

“Trauma Informed Advocacy:  
Child Well-Being as the Path to  
Permanency - The Lawyer’s Ethical Duty”

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## FACTS FOR POLICYMAKERS

### Complex Trauma and Mental Health of Children Placed in Foster Care

#### *Highlights from the National Center for Child Traumatic Stress (NCCTS) Core Data Set*

#### BACKGROUND

##### *National Child Traumatic Stress Network*

Authorized by Congress in 2000, the National Child Traumatic Stress Network (NCTSN) is a federally-funded child mental health service initiative designed to raise the standard of care and increase access to services for traumatized children and their families across the United States.

The NCTSN is an interdisciplinary network comprised of community-, university-, and hospital-based practice and research centers. The NCTSN addresses a broad range of trauma types and serves all age groups

ranging from early childhood to early adulthood (0 to 21 years). The centers provide trauma-informed, evidence-based mental health treatment and other services to children in diverse settings, including child mental health, child welfare, schools, primary care, and juvenile justice systems.

An integral part of the mission of the NCTSN is to collect, analyze, and disseminate clinical data relating to the needs and effective treatment of trauma-exposed youth and families.

#### STUDY RESULTS

The study “Complex Trauma and Mental Health of Children Placed in Foster Care” (Greeson et al., 2012) examined trauma histories (including complex trauma<sup>1</sup> exposure) and trauma reactions (i.e., PTSD, behavioral and emotional problems) of 2,251 children and adolescents in foster care, referred for treatment to NCTSN centers throughout the United States between spring 2004 and fall 2010.

Children and adolescents in the child welfare system (CWS) typically have experienced at least one caregiver-related trauma (e.g., abuse or neglect). In fact, many children in the CWS have extensive histories of complex and chronic maltreatment (Table 1) associated with a range of severe reactions.

The study’s findings are consistent with the growing literature on multiple victimization indicating that **individuals who experience multiple types of trauma**

**are at greater risk for psychosocial maladjustment and mental health problems** (Finkelhor, Ormrod, & Turner, 2007; Kisiel et al., 2009).

The study found that:

- Over 70% of youth reported at least 2 of the traumas that constitute complex trauma<sup>1</sup>
- At least 83% of youth received at least one clinical diagnosis, such as depression and generalized anxiety disorder
- The mean number of types of traumatic exposure was 5 for the total sample and 6 for the complex trauma subsample
- Youth with complex trauma histories experienced significantly more trauma types overall than those without such histories

<sup>1</sup>The term *complex trauma* is used to describe the exposure to chronic interpersonal traumatic experiences at the hands of a caregiver. The authors use the term *complex trauma* to describe exposure to *at least two* of the following interpersonal traumas: physical abuse, sexual abuse, emotional abuse, neglect, and domestic violence (For more information see Kisiel et al., 2009).

- Youth with complex trauma histories were significantly more likely to be white, non-Hispanic, and currently residing in foster care
- Compared to youth with other types of trauma, youth with complex trauma histories had significantly higher rates of mental health and behavioral problems

**Table 1.** The frequency of trauma types for the total sample of children in foster care (2,251) as well as for the subsample of children with complex trauma histories (1,584).

Variable	Total Sample (%)	Complex Trauma Subsample (%)
Neglect	68.0	82.6
Traumatic loss/bereavement/separation	63.1	66.2
Impaired caregiver	59.8	74.4
Domestic violence	54.2	72.0
Emotional abuse	51.4	71.9
Physical abuse	48.4	64.0
Sexual abuse	32.0	41.9
Sexual assault	15.1	17.2
Community violence	14.3	16.7
Physical assault	12.0	14.6
Other trauma	11.8	12.8
Illness/medical trauma	8.3	9.7
School violence	8.0	8.8
Serious injury/accident	7.5	8.8
Extreme interpersonal violence	5.4	6.7
Natural disaster	3.0	3.2
Forced displacement	2.2	2.4
Kidnapping	1.8	2.3
War/terror in United States	0.3	0.4
War/terror outside United States	0.5	0.4

## RECOMMENDATIONS

### 1. Children in the child welfare system should be systematically screened, assessed, and referred to appropriate trauma-informed services.<sup>2</sup>

A comprehensive assessment of traumatic experiences, posttraumatic stress symptoms, emotional/behavioral problems, and functional

difficulties is essential for making appropriate service recommendations within child welfare (Kisiel et al., 2009). Unfortunately, many child welfare systems do not routinely screen for trauma exposure and associated symptoms beyond an initial assessment of the precipitating event.

<sup>2</sup> A trauma-informed child and family-serving system is one in which all parties involved recognize and respond to the impact of traumatic stress on those who have contact with the system, including children, caregivers, and service providers. Programs and agencies within such a system infuse and sustain this trauma awareness, knowledge, and skills into their organizational cultures, practices, and policies. They act in collaboration with all those who are involved with the child, using the best available science, to facilitate and support the recovery and resiliency of the child and family. A service system with a trauma-informed perspective is one in which programs, agencies and service providers would: (1) routinely screen for trauma exposure and related symptoms; (2) use culturally appropriate evidence-based assessment and treatment for traumatic stress and associated mental health symptoms; (3) make resources available to children, families, and providers on trauma exposure, its impact, and treatment; (4) engage in efforts to strengthen the resilience and protective factors of children and families impacted by and vulnerable to trauma; (5) address parent and caregiver trauma and its impact on the family system; (6) emphasize continuity of care and collaboration across child-serving systems; and (7) maintain an environment of care for staff that addresses, minimizes and treats secondary traumatic stress and increases staff resilience. ([www.nctsn.org](http://www.nctsn.org))

**2. Partnerships across disciplines such as mental health, child welfare, and other child-serving professions should be established and strengthened.**

Mental health therapists and child welfare workers often share similar goals for children (e.g., reduced number of placements, better academic and health outcomes, and improved emotional and social functioning), but they often confront barriers that prevent nurturing of long term and positive professional relationships. These cross-discipline partnerships should be supported so as to ensure that children have their needs met following a traumatic experience.

NCTSN has been successful in establishing and enhancing positive working relationships across mental health, child welfare, and family partners through the Breakthrough Series Collaborative (BSC) training and systems change approach. One such BSC, *Using Trauma-Informed Child Welfare Practice to Improve Foster Care Placement Stability (TICWP)*, focuses on making child welfare more trauma-informed with a primary goal of stabilizing placements of children in foster care. Mental health and child welfare professionals—along with

family members—collaborate toward this shared goal. The BSC is a useful model for mental health and child welfare groups to promote ongoing communication, share relevant information and resources, and develop policies and procedures. Such collaboration can streamline the process of identifying trauma, assess the impact of trauma, link children to effective treatments, and improve systems for the benefit of children.

**3. Identify subgroups of children and adolescents in child welfare who face uniquely challenging issues (e.g., multiple trauma exposures), in order to better target resources.**

By developing “risk profiles,” of such groups (e.g., young children who may be at increased risk for chronic trauma exposures and multiple placements, older youth who may be at risk for crossover placements in juvenile justice systems, and youth who have experienced multiple interpersonal traumas exhibiting emotional and behavioral problems), more informed decisions can be made with regard to cost-effective allocation of scarce resources and promotion of specific positive outcomes.

## IMPLICATIONS FOR FUTURE RESEARCH

- 1. Findings from this study suggest the value of understanding “profiles of risk” for behavioral problems and symptoms related to prevention and early intervention efforts.** Factors—such as being older, being female, being eligible for public insurance, and residing in foster care as a primary residence—increased the likelihood that a youth would experience specific problems which, left unaddressed, could have long-term implications for health. Future studies should examine patterns of complex trauma in children in foster care and assess the distinct risks for mental health and behavioral problems.
- 2. An emerging issue for the child trauma field is how best to define different types of trauma exposure histories (e.g., exposure to sequential and repeated traumas, or to multiple types of traumatic events, or to specific constellations of types of traumas).** Currently, the child trauma field utilizes multiple terminologies for the same

phenomena, including “complex trauma,” “poly-victimization,” and “cumulative risk/adversity.” It will be important to clarify the conceptual similarities and differences inherent in these and other terms, thereby establishing a common language and providing greater clarity for researchers, clinicians, and policymakers.

- 3. Race and ethnicity were found to have significant associations with complex trauma.** Future research should explore the relationship between complex trauma and race/ethnicity, including among urban minority children and adolescents who are at greater risk for placement in foster care, and residential treatment facilities.

## REFERENCES

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- Kisiel, C. L., Fehrenbach, T., Small, L., & Lyons, J. (2009). Assessment of complex trauma exposure, responses and service needs among children and adolescents in child welfare. *Journal of Child and Adolescent Trauma, 2*, 143-160.

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# Identifying Polyvictimization and Trauma Among Court-Involved Children and Youth: A Checklist and Resource Guide for Attorneys and Other Court-Appointed Advocates<sup>1</sup>

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Identifying past exposure to violence (including both witnessing and being a victim of violence) is essential because research shows that the more types of victimization a child or adolescent experiences, the more likely he or she is to be affected physically, socially, and emotionally. Researchers have labeled children who have experienced seven or more types of victimization “polyvictims” and have suggested that “victimization exposure across so many domains may be what leaves these children so particularly distressed. There are relatively few areas of safety for them.”<sup>2</sup>

This Polyvictimization and Trauma Identification Checklist and Resource Guide (Checklist) was developed by the Safe Start Center, the American Bar Association (ABA) Center on Children and the Law, and Child & Family Policy Associates to help lawyers and other legal advocates for children recognize the prevalence and impact of polyvictimization<sup>3</sup> and perform more trauma-informed legal and judicial system advocacy. The Checklist, along with the Flowchart on Trauma-Informed Actions (Flowchart) below, can be used by children’s attorneys, juvenile defenders, Court Appointed Special Advocates, and other advocates in both the dependency (child welfare) and delinquency (juvenile justice) systems.

The Checklist is not meant to be a diagnostic instrument, but rather a vehicle for lawyers and advocates to understand how exposure to violence may influence their clients’ current behavior. *Before using*

*the Checklist and Flowchart for the first time, please review this entire document, which provides guidance and information for using these resources.*

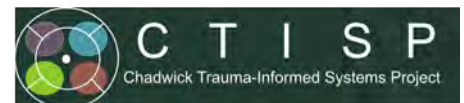
Using the Checklist below will allow lawyers and advocates to focus on important information about clients’ past victimization history and help advocates better identify and advocate for appropriate placements, disposition plans, trial strategies, services, and treatment. In some instances, this information may also offer advocates mitigating and extenuating circumstances they can use to positively affect case outcomes for clients.

<sup>1</sup> This document is an educational tool only. It is not meant to provide legal advice or to diagnose or rule out any mental or physical health problems. It does not represent official policy of the US Department of Justice, the American Bar Association, the Safe Start Center/JBS International, Inc., or Child & Family Policy Associates.

<sup>2</sup> Finkelhor, D., Turner, H., Hamby, S., & Ormrod, R. (2011). Polyvictimization: Children’s exposure to multiple types of violence, crime, and abuse. *Juvenile Justice Bulletin*, NCJ 235504. Washington, DC: U.S. Government Printing Office. Available at <http://www.unh.edu/ccrc/pdf/jvq/Polyvicimization%20OJJDP%20bulletin.pdf>

<sup>3</sup> The term “polyvictimization” is used throughout this document because much of this resource is inspired by and based on critical research that relies on this term (see footnote 2) to explain the effects of children’s exposure to violence on their lives. When talking to or about clients, advocates should forgo the term “victimization” and its variations but rather use neutral or strength-based language.

*An electronic version of this publication can be found on the Web at [www.safestartcenter.org](http://www.safestartcenter.org).*



## Polyvictimization and Trauma Symptom Identification Checklist

### Completing the Checklist

This Checklist is an “information integration tool,” allowing attorneys and other advocates to use and organize information they may already have to identify past victimization and critical trauma-related issues and make better decisions on how to help clients. It is designed to be completed based on current knowledge (such as information users have learned from clients, service providers, mental health professionals or others, and case files or court testimony), rather than administered as a client interview or self-report form. In some cases, users may wish to ask clients directly about some or all of the experiences or symptoms below, *keeping in mind the limits of confidentiality, the ethics rules in their State, their role in the case, and issues around protection from self-incrimination for youth charged with offenses*; see page 6 for more information.

Using the Checklist is *not* intended to result in a numerical score but instead should allow users to think about clients and their needs in a more trauma-informed way. After completing the Checklist, users should also review the Flowchart below for general guidance on immediate and long-term steps to take based on the information they have.

### Target audience and timing for use

The Checklist can be used for clients of any age. Users may wish to complete it several times, at regular intervals during a case or after particular milestones or case events. Entering a juvenile detention facility, removal from home or a foster care placement, or conflicts with or negative developments involving a child’s family members can be a traumatic experience for a child or serve as a trigger for past traumatic experiences. Symptoms of past exposure to violence may also begin to show when children or youth experience changes—even after a prolonged period of stability in their lives. Involvement with the court process can, for just about anyone, also be a traumatic experience and may induce trauma-related reactions in previously victimized clients.

### Interpreting terms and definitions in the Checklist

When using the Checklist, users may have questions about definitions of the victimization experiences that are listed (e.g., physical or emotional abuse). In assessing whether a client has experienced different types of victimization, the user may apply state law definitions of these terms or other definitions that he or she thinks appropriate. The definition of a term is less important than the impact the experience had on the client and how it affects the advocate’s perception of the client’s needs. To see how other instruments have defined or explained these terms, see the section on “Questioning child clients about past experiences” below.

Similarly, users may have questions about the definitions of symptoms that are related to the traumatic experiences. The language in the Checklist was adapted from the National Child Traumatic Stress Network’s (NCTSN’s) *Child Welfare Trauma Referral Tool*<sup>4</sup> and reviewed by mental health experts. Clinical terms that may appear in clients’ case files or that users may hear from mental health experts are listed, along with “translations” into non-clinical language or examples of specific behaviors that attorneys or others may notice in a client. Again, these terms, and users’ decisions about whether they apply to a particular client, are simply a way to inform their thinking about the client and to help users consider the possible impact of past traumatic experiences.

Users may also notice that some of the symptoms listed (e.g., being easily distracted or withdrawn) are typically associated with many other conditions. These similarities are important to recognize because the effects of traumatic experiences are often misdiagnosed as other conditions (particularly attention deficit/hyperactivity disorder, oppositional defiant disorder, or conduct disorder) and because exposure to violence can sometimes result in conditions other than post-traumatic stress syndrome (PTSD), such as depression, eating disorders, or difficulties engaging in appropriate relationships. Users also should keep in mind that impulsivity, irritability, and similar behaviors mentioned may be typical for adolescents; only extreme, unusual, or new/sudden behavior following exposure to traumatic experiences should be cause for concern.

<sup>4</sup> Taylor, N., Steinberg, A., & Wilson, C. (2006). *The Child Welfare Trauma Referral Tool*. San Diego, CA: Chadwick Center for Children and Families, Rady Children’s Hospital. Retrieved July 2, 2012, from [http://www.nctsn.org/sites/default/files/assets/pdfs/cwt3\\_sho\\_referral.pdf](http://www.nctsn.org/sites/default/files/assets/pdfs/cwt3_sho_referral.pdf)

## Polyvictimization/Trauma Symptom Checklist

### Part A: Past Experiences

Has the child/youth experienced the following types of <b>victimization/exposure to violence</b> :	In the <b>past year?</b> (check if Yes)	Over her/ his <b>lifetime?</b> (check if Yes)
<b>Physical Abuse in the Home</b>		
<b>Abuse or Neglect in a Foster Home, Residential Placement, or Detention Facility</b> (including by other youth)		
<b>Assault/Battery by a Non-Caretaker</b> (completed or attempted)		
<b>Severe Physical Injury</b> (e.g., requiring hospitalization)		
<b>Sexual Abuse/Assault by a Parent or Relative Caregiver</b> (completed or attempted)		
<b>Other Sexual Abuse/Assault</b> (e.g., by a non-relative caregiver, at school, by a family friend or stranger; completed or attempted)		
<b>Victim of Sex or Labor Trafficking</b> (e.g., being prostituted, forced involvement in sexual performances, photographed for child pornography, involved in domestic servitude or other harmful or exploitative labor)		
<b>Severe Neglect</b> (e.g., young children being left unattended for long periods, serious malnutrition due to lack of adequate food, ongoing failure to provide necessary medical care that results in hospitalization)		
<b>Extreme Emotional/Verbal Abuse by a Parent or Caretaker</b>		
<b>Witnessing Domestic Violence</b>		
<b>Witnessing School Violence</b>		
<b>Witnessing Community Violence</b>		
<b>Witnessing Animal Cruelty</b>		
<b>Chronic or Repeated Bullying or Harassment</b> (e.g., based on race, ethnicity, appearance, gender or sexual identity, learning problems, or poverty)		
<b>Victim of a Hate Crime that was Reported to the Police</b>		
<b>Teen Dating Violence</b>		
<b>Statutory Rape</b>		
<b>Victim of a Property Crime</b> (burglary, robbery)		
<b>System-Induced Trauma</b> (e.g., arrest situations violent enough to leave bruises or injuries, difficult experiences testifying against abuser at trial)		
<b>Permanent or Long-Term Loss of a Parent or Caregiver Due to Illness, Death, or Incarceration</b>		
<b>Disrupted Caregiving</b> (a change of custody among family members or numerous changes in foster care placements)		
<b>Victim of War, Terrorism, or Natural Disaster</b>		
<b>Other Significant (but not necessarily violent) Life Challenges</b> (e.g., homelessness, poverty, having a caregiver who suffered from substance abuse or mental health issues, or a life-threatening illness or injury of the child)		



Part B: Past and Current Symptoms<sup>5</sup>

Has the child/youth exhibited the following <b>symptoms that may indicate traumatic stress?</b> (Adapted from the NCTSN <i>Child Welfare Trauma Referral Tool</i> )	In the <b>past year?</b> (check if Yes)	Over her/his <b>lifetime?</b> (check if Yes)
<b>Sleep Disturbances</b> (e.g., night terrors, sleeplessness, excessive sleepiness)		
<b>Attachment Problems</b> (e.g., overly affectionate with strangers, consistently avoids eye contact, fails to engage in interactions or conversations appropriately even with people the child knows well, extreme separation anxiety)		
<b>Arousal</b> (e.g., startles easily, trouble concentrating, easily distracted, inattentive or impulsive)		
<b>Regression</b> (stops engaging in age-appropriate behaviors already mastered, e.g., using the toilet, speaking in full sentences, independently completing schoolwork, socializing with same-age or older peers)		
<b>Affect Dysregulation</b> (trouble feeling or expressing emotions other than frustration or impatience or difficulties recovering from emotional distress)		
<b>Somatization</b> (frequent physical complaints with no apparent cause or more severe or resistant to treatment than physically explainable)		
<b>Hypervigilance</b> (overly aware or concerned about potential dangers; uses anger or aggression to protect self/others)		
<b>Re-experiencing</b> (strong reactions to reminders of trauma or loss, nightmares, flashbacks, sensation of reliving the events, working traumatic experiences into play)		
<b>Anxiety</b> (overly tense or worried, to the point of withdrawal from activities, experiencing panic attacks, or needing excessive reassurances)		
<b>Avoidance</b> (avoiding places, people or other stimuli associated with past trauma, refusing to discuss specifics of traumatic experiences)		
<b>Extreme Impulsivity</b> (sudden, strong, even irrational urge to engage in risky behavior without considering consequences first)		
<b>Attention/Concentration Difficulties</b> , leading to trouble forming strong friendships or completing work		
<b>Dissociation</b> (frequent daydreaming, forgetfulness, rapid personality changes, emotional detachment)		
<b>Emotional or Behavioral Problems:</b> <sup>6</sup>		
<ul style="list-style-type: none"> <li>• <b>Numbing</b> (feeling detached, estranged from or “out of sync” with others, limited emotional range, avoiding thinking or talking about the future)</li> </ul>		
<ul style="list-style-type: none"> <li>• <b>Oppositional (hostile/defiant) Behaviors</b></li> </ul>		
<ul style="list-style-type: none"> <li>• <b>Conduct Problems</b> (physically or verbally aggressive, destroys property or otherwise breaks the law, sexually promiscuous or aggressive)</li> </ul>		
<ul style="list-style-type: none"> <li>• <b>Substance Abuse</b></li> </ul>		
<ul style="list-style-type: none"> <li>• <b>Sexual Behavior not Typical of Age Group</b></li> </ul>		
<ul style="list-style-type: none"> <li>• <b>Other Risky Behaviors</b> (e.g., truancy, stealing)</li> </ul>		
<ul style="list-style-type: none"> <li>• <b>Eating Disorder</b></li> </ul>		
<ul style="list-style-type: none"> <li>• <b>Self-harm</b> (e.g., cutting)</li> </ul>		
<ul style="list-style-type: none"> <li>• <b>Suicide Attempt or Discussion or Thoughts of Suicide</b></li> </ul>		

<sup>5</sup> Note that some of these symptoms could indicate either trauma-related issues or a developmental disorder. An assessment by a mental health professional can determine the underlying cause.

<sup>6</sup> Traumatic stress symptoms may take the form of common emotional or behavioral problems, including the symptoms listed in this section. When those problems are identified, it is important to consider whether they involve (or are exacerbated by) any of the traumatic stress symptoms.

## Flowchart on Trauma-Informed Actions

(Adapted from the NCTSN *Child Welfare Trauma Referral Tool*)

<p><b>Child/Youth Has:</b> Attempted suicide or expressed a suicidal intent;<sup>7</sup> a severe eating disorder; a substance use problem; or a chronic sleep disturbance</p> <p><b>Child/Youth May Need:</b> Immediate stabilization, including inpatient care or services may be required. Advocate should counsel the client in a developmentally appropriate manner, encouraging him or her to receive treatment and/or services if that is what he or she wants. (If the child is at imminent risk, attorneys should act according to State ethical rules.)</p>	<p><b>Child/Youth Has:</b> Experienced past severe victimization including sexual assault; severe injury; multiple separations from family or primary caregivers; witnessing chronic severe family violence; or 4 or more different types of victimization <b>or</b> Clear symptoms including pronounced reactions to reminders of traumatic experiences; multiple traumatic stress symptoms listed above <b>or</b> Exhibited a major change in his or her behavior, emotional state, interests or abilities during or soon after traumatic events, as described by the child or caregiver.</p> <p><b>Child/Youth May Need:</b> Trauma-specific mental health assessment/ services. Advocate should counsel the client in a developmentally appropriate manner, helping obtain services if that is what the client wants.*</p>	<p><b>Child/Youth Has:</b> Behavior/ functioning problems without severe or multiple types of victimization</p> <p><b>Child/Youth May Need:</b> General mental health assessment and related services. Advocate should counsel the client in a developmentally appropriate manner, helping the client obtain services if that is what he or she wants.*</p>	<p><b>Child/Youth Has:</b> Past victimization with no current behavior/ functioning problems</p> <p><b>Child/Youth May Need:</b> No immediate action, but should be monitored for future needs and for signs of system-induced trauma.</p>
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\* In some cases (particularly in delinquency proceedings), advocates may want to help connect children and youth to services offered in their community, rather than ask that services be court ordered or delivered through the child welfare or juvenile justice agency.

As demonstrated in the National Survey of Children’s Exposure to Violence (NatSCEV), many clients entering the court system have had some past victimization experiences. Children and youth in the dependency, status offense, and delinquency systems may have been victims of abuse or neglect but may also have been bullied in school, have witnessed a shooting or stabbing in their community, or have experienced the death of a loved one through illness or violence.<sup>8</sup> Understanding what those experiences were and how they are currently affecting the young person is essential to ensuring that appropriate assistance is provided. Research has shown a significant increase in symptoms among youth who experience seven or more types of victimization; however, there is no set number or type of experiences that determine whether a child will suffer a negative impact from exposure to violence.

### Using the Flowchart

The Flowchart can provide general guidance on critical immediate or longer term actions for follow-up. For experiences or symptoms identified by the Checklist, attorneys can work with clients to seek out service

providers or discuss with clients the possibility of asking agency or court personnel to make a referral for appropriate services. Or attorneys may provide the client and his or her family with a list of providers of evidence-based interventions available in their community. The following examples describe some specific service responses that may be needed:

- A client has *suicidal intent or a severe eating disorder, substance use problem, or sleep disturbance*; he or she may need immediate hospitalization or need to immediately receive specialized services.
- A client has experienced severe victimization, such as sexual assault, severe injury, or direct victimization (as opposed to witnessing violence) at a very young age; it may be important to use trauma-specific assessments and services by mental health providers with training/experience on evidence-based interventions to address the issues of concern.
- A client or his or her caregiver identifies exposure to violence as a source of problems or a client has multiple traumatic stress symptoms, serious

<sup>7</sup> For more guidance on suicidality and youth in the child welfare system, see Youth Suicide and Self-Harm: What Advocates Need to Know, Washington, DC: American Bar Association Center on Children and the Law, *ABA Child Law Practice*, 27(4), June 2008. Available at <http://www.americanbar.org/content/dam/aba/migrated/child/PublicDocuments/suicideprevention.authcheckdam.pdf>

attachment issues, or pronounced reactions to reminders of trauma; a trauma-specific referral may be the appropriate course of action.

- A client has behavior or functioning problems but has not experienced severe or multiple types of victimization; a general mental health assessment or some services may be helpful.
- A client has experienced one or more types of exposure to violence but does not currently exhibit traumatic stress symptoms or have trouble with day-to-day functioning; no referral may be needed at this time. However, it is highly recommended that users watch for new symptoms and consider using the Checklist again later in the case to identify new trauma caused by system involvement or other life changes.

Note that the services discussed here are *recommendations from a mental health perspective* (according to the NCTSN *Child Welfare Trauma Referral Tool*, on which this Flowchart is based). The specifics of the attorney's role in advising his or her client and connecting the client to services will vary based on the system the child is in, the attorney's role and confidentiality requirements, and the relationship between the attorney and client. Also see "Other responses to exposure to violence" below.

To the extent clients or their advocates are seeking a trauma-specific assessment or service, a partial list of federally and locally funded trauma centers is available at <http://www.nctsn.org/about-us/network-members>. NCTSN's *Questions to Ask Mental Health Providers*, available at [http://www.nctsn.org/sites/default/files/assets/pdfs/cwt3\\_sho\\_questions.pdf](http://www.nctsn.org/sites/default/files/assets/pdfs/cwt3_sho_questions.pdf), can also help determine whether a specific provider can offer trauma-responsive services.

In addition, several databases provide information about evidence-based interventions, for example, in juvenile justice (<http://www.crimesolutions.gov>); mental health (<http://www.nrepp.samhsa.gov>); exposure to violence (<http://www.safestartcenter.org>); child welfare (<http://www.cebc4cw.org>); or trauma-specific services (<http://www.nctsn.org>).

### Using information gathered

There is no set number of "yes" answers to the Checklist questions above that determines which

children need treatment and which do not, but the Checklist can help users determine whether a child should be seen by a mental health professional who can make a determination of further needed actions, giving the advocate more information to counsel the client appropriately. As advocates use this Checklist with more and more clients, they will be able to look for key experiences or symptoms without necessarily having to refer to the specific questions. Users will also have a better sense of which clients have suffered more types of victimization or are displaying more trauma-related symptoms than other clients in their caseload and, therefore, may have a greater need for trauma-related assessment and possible intervention.

### Questioning child clients about past experiences: Ethical and practice issues

Although the Checklist is intended primarily as a way to organize and apply information that users already have, in some cases (depending on their role and relationship with a client) users may wish to ask about specific experiences listed in the questions. Before asking a client or others about the client's history, advocates should be clear about whom they represent, what they will do with the information, and under what circumstances, if any, they will have to share the information with others.

Attorneys should also be familiar with their jurisdiction's ethics rules, limits of confidentiality, and laws/cases related to self-incrimination of juvenile offenders. The attorney-client privilege has limits, so in some circumstances the information gathered in a Checklist could still be used against a client or against the client's wishes. In these instances, or if the user believes that a client could be harmed by disclosing information, the advocate should counsel the client in a developmentally appropriate manner about seeking a victimization/trauma screening by a professional who would have a privileged relationship with the client.

Other advocates might choose to skip some questions that may produce answers prejudicial to the client. In each case, advocates will need to weigh the relative benefits and harms of getting the information by asking the client or not getting the information at all. Discussions about sensitive and possibly privileged subjects should never take place in courtroom hallways or anywhere else they might be overheard.

<sup>8</sup> For case examples describing how victimization and trauma can affect youth in the dependency and delinquency systems, see *Victimization and Trauma Experienced by Children and Youth: Implications for Legal Advocates*. Available at [http://www.safestartcenter.org/pdf/issue-brief\\_7\\_courts.pdf](http://www.safestartcenter.org/pdf/issue-brief_7_courts.pdf)

In addition, when seeking court-based or court-ordered services for the client based on an understanding of the client’s past experiences, the advocate should consult with the client in a developmentally appropriate manner and identify and request services at the client’s direction that will help resolve the issues the client currently faces. In many cases (particularly in delinquency matters), advocates should consider discussing with clients the possibility of connecting them to services offered in their communities, rather than asking that they be court-ordered or formally delivered through the child welfare or juvenile justice agency. Doing so will avoid opening access to information that might be used against clients in the court case.

Also, advocates should be aware that asking about past traumatic experiences may be potentially distressing to clients, particularly if it is information they have not shared before. Clients may be hesitant to share this information directly with advocates if discussing the issue creates distress or they fear what will happen with their case once they share the information (e.g., concern regarding the parents’ status). Clients may also deny experiencing symptoms for fear of being labeled or treated differently. Advocates should not ask these questions of clients unless they are knowledgeable about safe interviewing techniques and how to handle any complications or crises that may arise from questioning. If discussing any past experiences might cause a client distress, the advocate should ask for the client’s permission to let a caregiver or someone else in the home or facility know that the client recently had a difficult interview and may be upset and require special attention.

Several resources are available that give advice on talking to children about these issues:

*Attorneys for Children Guide to Interviewing Clients: Integrating Trauma Informed Care and Solution Focused Strategies* <http://www.nycourts.gov/ip/cwcip/Publications/attorneyGuide.pdf>

*Handbook on Questioning Children: A Linguistic Perspective* [http://www.americanbar.org/content/dam/aba/administrative/child\\_law/HandbookQC2.authcheckdam.pdf](http://www.americanbar.org/content/dam/aba/administrative/child_law/HandbookQC2.authcheckdam.pdf)

Advocates may wish to review existing tools that pose questions in age-appropriate language about past adverse experiences to children:

*Juvenile Victimization Questionnaire* (asks about conventional crime, child maltreatment, peer and sibling victimization, sexual assault, and witnessing and indirect victimization; available in interview, self-report, and caregiver report versions of varying lengths) <http://www.unh.edu/ccrc/jvq/natscev-toolkit.html>

*Children’s Exposure to Domestic Violence Scale* (42-item self-report measure that asks about direct experiences of violence, exposure to violence at home and in the community, involvement in violence, risk factors, and other victimization) <http://www.mincava.umn.edu/cedv/cedvmanual.pdf>

Advocates should also understand that the act of listening to a child’s experiences of violence may take an emotional toll that could affect an advocate’s professional or personal functioning. This experience is known as “secondary traumatic stress,” and it is common for professionals who frequently hear first-hand accounts of victimization and trauma to be at high risk for experiencing symptoms similar to those experienced by individuals with PTSD. Organizational leaders at law offices that handle cases involving children, Court Appointed Special Advocate programs, and juvenile defender units may want to consider offering a variety of informal assessments to identify and address how secondary stress affects their staff and themselves.<sup>9</sup>

For more information on how attorneys can ethically use information gained from clients, see:

- IJA/ABA *Juvenile Justice Standards on Counsel for Private Parties*, Washington, DC: Ballinger Publishing Company (1980), Standard 3.3;
- *ABA Model Act Governing the Representation of Children in Abuse, Neglect, and Dependency Proceedings* (2004), Washington, DC: ABA Section of Litigation (passed by the ABA House of Delegates as resolution 101A);
- Renne, J. (2004), *Legal Ethics in Child Welfare Cases*, Washington, DC: ABA Center on Children and the Law.

<sup>9</sup>NCTSN, Secondary Traumatic Stress Committee. (2011). *Secondary traumatic stress: A fact sheet for child-serving professionals*. Los Angeles, CA, and Durham, NC: NCTSN.

## Resource Guide: Understanding Polyvictimization and Traumatic Stress and Their Long Term Impacts

### What does “exposure to violence” mean in the context of trauma-informed advocacy?

For this document, “exposure to violence” includes both witnessing and experiencing acts of violence at home, at school, or in a young person’s community. “Trauma-informed care” has been defined as “an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives.”<sup>10</sup> Similarly, attorneys and others engage in trauma-informed advocacy when they use their understanding of the effects of trauma and their clients’ past experiences to better advise and represent their clients.

### Recent research on the relationship between polyvictimization and traumatic stress

The most comprehensive and recent data on polyvictimization comes from the NatSCEV<sup>11</sup> conducted by David Finkelhor and colleagues. The NatSCEV found that children and adolescents who have been exposed to or victimized by one type of violence are more likely to also experience other types of violence.<sup>12</sup> Children who experience numerous forms of victimization (polyvictimization) are also more likely to exhibit greater traumatic stress symptoms (such as anxiety, depression, or behavior problems) than children who are exposed to only one type of violence, even if that violence occurs more frequently.<sup>13</sup> Children that have experienced multiple types of violence are also more likely to have had other types of challenges throughout their lives, such as parental illnesses or substance abuse.

### Lifetime impact of childhood exposure to violence

Numerous studies have shown that children who are victims of maltreatment are more likely to commit

crimes and be arrested later in life, either as minors or as adults (even when race, socioeconomic status, and other factors are controlled for).<sup>14</sup> Similarly, studies of juvenile offenders have found that they were significantly more likely to report having been abused or neglected as children than the general population.<sup>15</sup> Other research has linked direct victimization to mental health problems, substance abuse, and suicide later in life.<sup>16</sup> Indirect victimization, such as witnessing family or community violence, can also lead to negative outcomes such as low self-esteem, anxiety, aggression, post-traumatic stress symptoms, depression, and social and academic challenges.<sup>17</sup>

One of the largest relevant studies on violence exposure and experiencing adverse events in childhood asked participants about whether they had, as children, experienced physical, emotional, or sexual abuse; witnessed domestic violence; or lived with someone who was mentally ill or suicidal, had substance abuse issues, or had ever been incarcerated. These “adverse childhood experiences” (ACEs) have been linked to numerous issues in adulthood, with the likelihood of risk behaviors and diseases increasing as the number of ACEs increase. Specifically, children who experienced four or more categories of adverse experiences were 4 to 12 times more likely as adults to suffer from alcohol and drug abuse, depression, and suicide attempts and were more likely to smoke, be obese, and have sexually transmitted diseases.<sup>18</sup>

Finding results similar to the NatSCEV data discussed above, researchers looking at the co-occurrence of ACEs found that having one ACE significantly increased an individual’s chances of having others. For example, 81% of individuals who had experienced emotional abuse had also experienced physical abuse (compared with 20% of those who had not experienced emotional abuse), and 65% of individuals who witnessed domestic violence as children also grew up with a substance-abusing parent (compared with 23% of those who did not witness domestic violence).<sup>19</sup>

<sup>10</sup> Substance Abuse and Mental Health Services Administration’s National Center for Trauma-Informed Care. *Welcome to the National Center for Trauma-Informed Care*. Available at <http://www.samhsa.gov/ntic>

<sup>11</sup> Finkelhor, D., Turner, H., Hamby, S., & Ormrod, R. (2011). Polyvictimization: Children’s exposure to multiple types of violence, crime, and abuse. *Juvenile Justice Bulletin, NCJ 235504*. Washington, DC: U.S. Government Printing Office. Available at <http://www.unh.edu/ccrc/pdf/jvq/Polyvictimization%20OJJDP%20bulletin.pdf>

<sup>12</sup> Ibid.

<sup>13</sup> Ibid.

<sup>14</sup> Siegfried, C.B., Ko, S.J., & Kelly, A. (2004). *Victimization and juvenile offending* (p. 5). Los Angeles, CA, and Durham, NC: NCTSN, Juvenile Justice Working Group.

<sup>15</sup> Ibid.

<sup>16</sup> Ibid.

<sup>17</sup> Ibid.

<sup>18</sup> Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Koss, M. P., et al. (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.

<sup>19</sup> Dong, M., Anda, R. F., Felitti, V. J., Williamson, D. F., Thompson, T. J., Loo, A. M., et al. (2004). The interrelatedness of multiple forms of childhood abuse, neglect, and household dysfunction. *Child Abuse and Neglect, 28*(7), 771–784.

## Other responses to exposure to violence

Individuals react to and are affected differently by exposure to violence. Some develop traumatic stress symptoms (which may or may not rise to the level of a clinical diagnosis of PTSD), whereas others may have difficulties forming or maintaining relationships or have other behavioral or functioning difficulties. For some youth, trauma induced by someone they trusted can result in a pervasive mistrust of others. This lack of trust can make it difficult for advocates to develop a good rapport with the client and elicit needed information to best represent the clients' interests. The advocate's being sensitive to these reactions, and being clear about the advocate's role with the client, can help the child overcome misgivings.

Advocates should also keep in mind that symptoms and responses to traumatic stress vary by age, types of victimization, previous exposures to violence, and the culture from which children and families come. Although children who are court involved may be more likely to have experienced trauma and to exhibit increased traumatic stress symptoms, it is important to remember that all children have different reactions to exposure to violence and not all children who experience traumatic events will have lasting issues as a result.

A youth's individual strengths and resiliency can also serve as protective factors and should be supported to the extent possible. See *Understanding Children's Exposure to Violence and Building Resilience: The Power to Cope with Adversity* (links below) for a discussion of factors that support resilience and reduce the impact of risk factors.

## Practice Considerations

### Addressing suspected or identified victimization and trauma when resources are limited

Attorneys and other advocates in the dependency and delinquency systems are often plagued by high caseloads, insufficient opportunities for advanced training, and a shortage of supportive resources. They also often find that when they (or a caseworker) can identify a particular assessment or service a child needs, the agency cannot provide it promptly because of a scarcity of funds and/or a shortage of qualified providers. Advocates may find that using this Checklist helps identify clients who may need additional assessment or services but that the advocates cannot adequately act on those findings. To address this situation, they can:

- Ask whether child welfare agency counterparts have relationships with mental health providers trained in trauma assessment and treatment who can offer more in-depth assessments and necessary follow-up care for children who are identified as needing it, work to help ensure that clients are properly assessed, and be vigilant about the possible need for follow-up assessments.
- Locate community-based organizations that provide voluntary services on a sliding payment scale or that will accept Medicaid, including those that can provide services for parents and caregivers who have been exposed to violence.
- Investigate using victim compensation or victim services funds to help pay for trauma-responsive mental health services.
- Work with their local mental health system to support training efforts on child/youth trauma-responsive treatment modalities, including education of biological and foster parents on understanding children's exposure to violence. Some foundations or other philanthropic organizations may be able to support the cost of training mental health providers on child/youth trauma-responsive treatments.
- Request that the agency or court contract with additional providers if necessary.

For additional practice tips for integrating understanding of polyvictimization and trauma into advocacy in specific cases, see *Victimization and Trauma Experienced by Children and Youth: Implications for Legal Advocates* ([http://www.safestartcenter.org/pdf/issue-brief\\_7\\_courts.pdf](http://www.safestartcenter.org/pdf/issue-brief_7_courts.pdf)). Keep in mind, however, that not all youth exposed to violence will exhibit traumatic stress symptoms and that reactions to exposure to violence can vary among different cultural groups.<sup>20</sup> Exposure to violence can lead to issues beyond the traumatic stress symptoms discussed above, such as long-term difficulties developing and maintaining healthy relationships. Although this Checklist and other measures may help identify some youth who are struggling with exposure to violence, they may not identify all of these youth. Legal system advocates can help promote practices and policies that support families and communities as a whole, not just individuals who exhibit specific symptoms.

<sup>20</sup> Cohen, E. & Davis, L. (2010). "No Wonder We are Dizzy: We are Running Around in Circles." *The Impact of Exposure to Violence on Adolescents, Protecting Children* Vol. 22, Numbers 3 & 4, 2007.

### Concerns for juvenile defenders

Attorneys charged with defending youth in the juvenile justice system must be knowledgeable about how information shared with mental health providers and others in assessments and treatment may be used in court. They must educate their clients on this issue and advocate zealously to prevent information regarding young people's victimization being used against them in their court cases.

The fact that a youth may have been exposed to violence, and/or be experiencing trauma symptoms related to such violence, should never be used for "widening the net" of juvenile justice system involvement. Given the adverse collateral consequences of involvement in delinquency proceedings and delinquency adjudications, there should never be delinquency findings made, nor should juvenile proceedings be extended, simply because a youth has been victimized and may be in need of treatment as a result of that victimization. In such situations, services to the youth and his or her family to address the consequences of that victimization should be accomplished through voluntary, confidential arrangements. However, in all cases, juvenile defense attorneys must ensure that any mental health assessments or treatment provided through the court or juvenile justice agency respects each youth's right to privacy and right to avoid self-incrimination.<sup>21</sup>

### Changes that can support children and youth exposed to violence<sup>22</sup>

There are many things legal advocates can do to advance policy and legislation that will support improvements in trauma-informed practice. Forming workgroups of key stakeholders or establishing partnerships with entities that advocate for children at the local or state level will help educate system stakeholders on trauma-informed practices and obtain necessary buy-in to implement change. Other things attorneys can advocate for include:

- Ensuring that the child client's safety and basic needs are met, which is especially critical for children who have been exposed to violence, while

For examples of state and local initiatives to address trauma within the child welfare and juvenile justice systems, see *Victimization and Trauma Experienced by Children and Youth: Implications for Legal Advocates*, available at [http://www.safestartcenter.org/pdf/issue-brief\\_7\\_courts.pdf](http://www.safestartcenter.org/pdf/issue-brief_7_courts.pdf).

recognizing that many youth experience very high levels of different types of victimization that affect their safety and well-being.

- Helping their organization or the court they practice in offer classes or host awareness-raising events, which include presentations by mental health professionals who specialize in child/youth trauma-focused treatment.
- Urging the juvenile justice or child welfare agencies they work with to institute policies that require agency-contracted foster care providers, group homes, detention centers, and other facilities to provide mandatory staff training on child/youth trauma and exposure to violence, while recognizing that most violence-exposed children will benefit from placement in the least restrictive, most family-like, setting.
- Advocating for local and state governments to fund programs that use evidence-supported techniques<sup>23</sup> to identify and address trauma and exposure to violence among court-involved children and youth while helping clients build positive and sustaining adult relationships.
- Advocating for court policies or rules that do not penalize youth whose actions are a direct result of victimization or trauma. For example, courts can limit or prevent youth from entering the status offense or juvenile justice system because of neglect or abuse in their family (e.g., preventing a runaway youth from entering the status offense system because he or she is fleeing an abusive home).
- Building partnerships with local pediatric hospitals and medical centers, because they may be in a position to identify, provide treatment to, consult, or provide training to other professionals on managing victims who are identified as being in acute distress.
- Requesting that the courts they work in adapt court order forms to include questions judges should consider before ordering screenings, assessments, and treatment for youth exposed to violence.
- Ensuring that policies or laws are in place that respect violence-exposed client confidentiality and do not allow a child's exposure to trauma to be used as a basis for finding him or her delinquent or to extend justice system involvement.

<sup>21</sup> Rosado, L. M., & Shah, R. S. (2007). Protecting youth from self-incrimination when undergoing screening, assessment and treatment within the juvenile justice system. Philadelphia: Juvenile Law Center. Available at [http://www.jlc.org/sites/default/files/publication\\_pdfs/protectingyouth.pdf](http://www.jlc.org/sites/default/files/publication_pdfs/protectingyouth.pdf)

<sup>22</sup> This section is reprinted/adapted from Pilnik, L., & Kendall, J. R. (2012). *Victimization and trauma experienced by children and youth: Implications for legal advocacy for court-involved youth*. Moving From Evidence to Action: The Safe Start Series on Children Exposed to Violence, Issue Brief #7. North Bethesda, MD: Safe Start Center, Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice.

<sup>23</sup> See links to more information in the Resource Guide section titled "Evidence-based and promising interventions for children and adolescents exposed to violence."

## More Resources on Topics Raised by the Polyvictimization and Trauma Identification Checklist

### Research on prevalence of polyvictimization

*Adverse Childhood Experiences (ACE) Study*  
<http://www.cdc.gov/ace/index.htm>

*Polyvictimization: Children's Exposure to Multiple Types of Violence, Crime, and Abuse* <http://www.unh.edu/ccrc/pdf/jvq/Polyvictimization%20OJJD%20bulletin.pdf>

### Impact of exposure to violence and traumatic stress; Child and adolescent development

*Birth Parents with Trauma Histories and the Child Welfare System: A Guide for Judges and Attorneys*  
[http://nctsn.org/sites/default/files/assets/pdfs/birth\\_parents\\_trauma\\_guide\\_judges\\_final.pdf](http://nctsn.org/sites/default/files/assets/pdfs/birth_parents_trauma_guide_judges_final.pdf)

*Building Resilience: The Power to Cope with Adversity, Zero to Three* <http://www.zerotothree.org/maltreatment/31-1-prac-tips-beardslee.pdf>

*Child Welfare Trauma Training Toolkit*, National Child Traumatic Stress Network <http://www.nctsn.org/products/child-welfare-trauma-training-toolkit-2008>

*Complex Trauma in Children and Adolescents*, National Child Traumatic Stress Network [http://www.nctsn.org/sites/default/files/assets/pdfs/ComplexTrauma\\_All.pdf](http://www.nctsn.org/sites/default/files/assets/pdfs/ComplexTrauma_All.pdf)

"A Developmental View of Youth in the Juvenile Justice System," *Juvenile Justice: Advancing Research, Policy and Practice* [http://www.martybeyer.com/user\\_files/documents/beyer-juvjus\\_chapter.pdf](http://www.martybeyer.com/user_files/documents/beyer-juvjus_chapter.pdf)

"The Impact of Trauma on Child Development," *Juvenile and Family Court Journal* <http://www.psychceu.com/nctsn/Putnam.impact.pdf>

*Juvenile Justice Trauma Training Toolkit*, National Child Traumatic Stress Network <http://www.nctsn.org/resources/topics/juvenile-justice-system>

*Trauma Among Girls in the Juvenile Justice System* [http://www.nctsn.org/nctsn\\_assets/pdfs/edu\\_materials/trauma\\_among\\_girls\\_in\\_jjsys.pdf](http://www.nctsn.org/nctsn_assets/pdfs/edu_materials/trauma_among_girls_in_jjsys.pdf)

*Trauma Among Youth in the Juvenile Justice System: Critical Issues and New Directions*, National Center for Mental Health and Juvenile Justice [http://www.ncmhjj.com/pdfs/publications/Trauma\\_and\\_Youth.pdf](http://www.ncmhjj.com/pdfs/publications/Trauma_and_Youth.pdf)

*Types of Traumatic Stress* <http://nctsn.org/trauma-types>  
*Understanding Child Traumatic Stress* [http://www.nctsn.org/sites/default/files/assets/pdfs/understanding\\_child\\_traumatic\\_stress\\_brochure\\_9-29-05.pdf](http://www.nctsn.org/sites/default/files/assets/pdfs/understanding_child_traumatic_stress_brochure_9-29-05.pdf)

*Understanding Children's Exposure to Violence, Moving from Evidence to Action*, Safe Start Center Series on Children Exposed to Violence [http://safestartcenter.org/pdf/IssueBrief1\\_UNDERSTANDING.pdf](http://safestartcenter.org/pdf/IssueBrief1_UNDERSTANDING.pdf)

*Victimization and Juvenile Offending* [http://www.nctsn.org/nctsn\\_assets/pdfs/edu\\_materials/victimization\\_juvenile\\_offending.pdf](http://www.nctsn.org/nctsn_assets/pdfs/edu_materials/victimization_juvenile_offending.pdf)

*What Is Child Traumatic Stress?* [http://www.nctsn.org/sites/default/files/assets/pdfs/what\\_is\\_child\\_traumatic\\_stress\\_0.pdf](http://www.nctsn.org/sites/default/files/assets/pdfs/what_is_child_traumatic_stress_0.pdf)

### Resources for lawyers, judicial officers, Court Appointed Special Advocates and child-serving organizations on victimization and trauma

*Creating Trauma-Informed Child-Serving Systems* [http://www.nctsn.org/sites/default/files/assets/pdfs/Service\\_Systems\\_Brief\\_v1\\_v1.pdf](http://www.nctsn.org/sites/default/files/assets/pdfs/Service_Systems_Brief_v1_v1.pdf)

*Creating Trauma-Informed Systems: Child Welfare, Education, First Responders, Health Care, Juvenile Justice* <http://www.mhcc.org.au/TICP/research-papers/Ko-Ford-Berkowitz-et-al-2008.pdf>

*Healing Invisible Wounds: Why Investing in Trauma-Informed Care for Children Makes Sense* [http://www.justicepolicy.org/images/upload/10-07\\_REP\\_HealingInvisibleWounds\\_JJ-PS.pdf](http://www.justicepolicy.org/images/upload/10-07_REP_HealingInvisibleWounds_JJ-PS.pdf)

*Helping Traumatized Children: Tips for Judges* <http://nctsn.org/sites/default/files/assets/pdfs/JudgesFactSheet.pdf>

*Judicial Checklist for Children and Youth Exposed to Violence* [http://www.safestartcenter.org/pdf/childandyouth\\_checklist.pdf](http://www.safestartcenter.org/pdf/childandyouth_checklist.pdf)

*Victimization and Trauma Experienced by Children and Youth: Implications for Legal Advocates*, Moving from Evidence to Action, Safe Start Center Series on Children Exposed to Violence [http://www.safestartcenter.org/pdf/issue-brief\\_7\\_courts.pdf](http://www.safestartcenter.org/pdf/issue-brief_7_courts.pdf)

### Trauma-focused and other mental health assessments in child welfare and juvenile justice

*Child Welfare Trauma Referral Tool* [http://www.nctsn.org/sites/default/files/assets/pdfs/cwt3\\_sho\\_referral.pdf](http://www.nctsn.org/sites/default/files/assets/pdfs/cwt3_sho_referral.pdf)

*Children's Advocacy Center Directors' Guide to Mental Health Services for Abused Children* [http://www.nctsn.org/sites/default/files/assets/pdfs/CAC\\_Directors\\_Guide\\_Final.pdf](http://www.nctsn.org/sites/default/files/assets/pdfs/CAC_Directors_Guide_Final.pdf)

*Measures Review Database*, National Child Traumatic Stress Network <http://nctsn.org/resources/online-research/measures-review>



*Post-traumatic Stress Disorder Reaction Index*, University of California at Los Angeles <http://www.ptsd.va.gov/professional/pages/assessments/ucla-ptsd-dsm-iv.asp>

*Screening and Assessment Tool Reviews for Child Welfare*, California Evidence-Based Clearinghouse for Child Welfare <http://www.cebc4cw.org/assessment-tools/>

*Screenings and Assessments Used in the Juvenile Justice System: Evaluating Risks and Needs of Youth in the Juvenile Justice System* [http://www.courts.ca.gov/documents/AOCBrief\\_AssessOnline.pdf](http://www.courts.ca.gov/documents/AOCBrief_AssessOnline.pdf)

*Trauma Symptom Checklist for Children* <http://www.johnbriere.com/tscc.htm>

*Trauma Symptom Checklist for Young Children* <http://www.johnbriere.com/tscyc.htm>

*Traumatic Events Screening Instrument* <http://www.ptsd.va.gov/professional/pages/assessments/tesi.asp>

### **Evidence-based and promising interventions for children and adolescents exposed to violence**

*Blueprints for Violence Prevention* <http://www.colorado.edu/cspv/blueprints/>

*Child Welfare Trauma Treatment (Child & Adolescent)*, California Evidence-Based Clearinghouse <http://www.cebc4cw.org/topic/trauma-treatment-for-children/>

*Empirically Supported Treatments and Promising Practices*, National Child Traumatic Stress Network <http://www.nctsn.org/resources/topics/treatments-that-work/promising-practices>

*Interventions Addressing Children Exposed to Trauma: Part 2—Trauma Other than Child Maltreatment and Family Violence* [http://effectivehealthcare.ahrq.gov/ehc/products/385/1017/PTSD-in-Children\\_Protocol\\_20120326.pdf](http://effectivehealthcare.ahrq.gov/ehc/products/385/1017/PTSD-in-Children_Protocol_20120326.pdf)

*National Registry of Evidence-based Programs and Practices*, Substance Abuse and Mental Health Services Administration <http://www.nrepp.samhsa.gov/>

*Program Reviews*, Office of Justice Programs <http://www.crimesolutions.gov>

*Victimization and Trauma Experienced by Children and Youth: Implications for Legal Advocates*, Moving from Evidence to Action, Safe Start Center Series on Children Exposed to Violence [http://www.safestartcenter.org/pdf/issue-brief\\_7\\_courts.pdf](http://www.safestartcenter.org/pdf/issue-brief_7_courts.pdf)

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