke, diabetes, cardiovascular disease, cancer, and early death.

Multiple, or co-morbid, conditions are the norm for youth in the juvenile justice system. The presence of these co-morbid conditions presents unique challenges for juvenile justice and behavioral health care service systems and practitioners alike. These youth present with the greatest impairment in individual and academic functioning, have elevated risk of suicide, and consistently have the poorest treatment outcomes.

Co-morbid mental health, substance use, and traumatic stress conditions interact in ways that tend to intensify one another. For example, a youth suffering from anxiety arising from PTSD may develop a substance use problem from efforts to self-medicate. To increase community safety, and support recovery and long-term success for these youth, it is essential that juvenile justice and community behavioral health care systems and practitioners develop a common understanding of the complex needs of these youth. Both systems should adopt practices that are collaborative in nature, designed to identify and quickly respond to the needs of these youth and their families, and that are trauma-informed and evidence-based.

"BAD" OR "VULNERABLE" YOUNG PEOPLE?

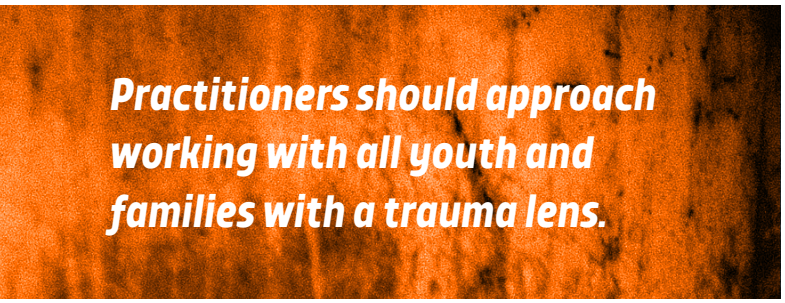
Not all exposures to adversities result in traumatic symptoms or persisting post-traumatic adaptations. For example, youth may have personal characteristics that support resilience, or family and other supportive relationships that buffer the impact of adversity. However, youth exposed to chronic and/or extreme adversities commonly do develop symptoms and adaptations arising from those experiences. Some of these young people will behave in ways that bring them into contact with police and courts. If their behavior is not viewed through a trauma-informed lens, their misconduct may prompt responses that make matters worse, lessen the prospects for rehabilitation, and increase the likelihood of deeper penetration into the juvenile justice system.

The variability of adaptations following exposures to adversities results in a kind of "clinical chameleon." Many youth will present with some features of PTSD but not meet enough diagnostic criteria to warrant that diagnosis. As a result, clinicians may attempt to capture the clinical presentation through assigning two or

more other diagnoses. Or, if the origins of symptoms in adversity exposures that have yielded trauma symptoms are not recognized, the youth may be misdiagnosed. Diagnosis will drive treatment and misdiagnosis runs a substantial risk of failure since it will not directly address symptoms and problematic behaviors that originate in adversity and trauma.

Young people whose problematic behaviors arise – at least in part – from traumatic exposures may elicit punitive rather than rehabilitative responses. For example, some whose exposures to violence have resulted in hypervigilance may respond aggressively when they feel they are threatened. Punishing the aggression without addressing the underlying problem with threat perception is likely to worsen the problem rather than resolve it.

Young people with significant histories of exposure to adversity are overrepresented in special educational, behavioral health, and juvenile justice settings. The kaleidoscope of diagnoses, supports, treatments, and other interventions they receive reflects both their vulnerability and a failure to consistently recognize the role of adversity and trauma in their development and, therefore, their problems with learning and behavior. As a result, practitioners also fail to consistently implement evidence-based practices to detect and respond to the array of behavioral health needs, identify their resiliencies, and support normalizing positive youth development.



AN INTERVENTION FRAMEWORK

Whether and how these needs are identified, understood, and addressed will greatly impact how juvenile justice systems react to these youth and their families. This, in turn, will deeply shape the outcomes for them and their communities. Juvenile justice practitioners and others will rely on different models for intervention based upon how they understand the behaviors resulting from developmental adaptations to adversity and symptoms of trauma.

It is essential for healthy development that youth be held progressively accountable for their decisions and behaviors as they mature. Accountability can be punitively imposed through correctional practices likely to exacerbate their vulnerabilities. However, accountability can be a component of broader rehabilitative strategies that include explicit instruction in emotional regulation, managing perceived threat, decision-making, building upon resiliencies, and addressing explicit symptoms of behavioral health and trauma conditions. Juvenile justice policies and practices that properly address behavioral health needs and that include trauma-informed, evidence-based clinical and organizational practices increase the prospects for rehabilitation, positive youth development, and community safety.

There are a number of approaches and interventions that practitioners in juvenile justice and behavioral health care can adopt to support better outcomes for these youth. Broadly, practitioners can rely upon a Risk-Needs-Responsivity (R-N-R) model to: (a) identify *risk* factors but also protective factors and resiliencies; (b) identify "criminogenic" *needs* (i.e., needs likely to result in criminal behavior) such as affiliation with delinquent peers, unsafe homes or neighborhoods, family substance use, and other factors related to delinquent misconduct which need to be addressed as part of a comprehensive intervention plan; and, (c) craft an individualized plan that takes into account "*responsivity*" factors such as a youth's learning style, culture, interests and competencies, family engagement, and other factors. These factors need to be taken into account to optimize the match between interventions and a youth and family.

The R-N-R model must be trauma-informed and responsive to behavioral health needs at each point to optimize selection, planning, and implementation of interventions. Youth with a history of significant exposure to adversities and indications of post-traumatic adaptations or symptoms must be seen through a trauma-informed R-N-R assessment. For example, substance use that is an effort at self-medication is a risk for misconduct, while engaged, positive parents are a protective factor; ongoing affiliation with delinquent peers or unsafe streets are conditions that need to be addressed, and recent immigration or other cultural factors would be responsivity factors that may require treatment in their language of origin, or adapted to respect cultural norms.

Optimal behavioral health and juvenile justice interventions are more likely to achieve positive outcomes if a trauma-informed R-N-R model is used to create a common understanding and coordinated efforts to address the needs of juvenile justice involved youth. Specifically, systems and practitioners should:

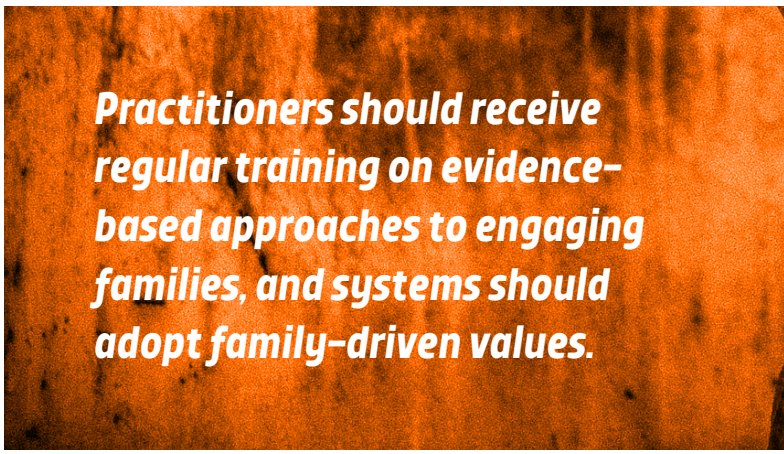
- Develop a common understanding of adolescent development and the behavioral manifestations of

common diagnoses or developmental adaptations to adversity. This usually occurs through regular cross-systems training efforts, alignment of mission or values statements, and implementation of policies that support rehabilitative rather than punitive responses.

- Practice trauma-informed care as the norm rather than the exception. Given the prevalence of exposure to violence and resulting traumatic stress, practitioners should approach working with all youth and families with a trauma lens.
- Engage and involve families in juvenile justice and behavioral health systems given the important role they play in supporting youth. Practitioners should receive regular training on evidence-based approaches to engaging families, and systems should adopt family-driven values.
- Use research-based tools to identify mental health, substance use, and traumatic-stress related conditions. For juvenile justice practitioners, this requires adoption of behavioral health and trauma screening procedures at all points of contact with the juvenile justice system. Given the prevalence and nature of co-occurring conditions, it is important that screening procedures target all conditions. When youth screen in, juvenile justice practitioners must be able to refer youth to community-based, clinical service providers who can conduct an in-depth assessment.
- Increase the community capacity to provide a comprehensive continuum of trauma-informed, co-occurring, or integrated care for youth. Too often services are segmented and treatment is offered by different practitioners that do not coordinate care or cover the wide range of treatment needs. Services that are rooted in an adolescent framework should be available for those with emergent needs, and to the most severely affected young people.

RESOURCES FOR RECOVERY AND REHABILITATION

Over the last decade, strategies and innovative models with demonstrated success have been developed by and for juvenile justice practitioners who work with these youth. These include operationalization of the R-N-R framework for identifying and responding to risk factors while building on and strengthening those factors that promote resilience. Toolkits, guidebooks, and training programs are available to support local adoption of this framework. Similarly, there are training curricula and cross-systems models for effective collaboration



and coordination of services to support practice that is trauma-informed, engages and involves families, and is rehabilitative rather than punitive. There are screening tools, validated for juvenile justice settings, which can identify mental health needs, substance use, and trauma-related stress among youth in contact with the juvenile justice system, and new evidence-based treatments and integrated approaches to meeting their behavioral health needs. Consult the National Center for Mental Health and Juvenile Justice (https://www.ncmhjj.com) for specific resources. Juvenile justice practitioners, now more than ever, have resources to support adoption of interventions that lead to better outcomes for youth with behavioral health and traumatic-stress conditions.

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