Trauma-informed Care & the WV Juvenile Justice System

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Why all of the talk about trauma?

- We see it all the time in many different settings! How many of you work with adults or adolescents who have experienced trauma or may still be at risk for traumatic experiences?
- Trauma is frequently the underlying cause of many symptoms and/or behavioral issues for the kids we serve.
Child Trauma

- Trauma as defined by the NIMH:
- The experience of an event by a person that is emotionally painful or distressful and which often results in lasting mental and physical effects.
  - Event
  - Experience (as painful or distressful)
  - effect
Why we are here today

- Objectives:
  1. Increase knowledge and understanding of child trauma and how traumatic experiences can impact youth behavior and development.
  2. Inform our participants of an evidenced-based practice available for treating trauma symptoms: Trauma-Focused Cognitive Behavioral Therapy (TF-CBT).
  3. Discuss the prevalence of trauma experiences with our youth in the juvenile justice system and what we are doing to provide treatment services.
Traumatic events include:

- Abuse (physical, emotional, sexual)
- Neglect
- Victimization
- Domestic/community violence
- Accident/illness
- Natural disaster
- War/terrorism
Trauma experiences can:

- Be life threatening
- Be overwhelming
- Be subjective, internal state
- Vary between people
- Vary over time with the same person
- Be a single incident or chronic incidents
Symptoms of trauma effects:

- Nightmares
- Flashbacks
- Fight or flight
- Disassociation
- Cutting/self-harm of any kind
- Hyper-arousal
- Hypervigilance
- Overreaction
- Misinterpretation of cues
Events can be experienced; or in some cases, witnessed; or even learned about later. First responders such as police officers and firefighters, and military personnel are specifically acknowledged as being at risk.

- After experiencing the event, the person must exhibit four types of symptoms:
  - Re-experiencing
  - Avoidance
  - Heightened arousal
  - Ongoing negative thoughts and moods
Discussion

- What types of clients are you seeing who meet the criteria for PTSD or a trauma-related disorder?
- What symptoms are you seeing?
- Treatment: what is working for the client?
- Have you tried Trauma-Focused Cognitive Behavioral Therapy? (TF-CBT)
Trauma and its long-term impact

- The Adverse Childhood Experiences Study (ACES) examined youth who experienced the following:
  - Physical abuse and neglect
  - Emotional abuse and neglect
  - Sexual abuse

- It also examined youth growing up in a household with:
  - An alcohol or drug abuser
  - An incarcerated household member
  - Someone who is chronically depressed, suicidal, institutionalized, or mentally ill
  - Domestic violence
The ACES STUDY

http://acestudy.org/

The ACE Study revealed:

Out of 100 People

<table>
<thead>
<tr>
<th>33% Report No ACEs</th>
<th>51% Report 1-3 ACEs</th>
<th>16% Report 4-10 ACEs</th>
</tr>
</thead>
<tbody>
<tr>
<td>With 0 ACEs</td>
<td>With 3 ACEs</td>
<td>With 7+ ACEs</td>
</tr>
<tr>
<td>1 in 16 smokes</td>
<td>1 in 9 smokes</td>
<td>1 in 6 smokes</td>
</tr>
<tr>
<td>1 in 69 are alcoholic</td>
<td>1 in 9 are alcoholic</td>
<td>1 in 6 are alcoholic</td>
</tr>
<tr>
<td>1 in 480 use IV drugs</td>
<td>1 in 43 use IV drugs</td>
<td>1 in 30 use IV drugs</td>
</tr>
<tr>
<td>1 in 14 has heart disease</td>
<td>1 in 7 has heart disease</td>
<td>1 in 6 has heart disease</td>
</tr>
<tr>
<td>1 in 96 attempts suicide</td>
<td>1 in 10 attempts suicide</td>
<td>1 in 5 attempts suicide</td>
</tr>
</tbody>
</table>
The long-term impact of trauma

- Based on exposure to these adverse experiences, there is an increase of a youth’s risk for the following:
  - Major mental illness
  - Substance abuse
  - AIDS or other sexually transmitted diseases
  - Impaired physical health
  - Risk for intimate partner violence
  - Early death
Long-term impact of trauma, cont.

- In terms of physical health, the ACES found an increased risk of the following:
  - Smoking
  - Obesity
  - Heart disease
  - Cancer
  - Chronic obstructive pulmonary disease
    - (COPD)
The impact of trauma on our kids

- Which 3 year old is going to be ready to start school?
- Which one will act out more in school or at home?
Evidence-based practices

- Why do we use Evidence-Based Practices for treating our clients?
  - We want treatment that works
  - EBPs have been put to the test
    - EBPs include interventions that have been shown to be effective through scientific research.
  - When available and appropriate, the use of an EBP ensures that the intervention, when used as intended, will produce the desired outcomes.

- Evidence-Based Practices for Trauma treatment:
  - Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
  - Cognitive Behavioral Therapy
Trauma-Focused Cognitive Behavioral therapy (TF-CBT)

- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a components-based psychosocial treatment model that incorporates elements of cognitive-behavioral, attachment, humanistic, empowerment, and family therapy models. It includes several core treatment components designed to be provided in a flexible manner to address the unique needs of each child and family.

- Here are some important facts. TF-CBT:
  - works for children who have experienced any trauma, including multiple traumas.
  - is effective with children from diverse backgrounds ranging in ages 3-18 years old.
  - works in as few as 12 treatment sessions.
  - has been used successfully in clinics, schools, homes, residential treatment facilities, and inpatient settings.
  - works even if there is no parent or caregiver to participate in treatment.
  - works for children in foster care.
  - has been used effectively in a variety of languages and countries.
TF-CBT Integrates several approaches

- TF-CBT integrates several treatment approaches including the following:
  - Cognitive Therapy: aims to change behavior by addressing client’s thoughts/perceptions, particularly thinking patterns that created distorted or unhelpful views.
  - Behavioral Therapy: focuses on modifying typical responses (i.e. anger, fear) to identified situations or stimuli.
  - Family Therapy: examines patterns of interactions among family members to identify and assist in alleviating problems.
What does the research say about TF-CBT?

- Effectiveness outcome studies for TF-CBT include at least 11 studies conducted evaluating the impact of TF-CBT on children who have been victims of sexual abuse or other traumas. There have also been studies to show specific effectiveness of TF-CBT for children exposed to domestic violence.

- Findings consistently demonstrate TF-CBT is useful in reducing symptoms of PTSD and symptoms of depression and behavioral issues.
The specific components of TF-CBT are summarized by the acronym **PRACTICE**: 

- **Psycho-education** is provided to children and their caregivers about the impact of trauma and common childhood reactions 
  - Normalizing the child’s and parent’s reactions to severe stress 
  - Instill hope for child and family recovery 
  - Help the child and family understand more about their particular traumatic experiences 
  - Provide general information about the traumatic event (who experiences it, frequency, causes, etc.)
The process for TF-CBT

- **Parenting Skills**- assisting caregivers with...
  - Teaching children good vs. bad touch, sexual safety, and supporting the child’s recovery.
  - Understanding the connections between the child’s behaviors and the impact of the trauma.
  - Using trauma-informed and effective discipline techniques.
  - Developing appropriate coping skills related to the experiences of trauma.
  - Establishing the parent as a support system and reliable person for the child to turn to.
The process for TF-CBT

- **Relaxation** and stress management skills are individualized for each child and parent.
  - Identifying and managing stress triggers.
  - Explain body responses to stress
  - Developing a plan of relaxation that addresses the child’s needs related to their triggers and traumatic reminders.

Techniques:
- Cat stretch
- Mindfulness
- Progress Muscle Relaxation (PMR)
- Deep breathing (belly breathing)
- Enjoyable activities such as coloring, doodling, painting, ways or activities the family likes to relax
The process for TF-CBT

- **Affective expression** and modulation are taught to help children and parents identify and cope with a range of emotions.
  - Enhancing awareness of their emotions
  - Expanding vocabulary of emotions
  - Expressing/managing emotions in healthy ways

**Strategies/Tools:**
- Feelings identification games
- Board games
- Emotions charades
- Color my life or person (somatic)
The process for TF-CBT

– **Gradual Exposure:**
  Explore what the client’s feelings were during, after the trauma and now as they reflect on reminders or experiences of the trauma.
  - Card game exercise
THE PROCESS FOR TF-CBT

- **Cognitive coping** and processing are enhanced by illustrating the relationships among thoughts, feelings and behaviors. This helps children and parents modify inaccurate or unhelpful thoughts about the trauma.
The process for TF-CBT

- **Trauma narrative**, in which children describe their personal traumatic experiences, is an important component of the treatment.
Trauma Narrative

The narrative can be in the form of the following:

- A story written, drawn or recited to include:
  - Chapter 1: About You
  - Chapter 2: Life before the bad thing(s) happened to you
  - Chapter 3: The bad thing(s) that happened to you in detail
  - Chapter 4: What your life is like now
  - Chapter 5: Your hopes & dreams for the future

- Cartoon or comic strip
- A play or movie script
- GET CREATIVE!
THE PROCCESS FOR TF-CBT

- *In vivo desensitization of trauma reminders is used to help children overcome* their avoidance of situations that are no longer dangerous, but which remind them of the original trauma.

  - Address avoidance behaviors, gradually modify
  - Gradually help the child get used to the feared situation(s)
  - Identify feared situations
  - Praise and enforce in vivo work
The process for TF-CBT

– Conjoint child-parent sessions help the child and parent talk to each other about the child’s trauma.
Process for TF-CBT

- **Enhancing safety and social skills:**
  - Address current safety needs (emotional/physical).
  - Develop skills for a safer future.
  - Typically done in conjoint parent-child sessions but may also be done individually.
  - Practicing skills outside of therapy.
  - Develop a safety plan which is responsive to the child’s and family’s realistic abilities.
TF-CBT PROCESS AS A WHOLE

- **PRACTICE**:
  - Psycho-education and parenting skills
  - Relaxation
  - Affective modulation
  - Cognitive processing
  - Trauma narrative
  - In vivo desensitization
  - Conjoint parent-child sessions
  - Enhancing safety and social skills
When children experience serious traumas, other family members are affected as well. This is why TF-CBT typically includes parents or caregivers in treatment. TF-CBT is effective in helping parents to:

- Overcome general feelings of depression
- Reduce PTSD symptoms
- Reduce emotional distress about the child's trauma
- Improve parenting practices
- Enhance their ability to support their children

*If the parents are not involved with the child, there are ways to include foster parents, caregivers or guardians and even case workers.
Screening & assessment for TF-CBT

- UCLA PTSD INDEX FOR DSM-IV
  - Child Version, Revision 1
  - Adolescent Version
  - Parent Version, Revision 1

- Life Events Checklist (LEC)
  - If any items on the list reported, administer the Post-traumatic Stress Disorder Checklist (PCL-C)

- Post-traumatic Stress Disorder Checklist (PCL-C)

- Adolescent Dissociative Experiences Scale II
  - 30-item self-report measure for ages 11-18 years of age. The A-DES is scored by summing item scores and dividing by 30 (# of items). The overall score ranges from 0-10. A-DES scores of 4 or greater suggest pathological levels of dissociation, and further evaluation is warranted.
Where to find the screening tools

  - All three versions are available on this website
    - LEC-5, LEC-5 Extended and the Interview.
- [http://www.mirecc.va.gov/docs/visn6/3_PTSD_CheckList_and_Scoring.pdf](http://www.mirecc.va.gov/docs/visn6/3_PTSD_CheckList_and_Scoring.pdf)
- PCL-C checklist available online with a scoring guide
- Adolescent Dissociative Experiences Scale-II (A-DES)
Trauma-informed care in the juvenile justice systems of WV

- Mental health professionals are now providing a Mental Health Training Curriculum for Juvenile Justice in an attempt to increase knowledge and understanding of child trauma, its prevalence among youth involved in the juvenile justice system, and how traumatic experiences can impact youth development, behavior and delinquency.
Trauma in Juvenile Corrections

There are 10 juvenile correctional facilities in West Virginia:

- James H. “Tiger” Morton Juvenile Center
- Donald R. Kuhn Juvenile Center
- Robert L. Shell Juvenile Center
- Lorrie Yeager, Jr. Juvenile Center
- Sam Perdue Juvenile Center (sex offender program)
- Gene Spadaro Juvenile Center
- J.M. “Chick” Buckbee Juvenile Center
- Kenneth “Honey” Rubenstein Center
- Vicki V. Douglas Juvenile Center
- Ronald C. Mulholland Center
Pathways into the juvenile justice system

Juveniles can enter the juvenile justice system from many different avenues such as:

- Probation
- Parent/Guardian
- School
- Hospitals/Inpatient Programs
- DHHR
- Law Enforcement
Court System Flow Chart

Court Referral
(victim, parent, school, law enforcement, probation, other agency)

Petition filed (formal case)

Detention Hearing

Informal Adjustment

Preliminary Hearing

Adjudicatory Hearing

Dismissing

Disposition

Community

Improvement Period

Probation/Specialty Crts.

DHRR Referral

DHRR Custody and Probation

DHRR Custody

State Custody

DJS Custody
Our population

- You have discussed the different pathways into the juvenile justice system, here are some of the places referring juveniles in our community:
  - Inpatient/hospitalization programs
  - Foster care
  - Shelters
  - Out of state programs
  - Schools
  - Families (filing incorrigible)
  - Probation
  - Independent Living Programs
What we have seen

- Juveniles being sent from out of state as “drug runners” for heroin, cocaine, marijuana, etc.
- Additional charges from placements
- Juveniles being bounced from one placement or facility to another
- Assault/battery charges
- Drug-related charges and substance abuse
- Petty crimes with long periods of incarceration in detention
- Serious charges leading to transfers to adult status and sentencing
What we have seen cont.

- Adopted kids entering the juvenile justice system and parental rights being terminated.
- Juveniles being sent out of state.
- Lack of connection and transition for juveniles returning to WV from out of state placements.
- Referrals to juvenile justice from hospitals, programs, shelters, and schools.
Significant changes in our juvenile justice system

– DJS is relatively young when compared to other State Agencies. The State took the juvenile detention centers from DHHR and the two juvenile correctional facilities from DOC to create DJS. The first ten years was focused on infrastructure building.

– National and state trends, research, and recognition of our changing population has brought the focus of DJS to providing appropriate treatment and rehabilitation of our residents while still maintaining safety and security.
Placements for juvenile offenders

- These are some of terms our staff are familiar with regarding placements:
  - Highland Hospital; Riverpark Hospital; BAR-H; Chestnut Ridge Hospital
  - Acute vs. PRTF vs. Mental Hygiene
  - Diagnosis
  - Out of State Placements
  - DHHR placements
  - Juvenile Shelters
Resources for our Juveniles

- WV Dept. of Education (Office of Institutional Education)
- OIEP Transition Specialists
- Big Brothers, Big Sisters of Central WV
  - Youth Workforce Opportunity Initiative
- MODIFY for DJS youth
- Daymark (Patchwork & Turning Point)
- Community Resource Coordinators (CRC Aftercare)
- Inspiring WV
  - (non-profit organization to keep WV students in WV after graduation)
- KISRA projects
  - Second Chance Mentoring Program
Barriers to accessing services

Youth and families face difficulties when trying to access mental health services in our community. In many cases these barriers often lead families down a path through juvenile justice.

Barriers might include:

- Transportation
- Lack of resources
- Insurance
- Long wait periods
- Bed availability
- Access to Information
- Stigma
There is always hope

– Governor Tomblin has signed the juvenile justice reform bill, a $4.5 billion dollar initiative places truancy diversion specialists in all 55 counties of WV to provide early intervention. In addition to other community resources to help our juveniles and their families (i.e. Youth Report Centers, Aftercare Workers, etc.).

– We are providing state-wide Mental Health for Juvenile Justice Training Curriculum for all Division of Juvenile Services (DJS) staff to provide information and training for working with juveniles, specifically those with a history of mental health diagnoses, symptoms and trauma. This training covers everything from the definition of trauma, the DSM-V and successful interventions.
References

– How to Implement Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) The National Child Traumatic Stress Network
  www.NCTSN.org

– https://www.childwelfare.gov/

– Mental Health Training Curriculum for Juvenile Justice
We also have fun in treatment...
Sheldon visits the facility 1-2 times per month for pet recreation “therapy”
THANK YOU!