Open Access 6 Article

Delivering Trauma-Informed Care in the Juvenile Justice Setting

Darson Rhodes[a], Carol Cox[b] ✉, Patrick C. Herbert[c], Haley Bylina[b], Parker Heman[b], Emily Rembush[b], and Johnnie Mehl[b]

[a]The College at Brockport - State University of New York, [b]Truman State University, [c]Towson University

ABSTRACT

Youth taken from the home and placed in emergency shelter, secure detention, and residential settings are exposed to new sources of trauma and danger that may re-activate severe stress symptoms leading to re-traumatization. A juvenile justice center planned a trauma-informed, system-focused intervention that included recommended elements: appropriate assessments of trauma symptoms, evidence-based programs and treatments to build resilience skills in youth and families, staff training, community collaboration and partnerships, and a safe environment to reduce the risk of re-traumatization. The purpose of this study was to describe the implementation over two years of the trauma-informed, system-focused intervention in the juvenile justice center and associated effects on youth trauma symptoms. Current and past traumatic event exposure, change in youth participants' emotional regulation, effects of an evidence-based, trauma-informed therapeutic intervention on youth participants' stress symptoms, and quality of the organizational trauma-informed care plan were assessed. Although efforts to improve participant emotional regulation and post-traumatic stress symptoms did not demonstrate significant differences, efforts to screen for trauma exposure at intake provided important information about participant multiple traumas to assist with the therapeutic process. Efforts in changing organizational culture and policy did result in minor self-reported facility environmental improvements. For the practitioner, even when an intervention is well planned, results are not always positive in actual practice.

Received February 2021; **Accepted** July 2021; **Published** September 2021 **DOI:** 10.52935/21.1881545.09

INTRODUCTION

Exposure to extreme, traumatic events can overwhelm the coping mechanisms of youth. Adverse childhood experiences such as exposure to abuse, neglect, violence, intense loss, drug abuse, and mental illness can negatively affect brain development, physical health, mental health, and health risk behaviors (Dye, 2018). Trauma can obstruct the development of emotional self-regulation, therefore, slowing the ability to understand consequences of actions and impeding healthy decision-making leading to delinquency (Evans-Chase, 2014). Over 80% of youth involved in the juvenile justice system/social services nationally have a history of multiple traumatic events

and stressors (poly-victimization) and are at high risk for stress-related disorders as well as socio-emotional, behavioral, and chronic health problems throughout their lives (Ford et al., 2014).

For juvenile justice-involved youth, those with more exposure to traumatic events, both before and after incarceration, are more likely to re-offend (Baglivio et al., 2014) and engage in violent behavior (Evans-Chase, 2014). Youth in the system are more likely than other youth to have incarcerated parents, be victims of violence, and live in poverty (Evans-Chase, 2014). Youth taken from the home and placed in emergency shelter, secure detention, and residential settings are exposed to new sources of trauma and danger that may re-activate severe stress symptoms leading to re-traumatization (Ford et al., 2014). Overall, the juvenile justice system has historically lagged behind other behavioral health systems on identifying and responding to youth trauma, and system-level reforms have been recommended (Buckingham, 2016).

Because youth involved in the juvenile justice system have a high degree of traumatic stress exposure, trauma-aware settings and interventions (youth and family engagement, empowerment, and collaboration as viewed through the lens of trauma) have been recommended for them. Not only trauma-aware practices but also trauma-informed policies and systems change are coming to the forefront to more comprehensively address the environment of care (Dierkhising et al., 2013). An evidence-based, trauma-informed juvenile justice system includes appropriate assessments of trauma symptoms, evidence-based programs and treatments to build resilience skills in youth and families, staff training, community collaboration and partnerships, and a safe environment to reduce the risk of re-traumatization (Dierkhising et al., 2013).

A judicial circuit court region for a three-county area in a Midwest state reported total removals of youth to foster care, re-entries to foster care, overall maltreatment reports, and physical abuse and neglect reports as higher than the state rate (Fostering Court Improvement, 2020). Over the past two decades, violent crime in the area increased by 69%. Additionally, in the largest county in the three-county area, 325 children were recently involved in hotline reports (mandated reporters such as teachers and social workers call the state department of mental health to report suspected abuse, neglect, or exploitation), and 55 children demonstrated substantiated abuse or neglect (United Health Foundation, 2020). Due to these trends, the juvenile justice center serving this area planned a trauma-informed, system-focused intervention that included recommended elements: appropriate assessments of trauma symptoms, evidence-based programs and treatments to build resilience skills in youth and families, staff training, community collaboration and partnerships, and a safe environment to reduce the risk of re-traumatization (Dierkhising et al., 2013). Therefore, the purpose of this study was to describe the implementation over two years of the trauma-informed, system-focused intervention in the juvenile justice center and associated effects on youth trauma symptoms.

RISK-FACTORS FOR FEMALE DELINQUENCY

Participants

From 2017-2019, 49 middle and high school aged youth adjudicated to a juvenile justice center (for both short- and long-term placement) from a Midwest state were asked to be in the study. After all consents, all (100%) youth chose to participate in the study. The secure, licensed juvenile justice center includes a residential treatment unit that houses youth who are victims of abuse and/or neglect with behaviors that are usually violent and unmanageable. It also includes a secure detention unit, housing youth who have committed delinquent acts. The juvenile justice center also offers educational, recreational, and social activities that meet the needs of the troubled youth.

Instruments

To describe current and past traumatic event exposure in youth entering the juvenile justice center, the Traumatic Events Screening Inventory for Children protocol was used. Administered as a semi-structured clinical interview by a qualified mental health professional, the 26-question instrument assesses respondent exposure to a variety of traumatic events. The score on the index is the total number of experiences classified as trauma. Additional questions categorize the trauma as a physical threat or subjective fear. The instrument is valid for assessment of stress disorder and complex trauma. Test-retest reliability ranges from.50-.70, and interrater agreement ranges from .73-1.00 (Ford, 2002).

To describe change in youth participants' emotional regulation pre-post community member-led, evidence-based, educational intervention, the 36-item Difficulties in Emotion Regulation Scale (DERS) was used. Content-valid with acceptable test-retest reliability and internal consistency (Cronbach alpha = .86), the instrument measures multiple characteristics of emotional regulation as part of complex child trauma. The instrument yields both total and sub-scale scores (Gratz & Roemer, 2004).

To describe the effects of an evidence-based, trauma-informed therapeutic intervention on youth participants' stress symptoms, the Clinician-Administered PTSD Scale for DSM-5-Child/Adolescent Version (CAPS-CA-5) was used. The 30-item scale, with strong psychometric properties (internal consistency: Cronbach alpha=.78), is administered by a therapist and measures post-traumatic stress disorder symptoms using standardized questions and follow-up probes. Stress symptom frequency and intensity are calculated to create total and symptom cluster severity scores to determine symptom impact on participant function (Pynoos et al., 2015).

To describe the quality of the organizational trauma-informed care plan pre-post intervention, the National Council's Seven Domains of Trauma-Informed Care/Organizational Culture Scale (National Council for Behavioral Health, 2017) was used. A self-report, degree of alignment with the core principles of a trauma-informed organization are rated on a scale of 0 (do not meet the standard) to 4 (exemplary meeting of the standard). The organization management self-rates on alignment to the following standards: Domain 1 - Early Screening and Comprehensive Assessment, Domain 2 – Consumer Driven Care and Services, Domain 3 - Trauma-Informed, Educated and Responsive Workforce, Domain 4 - Trauma-Informed, Evidence-Based and Emerging Best Practices, Domain 5 - Safe and Secure Environments, Domain 6 - Community Outreach and Partnership, and Domain 7 - Ongoing Performance Improvement and Evaluation.

Procedure

Over the course of two years, the juvenile justice center administration and staff created and implemented a plan that included recommended elements for a trauma-informed service system. To meet the 'appropriate assessments of trauma symptoms' recommendation, trauma screening of all youth at intake was initiated first, during year one. Using the Traumatic Events Screening Inventory, front line staff interviewed youth participants during the juvenile justice center entry and processing process. Post-traumatic stress disorder is estimated to be about eight times more prevalent in adjudicated youth than in their non-adjudicated peers (Ford et al., 2014). As they enter the system, universal screening tools, like the Traumatic Events Screening Inventory, can identify any youth in need of additional assistance related to past trauma; however, few in the juvenile justice system are screened for trauma-related disorders. Once a positive screen identifies a need, a more comprehensive diagnostic assessment by trained clinicians or staff can inform the treatment and therapy

plan and evaluate therapeutic progress (Ford et al., 2014).

Next, to meet the 'evidence-based programs and treatments to build resilience skills in youth and families' as well as the 'community collaboration and partnerships' recommendations, a youth education through community partnership program was established. Each semester, starting at year one, Trauma Affect Regulation: Guide for Education and Therapy, an evidence-based, trauma-specific, educational intervention for youth in juvenile justice, was taught to youth participants by trained community member partners. The curriculum supports a systems-approach and aligns well with therapeutic treatments like Dialectical Behavior Therapy. The curriculum included weekly, hour-long, group educational sessions that taught skills for emotional processing and self-regulation for intense, trauma-related emotional reactivity (Advanced Trauma Solutions, n.d.).

Following screening and educational component enactment, staff training in a trauma-specific therapeutic intervention and administrative changes to the physical environment and emotional climate were enacted during year two to meet recommendations for 'staff training' and 'safe environment to reduce the risk of re-traumatization'. All therapists were trained in Dialectical Behavior Therapy, a trauma-focused, behavioral therapy used to help youth regulate intense emotions, teach distress tolerance skills, improve relationships in spite of overwhelming stress, and reduce self-destructive behaviors (Rathus & Miller, 2014). The therapy was used in all appropriate youth counseling sessions and family therapy sessions post-training.

For any therapeutic intervention program for trauma-affected youth in juvenile justice to be effective, the physical environment and emotional climate of the facility have to be supportive of the intervention to avoid re-traumatization. Staff training, administrative support, and policies and procedures need to be in place to ensure youth can benefit from the therapy (Ford et al., 2014). Environmental and organizational changes can help reduce the risk of institutional trauma but require a major paradigm or culture shift. Staff training, facility mission, and behavior management or housing policies are examples of areas that can be developed in a systems approach to creating a trauma-informed, safe environment (Burrell, 2013). The National Council for Behavioral Health's 'Trauma-informed Care Initiative' (National Council for Behavioral Health, 2017) was conducted by juvenile justice center administrators. Early in year one, an organizational audit/self-assessment of readiness to adopt trauma-informed care was conducted. Over the course of two years, results were reviewed with the entire staff, and National Council consultants met with staff and conducted trainings, webinars, and consultation calls. Resources, tools, and organizational improvement strategies were then delivered by the National Council to address identified policy, procedure, and other environmental gaps. At the end of year two and after selected strategies were implemented, the organizational audit/self-assessment was conducted again to note any progress towards a more trauma-informed system-wide approach.

Analysis

Descriptive statistics were computed for items on the Traumatic Events Screening Inventory for Children (TESI-C), Difficulties in Emotion Regulation Scale (DERS), Clinician-Administered PTSD Scale for DSM-5-Child/Adolescent Version (CAPS-CA-5) as appropriate. Total scores and were computed on the subscales and total scales for the DERS and CAPS-CA-5. Paired t-tests were computed on pre- and post-DERS scores. Frequencies were computed for the pre- and post-assessments using the National Council's Seven Domains of Trauma-Informed Care/Organizational Culture Scale.

RESULTS

There was a total of 24 youth to whom the TESI-C was administered at intake. An average of 7.75 traumas were reported (SD = 3.33). The greatest number of traumas reported by any one youth was 13 and the least number was two. The most frequently reported traumas were having known someone who got really hurt or sick or even died, and having a family member put in jail/prison, or having the police or soldiers come to one's house and indicate the family was in big trouble. These traumas were reported by 20 of the 24 youth. The least commonly reported trauma was being kidnapped or having someone in the family kidnapped, which was reported by two youth. See Table 1.

The Difficulties in Emotion Regulation Scale (DERS) was initially completed in full on 31 youth, and partial data were collected for one youth. Higher scores on the DERS reflect greater problems with emotion regulation. Of the six subscales within the DERS, the subscale that youth scored the poorest on was the Difficulty Engaging in Goal-Directed Behavior (i.e. Goals) subscale with a mean score of 15.52 (SD = 5.76) and grand mean of 3.10. The subscale that youth scored the most favorably on was the Lack of Emotional Clarity (i.e. Clarity) subscale with a mean score of 11.16 (SD = 4.14) and grand mean of 2.23. The total mean on the DERS was 94.80 (SD = 26.96) and a grand mean of 2.63. See Table 2. There were four youth that completed a DERS partially through their time in detention or at exit from detention. A statistical analysis using a series of paired samples t-test was computed to compare the differences in the intake and to the most current scores of these youth. Results were not statistically significant.

The Clinician-Administered PTSD Scale for DSM-5 – Child/Adolescent Version (CAPS-CA-5) was completed at intake for 30 youth. Of those 30, two youth were discharged and completed the CAPS-CA-5 at that time. Of the four categories of symptoms within the CAPS-CA-5, the symptoms that were most often reported at intake with respect to comparing grand means were in the Intrusion category and the Avoidance category, both with a grand mean of 0.8. Symptoms in the Cognitions and Mood category and Arousal and Reactivity category were least often reported at intake, both with a grand mean of 0.6. The total mean on the intake CAPS-CA-5 was 5.40 (SD = 9.22) and a grand mean of 0.07. See Table 3. For the two youth who completed both the intake and exit CAPS-CA-5 instrument, the intake total scores were 2.00 and 5.00 and decreased to 1.00 and 0.00, respectively at discharge.

The National Council's Seven Domains of Trauma-Informed Care/Organizational Culture Scale was completed at the beginning and end of the intervention. Scores were higher in all domains on the second assessment except for two categories. In Domain 1: Screening Assessment, pre- and post-scores were the same at 3.2, and in Domain 4: Best Practices post- scores were 3.2 while pre-scores were 3.3. Overall, the highest score was the post-score in Domain 4: Safety Environment with a score of 3.6. See Table 4.

DISCUSSION

Based on current trends and best practices in the field, a Midwest juvenile justice center implemented a trauma-informed, system-focused intervention with recommended elements for a trauma informed system. This type of systems-based approach has been shown to improve the physical and psychological safety of youth detained in the juvenile justice system, as well as staff members (Pickens, 2016). Associated effects on youth trauma symptoms were also studied over this two-year period. In analyzing the recommended elements for a trauma-informed service system, four tools were used in this study:

Traumatic Events Screening Inventory for Children (TESI-C), Difficulties in Emotion Regulation Scale (DERS), Clinician-Administered PTSD Scale for DSM-5-Child/Adolescent Version (CAPS-CA-5) and the National Council's Seven Domains of Trauma-Informed Care/Organizational Culture Scale.

The Traumatic Events Screening Inventory for Children (TESI-C) scores demonstrate a need for a trauma-informed approach as the majority of the participants exhibited multiple traumas in their lives, consistent with previous findings (Ford et al., 2014). Also, similar to previous literature (Evans-Chase, 2014), about 80% reported having incarcerated parents as a traumatic event. More trauma in their lives places these youth at higher risk for other socio-emotional problems and increased risk for re-offending (Baglivio et al, 2014; Ford et al, 2014). Screening for early identification of traumas can help therapists target specific therapeutic modalities for specific issues. Ultimately, the goal is to promote healthier ways to deal with exposure to traumatic events through this type of approach, instead of re-traumatizing individuals in the juvenile justice system (Ko et al., 2008).

Scores for the DERS were not statistically significant from beginning to end of the intervention. The trauma-specific, educational intervention did not seem to improve participant emotional processing skills. Although the educational sessions offered skill-based lessons for self-regulation that aligned well with the therapeutic treatment participants were receiving (Advanced Trauma Solutions, n.d.), there may have been limited opportunity in the highly structured center environment for independent skill practice. Participant readiness and openness for educational lessons may have also been low as they were dealing with some traumas that may have made it extremely difficult to focus on classroom-style lessons.

Although all therapists were trained in a new trauma-specific therapeutic intervention, participant post-traumatic stress symptoms did not significantly decrease. The Clinician-Administered PTSD Scale for DSM-5 – Child/Adolescent Version (CAPS-CA-5) was used to measure PTSD symptoms among the participants. This instrument showed that youth in this juvenile justice center displayed a number of current PTSD symptoms with the categories of intrusion and avoidance most often displayed among the participants. It may take a different style of therapy or a longer length of time than an average participant stay at the center to decrease these types of symptoms.

The National Council's Seven Domains of Trauma-Informed Care/Organizational Culture Scale was used to self-report the changes from the perspective of the organization's administration. Organizational culture can be slow to change, and it seemed that only minor improvements were made on environmental and policy issues. This type of tool is necessary, however, to audit the organization's strengths and needs as changes are implemented in the prevailing culture (Pickens, 2016). This audit will also help inform strategic planning moving forward in this juvenile justice center. Five of the seven domains showed improvement after implementation of the organization care plan; however, none were statistically significant. Overall, the post-scores were at least partially meeting or meeting all of the standards, with half classified as mostly meeting the standards.

For staff and practitioners considering a more trauma-aware focus in their professional practice or facility, the practical implications of this study are numerous. Attempting to transform to a more trauma-aware or trauma-focused practice is feasible and does not require a great time commitment. For example, the minimal time dedicated to trauma screening at intake, quickly conducted by any staff member, may increase awareness of complex traumas and decrease practitioner frustration when dealing with client behaviors upon entry and processing – saving valuable time in the end. Some additional

time taken to assess specific characteristics of negative emotional regulation pre-treatment may also improve choice of treatment modalities. The screenings and assessments may take a little time, but cost is minimal. Assessing the environment and making appropriate policy modifications can also support client behavior changes learned during therapy. Although only small positive changes and trends in some areas were demonstrated in this study, and sometimes change may be difficult to accept for some staff and practitioners, it may be well worth pursuing a more trauma-informed or trauma-focused practice.

For the juvenile justice center in this study, lessons were learned about changes needed to move forward. Efforts that have not shown positive results may need to be changed, and efforts that have shown at least some promise may need to be enhanced. Specifically, an emotional regulation intervention that is not as classroom-focused could be implemented, and a different type of therapy, such as trauma-focused cognitive behavioral therapy, could also be tried. Maintenance of the trauma screening at intake is recommended to track any changes in number and types of traumas students present with as they arrive. Lastly, because at least some progress was made in most Domains, aligning center policies with the National Council's Seven Domains of Trauma-Informed Care (National Council for Behavioral Health, 2017) should be continued as part of the center's strategic plan.

This study also has several implications for juvenile justice facilities. Other centers looking to become more trauma-aware or trauma-focused may wish to use different interventions as the suggested elements, try implementing the interventions in a phased-in manner instead of all at once, and use a longer program evaluation timeline to note any changes or differences. Taking the time, although difficult to do in some situations, and results may not always be what was expected, to pre-post-evaluate programs for changes may help target interventions and programming to meet priority needs of the adjudicated youth.

Limitations

While this study highlights the steps to implementing a trauma-informed, system-focused intervention, the findings of this study should be interpreted considering its limitations. First, the youth participants were drawn from one juvenile justice center in the Midwest. Second, the current study did not employ a control group of comparable youth in the juvenile justice system. In addition, many participants were undergoing some longer-term therapies that extended beyond the study timeframe and others were taken to alternative placements before they could complete post-tests at exit. It is also unknown if additional factors outside of the scope of the study may have impacted the results. Lastly, the study results should not be generalized across all juvenile justice youth populations due to the homogenous nature of the sample in this study.

CONCUSION

The system-focused intervention in this study included all of the elements that the literature suggested leads to a successful trauma-informed system of care in a juvenile justice center (Dierkhising et al., 2013). Evidenced-based programs that included community collaboration, staff training in evidenced-based therapies, and justice center climate changes to avoid student re-traumatization, all recommended elements, were implemented over two years. Even with a well-planned, trauma-informed intervention, positive results are not always demonstrated in actual practice.

REFERENCES

Advanced Trauma Solutions. (n.d.). Trauma Affect Regulation: Guide for Education & Therapy. Retrieved January 25, 2017 from: http://www.advancedtrauma.com/Services.html

Baglivio, M. T., Epps, N., Swartz, K., Huq, M. S., Sheer, A, & Hardt, N. S. (2014, Spring). The prevalence of adverse childhood experiences (ACE) in the lives of juvenile offenders. Journal of Juvenile Justice, 3(2), 1-23

Buckingham, S. (2016, June 12). Trauma informed juvenile justice. 53 American Criminal Law Review 641 (2016), Loyola Law School, Los Angeles Legal Studies Research Paper No. 2016-15, Available at SSRN: https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2794718

Burrell, S. (2013). Trauma and the environment of care in juvenile institutions. The National Child Traumatic Stress Network. Retrieved March 22, 2017, from http://www.nctsn.org/sites/default/files/assets/pdfs/jj_trauma_brief_environofcare_burrell_final.pdf

Dierkhising, C.B., Ko, S., and Halladay Goldman, J. (2013). Trauma-informed juvenile justice roundtable: Current issues and directions in creating trauma- informed juvenile justice systems. Los Angeles, CA & Durham, NC: National Center for Child Traumatic Stress.

Dye, H. (2018). The impacts and long-term effects of childhood trauma. Journal of Human Behavior in the Social Environment, 28(3), 381-392.

Evans-Chase, M. (2014). Addressing trauma and psychosocial development in juvenile justice-involved youth: A synthesis of the developmental neuroscience, juvenile justice and trauma literature. Laws, 3(4), 744-758. doi:10.3390/laws3040744

Ford, J. D., Kerig, P. K., & Olafson, E. (2014). Evidence-informed interventions for posttraumatic stress problems with youth involved in the juvenile justice system. Retrieved March, 2017, from http://www.nctsn.org/sites/default/files/assets/pdfs/trauma_focused_interventions_youth_jjsys.pdf

Ford, J., Racusin, R., Rogers, K., Ellis, C., Schiffman, J., Ribbe, D., & Edwards, J. (2002). Traumatic Events Screening Inventory for Children (TESI-C) Version 8.4. National Center for PTSD and Dartmouth Child Psychiatry Research Group, Dartmouth VT.

Fostering Court Improvement, 2020 Statistics for Adair County. Retrieved from: https://fosteringcourtimprovement.org/mo/County/Adair/

Gratz, K. L., & Roemer, L. (2004). Multidimensional assessment of emotion regulation and dysregulation: Development, factor structure, and initial validation of the difficulties in emotion regulation scale. Journal of Psychopathology & Behavioral Assessment, 26(1), 41-54.

Ko, S. J., Ford, J. D., Kassam-Adams, N., Berkowitz, S. J., Wilson, C., Wong, M., … Layne, C. M. (2008). Creating trauma-informed systems: Child welfare, education, first responders, health care, juvenile justice. Professional Psychology: Research and Practice, 39(4), 396.

National Council for Behavioral Health. (2017). Consulting & Training Services. Retrieved January 25, 2021 from: https://www.thenationalcouncil.org/center-for-consulting-training/consulting-training-services/

Pickens, I. (2016). Laying the groundwork: Conceptualizing a trauma-informed system of care in juvenile detention. Journal of Infant, Child & Adolescent Psychotherapy, 15(3), 220-230.

Pynoos, R. S., Weathers, F. W., Steinberg, A. M., Marx, B. P., Layne, C. M., Kaloupek, D. G., Schnurr, P. P., Keane, T. M., Blake, D. D., Newman, E., Nader, K. O., & Kriegler, J. A. (2015). Clinician-Administered PTSD Scale for DSM-5 - Child/Adolescent Version. Scale available from the National Center for PTSD at www.ptsd.va.gov.

Rathus, J., & Miller, A. (2014). DBT Skills Manual for Adolescents. NY: Guilford Publications.

Table 1

Trauma Reported by Youth at Intake (n = 24)

Trauma	Frequency & Percentage
Really bad accident, like a car accident, a fall or a fire	
Yes	5 (20.8%)
No	19(79.2%)
Seen a really bad accident that you weren't actually in	
Yes	8 (33.3%)
No	16 (66.7%)
Been in a really bad storm, like a tornado, hurricane, or a blizzard; or in flood or an earthquake; or hit by lightening	
Yes	12 (50.0%)
No	12 (50.0%)
Known someone who got really hurt or sick, or even died	
Yes	20 (83.3%)
No	4 (16.7%)
Ever had to stay overnight at the hospital or have an operation	
Yes	11 (45.8%)
No	13 (54.2%)
Ever had to go away from your parents or family for a long time; or did your mother, father, or someone else who look after you ever go away for a long time	
Yes	18 (75.0%)
No	6 (25.0%)

Ever attacked you or tried to hurt you really badly on purpose; or has been punished so hard that you were hurt really badly or had to go to the doctor or hospital	
Yes	10 (41.7%)
No	14 (58.3%)
Ever been told by someone they were going to hurt you really badly, or acted like they were going to hurt you really badly	
Yes	7 (30.4%)
No	16 (69.6%)
Even been mugged or were present when a family member or friend was mugged	
Yes	4 (17.4%)
No	19 (82.6%)
Ever kidnapped or have a family member or close friend who was kidnapped	
Yes	2 (8.3%)
No	22 (91.7%)
Ever attacked by a dog or another animal	
Yes	8 (33.3%)
No	16 (66.7%)
Ever seen people in your family fighting (physically) or attacking each other	
Yes	13 (54.2%)
No	11 (45.8%)
Ever heard people in your family really yelling and screaming at each other a lot	
Yes	16 (66.7%)
No	8 (33.3%)

Had a family member put in jail/prison or had the police or soldiers come to your house and indicate your family was in big trouble	
Yes	20 (83.3%)
No	4 (16.7%)
Ever seen people outside your home fighting or attacking each other	
Yes	10 (41.7%)
No	14 (58.3%)
Ever heard people outside your home really yelling and screaming at each other a lot	
Yes	9 (39.1%)
No	14 (60.9%)
Ever seen or heard people attacking each other for real on television or radio (like a war or building blowing up)	
Yes	3 (12.5%)
No	21 (87.5%)
Ever touched by someone in a way you didn't want them to or in way that made you uncomfortable	
Yes	6 (25.0%)
No	18 (75.0%)
Ever been other times when somebody did or said something that made you feel the most sad or scared or unhappy you've ever felt, or that bothers you a lot now; or when you were left all alone and you were afraid you would die or no one would ever help	
Yes	4 (16.7%)
No	20 (83.3%)

Note: Frequencies not summing to 24 reflect missing responses for that item

Table 2

Measures of Tendency and Dispersion for Subscales of Difficulties in Emotion Regulation Scale (DERS) at Intake

Subscale	n	Possible Scores	Mean	Grand* Mean	Std. Deviation
Nonac-ceptance	31	6-30	13.48	2.25	6.04
Goals	31	5-25	15.52	3.10	5.76
Impulse	31	6-30	16.03	2.67	7.23
Awareness	30	6-30	17.77	2.96	5.78
Strategies	31	8-40	20.10	2.51	7.77
Clarity	31	5-25	11.16	2.23	4.14
Total DERS Score	30	36-180	94.80	2.63	26.96

*Grand means are computed by dividing the mean by the number of items in the subscale.

Table 3

Measures of Tendency and Dispersion for Symptom Categories of Clinician-Administered PTSD Scale for DSM-5 – Child/Adolescent Version (CAPS-CA-5) at Intake

Symptom Category	n	Possible Scores	Mean	Grand* Mean	Std. Deviation
Intrusion	30	0-20	1.57	0.08	3.96
Avoidance	30	0-8	0.67	0.08	1.37
Cognitions and mood	30	0-28	1.73	0.06	3.24
Arousal and reactiv-ity	30	0-24	1.43	0.06	1.98
Total CAPS-5-CA	30	0-80	5.40	0.07	9.22

*Grand means are computed by dividing the mean by the number of items in the subscale.

Table 4

National Council's Seven Domains of Trauma-Informed Care/Organizational Cultures

Domain	Pre Scores	Post Score
Domain 1: Screening Assessment	3.2	3.2
Domain 2: Consumer Driven	3.0	3.2
Domain 3: Workforce	1.3	2.9
Domain 4: Best Practices	3.3	3.2
Domain 5: Safety Environment	3.2	3.6
Domain 6: Community Outreach	2.3	2.8
Domain 7: Evaluation Data	2.0	2.3

Note: Reponses ranged from 0 to 4. 0 = we don't meet this standard at all, 1 = we minim this standard, 2 = we partially meet this standard, 3 = we mostly meet this standard, 4 = plary in meeting this standard.

ABOUT THE AUTHORS

Darson Rhodes, PhD, MCHES®, SUNY Brockport.
Dr Rhodes' research interests are in the area of youth with disabilities with recent publications including: Banez, C., Rhodes, D., Visker, J., Larson, K., & Cox C. (2020). A traditional, but brief, job-readiness training program for school-work transition. Int J Disability, Community & Rehabilitation, 18(1), ISSN 1703-3381.

Carol Cox*, PhD, MCHES®, Truman State University
Dr. Cox's research interests are in the area of youth and school health with recent publications including: Visker, J., Cox, C. Banez, J.C., Azim, S., Wang, A., Dunseith, N., & Lasser, B. (2020). Assessing changes in attitudes concerning Developmental Assets among selected middle school students. The Health Educator, 51(1), 48-58.

Patrick C. Hebert, PhD, CHES®, Towson University
Dr. Hebert's research interests are in the area of school health with recent publications including: Rhodes, D., Hebert, P., Whitney, E., Tiberi-Ramos, J., Baer, H., Bylina, H., & Cox, C. (2020). Using a puppet-based, prosocial skills curriculum in an afterschool program to affect prevention knowledge and social behaviors. American Journal of Health Studies, 35(3).

Haley Bylina, Truman State University
Ms. Bylina's research interests are in the area of youth health with recent publications including: Rhodes, D., Visker, J., Forsyth, E., Bylina, H., Cichon, T., & Cox, C. (2019). Change in self-reported inter-professional behaviors of undergraduate health professions students after participating in inter-professional training, Health and Inter-professional Practice 3(4), p.eP1180. https://hipe-pub.org/articles/abstract/10.7710/1180/

Parker Heman, Truman State University
Ms. Heman's research interests are in the area of youth health with recent publications including: Heman, P. (2020). Soft skills for middle school and future work program: A case study. Lethbridge Undergraduate Research Journal, In-review.

Emily Rembush, Truman State University
Ms. Rembush's research interests are in the area of youth health with recent publications including: Visker, J., Forsyth, E., Shertzer, R., Rembush, E., Mehl, J., &Cox, C. (2020). Percieved interprofessional collaborative competencies of intrprofessional faculty. Education for Health. In-review.

Johnnie Mehl, Truman State University
Ms. Mehl's research interests are in the area of youth health with recent publications including: Rhodes, D., Forsyth, E., Visker, J., Bylina, H., Baer, H., Rembush, E., Mehl, J., &Cox, C. (2020). Indirect measure of firefighter productivity and fatigue: A case history. Jrl Hlth Safety Res Prct. In-review.

*Address correspondence to Carol Cox, PhD, MCHES®, Address Truman State University; 2123 Pershing Building, Kirksville, MO 63501; 660 785 7256; Fax: 660 785 7492. Email: ccox@truman.edu