**Trauma, Psychiatric, Substance Use and Thought Disturbance Among Youth in the Juvenile Justice System and How to Deal with Them**

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***ABSTRACT***

The personal stories that youth in juvenile facilities report to their counselors are heart breaking because they are filled with accounts of excessive trauma resulting from neglect, physical, sexual and emotional violence perpetrated on these children. Perry, B.D. (2006) found that trauma develops from severe neglect, abuse and living in terrorizing environments. It changes the neural processing ability within the child’s developing brain and leads to hyper vigilance and dysfunctional behavior.[[1]](#endnote-1) Widom, C. (2001) found that children who had been abused or neglected as children have 30 percent higher arrests as a juvenile and as an adult for a violent offense.[[2]](#endnote-2)

People working with youth in the juvenile justice field should be aware of the impact that adverse experiences have on the child’s brain development. They should adapt their therapeutic interventions and the facilities in which they are housed. Youth with disorders, particularly trauma disorders, experience their world through a lens of distrust and fear of others because these emotions protect them against further hurt and humiliation. Without this knowledge, it is easy for clinicians, staff and parents to interpret their behaviors as intentional defiance against authority. These youth did not start out their life as predators. They developed antisocial values and behaviors over years of being physically, emotionally and sexually assaulted by others and frequently witnessing violence.

This article is intended to create greater awareness of the trauma, psychiatric, and substance abuse disorders experienced by so many youth within the juvenile justice system. It describes the psychological impact of some types of detention and corrections facilities on these youth. For example, the conditions in some detention and correctional facilities have deteriorated to the point that they have become unsafe, depressing environments. Older, traditional juvenile facilities often provide threatening, jail-like settings that escalate a child’s fear, stress, distrust and trauma; however, these environments do not have to be built in this manner. Combined with positive therapeutic interventions, youth can be directed toward a healthier and more productive life.

This article recommends a juvenile services delivery model that will help reduce these disorders, improve the youth’s overall functioning and reduce future recidivism. The model that is described is embodied within the Principles of Effective Intervention (PEI) and informed by the literature on the effects of trauma.

**The Case of Shelly M.**

Many of Shelly’s problems began when her father was imprisoned for aggravated assault when she was 3 years old and her feelings of abandonment escalated when her mother left the home when she was 11 years old. Shelly returned home from school one day and could not find her mother. According to Shelly’s aunt, Shelly’s mother was a chronic substance abuser with bi-polar disorder and lived an unstable life. Shelly spent two years with her aunt but when she became an adolescent, her aunt, who was an alcoholic, could not manage her outbursts of anger and uncontrollable behavior. In counseling, it was learned that her aunt’s boyfriend hit Shelly and sexually molested her. Once Child Protective Services learned this, Shelly was placed in a foster home at age 13. Shelly ran away from the foster home three times and began using drugs and committing thefts to support her habit. Shelly was suspended from school for repeated fighting and was admitted to juvenile detention. The detention center was crowded so she had to live in a room with another girl whom she feared. At night, she could not sleep because the staff’s footsteps in the hall to conduct room checks reminded her of the times her aunt’s boyfriend came into her room to rape her. She was very withdrawn, angry and had no friends while at the detention center.

Shelly’s case is similar to many youth who are placed in detention centers. The abandonment at an early age and the sexual molestation made her fearful and distrustful of others and altered her ability to form healthy relationships. Flashbacks from hearing footsteps in the hall are symptomatic of post-traumatic stress. Shelly began self-medicating through drugs and this led to other criminal and other aggressive, violent behavior. Shelly did not feel sufficiently safe at the detention center to form friends. These early traumatic experiences altered Shelly’s brain so when she experienced potential threats, her behavior became dysfunctional and inappropriate. It will take numerous experiences with non-abusing adults in safe, un-threatening environments for Shelly to form positive, healthy relationships to replace her negative and violent past.

Children, like Shelly, will need a safe, nurturing and supportive environment for her to thrive. However, placement in a juvenile facility does not guarantee safety because in some facilities, children experience sexual abuse, violence, excessive force, isolation and restraint thus escalating their trauma. Beck, A.J. et al (2010) documented 12 percent of the youth in state juvenile facilities and large non-state facilities reported experiencing one or more incidents of sexual victimization.[[3]](#endnote-3) Numerous lawsuits have cited problems with environmental safety and lack of constitutionally mandated education, health care and mental health treatment.[[4]](#endnote-4)

**Literature Review on the Incidence of Psychiatric Disorders among Youth in the Juvenile Justice System**

Extensive studies have documented that youth in the juvenile justice system have higher incidences of psychiatric, trauma, substance abuse and thought disorders than the general population. Post-traumatic stress disorders were originally discovered among populations living in war-torn countries and among soldiers. Today, we have found that many youth in the juvenile justice system also experience post-traumatic stress from the threatening environments they live in. This literature review represents some of the most widely used studies documenting trauma and other disorders among youth involved the juvenile justice system.

Ford et al (2007) found that youth in the juvenile justice system report Post-traumatic Stress Disorder rates as high as 90 percent.[[5]](#endnote-5) Arroyo, W. (2001) found that posttraumatic stress was higher among females than males (49 percent among females compared to 32 percent among males).[[6]](#endnote-6) To date, there is not widespread use of trauma-informed assessments by juvenile justice agencies so the facility’s staffs are unaware of the extent of their trauma and may traumatize these youth and make their symptoms worse. Due to staff cutbacks, even if these disorders were diagnosed, there are few psychologists and trained clinicians available to treat them.

The features of Post-traumatic Stress Disorder are defined in the Diagnostic Statistical Manual of Mental Disorders-Fourth Edition (DSM-IV-TR) as:

*“Symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one’s physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate. The child’s response involves intense fear, helplessness, disorganized or agitated behavior, stomachaches, headaches, outbursts of anger, and irritability”.[[7]](#endnote-7)*

Cocozza & Shufelt (2007) found that 70 percent of youth in juvenile justice facilities have psychiatric disorders and that 27 percent of these youth have severe impairment.[[8]](#endnote-8)

Among youth confined in detention centers, Teplin, L.A. et al (2006) documented 66.3 percent of the males and 73.8 percent of the females in the Cook County Juvenile Detention Center had “any” disorder (including conduct disorders and oppositional defiant disorders). This study used an objective assessment instrument to assess adolescents to determine the prevalence of disorders among 1,829 youth detained in the Cook County, IL Detention Center.[[9]](#endnote-9) Disruptive behavior disorders (defined as conduct disorders and oppositional-defiant disorders) were documented to be 41.4 percent for males and 45.6 percent for females.

While these national studies are well known to many in the juvenile justice field, this information does not always get translated into practice. Many youth admitted to detention do not receive a comprehensive screening or assessment of trauma, psychiatric or substance abuse disorders while in detention thus staffs are not aware of the number of youth suffering from these disorders. Some detention center staff claim there is not sufficient time to conduct these assessments; however, others make the time to conduct a screening and assessment prior to release. Many psychiatrically-impaired youth are housed in the same housing unit as youth without these disorders thus jeopardizing the safety of youth suffering from psychiatric problems.

Among committed populations confined in long-term correctional facilities, Wasserman et al (2004) found that 59.8 percent of the youth housed in secure corrections centers in Illinois and in New Jersey were diagnosed with any disorder.[[10]](#endnote-10)

The impacts of these psychiatric disorders on youth who are on probation supervision or confined in a juvenile detention or correctional facility are profound. Ford et al (2007) found that traumatic stress has shown to reduce the child’s ability to think clearly, learn and to fully develop their physical, emotional and intellectual development.[[11]](#endnote-11) Veysey (2008) also describes the emotional, health and behavioral health problems that manifest themselves when children have experienced severe trauma, particularly abuse and neglect:[[12]](#endnote-12)

* Depression
* Suicide attempts
* Anxiety
* Conduct disorders
* Oppositional or defiant behavior
* Violent behavior against others (for males)
* Violent behavior against oneself (for females)
* Sleep disturbances
* Severe obesity
* Alcohol and drug use
* Adolescent pregnancy
* Panic reactions

If correctional staffs are not aware of these disorders and their impact on the child’s behavior, they often interpret behavior as intentional defiance which creates the potential for a power struggle between the youth and the staff. When this occurs, the youth becomes disengaged in the relationship and correctional supervision becomes less effective.

**Incidence of Psychiatric Disorders in One County**

To quantify the extent to which trauma, psychiatric and substance abuse problems contribute to a minor’s criminal behavior, Huskey & Associates conducted a study of the youth housed in a juvenile detention center and in two juvenile correctional facilities. During May-June 2008, a total of 138 youth were interviewed, 82 youth were housed in these three facilities and 56 youth were supervised on probation.

The youth in custody were selected randomly among 12 groups. Examples included pre-adjudicated, currently confined in detention or in one of the facilities, deferred judgment, pending transfer to correctional facility, and commitment. A sample representing 55.8 percent of the total number of youth housed in all three facilities was selected.

The purpose of this assessment was to examine the extent to which the youth in custody and on probation presented one or more psychiatric and substance abuse disorders. The goal was to use this information to help inform policy makers of the type, dosage and duration of treatment and support services required by these youth to improve their overall functioning while in custody and while on probation.

An objective, standardized assessment tool was used to assess the youth. Trauma was assessed using the following factors:

* History of being physically or sexually abused
* History of abandonment
* Prior serious head injury
* History of psychiatric treatment
* History of drug/alcohol treatment
* Prior attempts at suicide
* Parent’s attempts at suicide
* Parent(s) psychiatric problems
* Parent(s) drinking and drug problems
* Parent’s history in the child welfare system

**Findings**

Among the 82 youth who were housed in the three facilities, 91.7 percent of the females and 81 percent of the males had one or more trauma factors identified.

**Table 1**

**Detained Youth**

**Number of Trauma Factors**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Number of Factors** | **Males** | | **Females** | | **Total** | |
| **N** | **%** | **N** | **%** | **N** | **%** |
| 0 | 11 | 19.0% | 2 | 8.3% | **3** | **3.7%** |
| 1 | 15 | 25.9% | 4 | 16.7% | **22** | **26.8%** |
| 2 | 15 | 25.9% | 4 | 16.7% | **23** | **28.0%** |
| 3 | 10 | 17.2% | 4 | 16.7% | **15** | **18.3%** |
| 4+ | 7 | 12.1% | 10 | 41.7% | **19** | **23.2%** |
| **Total** | **58** | **100.0%** | **24** | **100.0%** | **82** | **100.0%** |

Source: Huskey & Associates in association with National Council on Crime and Delinquency. Interviews with 82 minors confined in the three facilities.

Among the 56 youth on probation supervision, 96.4 percent had at least one trauma factor noted. All females reported at least one trauma factor, and 72.7 percent noted four or more trauma factors in their histories. Over one quarter (26.7 percent) of the males had three or more factors noted.

**Table 2**

**Probation Youth**

**Number of Trauma Factors**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Number of Factors** | **Males** | | **Females** | | **Total** | |
| **N** | **%** | **N** | **%** | **N** | **%** |
| 0 | 2 | 4.4% | 0 | 0.0% | **2** | **3.6%** |
| 1 | 11 | 24.4% | 1 | 9.1% | **12** | **21.4%** |
| 2 | 20 | 44.4% | 1 | 9.1% | **21** | **37.5%** |
| 3 | 5 | 11.1% | 1 | 9.1% | **6** | **10.7%** |
| 4+ | 7 | 15.6% | 8 | 72.7% | **15** | **26.8%** |
| **Total** | **45** | **100.0%** | **11** | **100.0%** | **56** | **100.0%** |

Source: Huskey & Associates in association with National Council on Crime and Delinquency. Interviews with 56 minors on probation.

**Prevalence of Co-occurring Disorders**

Consistent with national studies, the existence of co-morbidity is also prevalent among the youth in custody. One-half of the detained females had a substance abuse and a psychiatric problem combined compared to 41.4 percent of the in-custody males.

**Table 3**

**Co-morbidity: Detained Youth with Substance Abuse and Emotional Problems**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Males** | | **Females** | | **Total** | |
| **N** | **%** | **N** | **%** | **N** | **%** |
| **Total** | **58** | **100.0%** | **24** | **100.0%** | **82** | **100.0%** |
| Alcohol and emotional problems | 14 | 24.1% | 6 | 25.0% | **20** | **24.4%** |
| Drug and emotional problems | 19 | 32.8% | 12 | 50.0% | **31** | **37.8%** |
| Alcohol or drug and emotional problems | 24 | 41.4% | 12 | 50.0% | **36** | **43.9%** |

Source: Huskey & Associates in association with National Council on Crime and Delinquency. Interviews with 82 minors confined in three facilities.

Nearly two-thirds of the females on probation and almost 40 percent of the males were identified as exhibiting alcohol or drug problems combined with emotional problems that affect their behavior.

**Table 4**

**Co-morbidity: Probation Youth with Substance Abuse and Emotional Problems**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Males** | | **Females** | | **Total** | |
| **N** | **%** | **N** | **%** | **N** | **%** |
| **Total** | **45** | **100.0%** | **11** | **100.0%** | **56** | **100.0%** |
| Alcohol and Emotional Problems | 6 | 33.3% | 2 | 25.0% | **8** | **14.3%** |
| Drug and Emotional Problems | 3 | 16.7% | 4 | 50.0% | **7** | **12.5%** |
| Alcohol or Drug and Emotional Problems | 7 | 38.9% | 5 | 62.5% | **12** | **21.4%** |

Source: Huskey & Associates in association with National Council on Crime and Delinquency. Interviews with 56 minors on probation.

This study documents that the youth on field supervision also exhibit high degrees of trauma, psychiatric and drug and alcohol problems. The findings substantiate that more than 60 percent of the females have suffered trauma and have multiple diagnoses compared to 39 percent of the males. More males on probation were assessed as experiencing one or more trauma factors than the males in custody.

These findings underscore the need to assess other disorders at the same time. The DSM-IV-TR indicates that there is evidence of an intergenerational transmission of Post-traumatic Stress Disorder along with depression.[[13]](#endnote-13) Family members who have a history of depression are also vulnerable to Post-traumatic Stress Disorder. All three disorders (trauma, psychiatric and substance abuse problems) need to be assessed and addressed by the clinician in an integrated manner.

**Implications for Intervention**

These findings serve as the basis for the following model for delivering services to juvenile justice youth with psychiatric, trauma, and substance abuse disorders.

1. Screening: Because many juvenile justice systems process thousands of youth on an annual basis, the first step in early identification is the *screening process*. This process is necessary to identify acute problems that must be addressed immediately. While this process screens youth in need of treatment, it also screens out youth who do not require intensive and costly assessment and treatment services.
2. Assessment: If the screening process identifies caution or warning, the second step is to conduct *an in-depth assessment*. This process uses an objective, standardized assessment tool that has been validated on youth with specific disorders. While the screening process identifies a youth with potential problems, the assessment process defines the specific type and degree of the disorder. The clinical purpose of the assessment process is to gather sufficient data from the adolescent and their family upon which to first, develop *a diagnosis* and secondly, to develop the *treatment plan*.

Screening and assessment is so important that the U.S. Substance Abuse Mental Health Services Administration has recommended that screening for trauma and early intervention and treatment be common practice in the future.[[14]](#endnote-14)

1. Treatment Planning: A key component of the treatment planning process is to develop effective interventions to improve a child’s overall functioning and to lower the child’s risk to reoffend. Andrews and Bonta (2010) found the following eight risk factors to be significantly associated with reoffending:[[15]](#endnote-15)
2. Antisocial/procriminal attitudes, values, beliefs and cognitive-emotional states
3. Procriminal associates and isolation from prosocial others
4. Temperamental and antisocial personality pattern conducive to criminal activity including
5. A history of antisocial behavior
6. Family factors that include criminality and a variety of psychological problems in the family of origin including
7. Low levels of personal educational, vocational or financial achievement
8. Low levels of involvement in prosocial leisure activities
9. Abuse of alcohol and/or drugs

Each of these risk factors can be altered through effective interventions and treatment. There are a number of trauma-informed therapies that clinicians can use in detention and correctional facilities such as:

* Trauma Survivors Groups
* Seeking Safety
* Trauma Affect Regulation: A Guide for Education and Therapy (TARGET)
* Trauma Recovery and Empowerment Model (TREM)
* Eye Movement Desensitization and Reprocessing Therapy (EMDR)
* Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)
* MOVING-ON
* Cognitive Behavioral Therapy combined with Social Skills Training
* Skills Training in Affective and Interpersonal Regulation (STAIR)
* Integrated Treatment for Co-Occurring Disorders
* Dialectical Behavior Therapy
* Brief Eclectic Therapy
* Functional Family Therapy
* Multi-systemic Family Therapy

Programs do not need to be only “brand programs” as defined above to be evaluated as “effective”, but rather, each program serving delinquents must be based on the cognitive behavioral model and adhere to the scientific *Principles of Effective Intervention* to be rated as “effective”*.* These principles are 1) Risk Principle (Target the Highest Risk to Recidivate for Intensive Therapy), 2) Need Principle (Target Criminogenic Needs in Treatment Plan), 3) Responsivity Principle (Adapt Therapy to Individual Needs) and 4) Fidelity Principle (Deliver Treatment Consistent with its Intended Design and Measure its Effectiveness). Programs also need to have the appropriate duration and dosage to be effective.[[16]](#endnote-16)

Landenberger and Lipsey (2005) found that offenders involved in cognitive behavioral treatment had a one and one half times greater likelihood of not recidivating after discharge from correctional supervision than those who were not involved in this type of treatment.[[17]](#endnote-17) Cognitive behavioral treatment has the following features:

* Teaches pro-social values, attitudes, thinking and behavior patterns
* Rehearses and role plays these new skills
* Instructor provides feedback and models the new skills

They also found that low risk youth require little intervention while moderate risk youth required 100 hours of treatment and high risk youth required 200-300 hours of treatment.[[18]](#endnote-18)

The features of these cognitive behavioral programs differ profoundly from treatment approaches that are based on the medical/disease model, that are aimed at merely increasing self-awareness, self-esteem and insight and that are non-directive and client centered. Perry, B.D. (2006) points out that the medical model has failed to reorganize the brainstem-related neural systems within youth with severe trauma disorders.[[19]](#endnote-19) His research found that cognitive behavioral methods were more effective because they provided the repetition, duration and dosage needed for maltreated children.

All detention and corrections facilities operate with behavior management programs that reward prosocial behavior and discipline non-compliant behavior. However, if the system is carried out in a harsh and punitive manner instead of an instructive and supportive approach, youth with trauma disorders will feel unduly threatened, and it will result in even more unruly behavior. Boesky, L. (2011) points out that effective behavior management systems are not used to control or dominate youth, but rather, to help youth learn skills that help them internalize impulse control.[[20]](#endnote-20)

In summary, a combination of treatment modalities is required for youth with disorders. All of these are critical in improving the child’s overall functioning and in reducing recidivism and with youth suffering from psychiatric, trauma, substance abuse and thought disorders.

**Psychological Impact of Confinement on Youth with Psychiatric, Trauma and Thought Disorders**

It is a widely known fact that one’s environment impacts on one’s physical and emotional health and one’s ability to think and learn. Since so many youth in juvenile justice facilities have experienced severe trauma disorders, providing a calm and supportive physical environment is as important for their rehabilitation as the programs themselves. Ford et al (2007) found that youth placed in traumatic environments such as a correctional institution respond with indifference, aggression, anxiety and depression which are often interpreted by detention staff as defiance.[[21]](#endnote-21)

There is an emerging field called neuroscience that studies the impact of environmental conditions on one’s brain functioning and behavior patterns. Eberhard, J. et al (2006) found the following features within correctional environments that are harmful to one’s physical and emotional health and cognitive ability:[[22]](#endnote-22)

* Lack of natural daylight and views to the outside inhibits the retinal area of the visual cortex resulting in reduced sense of well-being and irregular biological clocks
* Lack of restful sleep results in harm to one’s physical health, productivity and problem solving ability
* Lack of access to nature and view to the outside increases one’s blood pressure, stress and fatigue
* Small slit windows restrict one’s view of natural light, trees, sky and birds
* Ambient noise in excess of 60 db raises one’s cortical levels and increases one’s physical and emotional stress
* Deprivation and isolation triggers the amygdala and heightens anger, anxiety and irritability
* Highly dense environments and large correctional facilities increase stress and anxiety leading to more incidents
* Institutional, dull colors irritate and depress rather than uplift one’s mood, and works against promoting a calm living environment

Thayer, J (2006) says “lighting that follows natural circadian rhythms will result in better sleep patterns, which in turn lead to greater calm, less irritability and aggression, and improves program participation”.[[23]](#endnote-23)

However, the conditions found in some correctional facilities inhibit the optimum functioning of the brain. Traditional correctional designs such as maximum security hardware, steel furniture, electronic surveillance devices, security glass, small slit windows, sparse sleeping rooms, no areas for personalizing one’s room and the use of metal doors throughout the facility escalates the trauma that youth experience in correctional facilities. Sullivan, P. (2010) pointed out that correctional facilities are often designed to be “hard, barren and noisy because designers are unaware of the negative psychological effect on the individual and the staff”.[[24]](#endnote-24) Experience shows that these conditions are promoted based on the unfounded perception that being harsh will lead to reduced recidivism. However, the evidence demonstrates that these conditions do not deter future crime. The Pew Center on the States (April 2011) reports that four out of every 10 persons released from correctional facilities return within three years.[[25]](#endnote-25)

If these conditions deterred crime, the recidivism rate would be much lower. Youth who have experienced severe trauma react negatively to jail-like environments such as these by either withdrawing or by lashing out at staff and at other youth.

On the other hand, secure behavioral health designs that take into account the findings in the neuroscience research provide a less threatening and greater calming environment for juveniles with trauma disorders. The evidence from this research shows that behavioral health designs enhance the youth’s physical and emotional health, minimizes their trauma and reduces their anxiety making it much easier for correctional staff. Elements of evidence-based designs include:

1. Natural light that supports natural circadian rhythms
2. Views of nature through windows and courtyards
3. View to the outside through windows in the sleeping rooms and in dayrooms
4. Artificial lights that can be dimmed
5. Calming rooms with a rocking chair
6. Live plants
7. Small, podular dayrooms sized for good lines of sight and for frequent communication without raising one’s voice
8. Movable, durable but non-jail-like furniture in medium and minimum security housing units
9. Carpet to reduce noise
10. High ceilings
11. Interesting and calming colors

The American Correctional Association (ACA) is the national organization in the U.S. that promulgates performance-based standards for juvenile detention and correctional facilities and accredits these facilities. The ACA standards require access to direct sunlight in sleeping rooms and in dayrooms, artificial lighting that is sufficient to complete tasks, db levels that minimize noise, small dayrooms and non-steel furnishings in medium and minimum security housing units.[[26]](#endnote-26) These standards were based on years of research, case law and the experience of thousands of juvenile justice practitioners. Restorative environments such as these promote rehabilitation and improve overall morale of youth and staff.

It is hoped that juvenile justice professionals in the future will learn from the lessons experienced by those that come before them and upgrade the programs and physical environments within detention and correctional institutions.

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