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

By Bobbie L. Huskey and Paula Tomczak

ABSTRACT

The personal stories that youth in juvenile facilities report to their counselors are heartbreaking because they are filled with accounts of excessive trauma resulting from neglect, physical, sexual, and emotional violence perpetrated on these children. Perry found that trauma develops from severe neglect, abuse, and living in terrorizing environments. Trauma changes the neural processing ability within the child’s developing brain which can lead to hypervigilance and dysfunctional behavior.1 Widom found that children who had been abused or neglected as children have 30% higher arrests as a juvenile and as an adult for a violent offense.2

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.


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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. Combined with positive therapeutic interventions, youth can be directed toward healthier and more productive lives.

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 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 bipolar 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 stealing 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 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, non-threatening environments for Shelly to form positive, healthy relationships to replace her negative and violent past.

Children, like Shelly, need a safe, nurturing and supportive environment for them 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 et al. documented 12% of the youth in state juvenile facilities and large non-state facilities reported experiencing one or more inci-
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 presents some of the most widely used studies documenting trauma and other disorders among youth involved in the juvenile justice system.

Ford et al. found that youth in the juvenile justice system report post-traumatic stress disorder rates as high as 90%. Arroyo found that post-traumatic stress was higher among females than males (49% among females compared to 32% among males). To date, there is no widespread use of trauma-informed assessments by juvenile justice agencies. The facility’s staffs are often unaware of the extent of their trauma, and how their actions 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 and Statistical Manual of Mental Disorders-Fifth Edition (DSM-5) as:

Trauma and stressor-related disorders resulting from sexual abuse, physical abuse, traumatic brain injury, bi-polar disorder, depression, fear, anger, rage, aggression, anxiety and witnessing violence. The youth will present dissociative amnesia, present outbursts of anger, engage in reckless or destructive behavior, display a blurred sense of identity or some combination of these disorders.

5 Julian D. Ford, John F. Chapman, Josephine Hawke, & David Albert, Trauma Among Youth in the Juvenile Justice System: Critical Issues and New Directions, RESEARCH AND PROGRAM BRIEF (National Center for Mental Health and Juvenile Justice, June 2007).
Cocozza et al. found that 70% of youth in juvenile justice facilities have psychiatric disorders and that 27% of these youth have severe impairment.\(^8\)

Among youth confined in detention centers, Teplin et al. documented 66.3% of the males and 73.8% of the females in the Cook County Illinois Juvenile Temporary Detention Center (CCJTDC) 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 CCJTDC.\(^9\)

Disruptive behavior disorders (defined as conduct disorders and oppositional-defiant disorders) were documented to be 41.4% for males and 45.6% 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 indicate that 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 violent youth, thus jeopardizing the safety of youth suffering from psychiatric problems.

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

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. found that traumatic stress reduces a child’s ability to think clearly, learn, and fully develop physically, emotionally, and intellectually.\(^11\) Veysey also describes the emotional, physical, and behavioral health problems that manifest themselves when children have experienced severe trauma, particularly abuse and neglect:\(^12\)

\begin{itemize}
  \item Depression,
  \item Suicide attempts,
  \item Anxiety,
  \item Conduct disorders,
  \item Oppositional or defiant behavior,
  \item Violent behavior against others (by males),
\end{itemize}

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11 Ford et al., supra note 5.

12 Bonita M. Veysey, Mental Health, Substance Abuse and Trauma, in TREATING THE JUVENILE OFFENDER (Robert D. Hoge, Nancy G. Guerra, & Paul Boxer eds., The Guilford Press, 2008).
• Violent behavior against oneself (by females),
• Sleep disturbances,
• Severe obesity,
• Alcohol and drug use,
• Adolescent pregnancy, and
• 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 youth’s criminal behavior, Huskey & Associates conducted a study of the youth housed in a juvenile detention center and in two juvenile correctional facilities in one California county. During May-June 2008, a total of 138 youth were interviewed.

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 a correctional facility, and commitment. A sample representing 55.8% 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 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, and
• Parent(s)’ history in the child welfare system.
Findings

In Table 1, the findings represent the total number of youth in custody in three juvenile facilities who experienced severe trauma. Among the 82 youth who were housed in the three facilities, 92% of the females (22 of 24) and 81% of the males (47 of 58) experienced one or more trauma factors in their life.

Table 2 shows the number of youth on field probation that experienced severe trauma. Among the total 56 youth on probation supervision, 96% (54 of 56) had at least one trauma factor noted. All females reported at least one trauma factor, and 73% noted four or more trauma factors in their histories. Over 96% (45 of 45) of the males experienced one or more trauma factors.

TABLE 1
Incarcerated Youth
Number of Trauma Factors

<table>
<thead>
<tr>
<th>Number of Factors</th>
<th>Males</th>
<th></th>
<th>Females</th>
<th></th>
<th>Total</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>0</td>
<td>11</td>
<td>19.0%</td>
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<td>8.3%</td>
<td>13</td>
<td>15.9%</td>
</tr>
<tr>
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<td>15</td>
<td>25.9%</td>
<td>4</td>
<td>16.7%</td>
<td>19</td>
<td>23.2%</td>
</tr>
<tr>
<td>2</td>
<td>15</td>
<td>25.9%</td>
<td>4</td>
<td>16.7%</td>
<td>19</td>
<td>23.2%</td>
</tr>
<tr>
<td>3</td>
<td>10</td>
<td>17.2%</td>
<td>4</td>
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<td>14</td>
<td>17.0%</td>
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<td>10</td>
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<td>17</td>
<td>20.7%</td>
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<tr>
<td>Total</td>
<td>58</td>
<td>100.0%</td>
<td>24</td>
<td>100.0%</td>
<td>82</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

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

TABLE 2
Probation Youth
Number of Trauma Factors

<table>
<thead>
<tr>
<th>Number of Factors</th>
<th>Males</th>
<th></th>
<th>Females</th>
<th></th>
<th>Total</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>0</td>
<td>2</td>
<td>4.4%</td>
<td>0</td>
<td>0.0%</td>
<td>2</td>
<td>3.6%</td>
</tr>
<tr>
<td>1</td>
<td>11</td>
<td>24.4%</td>
<td>1</td>
<td>9.1%</td>
<td>12</td>
<td>21.4%</td>
</tr>
<tr>
<td>2</td>
<td>20</td>
<td>44.4%</td>
<td>1</td>
<td>9.1%</td>
<td>21</td>
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<tr>
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<td>5</td>
<td>11.1%</td>
<td>1</td>
<td>9.1%</td>
<td>6</td>
<td>10.7%</td>
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<tr>
<td>4+</td>
<td>7</td>
<td>15.6%</td>
<td>8</td>
<td>72.7%</td>
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<td>26.8%</td>
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<tr>
<td>Total</td>
<td>45</td>
<td>100.0%</td>
<td>11</td>
<td>100.0%</td>
<td>56</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Source: Huskey & Associates in association with National Council on Crime and Delinquency. Interviews were conducted with 56 youth on probation. Percentages may not total 100% due to rounding.
Prevalence of Co-occurring Disorders

Consistent with national studies, the existence of co-morbidity is also prevalent among the youth in custody. Table 3 shows that one-half of the incarcerated females had all three disorders (substance abuse and a psychiatric problem combined) compared to 42% of the males.

These findings underscore the need to assess psychiatric, trauma, and substance abuse disorders together. All three disorders (trauma, psychiatric, and substance abuse problems) need to be assessed and addressed by the clinician in an integrated manner because when even one disorder is diagnosed, there is a high likelihood that the other two disorders will be present. This is important since the interventions and treatment modalities for these disorders will vary.

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 identifies 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 potential problem areas, 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

<table>
<thead>
<tr>
<th>TABLE 3</th>
<th>Co-morbidity: Incarcerated Youth with Substance Abuse and Emotional Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Males</strong></td>
</tr>
<tr>
<td></td>
<td>N</td>
</tr>
<tr>
<td>Total</td>
<td>58</td>
</tr>
<tr>
<td>Alcohol, drug and emotional problems</td>
<td>24</td>
</tr>
</tbody>
</table>

Source: Huskey & Associates in association with National Council on Crime and Delinquency. Interviews were conducted with 82 youth confined in three facilities.
and his family upon which to first, develop a diagnosis and second, to develop the treatment plan.

Screening and assessment is so important that the U.S. Substance Abuse and Mental Health Services Administration has recommended that screening for trauma and early intervention and treatment be common practice in the future.  

3. 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 found the following eight risk factors to be significantly associated with reoffending:  

1. Antisocial/procriminal attitudes, values, beliefs, and cognitive-emotional states;  
2. Procriminal associates and isolation from prosocial individuals;  
3. Temperamental and antisocial personality pattern conducive to criminal activity;  
4. A history of antisocial behavior;  
5. Family factors that include criminality and a variety of psychological problems in the family of origin;  
6. Low levels of personal, educational, vocational, or financial achievement;  
7. Low levels of involvement in prosocial leisure activities; and  
8. 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, and  
- 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 delinquent youth 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 Youth with the Highest Risk to Recidivate for Intensive Therapy); 2) Need Principle (Target Criminogenic Needs in the Treatment Plan); 3) Responsivity Principle (Adapt Therapy to Individual Needs); 4) Fidelity Principle (Deliver Treatment Consistent with its Intended Design and Measure its Effectiveness) and 5) Appropriate Duration and Dosage to meet initial and ongoing assessment of needs.\(^\text{15}\)

Landenberger and Lipsey 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.\(^\text{16}\) Cognitive behavioral treatment has the following features:

- Teaches pro-social values, attitudes, thinking, and behavior patterns;
- Instructor provides feedback and models the new skills; and
- Youth rehearses and role plays these 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 to lower the risk of reoffending.\(^\text{17}\)

The features of these cognitive behavioral programs differ profoundly from treatment approaches that are based on the self-realization and pharmacological model, that are aimed at merely increasing self-awareness, self-esteem, and insight with heavy doses of medications. Perry points out that the medical model has failed to reorganize the brainstem-related neural systems within youth with severe trauma disorders.\(^\text{18}\) 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, resulting in even more unruly behavior. Boesky points out that effective behavior management systems should not be used to control or dominate youth, but rather, to help youth learn skills that help them internalize impulse control.\(^\text{19}\)


\(^{17}\) Id.

\(^{18}\) Perry, supra note 1.

\(^{19}\) L.M. Boesky, Juvenile Offenders with Mental Health Disorders: Who Are They, and What Do We Do With Them? (American Correctional Association, 2nd ed., 2011).
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 with youth suffering from psychiatric, trauma, substance abuse, and thought disorders.

**PSYCHOLOGICAL IMPACT OF CONFINEMENT ON YOUTH WITH PSYCHIATRIC, TRAUMA, AND THOUGHT DISORDERS**

Most people agree that a person’s environment impacts his or her physical and emotional health and ability to think and learn. Since so many youth in juvenile justice facilities have experienced severe trauma, providing a calm and supportive physical environment is as important for their rehabilitation as the programs themselves. Ford et al. found that youth placed in harsh and punitive environments such as in some correctional institutions respond with indifference, aggression, anxiety, and depression which are often interpreted by detention staff as willful defiance.20

Today, there is a greater emphasis in corrections on the impact of environmental conditions on one’s brain functioning and behavior patterns. According to Eberhard and Wener, the following features within correctional environments are harmful to one’s physical and emotional health and cognitive ability:21

- Lack of natural daylight and views to the outside inhibits the retinal area of the visual cortex resulting in a reduced sense of well-being and an irregular biological clock;
- 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 to natural light, trees, sky, and birds;
- Ambient noise in excess of 60 db raises one’s cortical levels and increases physical and emotional stress;
- Deprivation and isolation lead to abnormal functioning of the amygdala and heighten anger, anxiety, and irritability;
- Highly dense environments and large correctional facilities increase stress and anxiety leading to more assaults and negative incidents; and
- Institutional, dull colors irritate and depress rather than uplift one’s mood, and work against promoting a calm living environment.

20 Ford et al., *supra* note 5.
Thayer says “lighting that follows natural circadian rhythms will result in better sleep patterns, which in turn leads to greater calm, less irritability and aggression, and improved program participation.”

However, the conditions found in some correctional facilities inhibit the optimum functioning of the brain. Traditional correctional designs utilizing small slit windows, maximum security hardware, steel furniture, electronic surveillance devices, security glass, sparse sleeping rooms, no areas for personalizing one’s room, and the use of metal doors throughout the facility escalate the trauma that youth experience in correctional facilities. Sullivan pointed out that correctional facilities are often designed to be “hard, barren, and noisy because designers are unaware of the harmful psychological effects of some environments on the individual and the staff.” Experience shows that these conditions are promoted because of 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 reports that four out of every 10 persons released from correctional facilities return within three years.

If these environmental conditions deterred crime, the recidivism rate would be much lower. Youth who have experienced severe trauma react negatively to such jail-like environments 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 youth’s physical and emotional health, minimize their trauma, and reduce their anxiety making it much easier for correctional staff to engage youth in positive activities. Elements of evidence-based designs as described by Eberhard, Wener, and Sullivan include:

1. Natural light that supports natural circadian rhythms;
2. Views of nature through windows in sleeping rooms, in dayrooms, and from courtyards;
3. Artificial lights that can be dimmed;
4. Calming rooms with a rocking chair;
5. Live plants;
6. Small, podular dayrooms sized for good lines of sight and for frequent communication without raising one’s voice;
7. Movable, durable, but non-jail-like furniture in minimum security housing units;
8. Carpet in some areas to reduce noise and to lower one’s blood pressure;

23 Patrick M. Sullivan, Creating Treatment Environments for Troubled Youth: Evidence-Based Design in Architecture (American Correctional Association, 2010).
25 Eberhard & Wener, supra note 22; Sullivan, supra note 24.
9. High ceilings to reduce claustrophobia; and
10. Interesting and calming colors.

The American Correctional Association (ACA) and the Council of Juvenile Correctional Administrators are national organizations in the U.S. that promulgate performance-based standards for juvenile detention and correctional 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, intimate dayrooms, and non-steel furnishings in medium and minimum security housing units.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 the 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 so that youth will be sufficiently ready to be discharged to their families and communities.