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Incarcerated Youth & Childhood Trauma

Childhood Trauma

Childhood exposure to traumatic events can cause developmental issues and is associated with a variety of behavioral symptoms. The plasticity of the brain, meaning the ability to change and adapt based on exposure to different stimuli, is a crucial aspect of brain development.[1] The areas of the brain responsible for regulating emotion and behavior are especially sensitive to emotional and physical stress.[2]

Brain imaging has revealed that some of the brain structures that regulate emotion and behavior are measurably smaller and have irregular brain activity in abuse survivors.[3] Lower IQs; learning disabilities; and an increased likelihood of developing psychiatric conditions such as depression, substance abuse disorders, and posttraumatic stress disorder can all result from childhood trauma.[4]

Many "behavioral responses to trauma often resemble the common delinquent behaviors seen in youth referred to the justice system and are therefore under-identified as posttraumatic symptoms."[5] For example, recent brain research has indicated that chronic traumatic stress causes youth to develop an oversensitive warning system, which causes the youth to feel threatened and to overreact to misperceived threats. Therefore, the youth is unable to focus on tasks at hand such as schoolwork or long-term planning because they are operating in survival mode.[6] The behavioral symptom of overreacting to misperceived threats may resemble and be mistaken for aggression or hostility.

Trauma and the Juvenile Justice System

Childhood trauma is reported at alarming rates among children in the juvenile justice system. Although trauma is not exclusively a problem of incarcerated youth, the rate is much higher: 34 percent of children in the United States as a whole report having experienced at least one traumatic event compared to between 75 and 93 percent of youth entering the juvenile justice system.[7]

This is particularly problematic because of the risk of ongoing traumatic stress while in a detention facility. Certain practices in detention facilities, such as seclusion and the presence of male security guards, can be retraumatizing.[8]

Most youth who experience trauma are able to recover, but up to 50 percent of youth in the juvenile justice system do not recover and experience chronic, ongoing trauma-related

impairments.[9] The good news is that with adequate screening and treatment in juvenile facilities, recovery is possible. The bad news is that few juvenile justice facilities systematically screen for trauma symptoms,[10] and such symptoms are often misdiagnosed.[11]

There are new trauma screening instruments available that juvenile facilities could and should implement during their intake process to facilitate the diagnosis and treatment of trauma-related disorders.[12] Among these screening instruments are: the Massachusetts Youth Screening Instrument, 2nd Version; the Child and Adolescent Needs and Strengths assessment tool; and the Child and Adolescent Functional Assessment Scale. Each of the instruments is completed in a different way; requires a different amount of training; and has different strengths and focuses, so juvenile facilities have options with regard to how to conduct trauma screening.[13]

Trauma and the Illinois Department of Juvenile Justice

Two-thirds of youth in IDJJ custody have a *diagnosed* psychiatric disorder and require mental health treatment while in custody.[14] Although a recent report indicated that 79 percent of counties in Illinois are served by facilities that screen youth for mental health needs when they enter the facility, this study focused on the adult facilities because seven of the eight juvenile facilities did not respond to the questionnaire, and it is unclear whether any trauma-specific screening takes place.[15]

Moreover, as of July 2010, most staff members in IDJJ facilities had not received training on adolescent development, which is necessary to adequately respond to the mental health needs of youth in IDJJ care.[16] According to Acting Direct Arthur Bishop, IDJJ has recently trained supervisors on the impact and causes of trauma, and plans to eventually train other staff as well.

The effort to train staff is an important first step to enabling the facilities to handle youth with trauma-related disorders. But training alone is insufficient, and it is unclear whether IDJJ plans to implement the use of a trauma-screening instrument so as to effectively diagnose trauma symptoms, or whether treatment or therapy will be available for youth suffering from trauma-related disorders. Screening and treatment are imperative.

Beginning in 2000 as part of the Mental Health and Juvenile Justice Initiative, IDHS began contracting with mental health providers to monitor detained youth who were identified as having a mental health problem. Early results have indicated a lower recidivism rate among youth who have received mental health treatment—27 percent of participants were rearrested compared to a 72 percent recidivism rate among non-participants[17]—but eligibility requirements have limited the impact this program has had,[18] and IDHS should consider expanding the program to include youth who are suffering from a trauma-related disorder.

Moreover, one study has shown that taking the further step of diverting children with PTSD to mental health treatment instead of juvenile facilities would increase the chance

of recovery and lower recidivism.[19] IDJJ should consider investing in diversion programs for children suffering from trauma-related disorders.

Conclusions

Although IDJJ has started to recognize the significance of childhood trauma and train its supervisors, further action is necessary. IDJJ should implement a screening instrument to help diagnose trauma-related disorders, provide trauma therapy and treatment for incarcerated youth, and divert some youth with trauma-related disorders to treatment programs altogether.

This report was written by Angela Weis, Counsel & Policy Analyst for the John Howard Association.

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[1] Griffin, G. & Studzinski, A. (2010). Child Trauma as a Lens for the Public Sector to Consider When Viewing Its Youth. *Illinois Childhood Trauma Coalition*, 2.
[2] Adams, E. J., (2010). Healing Invisible Wounds: Why Investing in Trauma-Informed Care for Children Makes Sense. *Justice Policy Institute*, 2.
[3] *Id.*
[4] *Id.*
[5] *Id.* at 4.
[6] Griffin, *supra* 1 at 5.
[7] Adams, *supra* 2 at 5.
[8] Ford, J. D., Chapman, J. F., Hawke, J., & Albert, D. (2007). Trauma Among Youth in the Juvenile System: Critical Issues and New Directions. *National Center for Mental Health and Juvenile Justice*, 3.
[9] *Id.* at 2.
[10] *Id.* at 5–6.
[11] Redeploy Illinois Annual Report to the Governor and General Assembly, 17 (2010).
[12] Ford, *supra* 8 at 2.
[13] Bostwick, L. (2010). Mental health screening and assessment in the Illinois juvenile justice system. *Illinois Criminal Justice Information Authority*, 26–36.
[14] Illinois Models for Change Behavioral Health Assessment Team (2010). Report on the Behavioral Health Program for Youth Committed to Illinois Department of Juvenile Justice. *Illinois Models for Change*, 8.
[15] Bostwick, *supra* 13 at 8–9.
[16] *Illinois Models for Change*, *supra* 14 at 11.
[17] Bostwick, *supra 13* at 22–23.
[18] Only youth with a psychotic or affective disorder are eligible for the services. Youth with behavioral disorders are excluded from these services unless they also have a psychotic or affective disorder. Youth with personality disorders, developmental disabilities, or who are wards of the Illinois Department of Children and Family Services are also excluded. *Id.* at 23.
[19] Adams, *supra 2* at 7.