Children Who Have Been Traumatized: One Court's Response

By Judge Michael L. Howard and Robin R. Tener

ABSTRACT

A court that is trauma-informed can assist with the process of identifying children in need of trauma-focused services and can provide education and direction to families frustrated by prior treatment failures. The unique role of the juvenile court judge as a community convener offers an opportunity to increase community awareness about the impact of trauma, and to promote the adoption of evidence-based treatment for trauma victims. This article outlines the way that increased trauma awareness and trauma screening within a family court system mobilized the development of effective resources for children and families affected by trauma.

INTRODUCTION

Stark County Family Court in Canton, Ohio, is similar to most juvenile courts across the country. We have traditionally responded to delinquent children by providing consequences for bad behavior, assuming that negative consequences would deter future bad behavior. If the bad behavior continued, the court increased the intensity of the negative consequence. Because that response was not always successful, we widened our search for answers.

Since 2000, we have been educating ourselves about trauma and its effect on the children who come before our court. This is the story of that self-education process, which we illustrate with case studies from our court. When these children appeared before us, an initial review of the facts indicated that we were seeing a typical case that would require a typical response. Fortunately, because we were gradually developing our trauma awareness, we inquired more deeply into the backgrounds of these children and were able

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Judge Michael L. Howard has served on the Stark County (Ohio) Court of Common Pleas bench, Domestic Relations Division since 2005, after serving as Magistrate and Chief Magistrate since 1991. Correspondence: MLHoward@co.stark.oh.us

Robin R. Tener, Ph.D., is a Licensed Clinical Psychologist and Executive Director of Northeast Ohio Behavioral Health, Ltd. She works with the Stark County Trauma Task Force toward the goal of increasing the availability of trauma treatment to incarcerated youths. Correspondence: RTener@roadrunner.com

to provide a more appropriate response. Ultimately, we saw the need to formalize our inquiries by using a recognized trauma screening tool. We chose the UCLA Post-Traumatic Stress Disorder Index (UCLA PTSD Index) (Steinberg, Brymer, Decker, & Pynoos, 2004), which will be described later in more detail. Once trauma was identified, we wanted to provide the most appropriate and effective treatment, not just generic counseling. That meant assessing the resources of our community and, where those resources were lacking, building capacity to provide trauma-specific treatment. We present the story of our collaborative efforts as one model for becoming not only a trauma-informed court but also a trauma-informed community.

CASE STUDIES

All juvenile court hearing officers begin their day with the awareness that they will be confronted with a virtual flood of issues requiring the best possible decisions. In that way, Stark County Family Court is no different from juvenile courts across the country. Beginning at 9:00 a.m., the daily docket indicates an arraignment every 15 minutes until noon. These hearings generally take longer than 15 minutes, and by 11:00, the court is so far behind that a lunch break seems unlikely. Within the tide of every-day offenses, a certain predictability of response can become routine.

The next hearing involves Josh, a 15-year-old charged with truancy. He pleads true. The magistrate begins to prepare her standard speech: "You have to go to school. It's the law, and your education is critical to your future." As she mentally rehearses her speech, the court intake worker recites the facts, and the magistrate realizes truancy has *not* been a chronic problem for this child. In fact, his school record was pretty good until a few months ago. The sudden change in his behavior causes the magistrate to inquire about drug or alcohol abuse. She gets an emphatic denial from both Josh and his mother. Although she is far behind and short of time, the magistrate begins to ask more probing questions: "When did this all start? Did something occur around that time?" When mother and child are evasive, the magistrate's instincts tell her something is not right. She pushes harder. "Tell me what happened four months ago."

Mother looks down and begins to dab her eyes. "I had an abusive boyfriend. I got a restraining order. He violated it again and again. I was afraid he would kill both of us. Four months ago he came to the house drunk. When I wouldn't let him in, he kicked down the door and came after me in a rage. I shot him, and I killed him. Josh was beside me when it happened." Suddenly the magistrate is faced with more than a truancy case. She is going to have to do more than give a speech. However, what does she do? What are the resources at her disposal? How can she be certain that the core issues that prevent Josh from being successful in school are going to be resolved?

A few months later, Anthony, a 16-year-old, appears before the judge, charged with theft. The victim is Anthony's uncle, who is also his custodian, and the amount stolen is several thousand dollars. This is not the first time the uncle has had difficulty with Anthony, and he is pretty sure he does not want Anthony back in his home. Since future placement is in question, the judge refers Anthony for an evaluation by the court

placement department prior to holding a dispositional hearing. The placement officer, who has had trauma training, begins to ask the uncle about Anthony's history. The uncle is more than willing to tell this difficult story. When Anthony was nine, his father came home and asked the family to gather in the living room for a family meeting. When all were seated, he took out a gun and shot Anthony's mother in the chest and then fled from the house. Anthony remembers how many minutes it took the police to come. He remembers exactly how many police cars and emergency vehicles responded. He remembers they said they had to take his mom away, but that she would come back. She never did. Anthony's father is in prison. The family still owns the home where Anthony's mother was murdered, but no one lives there now. Anthony and his uncle go to the home once a month to clean, including the living room where the crime took place.

After reading the placement officer's report, the judge immediately knows he has more than a routine theft case. He understands the emotional impact on Anthony of re-entering a crime scene, and imagines his struggle to manage the loss he experienced during a single, terrible moment in his life. The judge is going to have to do more than simply find a place for Anthony to live. If his uncle agrees to keep him, how can this caregiver be helped to understand that this loss changed Anthony's view of the world forever? Will Anthony's vivid memories be addressed in a way that helps him gain a sense of control? Can the judge be certain that Anthony will receive treatment that helps him connect his behavioral choices and antisocial attitudes to the traumatic events in his life?

A few months later, Briana, a 17-year-old girl, comes before the court. She was taken into custody the night before, charged with domestic violence. Briana pulled the phone out of the wall and threw it at her mother. She has no prior offenses, but she has "an attitude" in the courtroom and refuses to go home. The judge has seen this before: this is the "bratty teenager." The judge gives his speech: "You have two parents who care about you. You don't realize how good you have it. You're almost emancipated, but in the meantime you're living in your mom and dad's house. Show some respect, and behave yourself. If you refuse to go home, we can accommodate you. You'll serve five days and be released to your parents at 9:00 a.m. on December 24th."

At 9:15 a.m. on December 24th, the judge gets a call from the detention facility. Briana refuses to go home with her parents. Because of his awareness of the impact of trauma, and its connection to family dynamics, the judge's antenna goes up. This is a teen who has been in lock-up for five days. It's Christmas Eve, and she won't go home? The judge recognizes that these reactions do not make sense unless there is something very wrong within this family unit. The judge dispatches the court placement officer to the detention facility. Because of the changes made in how the court responds to youths affected by trauma, the court placement officer is not only trained to recognize trauma reactions in the behavior of court-involved youths, he is also armed with a trauma screening tool, the UCLA Post-Traumatic Stress Scale. That afternoon, he reports to the judge and tells him Briana's history: She was raped by an older relative when she was nine. She told her parents, but they did not believe her and took no action. Every holiday she was faced with the prospect of seeing this relative. When Briana was 13, her younger sister was raped by the same relative. The family believed the sister and then turned on Briana saying, "This is your fault. Had you convinced us it had happened to you, we

could have protected your sister." Although the sister received counseling for sexual abuse, Briana did not.

Three months before Briana became involved with the court, she was date-raped. When she tried to talk to her mother about it, her mother accused her of inventing yet another story of sexual abuse. Briana had no one to confide in but her best friend. A few weeks later, that best friend, who had demons of her own, committed suicide.

Because the judge has learned about the effects of trauma, he now knows that Briana is much more than a "bratty teenager" (Pynoos, Frederick, & Nader, 1987). Holding her in detention might protect her from the immediate stress of a holiday visit with a family that does not emotionally support her, but what can the judge do to make certain that her family understands the importance of several traumatic life events? How can he be sure that mental health treatment for Briana will address the impact of these traumas and help her move from seeing herself as a victim to seeing herself as a survivor?

The terrifying thing about these cases is how close we, as a Family Court, came to responding to them as if they were only what they first appeared to be: truancy, theft, and domestic violence. Because of our tendency to focus on accountability, we almost limited our attention to only the behavioral symptoms of much deeper problems. As hearing officers, we were on the verge of imposing consequences for behavior without inquiring about the factors underlying the behavior. Had we only made speeches, or changed placements, or incarcerated these children, we would never have given them the help they needed.

TRAUMA AS A FACTOR IN DELINQUENCY

Fortunately, the Stark County Family Court has begun to understand the devastating effect that trauma has on children. The court does not view trauma as an excuse for delinquent behavior and neither do the kids who come before us. Not one child before our court has ever said, "I did it because I have been traumatized." Yet, in order to change the behavior of these traumatized children, courts must recognize, understand, and address the trauma reactions that form the basis of their dysfunctional view of themselves and the world. Traumatic events have repercussions that extend well beyond the event and are often "a marker" for behavioral changes that even people close to the child may fail to appreciate. The recognition that trauma reactions contribute to behavioral acting-out for a segment of youths has caused us to make dramatic changes in our court intake processes, as well as look deeper into the histories of troubled children who come before the court. Courts need to ask more questions about historic events, assess for continued reactions to trauma, and make it clear to children that we understand that these events have had an important impact on their lives. We renounce the notion that a child should have "moved on" and should have "already gotten over it."

Indeed, during trauma screenings, many children reveal a high degree of daily interference in basic functioning because they continue to struggle with nightmares, flashbacks, and intrusive thoughts. Their level of hypervigilance is so high that they routinely misread social situations (Berman, Kurtines, Silverman, & Serafini, 1996). The

mistaken belief that they are once again in danger, and must protect themselves, often leads to assaultive behavior. Many of the children screened for trauma at the court inform us that they have trouble with concentration and attention (Carrion, Weems, & Reiss, 2002). Because their symptoms resemble Attention-Deficit/Hyperactivity Disorder (ADHD), some tell us that they have been diagnosed with ADHD. Some report they have been given medication for ADHD, which did not alleviate their symptoms.

In Stark County, the court now understands that when children have been affected by trauma, they are "stuck" in a hypervigilant response. Being constantly on alert to danger decreases the ability of a youth to study and learn. This leads to increased frustration at school, as teachers and parents insist on good attention and good academic outcomes. These children tell us that they remain on alert at night, awakening easily and suffering from nightmares. This lack of sleep also interferes with learning and decision making. Youths screened for trauma reactions often recognize that they feel irritable and aggressive. They lose their temper and fight with little or no provocation.

For years our court treated these cases as "bad behavior" and "lack of self control." It is only in the last several years that we, as a court, have educated ourselves about trauma. As a result, we now know that it is important to ask about trauma. Indeed, we often discover a history of trauma that has gone undetected, despite attempts to help the child through traditional counseling services. When we ask about traumatic events, our court has also found that other family members are often impacted by the same trauma that the youth experienced. As a result, caregivers who might have provided assistance and support for the child have become paralyzed by their own reactions to the traumatic events.

A PROGRESSION IN IDENTIFYING TRAUMA IN DELINQUENCY CASES

The cases of Josh, Anthony, and Briana illustrate a progression in our methods for identifying trauma as a factor in the delinquency cases that come before the Stark County Family Court. In the case involving Josh's truancy, a magistrate actually uncovered the trauma by inquiring about it in the courtroom. Her instincts and education regarding trauma reactions led her to wonder if there was more to the story, and she pressed the issue. When we first were learning about the effects of trauma, we discovered most of the trauma history among our delinquents in this way. It became clear that we could uncover a vast array of information by simply asking questions about the possibility of traumatic events. Often, we learned of multiple traumas. Traumatic events such as parental abuse or domestic violence sometimes led to other traumas such as removal from the home, separation from siblings, or exposure to additional abuse or neglect.

Many youths expressed relief when the hearing officer told them the traumatic events were important in their lives, or that those events had something to do with their behavior. Some admitted that they had never revealed the events in traditional counseling, and in fact, had never been directly asked by their counselors if traumatic events had ever occurred. As adolescents who felt they had to appear strong and

self-sufficient, they had not always wanted to reveal the fear that they continued to experience. Moreover, many children had been convinced by family or friends that their reactions were abnormal. In contrast, the supportive reaction they received directly from the bench gave these children a different perspective about the importance of their trauma. They began to have hope that their feelings could be understood and dealt with appropriately, even in the midst of society's need to impose limits and consequences for their inappropriate behavior.

Anthony's case illustrates the next phase of trauma identification at our court. Because of the trauma awareness training provided for the Stark County Family Court staff, the court placement officer was sensitive to the effects of trauma. He uncovered Anthony's tragic history in the process of gathering background information and recognized the need for a mental health referral that would specifically address Anthony's trauma reactions and provide education and support for his caregivers.

Briana's case occurred after our court had recognized the wisdom of utilizing a recognized screening tool, in this case the UCLA Post-Traumatic Stress Disorder Index. At the point at which Briana's reactions began to suggest to the court that there was more to the story than she had first revealed, we had the appropriate tool to assess Briana, who benefited from this screening.

We chose a screening tool because we recognized the need to identify the types of trauma experienced by youths, the intensity of their reactions, and the amount of interference such reactions caused in their daily lives. While there are many excellent screening tools available, we chose the UCLA PTSD Index. It is a brief, easily understood, and quickly administered screening instrument, which asks questions about types of traumas that might have occurred and about typical feelings, sensations, and emotional symptoms that the youth might be experiencing in reaction to a traumatic event. Perhaps most importantly, the UCLA PTSD Index asks youths how often they experience symptoms such as nightmares, flashbacks, intrusive thoughts or images, and hypervigilant behavior. These questions are posed in an age-appropriate manner that can be comprehended by a youth with a fourth-to-fifth grade reading level. By exploring how much interference the youth is experiencing from trauma-related symptoms, the UCLA PTSD Index makes it possible to distinguish between those children with difficult life experiences who are coping and those whose behavior and functioning is chronically affected by the aftermath of trauma. The UCLA PTSD Index is available, free of charge, by writing to asteinberg@mednet.ucla.edu. The Index is easy to score, and the National Child Traumatic Stress Network (http://www.nctsn.org) has an excellent PowerPoint presentation about how to score it.

Our use of this screening tool has extended beyond simply providing a score indicating the likelihood of PTSD. The structure of the Index gave our court placement officer the opportunity to inquire more deeply, making it clear to the youth that the events that had taken place were important. A simple understanding that attitudes, beliefs, and feelings change dramatically as a result of trauma was an important link toward helping the youth gain a better sense of control. Since many children report more than one traumatic event, it was possible for our court placement officer to discuss the cumulative effects of trauma and the fact that people do not simply "get over it" or

become stronger as a result. Discussions about the questions posed by the UCLA PTSD Index also helped the adolescents understand that their reactions to the trauma were normal, not "crazy" or "weird." We found that such normalization and reassurance of "sanity" often exponentially increased the amount of data disclosed by the youth.

By using the Parent Version of the Index, the court has the opportunity to question parents and caregivers about their perceptions of the child's behavior and to ask for their recollections of traumatic events in the child's life. Our administration of both scales revealed that many caregivers had no idea that their children were struggling with significant fear, anxiety-provoking images, and hopelessness about the future. The children had simply not revealed their thoughts, feelings, and experiences. As adolescents, they did not want to admit that they avoided situations and other "triggers" because of the frightening memories and anxieties that resulted. They had not reported their nightmares, and their inability to stop thinking about the traumatic event, because they believed that these symptoms meant that something was wrong with them. Although caregivers often identified certain traumatic events in the life of the youth, they had not perceived the continuing negative repercussions of these experiences. Our discussions with these families made it obvious that they were frustrated with their children's behavior, but they had not connected the behavior with past traumas.

Thus, the use of the UCLA PTSD Index immediately provided our court with the opportunity to not only screen the children but also to educate their families regarding the effects of trauma and the necessity of appropriate treatment intervention. Since many traumas are shared experiences within a family, adult caregivers who responded to the UCLA PTSD Index sometimes recognized that they too continued to experience negative emotional effects from traumatic events. Quite often, the youth was presented to us as the identified trauma survivor, but as family members were educated about trauma, there was frequently much more to the story, and generational patterns of abuse and violence emerged. It was clear that, for many caregivers, their own trauma histories had negatively impacted their ability to parent their children effectively and empathically.

TRAUMA-FOCUSED TREATMENT

Our success with the UCLA PTSD Index has raised trauma awareness among those who work with children. Currently, when anyone on the court staff suspects trauma, he or she refers the child or adolescent for screening. Social workers, probation officers, detention staff, hearing officers, and guardians *ad Litem* know that trauma screening is available at the court. They understand that the screening tool is a valuable method of identifying youths who require a specific mental health intervention to alleviate their symptoms, and that intervention is trauma-focused treatment. There are a number of evidence-based, trauma-focused treatments available, and eventually we would like to offer more than one in our community. Initially, however, we chose Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) because it is well-established as an effective treatment for traumatized children and their caregivers, (Cohen, Mannarino, & Deblinger, 2006; Deblinger & Heflin, 1996). Because TF-CBT was developed and tested

within the past 20 years, many clinicians must undergo additional training in order to utilize it. A training Web site in TF-CBT is available at http://www.musc.edu/tfcbt, and there is now also a network of TF-CBT advanced trainers in every state. Information about TF-CBT and other efficacious trauma-focused treatments for youths and their caregivers is available at http://www.nctsn.org.

Once screening has taken place, the court refers cases to mental health providers who can provide the most effective trauma-focused treatment. Many youths in our system are veterans of older, unsuccessful mental health approaches and, therefore, view mental health intervention as tedious, useless, or worse. For those children, education about trauma-specific treatment is extremely important. Part of our approach includes discussion about how trauma-focused treatment is different from regular counseling. We explain that experiencing trauma makes it very difficult to feel capable and in control, and that building coping skills, and reducing fear and anxiety, will be a central focus of their treatment. Although many children surprise us with the degree of detail they provide at screening, we advise them that discussion of these experiences during counseling sessions will occur only at a pace that they can manage and directly control. We let children know that trauma-focused treatment does not involve "spilling your guts about what happened," but is a carefully measured approach that can help them truly appreciate the fact that they are not victims of trauma, but survivors of trauma.

Caregivers of trauma-affected youths often share their low confidence in mental heath intervention. We are careful to highlight the fact that the best trauma treatment approaches include a significant amount of caregiver intervention. Caregivers need to be convinced that their child can be helped with an evidence-based approach that will not simply constitute another treatment failure. We recognize their struggles in parenting a trauma-affected child and consider the caregiver's own trauma history. We make it clear to the caregivers that their input is important and that they can learn to respond to their children in helpful ways. Behaviors, attitudes, and feelings that once seemed intractable and confusing can make sense when viewed within the context of trauma. Because TF-CBT helps the youth organize and understand the impact of traumatic events, the caregiver can learn a great deal about their child through this counseling process.

TRAUMA IN CHILD PROTECTION CASES AND THE IMPORTANCE OF EARLY INTERVENTION

Although our court first became trauma-informed because of trauma in delinquency cases exemplified by Josh, Anthony, and Briana, trauma is obviously very much a part of the dependency, neglect, and abuse docket. Child Protective Services is charged with making reasonable efforts to reunify the family. This responsibility to reunify often narrows the focus to the emergent needs of the parents. While the social worker struggles to connect the parents to parenting classes, drug and alcohol treatment, and mental health counseling, the children are presumed to be fine if they are warm, dry, fed, and out of imminent danger. Yet, at a minimum, children have suffered the trauma of being removed from their parents. There are still those in the juvenile justice system who believe that children are resilient

and will grow out of the adversity experienced in childhood. In fact, some social workers and probation officers believe that addressing past trauma is actually harmful, and it is better not to revisit past events and stir up bad memories.

While many hearing officers also believe that children are tough, and that the passage of time and a protective environment will heal their wounds, the Stark County Family Court learned this was not an accurate assumption. The groundbreaking study by Kaiser Permanente and the Centers for Disease Control regarding the aftereffects of Adverse Childhood Experiences (ACE) (Felitti et al., 1998) demonstrated that children who experience bad things do not necessarily get over them or go on to live a healthy adult life. The ACE Study identified adverse childhood experiences such as psychological and physical abuse by parents, sexual abuse by anyone, household dysfunction such as substance abuse, mental illness, domestic violence, or the loss of parents due to imprisonment or abandonment. Children who had experienced one or more of the identified adverse experiences were, as adults, statistically more likely to suffer from health problems and high-risk behaviors that ultimately shorten their lives. The ACE Study found that a significant proportion of adult depression, drug abuse, alcohol abuse, smoking, lung disease, and severe obesity could be traced back to the aftereffects of adverse childhood experiences. In fact, the study concluded that adverse childhood experiences are strong predictors of the ten most common causes of death in the United States (Felitti et al., 1998). Simply put, without professional help and counseling, many kids do not get over bad things that happen in childhood. They do not get past it. They do not learn to live with it. Without help, a great many of them are forever scarred. They grow up self-medicating with drugs and alcohol. They engage in risky behavior that causes them to die prematurely.

Our court was deeply impressed by the ACE Study and its implications for children who come before the court. Many of these children have suffered multiple adverse experiences, often to an extreme degree, and in general, they lack the kinds of supports that make children resilient. They are not from supportive families and neighborhoods that augment their ability to withstand and recover from adverse experiences. Once we understood the effects of trauma, we could no longer accept the belief that recovery would occur automatically without mental health treatment that addressed trauma in efficient and effective ways. As a court, we believed that it was imperative to insist that our entire child-serving system—juvenile justice, child protective services, schools and mental health providers—become educated about trauma and the need to address it comprehensively. While there were many avenues of identification and intervention possible in our community, trauma awareness at our juvenile court was the first step toward a frank assessment of our community resources for trauma identification and treatment. The more we learned, the more we felt compelled to take a leadership role toward changing the status quo.

THE TRAUMATIZED CHILD TASK FORCE

A juvenile court judge enjoys a unique ability to act as a community convener. When the juvenile judge calls a meeting, people come, and that is exactly what happened

in this case. We arranged a presentation on trauma and post-traumatic stress for mental health professionals, social workers, school officials, criminal justice officials, and community activists. After hearing the presentation, all attendees were better informed about trauma, but a core group of about 25 felt strongly that trauma was an underlying factor for many children experiencing difficulty in our schools and our community. Because that core group wanted to know more and to do more, they formed our community's Traumatized Child Task Force.

One of the first projects for the Task Force was to bring well-known trauma researcher Dr. Bruce Perry to Stark County to raise community awareness about the issue of trauma in children. Dr. Perry first came to national attention for his work with the Branch Davidian children and, later, the children traumatized by the Oklahoma City bombing (Perry & Szalavitz, 2006). When we announced to our community that we were holding an all-day conference about the effects of trauma on children, we were hoping for 200 participants; more than 500 attended. This level of interest confirmed our belief that trauma and its effects on the behavior of children was an area of concern for our community. When Dr. Perry talked about the effects of trauma on the human body and mind, he told us he was speaking as a biologist. Dr. Perry told us, "This is not social theory. This is biology. When you subject the human organism to traumatic experiences, you get a very predictable result, and it is best summarized by the symptoms of PTSD." We decided to continue our effort to make our community more trauma-informed.

The next task for the Stark County Traumatized Child Task Force was to survey our mental health providers. We were surprised to learn that nearly all of them felt they were providing high quality trauma treatment and yet few were utilizing evidence-based treatments, such as Trauma-Focused Cognitive Behavioral Therapy. In addition, when hearing officers at the court asked juveniles about their trauma history, we learned that many severely traumatized children had been in counseling for years but had never once discussed with their therapist the terrible things that had happened to them.

As we studied our treatment providers, the Task Force began to realize that not all counselors were comfortable assisting clients with the powerful emotional responses that are often part of effective trauma treatment. We also found that, although our mental health providers had appropriate college and graduate training, this training had not included specific instruction regarding best practices for trauma treatment. Thus, although well-trained in many ways, many of our mental health providers were not necessarily qualified to assess and address trauma in an effective fashion.

Consider the case of a 9-year-old child who attacked his teacher in the classroom. The teacher leaned back against her desk and knocked a book to the floor, which landed with a loud smack. The boy came out of his seat in the front row and began to choke the teacher. The classroom aide pulled him off the teacher. He was arrested, charged with felonious assault on school personnel, and detained in our detention facility. The boy appeared for arraignment the next day. As he sat at the counsel table, his feet did not reach the floor. The boy had an attorney and he pled true to the offense. The incident happened in an alternative school for severely behaviorally handicapped children, which is partially staffed by children's mental health professionals. The treatment staff suggested keeping the boy locked up for a week in order to "teach him a lesson."

It is difficult for hearing officers to argue against mental health professionals who have been working with a child for a long time. Moreover, these mental health professionals were suggesting consequences for actions, which is a traditional juvenile justice disposition. Yet our knowledge of trauma suggested to the court that the assault might be attributed to a fight-or-flight reaction because it was unprovoked and preceded by a startling sound. If the boy's attack was a reaction, rather than a deliberate oppositional act, what lesson would he learn in lock-up? Our knowledge of trauma suggested that no matter how long he was locked up, the boy would react exactly the same way the next time he was frightened. A trauma assessment revealed that the boy had been the victim of severe physical abuse. He had never been screened or assessed for trauma or its possible impact on his behavior, and as a result, he had never been treated for trauma. Instead, he had been identified as having a severe behavior problem, and previous counseling had been directed at modifying his behavior rather than addressing the underlying causes of that behavior.

It is natural for the juvenile court to defer to mental health providers on issues of mental heath treatment. Yet, in our community, the juvenile court, rather than the mental health providers, has been the driving force in raising trauma awareness. The more progressive segments of the mental health community have been quick to embrace state-of-the-art trauma treatment and implementation of best practices. Some agencies have integrated trauma awareness into their entire culture. These agencies have begun trauma screening and referral to appropriately trained providers literally at the front desk of the organization. The receptionist is trained to ask the right questions and to immediately set up appointments with an appropriately trained therapist. At the same time, we continue to encounter community agencies and therapists who do not see the value in updating their knowledge and skills regarding trauma. In spite of the overwhelming evidence of the immediate and long-term effectiveness of trauma-focused treatment methods, some therapists have not embraced these techniques. Given this knowledge, we could not assume that all of our mental health providers were using evidence-based treatment, or were assessing for trauma in any organized fashion. Thus, while the assessment of our community mental health system revealed areas of strength and clinical excellence, it also revealed areas in need of improvement.

The Traumatized Child Task Force decided that we needed to facilitate training for therapists who wanted to be educated in best practice techniques for trauma treatment. We were able to obtain training at no cost from Community Treatment and Services Centers that are part of SAMHSA's National Child Traumatic Stress Initiative. These centers are required to disseminate evidenced-based treatment methods. With this help, and some small local grants, we have been able to move our trauma treatment initiative forward on a very modest budget. Although tremendous change is possible even with very little money, it quickly became clear that day-long seminars by outside trainers would not be sufficient to prepare our local therapists to competently administer TF-CBT and other evidence-based treatments. Therefore, we established a "Learning Collaborative" to assist our mental health professionals in enhancing their skills on an ongoing basis. These community-based clinicians meet once per month to discuss cases and techniques applicable to trauma treatment. Our Learning Collaborative also established

a listserv as a means of sharing articles and trauma information. Some providers developed educational presentations regarding trauma that could be delivered to the wider community, such as school counselors, foster parents, and child protective services caseworkers. One provider initiated trauma treatment for youths incarcerated in our local detention facility. Pre- and post-treatment evaluation of these youths revealed substantial symptom-reduction at the conclusion of the group. Long-term follow-up of these youths indicated very positive effects on recidivism and overall functioning within the community. Our court is currently considering additional ways to track the treatment outcomes of youths referred by the court for trauma-focused services, and has devoted staff resources toward this objective.

Despite these successes, working toward the goal of a fully trauma-informed mental health provider community has not been an easy task. Stark County's mental health system experiences the same stresses that persist elsewhere: limited funding and a high demand for services. The provision of specialized treatment for youths affected by trauma represented yet another area of need within a system that is already stretched to capacity and suffers from limited training, time, and money. Even when training was provided at no cost, our community mental health agencies struggled to support the continued mentoring and supervision of therapists interested in providing trauma-focused treatment. Our Learning Collaborative has attempted to provide support for these interested providers. We continue to stress the need to integrate trauma screening into diagnostic assessment procedures. Once trauma has been identified, agencies must create internal referral processes that will match those trauma-affected children with appropriately trained counselors utilizing evidence-based treatment.

In addition to building capacity to treat trauma, the Stark County Traumatized Child Task Force is striving to create greater community awareness about trauma and its effects on behavior. Our goal is for anyone serving children, including probation officers, school counselors, detention workers, nurses, and pediatricians, to understand trauma, its symptoms, and its long-term effects. We want mental health and medical professionals to inquire about, and screen for, trauma prior to diagnosing a child with Bipolar Disorder, Oppositional-Defiant Disorder, or Attention-Deficit/Hyperactivity Disorder. We want our local professionals to understand and use screening tools to determine if trauma is a factor in the behavior of a youth who may come to their attention and to ensure that the child receives evidenced-based treatment to help restore the child's sense of control over his or her life. An appropriate referral leading to trauma treatment conducted by a qualified mental health professional can make the difference between recovery and continued struggle for children and their caregivers.

It is an unfortunate fact that children affected by trauma exist in every community. Stark County, Ohio, is not unique in size, population, or government. Thus, our efforts to increase trauma awareness and improve the ability of our entire community to respond to traumatized children and their families, while far from being complete, may represent a model of system involvement that can be implemented and improved upon by others. Our children deserve our diligent efforts to actively use what we have learned about trauma to ensure that they have the opportunity to grow to healthy adulthood.

Lessons Learned:

1. Prior traumatic experiences often adversely affect children's behavior.
2. Trauma is prevalent among children on a juvenile court docket.
3. Juvenile judges and staff should be trained in order to be trauma-informed.
4. A juvenile court judge can convene the community to address trauma.
5. A task force of interested community stakeholders can enhance collaboration among child-serving agencies.
6. A nationally known speaker generates community interest and commitment.
7. Trauma assessment tools are readily available, easy to use, and some are free.
8. An inventory of community mental health services can identify gaps in service.
9. Evidence-based treatments are more efficacious, but not all therapists use them.
10. Training in evidenced-based treatment is available, sometimes without charge.
11. A learning collaborative helps therapists perfect trauma treatment skills and maintain fidelity to evidence-based models.
12. Excessive funding is not required to implement a trauma-informed program.
13. Addressing trauma reduces behavioral problems and recidivism.
14. Trauma treatment can make the difference between recovery and continued struggle for children and their caregivers.

Web-Based Resources:

- National Child Traumatic Stress Network (http://www.nctsn.org)
- National Council of Juvenile and Family Court Judges (http://www.ncjfcj.org) National Center for Trauma-Informed Care (http://www.mentalhealth.samhsa.gov/nctic)
- Child Trauma Academy (http://www.childtrauma.org)
- CARES Institute—Child Abuse Research Education Service (http://www.caresinstitute.org)
- Center for Traumatic Stress in Children and Adolescents—Allegheny General Hospital (http://www.pittsburghchildtrauma.org)
- National Institute for Trauma and Loss in Children (http://www.tlc.org)
- International Society for Traumatic Stress Studies (http://www.istss.org)
- Medical University of South Carolina (http://www.musc.edu/tfcbt)
- Ohio Can Do 4 Kids (http://www.ohiocando4kids.org)

REFERENCES

Berman, S. L., Kurtines, W. M., Silverman, W. K., & Serafini, L. T. (1996). The impact of exposure to crime and violence on urban youth. *American Journal of Orthopsychiatry*, *66*, 329-336.

Carrion, V. G., Weems, C. F., & Reiss, A. I. (2002). Toward an empirical definition of pediatric PTSD: The phenomenology of PTSD symptoms in youth. *Journal of the American Academy of Child and Adolescent Psychiatry*, *41*, 166-173.

Cohen, J. A., Mannarino, A. P., & Deblinger, E. (2006). *Treating trauma and traumatic grief in children and adolescents*. New York: Guilford Press.

Deblinger, E., & Heflin, A. H. (1996). *Treating sexually abused children and their non-offending parents: A cognitive-behavioral approach*. Thousand Oaks, CA: Sage Publications, Inc.

Felitti, F. J., Anda, R. J., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & 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 (http://www.acestudy.org).

Perry, B., & Szalavitz, M. (2006). *The boy who was raised as a dog: What traumatized children can teach us about loss, love and healing*. New York: Basic Books.

Pynoos, R. S., Frederick, C., Nader, K., et al. (1987). Life threat and posttraumatic stress in school-age children. *Archives of General Psychiatry*, *44*, 1057-1063.

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.