Victimization and Trauma Experienced by Children and Youth: Implications for Legal Advocates[1]

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Many children and youth in the child welfare (dependency) and juvenile justice (delinquency) systems have experienced or witnessed violence or other traumatic events and suffered the fear of ongoing exposure to harm; these experiences can lead to increased social, emotional, and physical needs. Trauma-informed care and evidence-based mental health treatments are a crucial part of recovery (Clawson, Salomon, & Grace, 2008). In trauma-informed care, treatment is guided by an understanding of exposure to violence and trauma-related issues that can present themselves in youth when they get involved with the courts. (In this document, the term "exposure to violence" includes both witnessing and personally experiencing violence.) Trauma-informed care is an important framework for accommodating these young people's vulnerabilities, although it is not designed to treat specific symptoms or syndromes. Evidence-based therapeutic and, sometimes, pharmacological approaches are the best path to improved functioning and quality of life from specific symptoms. Attorneys, guardians ad litem (GALs), Court Appointed Special Advocate (CASA) volunteers, and judges in abuse/neglect and juvenile justice cases can help the youth they work with and create a trauma-informed court system by learning about trauma, helping ensure youth receive appropriate treatment, and performing trauma-informed advocacy, as described on page 2.

The Safe Start Center Series on Children Exposed to Violence

Each Issue Brief in the series explains the importance of addressing exposure to violence to ensure the well-being of children from birth to age 18 in all systems that interact with vulnerable children and families. Through the use of literature reviews, case scenarios, and analyses of data, the Issue Briefs translate lessons learned from research and program practices into actions that can effectively prevent or reduce the negative impact of exposure to violence.

Issue Brief #7 translates emerging research and program practice into action steps for dependency and delinquency judges, attorneys, and legal advocates. The goal is to build their capacity to meet the needs of children and youth who are victimized and exposed to violence or other traumatic events. (For a complete list of Issue Briefs, see the box on page 16.)

Prevalence of Exposure to Violence

Numerous studies have shown that a large number of children have witnessed or experienced violence in their homes or communities and that these experiences are linked to negative outcomes later in life. The National

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[1] This educational document is not meant to provide legal advice or to diagnose or rule out any mental or physical health problems. It does not represent the official policy of the American Bar Association (ABA), the Safe Start Center/JBS International, Inc., or Child & Family Policy Associates.

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Case Scenarios: How Trauma Can Affect Children and Youth

From a dependency case:

An attorney GAL represents a 10-year-old client, Shayla, who was allegedly physically abused and neglected by her mother. Shayla's foster parents say she spends most of her time sleeping or watching television, and they often have difficulty getting her to wake up for school or join them for dinner. Shortly after Shayla had a phone conversation with her mother, she purposely cut herself. The GAL asks the caseworker to arrange a mental health assessment and learns that Shayla suffers from depression and has symptoms of traumatic stress. The GAL, therapist, and evaluator agree that Shayla should receive weekly therapy with a psychologist and visits twice a week from an in-home caseworker. Shayla's foster parents also meet with a counselor to learn how they can make Shayla feel more secure in their home. The GAL and the caseworker ensure that Shayla has regular followup to monitor her progress and encourage her to get involved in extracurricular activities at school.

From a delinquency case:

A juvenile defender has his first meeting with his 15-year-old client, Tyler, who broke into a neighbor's house and stole cash and electronics. A mental health screening administered during intake at the detention facility suggests Tyler needs further assessment for possible depression and post-traumatic stress disorder (PTSD). The defender learns that Tyler has been the subject of several unsubstantiated neglect allegations. After several meetings, Tyler confides in the defender that he has run away from home several times because he is scared of his mother's boyfriend, who has been violent with him and his mother, and he used the money he stole to buy food for himself. After receiving counseling about the benefits of sharing some of this information with the court, Tyler agrees to let the defender share some of his experiences with the court at the preliminary hearing, helping the judge understand Tyler's behavior in context. The judge agrees to hold the case in abeyance while Tyler and his mother seek services. The defender explains that if the judge is not satisfied with the family's effort, the defender will recommend to Tyler that they ask for an abuse/neglect case to be opened in place of the delinquency case. Tyler's defender gives Tyler and his family a list of agencies in the community that provide free or low-cost services. Tyler's family contacts the local mental health agency, and a counselor works with Tyler and his mother to educate them about the impact Tyler's exposure to violence may have on him. The counselor also shows Tyler some exercises he can use when he feels overwhelmed or stressed.

Survey of Children's Exposure to Violence (NatSCEV) (Finkelhor, Turner, Hamby, & Ormrod, 2011) interviewed a nationally representative sample of children and adolescents and found that approximately half had experienced two or more types of victimization in the past year.[3] Eight percent of respondents had experienced seven or more types of victimization (these children were termed "polyvictims" by the researchers). When only direct victimization was asked about (e.g., the child was the target of violence, rather than a witness to it), 10 percent of children had experienced more than 1 type of victimization, and 1.4 percent had experienced 10 or more types.

These numbers are likely higher among court-involved youth. Children in the dependency court system are alleged to have been abused or neglected, and research has shown a much higher level of past child maltreatment among youth in the juvenile justice system than among other youth (Siegfried, Ko, & Kelly, 2004). A national study of alleged child abuse or neglect victims found that nearly 12 percent had increased PTSD symptoms, including depression and anxiety related to trauma (compared with 2 percent of the general population reported in an earlier study) (Kolko et al., 2010).[4] Studies of youth in the juvenile justice system have found that these youth are at least twice as likely as other youth to have had past traumatic experiences and meet the diagnostic criteria for PTSD (Ford, Hartman, Hawke, & Chapman, 2008; Ford, Steinberg, Hawke, Levine, & Zhang, 2012). Polyvictimization has also been found to be more common among children with disabilities, particularly those with psychiatric problems (Turner, Vanderminden, Finkelhor, Hamby, & Shattuck, 2011).

[3] The study included the following types of victimization: "conventional crime, child maltreatment, victimization by peers and siblings, sexual victimization, witnessing and indirect victimization (including exposure to community violence and family violence), school violence and threats, and Internet victimization."

[4] Researchers in that study actually expected the difference to be greater and theorized that the results were influenced by the fact that the sample included all alleged victims, not just those for whom allegations were substantiated, so a number of the children probably had not actually been abused or neglected.

Although children who are court-involved are more likely to have experienced trauma and to exhibit increased traumatic stress symptoms, it is important to remember that children have different reactions to exposure to violence, and not all children who experience traumatic events will have lasting issues as a result (Conradi, Kisiel, & Wherry, 2012; Kolko et al., 2010). Whether traumatic experiences lead to PTSD or other conditions can be influenced by many different factors, such as frequency with which youth are exposed to reminders of trauma, preexistence of anxiety disorders, and family support (Agency for Healthcare Research and Quality, 2012). NatSCEV data has demonstrated that, for a large number of youth, any one type of victimization rarely occurs in isolation from other types, and a single traumatic experience is often the exception rather than the norm. Furthermore, individual incidents of exposure increase the risk for further victimization and have a negative impact on the safety and well-being of youth. (Finkelhor, Omrod, and Turner, 2007).

New Understanding of Characteristics and Impact of Multiple Exposures to Violence on Court-Involved Youth

Exposure to violence occurs along a continuum of complexity. Less complex instances may involve an isolated incident (e.g., witnessing a random shooting) where everything else is stable in the child's life. However, for children exposed to repeated and intrusive experiences, often of an interpersonal nature, such incidents may result in their being more vulnerable to traumatic stress symptoms that are due to a variety of factors, such as exposure to domestic violence or continued victimization. Court-involved youth are often on this end of the continuum.

The NatSCEV found that many children—called polyvictims—experience very high levels of victimization of different types. That is, for many youth, any one type of abuse rarely occurs in isolation of other types of abuse, and a single abusive experience is often the exception rather than the norm. The NatSCEV also found that polyvictimization onset is disproportionately likely to occur in the years prior to a child's 7th and 15th birthdays, corresponding roughly to his or her entry into elementary school or high school.

NatSCEV data indicate that the number of different kinds of victimization is a very important predictor of trauma symptoms. The data suggest the possibility that polyvictimization, more than the history of any type of individual victimization, is the greater risk factor for negative impacts from exposure to violence (Finkelhor, Omrod, Turner, 2007).

These NatSCEV findings are also supported by the Adverse Childhood Experiences study (one of the largest and longest running of its kind), which linked abuse, maltreatment, and instability at home (such as having a substance-abusing or suicidal parent) in childhood with an increased likelihood of risk behaviors and diseases. Children having 4 or more adverse childhood experiences were 4 to 12 times more likely to struggle with depression, suicide attempts, alcoholism, and drug abuse as adults (Felitti et al., 1998). Exposure to family or community violence and other forms of indirect victimization have also been linked to mental health issues, such as PTSD symptoms, depression, low self-esteem, anxiety, and aggression, as well as poor social functioning and academic performance (Siegfried et al., 2004).

The emotional effects of exposure to violence and polyvictimization can be persistent and devastating. Victimized youth may suffer from anxiety, panic disorders, major depression, substance abuse, and eating disorders, as well as combinations of these disorders.

Symptoms of Traumatic Stress[5]

In some cases, exposure to violence results in PTSD, a diagnostic category that was created originally for war combatants and disaster victims but that also applies to victims of other traumatic experiences, including exposure to violence (American Psychiatric Association, 2005). There is little information on the presentation of PTSD in children, because mental health systems have only recently begun identifying PTSD in this population (Pfefferbaum, 1997).

For those who struggle with PTSD, *typical* symptoms include:

- *Re-experiencing:* Children suffering from traumatic stress often have strong reactions to reminders of the trauma or loss they experienced. They may also have nightmares or flashbacks, feel as if they are reliving the events, or repeatedly incorporate their traumatic experiences into their play.

[5] This section is adapted from the Child Welfare Trauma Referral Tool available at http://www.nctsnet.org/sites/default/files/assets/pdfs/cwt3_sho_referral.pdf.

- *Avoidance:* Avoiding places, people, or other stimuli associated with past trauma, as well as refusing to discuss specifics of the experiences, can also be symptomatic of traumatic stress.
- *Numbing:* This can include feeling detached or estranged from other people, feeling "out of sync" with others, experiencing a more limited range of emotion, or not wanting to look too far into the future.
- *Arousal:* Children experiencing traumatic stress may have trouble concentrating or seem easily distracted, inattentive, or impulsive (which often leads to a misdiagnosis of attention-deficit/hyperactivity disorder [AD/HD]). They may be irritable, have outbursts of anger, startle easily, have trouble sleeping, or be hypervigilant (overly aware of or concerned about potential dangers).
- *Attachment issues:* Children may have trouble trusting or feeling secure with parents and other caregivers. They may show these difficulties in their interactions with others (e.g., by being overly affectionate with strangers; by avoiding eye contact and failing to engage in interactions or conversations appropriately).
- *Other reactions:*
  - Anxiety
  - Depression
  - Affect dysregulation (trouble expressing feelings/regulating emotions)
  - Attention/concentration difficulties, leading to trouble forming strong friendships or completing work
  - Dissociation (frequent daydreaming, forgetfulness, rapid personality changes, emotional detachment)
  - Suicidal behavior
  - Self-harm
  - Regression
  - Impulsivity
  - Oppositional (hostile/defiant) behaviors
  - Conduct problems

Other common symptoms for victimized youth are substance-related disorders, impulse control issues, conduct disorder, and AD/HD. Besides being exposed to a variety of traumatic events, victimized youth may frequently experience environmental and social stressors, such as involvement in the foster care system, running away, poverty, inadequate health care, academic problems, child abuse or neglect, or homelessness. Evidence suggests that boys are more likely to develop aggressive behavior as a result of their victimization (Finkelhor, et.al, 2009) whereas other research indicates that girls are more likely to experience depression and anxiety and to meet PTSD diagnostic criteria (National Council on Crime and Delinquency, n.d.). For youth, after these symptoms have been established, they can become chronic and debilitating if left untreated (Feeny, Treadwell, Foa, & March, 2004).

Children and adolescents who have been exposed to violence and display trauma-related symptoms may need referrals to mental health practitioners who are trauma-informed and knowledgeable about appropriate assessments and interventions.

Physical problems can also result from stress-related illnesses. For example, victimized children may complain of stomach pain or headaches. For some youth, the impact of exposure to violence, especially when it involves someone they once trusted, results in a pervasive mistrust of others and their motives. This mistrust can make it difficult for first responders and service providers to help. The confluence of these factors can result in children experiencing difficulties in attending school, holding down jobs, and integrating with their peers and community.

Role of Legal Advocates, Judges, and Court Staff

Attorneys, GALs, CASA volunteers, and judicial officers have an important role to play in making sure that children's mental health needs, including those related to trauma, are met, even when the young person already has a caseworker or mental health provider. There are many ways lawyers, lay advocates, and judges can, in both dependency and delinquency cases, become more trauma-informed in their practice. Attorneys representing status offenders may also benefit from reviewing both the child welfare and juvenile justice tips below.

For child welfare cases:

- As discussed, the number of exposures to violent events (including many types of victimizations commonly presumed to be less serious), appears to be linked to emotional problems more closely than any one particular kind of victimization. Therefore, it is important that children and youth are screened and assessed for a broad range of direct and indirect exposure to violence. Assessments should analyze the impact that the exposure had on the young person's

functioning (including symptoms of traumatic stress) and suggest appropriate, evidence-based treatments for those that need it (see information below on screening and intervention for exposure to violence).

- Ask what followup has been completed for identified exposure to violence events, and request that ongoing assessments be performed, where appropriate. Also, be aware that children may be further traumatized as a result of separation from family, their experiences in court, medical examinations or hospitalization, or experiences in foster care or other placements. They may also exhibit new symptoms from previous or cumulative exposure to violence.
- Request that parents and caregivers receive services as well, when appropriate. Many birth parents of court-involved children have also been exposed to violence, which may affect their ability to meet their children's and their own needs and to participate fully in the court process. Viewing parents through a trauma-informed lens can help advocates better understand the issues the child is facing. In some situations, the entire family may benefit from services to address exposure to violence.
- Ensure that biological and foster families learn about how a child's exposure to violence, or other traumatic experiences, may affect him or her and what the warning symptoms are for dangerous symptoms of traumatic stress.
- Help youth stay in the least restrictive setting that is appropriate for them. This includes staying in their own homes, when safe and possible, or therapeutic or family foster homes rather than group facilities when out-of-home care is necessary.
- Help child clients build long-term, positive, and sustaining adult relationships. A critical part of healing for children and youth exposed to violence involves the development of trusting, long-term relationships. This often needs to occur before children and youth are willing to engage in trauma-specific treatment. Connecting youth to mentoring organizations or faith-based groups, or simply supporting relationships with extended family members, can assist the recovery process.
- Ensure safety and basic service needs are met. Professionals working with youth exposed to violence must first ensure the child or young person is both physically and psychologically safe. This may mean working with the child or young person to assess his or her current safety level and working together to develop a plan to remain safe. It can also mean designing each component of the child's service plan to prioritize physical and psychological safety. For example, this can include working with a provider who is respectful and nonjudgmental and allows the young person to explore his or her history in a safe and supportive manner. Children and youth exposed to violence may lack basic necessities or services that are critical to comprehensively meet their needs, such as safe and stable housing, health care, appropriate educational services, and vocational supports.

For juvenile delinquency cases:

- Be aware that many youth experience very high levels of different types of victimization because they reside in a dangerous community; live in a home that is dangerous, chaotic, or facing multiple challenges; or have emotional problems that increase risky behaviors, engender antagonism, and compromise their capacity to protect themselves. This greatly increased risk for victimization has implications for their safety and well-being.
- Protect clients from self-incrimination. Be familiar with the jurisdiction's rules on privilege and confidentiality, and educate clients about what the roles of the attorneys, services providers, and others involved with their case are and how information clients share can or cannot be used by the court.
- Obtain the results of any screenings or assessments administered to the client. Learn about what these measures entail and their reliability; they can be used to support the client's position or argue against inappropriate treatment and intervention recommendations, if necessary.
- Find out what treatment, if any, the client has received. Learn about what the interventions entail and how effective they are (see information below on screening and intervention for exposure to violence). Attorneys and other advocates need to respect clients' privacy and keep client confidences, but they should also talk with clients about using information already before the court on past trauma to argue for their clients' expressed interests. This includes working with clients to tailor a plan that includes only necessary and appropriate services and interventions and using the information to advocate for dismissal, mitigation, or other preferred disposition options.

- Advocate for youth to stay in the least restrictive setting possible. This includes staying in their own homes or therapeutic or family foster homes, rather than group facilities, when out-of-home placement is ordered.
- Become familiar with research that shows the dangers of incarceration for youth (especially youth with trauma histories) and the benefits of appropriate treatment (e.g., cost-effectiveness, lowered recidivism). The Justice Policy Institute's *The Dangers of Detention* (Holman & Ziedenberg, 2006) and *Healing Invisible Wounds* (Adams, 2010) provide helpful information. Use this information to argue against inappropriate out-of-home placement for clients and for interventions and placements that will benefit them.
- Work with clients to develop plans and advocate for options that help youth address exposure to violence rather than exacerbate their stress. This can mean requesting diversion to alternative programs; arguing for adjudication to be held in abeyance to allow for assessment, service delivery, and then dismissal; or advocating for outright dismissal if warranted by the facts of the case (e.g., a truancy case where the real problem is the school's failure to meet a child's special education needs). For youth found to be delinquent of serious offenses, this may include using evidence of past trauma to argue for the least restrictive disposition options and keeping youth in the juvenile system (instead of transferring them to the adult criminal system).
- Learn about free or low-cost services offered in the community so clients can voluntarily get help without court involvement. Voluntary services for parents or the entire family may help address trauma experienced by parents as well as children, leading to more stable home lives and better outcomes for youth. This may be particularly beneficial in cases where status offenses or delinquent acts are triggered by instability at home. Educating families about services they can access on their own is also important, because delinquency courts should never become or stay involved in a case solely to ensure services are received.

For judges and advocates in child welfare, status offense, and delinquency systems

- Ensure that the child is in the most appropriate and helpful "system" possible. For example, an adolescent who has been charged with running away or assaulting a parent may really belong in the dependency system if his or her behavior stems from abuse or neglect by the parent. In delinquency matters, judges should consider holding cases in abeyance while the family works on addressing the issues on its own or with assistance from community providers.
- Learn about trauma and exposure to violence among children and adolescents and join or form a workgroup to bring training on the issue to legal, judicial, behavioral health, and social service professionals in the community.
- Learn about and request or order appropriate measures and interventions that screen for or address trauma and exposure across a broad range of experiences to capture polyvictimization violence (see information below on screening and intervention for exposure to violence). Ensure that decisions are made based only on measures that are reliable and appropriate for the child being assessed and that necessary followup happens promptly.
- Whenever safe and appropriate, allow youth to live with parents or other supportive adults instead of in a foster home, group home, or detention facility.
- Work to promote access to trauma-specific treatment and services. In addition to the trauma-informed care strategies discussed in this brief, courts working with youth exposed to violence must have access to a range of trauma-specific interventions, including clinicians who are willing, available, and culturally competent to work with youth who have been victimized.

Screening for Past Trauma and Exposure to Violence

Identification is the first and necessary step in ensuring youth will get the help they need. Judges, attorneys, GALs, CASA volunteers, and others involved in the child's court case often receive the results of mental health and trauma-specific screenings and assessments performed by mental health professionals, so understanding the basic characteristics of these instruments, which are described below, is important.

Although advocates may be able to introduce past trauma as a mitigating factor during sentencing hearings or request services for youth while they are awaiting adjudication or are in placement, attorneys in delinquency cases have the additional concern that assessment results, treatment outcomes, or other trauma-related information could be used against their clients

and/or that this information could lead to delinquency courts maintaining jurisdiction over youth simply to ensure service delivery. Because increasingly more courts and detention facilities are administering mental health or trauma-focused screenings as youth enter the system, advocates must be aware of what has been, or will be, asked about their clients' histories and how exactly the results will be used throughout the court process. Attorneys should be aware of State and Federal laws regarding privacy of health information and argue for any potentially incriminating information contained in assessment, screening, or other reports to be excluded. If a trauma-related or other mental health issue has been diagnosed, advocates should ensure that their client is receiving appropriate treatment from a qualified professional and that treatment-related information is kept private to the greatest extent possible and is not used to incriminate youth. (See Rosado & Shah, 2007, for more information on protecting youth from self-incrimination.) To the extent an advocate is aware of past exposure to violence or other traumatic experiences that are not currently part of the court case, he or she may wish to counsel the client and his or her family about receiving community-based services to address the issues (see "Role of Legal Advocates and Judges" above for more tips on how attorneys should respond to their clients' suspected or confirmed exposure to violence).

Surveys of child protective and other child-serving agencies indicate that the majority of agencies ask about past traumatic experiences and trauma-related symptoms (Conradi et al., 2012; Taylor et al., 2005). However, other agencies do not, or the information gathered may not be shared with courts or legal advocates. Judges, attorneys, and lay advocates should ask what, if any, trauma-focused or general mental health assessments or screenings have been performed on children in the dependency and delinquency systems and ensure they have access to the results of those measures, as well as to any background information they need to understand them. For general mental health assessments, advocates and judges should find out whether trauma and victimization history was asked about and reported on and request additional trauma-specific followup if necessary.

Trauma screenings, trauma assessments, and psychological evaluations have been described as "exist[ing] along a continuum to address the unique needs" of court-involved children (Conradi et al., 2012). Screening tools may be administered to children entering a system and are generally brief. Assessment instruments provide more types of information (e.g., risks, needs, strengths), may ask more in-depth questions, and may require more training and education to administer properly (Administrative Office of the Courts, 2011; Conradi et al., 2012). Psychological evaluations are much more comprehensive, are completed by a licensed psychologist, and may include trauma measures among tools that look for other mental health issues. Legal advocates and judges may also encounter other mental health assessments beyond those that are trauma focused, such as the Massachusetts Youth Screening Instrument Version 2 (MAYSI-2) (Grisso & Barnum, 2006) or the Child and Adolescent Needs and Strengths Assessment (Lyons, 1999). Although trauma is not their primary focus, these measures may capture some symptoms or issues related to traumatic stress and/or caused by exposure to violence, such as hypervigilance, sleep disturbances, depression, or anxiety.

Selected Screening and Assessment Instruments

- *Child and Adolescent Needs and Strengths Assessment*—http://www.praedfoundation.org/CANS-MH%20Form.pdf.
- *Child Welfare Trauma Referral Tool*—http://www.nctsnet.org/sites/default/files/assets/pdfs/cwt3_sho_referral.pdf.
- *Massachusetts Youth Screening Instrument Version 2*—http://vinst.umdnj.edu/VAID/TestReport.asp?Code=MAYSI
- *Traumatic Events Screening Inventory for Children*—http://www.ptsd.va.gov/PTSD/professional/pages/assessments/assessment-pdf/TESI-C.pdf
- *Trauma Symptom Checklist for Children*—http://www.johnbriere.com/tscc.htm
- *Trauma Symptom Checklist for Young Children*—http://www.johnbriere.com/tscyc.htm
- *University of California at Los Angeles Post-Traumatic Stress Disorder Reaction Index*—http://www.ptsd.va.gov/professional/pages/assessments/ucla-ptsd-dsm-iv.asp

Information on other screening and assessment tools is available from NCTSN at http://nctsnet.org/resources/online-research/measures-review and from the California Evidence-Based Clearinghouse for Child Welfare at http://www.cebc4cw.org/assessment-tools/.

Screenings and assessments that are evidence-based have been tested and shown to be reliable (have consistent outcomes over numerous and varied administrations) and valid (accurate at measuring what they are intended to evaluate). Many tools have been designed for and/or tested with children in different settings (e.g., schools, detention facilities) and of different ages, ethnicities, and social backgrounds. Before making decisions affecting youth based on screening results, judges and legal advocates may wish to ask questions of the caseworker or mental health professional to determine the appropriateness of the tool used.

Evidence-based instruments used with children and youth in the child welfare and juvenile justice systems across the country include:

- The *University of California at Los Angeles Post-Traumatic Stress Disorder Reaction Index* (UCLA PTSD Index) (Steinberg, Brymer, Decker, & Pynoos, 2004) determines whether individuals have experienced events that could cause trauma and whether their reactions to those events meet diagnostic criteria for PTSD.
- The *Traumatic Events Screening Inventory for Children* (TESI-C) (Ford & Rogers, 1997) asks about potentially traumatic events a child may have experienced or witnessed and gauges the child's emotional reactions to those events.
- The *Trauma Symptom Checklist for Children* (TSCC) and related *Trauma Symptom Checklist for Young Children* (TSCYC) (Briere, 1996, 2005) measure distress and related symptoms (e.g., anxiety, anger, depression) and may be used in tandem with other measures that ask about past *experiences* but not current *symptoms*.

Child welfare caseworkers in some jurisdictions also use the *Child Welfare Trauma Referral Tool* (CWTRT) (Taylor, Steinberg, & Wilson, 2006), an instrument that helps them integrate information from a child's case file and key informant interviews and uses a flowchart to make appropriate referrals for further assessment and services. Reliability and validity for the CWTRT, which was developed by the National Child Traumatic Stress Network (NCTSN), have not yet been established, but this measure is currently the only national screening instrument developed specifically for child welfare professionals. A resource for attorneys, GALs, and CASA volunteers is currently being developed by the Safe Start Center, the ABA Center on Children and the Law, and Child & Family Policy Associates and will be available at http://www.safestartcenter.org and http://www.americanbar.org/child when completed.

State and Local Initiatives

Several court jurisdictions and child welfare/juvenile justice programs are focusing on trauma using evidence-supported and promising practices for screening, assessment, and treatment. In most cases, the assessments and interventions discussed are used in the delinquency system only after a young person has been adjudicated. When screening or working with youth who have not yet been adjudicated, advocates and judges should ensure that information obtained is used and shared appropriately (e.g., to help understand a young person's actions in context rather than to incriminate a young person) and that youth are never found to be delinquent because of their service needs.[6]

Ohio's Stark County juvenile court takes a comprehensive approach to addressing trauma in juvenile justice cases. Led by Judge Howard, court, child-serving, and mental health personnel in Stark County have brought in national experts to educate professionals about child trauma, formed a task force on the issue, conducted screenings of youth in juvenile court for trauma, and educated parents and youth about the impact of trauma. Although court officials initially used the UCLA PTSD Reaction Index, they currently use a screening instrument developed by Dartmouth College that includes additional information, such as a depression scale and a substance abuse screen. The instrument uses a combination of interviews and self-reports; officials find that this method identifies a greater number of children who are struggling with traumatic stress. Youth who are identified as needing intervention receive trauma-focused cognitive-behavioral therapy (TF-CBT).

In *New York, the Chautauqua County Family Court* (with support from the New York State Child Welfare Court Improvement Project) is leading a 2-year project called "Integrating Trauma-Informed, Solution-Focused Strategies in Family Court." The work has included surveying youth and parents, guiding attorneys on interviewing clients using trauma-informed strategies, frontloading and expediting dispositions, and inviting youth ages 10 and older to participate in a court

[6] For more guidance, see Rosado & Shah, 2007.

orientation before they attend their first permanency hearing. The trainings are multidisciplinary and include social services caseworkers and their attorneys, attorneys for children, assigned counsel, public defenders, CASA volunteers, judicial and non-judicial court staff, and foster care contract agencies. The project does not use screening tools but assumes that all families entering the system have experienced trauma and should benefit from trauma-informed practice.

Through the *New Hampshire Bridge Project of the Dartmouth Trauma Interventions Research Center,* youth in four juvenile court pilot sites are screened for trauma exposure, PTSD, depression, substance use, and resiliency using a Web-based Stress and Resources Survey. Screening results are available immediately, and youth with identified needs are referred for evidence-based treatment. The project also offers training and supervision in TF-CBT and child–parent psychotherapy for care providers in community mental health centers, residential treatment facilities, and other treatment agencies that work with youth involved in the juvenile justice system and in the community.

North Carolina's Center for Child & Family Health includes legal, medical, mental health, and abuse prevention professionals who provide statewide and national training as well as evidence-based, trauma-focused assessment and treatment services to children and families. Given the Center's focus on trauma, many of the children served are involved with the child welfare, family court, or juvenile justice systems, and clinicians are often subpoenaed to testify. The Center's Legal Director provides in-house training on expert testimony related to trauma and on ways clinicians can support children and adolescents who are preparing to testify.

The *Trauma and Grief Component Therapy Learning Collaborative* provides sites in Delaware, Florida, North Carolina, Ohio, and Tennessee with training on trauma-informed assessment and implementation of the juvenile justice-adapted version of Trauma and Grief Component Therapy for Adolescents (TGCT-A). Staff members at participating sites are trained using NCTSN's Juvenile Justice Trauma Toolkit to help them become "trauma-informed and able to distinguish post-traumatic reactions from antisocial behaviors among the youth they serve and [capable of tailoring] their management and disciplinary strategies accordingly" (Olafson, 2012).

Through a collaboration between the *University of Connecticut Health Center* and the *Connecticut Court Support Services Division*, all youth entering State-run juvenile detention facilities, as well as more than 20 community-based programs, are screened for trauma history using the TESI-C Self-Report and the MAYSI-2 Trauma Experiences Scale; children with identified needs receive an evidence-supported intervention, usually Trauma Affect Regulation: Guide for Education and Therapy (TARGET).

Southwest Michigan Children's Trauma Assessment Center offers comprehensive trauma assessments for children in the child welfare and juvenile justice systems. The assessments include neurodevelopmental screening as well as measures from other disciplines, such as medicine, social work, occupational therapy, and speech and language pathology. The Center also provides training to juvenile justice and child welfare system professionals on the impact of exposure to trauma on brain development to help them view court-involved youth through a neurodevelopmental lens. It also trains mental health professionals to provide neurodevelopmentally informed assessments and TF-CBT.

Core Components of Trauma-Informed Care

Although the needs of children exposed to violence may vary considerably, the systems of care in which they are likely to present (child welfare, criminal justice, public health, behavioral health) can be better prepared to recognize their needs and help accordingly. A system of care that is responsive to trauma-related needs should consider the following core principles:

- At any age, trauma is a central life event with a complex course that can profoundly shape a person's sense of self and others.
- The symptoms, complaints, and behaviors of a young person who has been exposed to violence may be coping mechanisms that are not effective anymore.
- Interventions require the use of relational—rather than confrontational—approaches to behavior change.
- Services should be culturally responsive to the immediate mental health issues presented.

Adapted from Hodas, 2006.

Considerations Related to Developing a Trauma-Informed Legal Practice

Some of the significant challenges lawyers, and the court systems they work in, should consider in their efforts to become more trauma-informed include the following:

Avoiding self-incrimination/protecting others. Children and parents involved in the dependency and delinquency systems may choose not to share information with advocates, court personnel, and mental health professionals to protect themselves or others. Similarly, attorneys and other advocates may choose not to ask about past experiences or request screenings or assessments for fear of uncovering information that could be used against their client. To the extent possible, youth should be encouraged to form relationships and share information with professionals with whom there is a privileged or otherwise legally protected relationship. When mental health assessments and services have been administered, attorneys should obtain necessary consents, releases, and waivers so that they can be aware of the results. Advocates can also give copies of trauma-focused guides or handouts geared toward children or parents to all clients rather than single out particular youth (see http://www.nctsn.org for some examples). Attorneys and other advocates should be familiar with their State's ethical rules and relevant organizational policies. These rules (along with relevant Federal and State health privacy laws) may restrict the information that can be obtained from others in the child's life or may limit what information about the child can be shared with other professionals. Individuals should also be familiar with their State's mandatory reporting statute: although children's attorneys and CASA volunteers are not mandated reporters in the vast majority of States, others involved with the child welfare or juvenile justice systems, such as mental health professionals, may be.

Lack of resources. Many jurisdictions lack adequate resources and appropriate services to help youth affected by violence. Child welfare or juvenile justice attorneys may wish to connect their clients to other legal providers (e.g., a legal aid benefits attorney to address Medicaid eligibility) who can help overcome barriers. Evidence-based mental health services may be difficult to access because of their limited availability and cost, as well as their responsiveness to the full panoply of complex needs presented by youth exposed to violence. Agencies may wish to give priority to children suffering from traumatic stress when scheduling assessment and intervention services. Advocates in many States may be unaware of federally and locally funded trauma centers (a partial list is at http://www.nctsn.org/about-us/network-members). In addition, many free resources for different types of professionals working with trauma-affected youth are available from the Safe Start Center (http://www.safestartcenter.org) and NCTSN (http://www.nctsn.org).

Building relationships/accessing services for special populations. Professionals may struggle to engage youth in services and to establish trusting relationships with others working with these youth. Youth mistrust is often compounded by fears that a connection to a service provider or with law enforcement may compromise their independence. Many services are also time limited, making it difficult for professionals to spend the time needed for clients to open up and begin to address their trauma histories. For example, both domestic violence and runaway and homeless youth programs—where services may be provided to youth who have been exposed to violence—may only provide for short stays. Youth who were born outside the country, speak a different language, or come from a different cultural background may face additional difficulties in accessing services.

Policy Reforms to Promote Trauma-informed Legal Practice

There are many actions legal advocates and judicial officers can take to advance policy and legislative changes that support trauma-informed practice. This work often begins by forming workgroups of key stakeholders or establishing partnerships with entities that advocate for children at the local or State levels. Establishing these relationships will help educate system players on trauma-informed practices and obtain necessary buy-in to implement change. Courts, public defender offices, children's law offices, and CASA programs should:

- Offer classes or host events that raise awareness through presentations by mental health professionals who specialize in trauma-informed care and other experts.
- Urge juvenile justice and child welfare agencies to institute policies that require agency-contracted group homes and detention facilities to provide mandatory staff training on trauma and exposure to violence.

Evidence-supported and Promising Interventions

The following approaches developed for children and youth exposed to violence use individual or group therapy to address skill development, affect regulation, interpersonal connections, and competence and resiliency building. The U.S. Department of Justice's Office of Justice Programs (OJP) offers reviews of most of these interventions at http://www.crimesolutions.gov. According to OJP, effective programs "have strong evidence to indicate they achieve their intended outcomes when implemented with fidelity" and promising programs "have some evidence to indicate they achieve their intended outcomes." More information about these ratings is at http://www.crimesolutions.gov/about_starttofinish.aspx.

Child–Parent Psychotherapy (CPP) is a dyadic intervention that helps children (infants through children age 5) and their parents or caregivers create a more secure relationship and allows children to form healthful attachments and achieve better cognitive, behavioral, and social abilities. It is intended for children who have been victims of maltreatment, witnessed family violence, or have had other traumatic experiences. Treatment includes teaching parents/caregivers how exposure to violence affects children and (for older children) working directly with children through play and other interactions. As of 2010, five randomized trials of CPP had been conducted, and CPP had been used in 143 sites across the country. CPP has been found to favorably affect child and maternal PTSD symptoms, child behavior, and attachment security. OJP rates CPP a "promising" program. More information about CPP is at the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices (NREPP) (http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=194).

Trauma Affect Regulation: Guide For Education and Therapy (TARGET) teaches individuals impacted by trauma "a practical 7-step sequence of skills for processing and managing trauma-related reactions to current stressful experiences" (Ford & Hawke, 2012). Originally developed for use with adults, it has been shown to decrease the severity of PTSD, anxiety, and depression symptoms, as well as improve emotional regulation and health-related functioning in adults. TARGET has been adapted for use in juvenile detention facilities, and youth involved in a TARGET pilot test in Connecticut were found to have fewer disciplinary incidents and punitive sanctions than were youth in the same facilities before TARGET was implemented (Ford & Hawke, 2012). In a randomized clinical trial, TARGET was delivered as an individual therapy with girls involved in delinquency and was shown to reduce PTSD (intrusive re-experiencing and avoidance) and anxiety symptoms. Pilot testing in Ohio showed that TARGET delivered as a group therapy and organizational intervention reduced depression, anxiety, and PTSD; increased self-efficacy and satisfaction with services; and reduced threatening behavior and use of seclusion among youth receiving the intervention in specialized residential mental health juvenile justice facilities (Marrow, 2012). OJP rates TARGET an "effective" program.

Trauma-Focused Cognitive-Behavior Therapy (TF-CBT) has been used to reduce traumatic stress symptoms and emotional/behavioral issues caused by trauma in children who have experienced child maltreatment or witnessed family violence, among others. It was initially developed for child victims of sexual abuse. Children and parents/guardians receiving TF-CBT normally work individually and then in joint sessions with a trained therapist (although in some cases TF-CBT may be a group therapy). The therapy is appropriate for children and youth between ages 3 and 17. As of 2008, more than 60,000 mental health professionals had received training on TF-CBT. Experimental research has shown that TF-CBT helps with children's behavior, feelings of shame, depression, and traumatic stress symptoms. OJP rates TF-CBT an "effective" program. The official Web site for TF-CBT is http://tfcbt.musc.edu/. Additional information is available at NREPP (http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=135).

Cognitive Behavioral Intervention for Trauma in Schools (CBITS) aims to increase coping skills and decrease PTSD and depression symptoms, as well as behavioral problems, in students from grades three through high school (most often in grades six through nine). It is also designed to improve relationships with peers and parents. Its target audience is children who have been exposed to violence in their schools, communities, or homes. CBITS uses CBT techniques, such as social problem solving and relaxation methods, and exposes students to trauma reminders and education about trauma symptoms. It is administered in school settings and includes education sessions for teachers and parents as well as individual and group sessions for children. Studies have shown that CBITS improves PTSD and depression symptoms and child functioning. OJP rates CBITS an "effective" program. The official Web site for CBITS is http://cbitsprogram.org/. Additional information is available from NCTSN (http://www.nctsnet.org/nctsn_assets/pdfs/CBITSfactsheet.pdf) and at NREPP (http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=153).

Several other forms of CBT are available, including *Alternatives for Families: A Cognitive-Behavioral Therapy (AF-CBT)* (also known as *Abuse Focused CBT*) for families addressing physical abuse. OJP rates AF-CBT a "promising" program. More information is available at the Child Welfare Information Gateway (http://www.childwelfare.gov/pubs/cognitive/index.cfm) and at the California Evidence-Based Clearinghouse for Child Welfare (http://www.cebc4cw.org/program/alternatives-for-families-a-cognitive-behavioral-therapy/).

Parent–Child Interaction Therapy (PCIT) is an intervention for children who have conduct disorders and were exposed to substances before birth or experienced physical abuse. In this intervention, parents learn skills related to child- and parent-directed interaction and then practice these skills while receiving feedback from a therapist. PCIT focuses on improving family relationships and changing the way parents and children interact. Thousands of families have received PCIT, and numerous experimental trials have shown it to be effective. Research has shown improvements in parent–child interaction, child behavior, and parental distress, as well as decreases in physical abuse. PCIT has been evaluated for children up to age 12, although it was developed for children between ages 2 to 7. OJP rates PCIT an "effective" program. The official Web site for PCIT is http://www.pcit.org/. Additional information is at NREPP (http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=23).

Trauma and Grief Component Therapy for Adolescents (TGC T-A) is an assessment-driven, modularized treatment specifically designed for adolescents exposed to trauma and traumatic loss who are at high risk for severe persistent distress, functional impairment, and developmental disruption. Primary aims of TGCT-A include increasing adolescent insight into the ways trauma and loss reminders continue to affect young people's behavior, strengthening emotion self-regulation and other coping skills, enhancing social support and social connectedness, working through traumatic experiences, adjusting to deaths and other losses, and promoting adaptive developmental progression. TGCT-A's modularized design, engaging activities, and broad array of evidence-supported treatment components allow it to be flexibly tailored depending on adolescents' specific needs, strengths, and circumstances and implemented in group treatment, individual treatment, or classroom-based modalities. Versions of TGCT-A have been extensively field tested in a wide range of high-risk field settings, including juvenile justice, earthquake and war zones, inner-city schools exposed to severe community violence, and post-September 11 New York City. Program evaluations have shown significant and persistent symptom improvement in post-traumatic stress, traumatic grief, and depressive reactions, as well as in school behavior (Olafson, 2012). OJP has not yet rated TGCT-A.

Numerous other interventions exist that may be appropriate for children and youth dealing with trauma. OJP (http://www.crimesolutions.gov) and the California Evidence-Based Clearinghouse for Child Welfare (http://www.cebc4cw.org/topic/trauma-treatment-for-children/) have reviewed many of them. The Agency for Healthcare Research and Quality is conducting a review of interventions for children exposed to trauma (http://effectivehealthcare.ahrq.gov/ehc/products/385/1017/PTSD-in-Children_Protocol_20120326.pdf).

- Advocate for local and State governments to fund programs that use evidence-supported techniques to identify and address trauma and exposure to violence among court-involved children and youth.
- Promote court policies or rules that protect victims' rights during court proceedings and alternative dispute resolution sessions (e.g., developing protocols for children to testify in-camera under certain circumstances; letting victims attend mediation separately from alleged abusers).
- Support court policies or rules that limit or prevent a young person from entering the status offense or juvenile justice system because of neglect or abuse (e.g., preventing a runaway youth from being petitioned as a status offender because he is fleeing an abusive home).
- Adapt child welfare case intake forms to include questions about past victimization, screenings, assessments, and treatment for youth exposed to violence.
- Ensure that information related to trauma is never used as a basis for finding a youth to be delinquent.

Resources

Buffington, K., Dierkhising, C. B., & Marsh, S. C. (2010). *Ten things every juvenile court judge should know about trauma and delinquency.* Reno, NV: National Council of Juvenile and Family Court Judges.

Hennessey, M., Ford, J. D., Mahoney, K., Ko, S. J., & Siegfried, C. B. (2004). *Trauma among girls in the juvenile justice system.* Los Angeles, CA, & Durham, NC: National Child Traumatic Stress Network. Retrieved July 2, 2012, from http://www.nctsnet.org/nctsn_assets/pdfs/edu_materials/trauma_among_girls_in_jjsys.pdf

Howard, J. M. L., & Tener, R. R. (2008). Children who have been traumatized: One court's response. *Juvenile and Family Court Journal, 59,* 21–34.

Ko, S., & Sprague, C. (2007). *Creating trauma-informed child-serving systems.* Los Angeles, CA, & Durham, NC: National Child Traumatic Stress Network. Retrieved July 2, 2012, from http://www.nctsn.org/sites/default/files/assets/pdfs/Service_Systems_Brief_v1_v1.pdf

National Child Traumatic Stress Network, Child Welfare Committee. (2008). *Child welfare trauma training toolkit.* Los Angeles, CA, & Durham, NC: National Child Traumatic Stress Network. Retrieved July 2, 2012, from http://www.nctsn.org/products/child-welfare-trauma-training-toolkit-2008

National Child Traumatic Stress Network, Child Welfare Committee. (2011). *Birth parents with trauma histories and the child welfare system: A guide for judges and attorneys.* Los Angeles, CA, & Durham, NC: National Center for Child Traumatic Stress. Retrieved July 2, 2012, from http://nctsn.org/sites/default/files/assets/pdfs/birth_parents_trauma_guide_judges_final.pdf

National Child Traumatic Stress Network, Child Welfare Committee & National Children's Alliance. (2008). *CAC directors' guide to mental health services for abused children.* Los Angeles, CA, & Durham, NC: National Center for Child Traumatic Stress. Retrieved July 2, 2012, from http://www.nctsnet.org/sites/default/files/assets/pdfs/CAC_Directors_Guide_Final.pdf

National Child Traumatic Stress Network, Justice System Consortium. (2009). *Helping traumatized children: Tips for judges.* Los Angeles, CA, & Durham, NC: National Center for Child Traumatic Stress. Retrieved July 2, 2012, from http://nctsnet.org/sites/default/files/assets/pdfs/JudgesFactSheet.pdf

Mandatory Reporting

Many children experiencing crises or violence are also at risk for child abuse and neglect. All States have child welfare systems that receive and respond to reports of child abuse and neglect, offer services to families, provide foster homes for children who must be removed from their parents' care, and work to find permanent placements for children who cannot safely return home.

Domestic violence is not the legal equivalent of child abuse and neglect, and therefore not all cases of domestic violence must be reported to child protective services. When responding to families affected by domestic violence, it is critically important for practitioners to consider simultaneously the safety of the child and the safety of any adult victim.

State-by-State information on reporting requirements can be found at http://www.childwelfare.gov/systemwide/laws_policies/state.

National Child Traumatic Stress Network, Juvenile Justice Treatment Subcommittee. (in preparation). *Think trauma: A training for staff in juvenile justice residential settings.* Will be available from http://www.nctsnet.org/resources/topics/juvenile-justice-system

National Council of Juvenile and Family Court Judges. (2006). *Judicial checklist for children and youth exposed to violence.* Reno, NV: Author. Retrieved July 2, 2012, from http://www.safestartcenter.org/pdf/childandyouth_checklist.pdf

Osofsky, J. D., Putnam, F. W., & Lederman, C. S. (2008). How to maintain emotional health when working with trauma. *Juvenile and Family Court Journal, 59*(4), 91–102.

Sprague, C. (2008). Judges and child trauma: Findings from the National Child Traumatic Stress Network/National Council of Juvenile and Family Court Judges focus groups. *Service Systems Brief, 2*(2). Retrieved July 2, 2012, from http://nctsnet.org/sites/default/files/assets/pdfs/judicialbrief.pdf

References

Adams, E. J. (2010). *Healing invisible wounds: Why investing in trauma-informed care for children makes sense.* Washington, DC: Justice Policy Institute. Retrieved July 2, 2012, from http://www.justicepolicy.org/images/upload/10-07_REP_HealingInvisibleWounds_JJ-PS.pdf

Administrative Office of the Courts, Center for Families, Children & the Court. (2011). *Screenings and assessments used in the juvenile justice system: Evaluating risks and needs of youth in the juvenile justice system.* San Francisco: Judicial Council of California. Retrieved July 2, 2012, from http://www.courts.ca.gov/documents/AOCBrief_AssessOnline.pdf

Agency for Healthcare Research and Quality. (2012). *Interventions addressing children exposed to trauma: Part 2—Trauma other than child maltreatment and family violence.* Rockville, MD: Author. Retrieved July 2, 2012, from http://effectivehealthcare.ahrq.gov/ehc/products/385/1017/PTSD-in-Children_Protocol_20120326.pdf.

American Psychiatric Association. (2005). *Diagnostic and statistical manual of mental disorders* (4th edition, text revision). Washington, DC: Author.

Briere, J. (1996). *Trauma Symptom Checklist for Children.* Odessa, FL: Psychological Assessment Resources, Inc. Retrieved July 2, 2012, from http://www.johnbriere.com/tscc.htm

Briere, J. (2005). *Trauma Symptom Checklist for Young Children.* Odessa, FL: Psychological Assessment Resources, Inc. Retrieved July 2, 2012, from http://www.johnbriere.com/tscyc.htm

Clawson, H. J., Salomon, A., & Grace, L. G. (2008). *Treating the hidden wounds: Trauma treatment and mental health recovery for victims of human trafficking.* Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Retrieved July 2, 2012, from http://aspe.hhs.gov/hsp/07/humantrafficking/Treating/ib.htm

Conradi, L., Kisiel, C., & Wherry, J. (2012). Linking child welfare and mental health using trauma-informed screening and assessment practices. *Child Welfare, 90*(6), 129–147.

Feeny, N. C., Treadwell, K. R. H., Foa, E. B., & March, J. (2004) Posttraumatic stress disorder in youth: A critical review of the cognitive and behavioral treatment outcome literature. *Professional Psychology: Research and Practice, 35*(5), 466–476.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine, 14*(4), 245–258.

Finkelhor, D., Ormrod, R., & Turner, H. (2007). Polyvictimization: A neglected component in child victimization. *Child Abuse & Neglect, 31,* 7–26

Finkelhor, D., Turner, H., Hamby, S., & Ormrod, R. (2011). *Polyvictimization: Children's exposure to multiple types of violence, crime, and abuse* (NCJ 235504). Washington, DC: U.S. Government Printing Office. Retrieved July 2, 2012, http://www.unh.edu/ccrc/pdf/jvq/Polyvictimization%20OJJDP%20bulletin.pdf

Ford, J. D., Hartman, J. K., Hawke, J., & Chapman, J. F. (2008). Traumatic victimization, posttraumatic stress disorder, suicidal ideation, and substance abuse risk among juvenile justice-involved youth. *Journal of Child & Adolescent Trauma, 1*(1), 75–92.

Ford, J. D., & Hawke, J. (2012). Trauma affect regulation psychoeducation group attendance is associated with reduced disciplinary incidents and punitive sanctions in juvenile detention facilities. *Journal of Aggression, Maltreatment & Trauma, 21*(4), 365–384.

Ford, J. D., & Rogers, K. (1997). *Traumatic Events Screening Inventory for Children.* Retrieved July 2, 2012, from http://www.ptsd.va.gov/PTSD/professional/pages/assessments/assessment-pdf/TESI-C.pdf

Ford, J. D., Steinberg, K., Hawke, J., Levine, J., & Zhang, W. (2012). Randomized trial comparison of emotion regulation and relational psychotherapies for PTSD with girls involved in delinquency. *Journal of Clinical Child and Adolescent Psychology, 41,* 27–37.

Grisso, T., & Barnum, R. (2006). *Massachusetts Youth Screening Instrument Version 2 (MAYSI-2).* Retrieved July 2, 2012, from http://vinst.umdnj.edu/VAID/TestReport.asp?Code=MAYSI

Hodas, G. D. (2006). *Responding to childhood trauma: The promise and practice of trauma-informed care.* Harrisburg, PA: Pennsylvania Office of Mental Health and Substance Abuse Services.

Holman, B., & Ziedenberg, J. (2006). *The dangers of detention: The impact of incarcerating youth in detention and other secure facilities.* Washington, DC: Justice Policy Institute. Retrieved July 2, 2012, from http://www.justicepolicy.org/images/upload/06-11_REP_DangersOfDetention_JJ.pdf

Kolko, D. J., Hurlburt, M. S., Zhang, J., Barth, R. P., Leslie, L. K., & Burns, B. J. (2010). Posttraumatic stress symptoms in children and adolescents referred for child welfare investigation: A national sample of in-home and out-of-home care. *Child Maltreatment, 15*(1), 48–63.

Lyons, J. S. (1999). *Child and Adolescent Needs and Strengths Assessment.* [Measurement instrument]. Retrieved July 2, 2012, from http://www.praedfoundation.org/CANS-MH%20Form.pdf

Marrow, M. (2012). The value of implementing TARGET within a trauma-informed juvenile justice setting. *Journal of Child and Adolescent Trauma*, 5, 3, 257-270.

National Council on Crime and Delinquency, Center for Girls and Young Women. (n.d.). *Understanding trauma through a gender lens.* Jacksonville, FL: Author. Retrieved July 2, 2012, from http://www.nccdglobal.org/sites/default/files/publication_pdf/understanding-trauma.pdf

Office for Victims of Crime. (1998). New directions from the field: Victims' rights and services for the 21st century, mental health community (NCJ No. 172819). Washington, DC: Author.

Olafson, E. (2012). *Trauma and Grief Component Therapy for Adolescents 101.* [Unpublished document written for clinical staff involved with the TGCT-A learning collaborative, based on the work of TGCT-A authors C. W. Saltzman, & R. Pynoos].

Pfefferbaum, B. (1997). Posttraumatic stress disorder in children: A review of the past 10 years. *Journal of the American Academy of Child & Adolescent Psychiatry, 36*(11), 1503–1511.

Rosado, L. M., & Shah, R. S. (2007). *Protecting youth from self-incrimination when undergoing screening, assessment and treatment within the juvenile justice system.* Philadelphia: Juvenile Law Center. Retrieved July 2, 2012, from http://www.jlc.org/sites/default/files/publication_pdfs/protectingyouth.pdf

Siegfried, C. B., Ko, S. J., & Kelly, A. (2004). *Victimization and juvenile offending.* Los Angeles, CA, & Durham, NC: National Child Traumatic Stress Network, Juvenile Justice Working Group. Retrieved July 2, 2012, from http://www.nctsnet.org/sites/default/files/assets/pdfs/victimization_juvenile_offending.pdf

Steinberg, A. M., Brymer, M. J., Decker, K. B., & Pynoos, R. S. (2004). The University of California at Los Angeles Post-Traumatic Stress Disorder Reaction Index. *Current Psychiatry Reports, 6*, 96–100.

Taylor, N., & Siegfried, C. B. (2005). *Helping children in the child welfare system heal from trauma: A systems integration approach.* Los Angeles, CA, & Durham, NC: The National Child Traumatic Stress Network.

Taylor, N., Steinberg, A., & Wilson, C. (2006). *The Child Welfare Trauma Referral Tool.* San Diego, CA: Chadwick Center for Children and Families, Rady Children's Hospital. Retrieved July 2, 2012, from http://www.nctsnet.org/sites/default/files/assets/pdfs/cwt3_sho_referral.pdf

Turner, H. A., Vanderminden, J., Finkelhor, D., Hamby, S., & Shattuck, A. (2011). Disability and victimization in a national sample of children and youth. *Child Maltreatment, 16,* 275–286.

Moving From Evidence to Action
The Safe Start Center Series on Children Exposed to Violence

Core Concepts

Exposure to violence. The Issue Briefs in this series use the definition of exposure to violence of the Safe Start initiative: "direct and indirect exposure to violence in [the] home, school, and community."

Impact of exposure to violence. Children react to exposure to violence in different ways, and many children demonstrate remarkable resilience. However, children's exposure to violence has been associated with difficulties with attachment, regressive behavior, anxiety and depression, aggression and conduct problems, dating violence, delinquency, and involvement with child welfare and juvenile justice systems. In addition there is a strong likelihood that exposure to violence will affect children's capacity for partnering and parenting later in life, continuing the cycle of violence for the next generation.

Risk and protective factors. The impact of a child's exposure to violence is influenced by both risk factors that increase the likelihood of a disruption in the developmental trajectories and protective factors in the environment. These risk and protective factors depend on the child's age and developmental level and the type and intensity of challenges present in his or her environment. The presence of supportive adults and/or nurturing environments provides a powerful buffer to children from the more intense stress or anxiety that may occur when children are exposed to violence.

Effective interventions. Research has documented the effectiveness of the following strategies to address the needs of vulnerable children and families—including children exposed to violence:

- Participation in *high-quality early care and education programs* can enhance physical, cognitive, and social development and promote readiness and capacity to succeed in school.
- *Early identification of and intervention with high-risk children* by early education programs and schools, pediatric and mental health programs, child welfare systems, and court and law enforcement professionals can prevent threats to healthy development by detecting and addressing emerging problems.
- For children and families already exposed to violence, *intensive intervention programs* delivered in the home or in the community can improve outcomes for children well into their adult years and generate benefits to society that far exceed program costs.
- Outcomes improve when highly skilled professionals provide *intensive, trauma-focused psychotherapeutic interventions* to stop the negative chain reaction following exposure to traumatic stressors (e.g., child abuse and neglect, homelessness, severe maternal depression, domestic violence). Treatment is an essential component of successful adjustments to exposure to violence, especially for children who have frequent exposure and who have complicated courses of recovery.

Guiding Principles to Support Best Practices

- ***Safety*** of the non-offending parent and of the children ***must be paramount and addressed concurrently*** in cases involving domestic violence.
- Children ***must be understood in the context*** of their individual traits, families, and communities (***a socio-ecological approach***).
- Responsibility for a child's well-being must be owned by parents, community agencies, and public systems together—***addressing children's exposure to violence is everyone's responsibility***.
- Agencies must ***work together in a coordinated manner*** to expand and enhance service delivery.
- Policies, programs, and services must be ***developmentally appropriate and culturally responsive*** and offered in the family's preferred language.
- Programs and services need to be ***evaluated rigorously*** for effectiveness—efficacy is key. We must continue to ***learn what works***.

Available Issue Briefs in the *WORKING TOGETHER TO HELP CHILDREN EXPOSED TO VIOLENCE SERIES*

Each Issue Brief in the series explains the importance of addressing exposure to violence to ensure the well-being of children from birth to age 18 in all systems that interact with vulnerable children and families. Through the use of literature reviews, case scenarios, and analyses of data, the Issue Briefs translate lessons learned from research and program practices into actions that can effectively prevent and reduce the negative impact of exposure to violence.

The goal of the series is to build the capacity of practitioners in a variety of different fields to offer sensitive, timely, and appropriate interventions that enhance children's safety, promote their resilience, and ensure their well-being.

Issue Brief #1: ***Understanding Children's Exposure to Violence***
Issue Brief #2: ***Pediatric Care Settings***
Issue Brief #3: ***Schools***
Issue Brief #4: ***Child Welfare Systems***
Issue Brief #5: ***Domestic Violence Agencies and Shelters***
Issue Brief #6: ***Homeless Shelters, Permanent/Supportive Housing, and Transitional Housing***
Issue Brief #7: ***Victimization and Trauma Experienced by Children and Youth: Implications for Legal Advocates***

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Safe Start Initiative

The Safe Start initiative is funded by the U.S. Department of Justice's Office of Juvenile Justice and Delinquency Prevention. The goal of the initiative is to increase the knowledge of and promote community investment in evidence-based strategies for preventing and reducing the impact of children's exposure to violence.

Eleven demonstration sites were funded from 2000 to 2006 to create a comprehensive service delivery system to improve the accessibility, delivery, and quality of services for children exposed to violence at any point of entry. A national evaluation broadened understanding of how communities can successfully implement a comprehensive system of care with policy and practice interventions to minimize the negative consequences of exposure to violence. For a description of the evaluation findings, see *Communities Working Together to Help Children Exposed to Violence: Findings from Phase I of the Safe Start Initiative* http://www.safestartcenter.org/pdf/ssc_findings-brief-1108.pdf

Fifteen Promising Approaches sites funded from 2005 to 2010 focused on implementing and measuring developmentally appropriate services for children exposed to violence within the context of the systems that serve them. A national evaluation of these sites conducted by the RAND Corporation analyzed the impact of specific intervention strategies on outcomes for children and families. For a description of findings, see *National Evaluation of Safe Start Promising: Approaches Assessing Program Implementation* http://www.rand.org/pubs/technical_reports/2010/RAND_TR750.pdf.

Eight Safe Start Promising Approaches sites are receiving funding until 2015 and will provide evidence- or theory-based interventions to prevent and reduce the impact of children's exposure to violence in their homes and communities. These interventions address the needs of children and youth who have been exposed to violence and their families through a comprehensive and collaborative approach that uses the current knowledge base to address children's exposure to violence. A cross-site evaluation is being conducted by the RAND Corporation.

The Safe Start Center is a resource center designed to support the Safe Start initiative on a national level and to broaden the scope of knowledge and resources for responding to the needs of children exposed to violence and their families. For more information on the Safe Start initiative and Safe Start Center, visit www.safestartcenter.org.

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