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A Critical Look At Trauma-Informed Care Among Agencies and Systems Serving Maltreated Youth and Their Families

Rochelle F. Hanson[1] and Jason Lang[2]

Abstract

The past two decades have witnessed an increase in programs targeting children and youth impacted by traumatic events, with a heightened focus on ensuring that all such programs and relevant service systems are trauma informed. While such efforts are laudable, trauma-informed care (TIC) is defined in a number of ways, limiting evaluation of these initiatives, specifically as they relate to the potential for improved outcomes or reduced costs often used to advocate for TIC. Widespread interest in TIC, despite an apparent dearth of empirical research, served as the impetus for this special section. Our goal was to identify the most rigorous empirical studies available. These six papers were selected based on their inclusion of a definition of TIC, focus on at least one component of TIC in a child-serving system, and availability of empirical data demonstrating the effectiveness of their efforts. In addition to introducing these papers, we share preliminary data from a brief, anonymous survey of child-serving professionals across various systems and roles to obtain feedback about definitional and conceptual issues related to TIC. While this special section provides a representation of available empirical work, significant gaps between research and practice of TIC remain, with important implications for future work.

Keywords

service delivery, child trauma, Child Welfare Services, definitional issues

Given the readership of this journal, it is preaching to the choir to state that child maltreatment and exposure to other forms of trauma pose significant and costly health risks both acutely and long term (e.g., Carrion, Weems, & Reiss, 2007; Corso, Edwards, Fang, & Mercy, 2008; Fang, Brown, Florence, & Mercy, 2012; Finkelhor, Turner, Stattuck, & Hamby, 2015; Price, Higa-McMillan, Kim, & Frueh, 2013). This is not new information. More than 30 years ago, Surgeon General Everett Koop stated that, "Interpersonal violence has grown to become one of the major public health problems in American society today" (Koop, 1982, p.1). The Adverse Childhood Experiences (Dube, Felitti, Dong, Giles, & Anda, 2003; Edwards, Holden, Anda, & Felitti, 2003; Felitti et al., 1998) study had a substantial impact on increasing awareness of the potential long-term behavioral and physical health consequences of early childhood adversities. There is agreement that early stressors and trauma can cause changes in biological, psychological, and social development that can influence later outcomes (Shonkoff et al., 2012).

Over the past two decades, we have witnessed an increasing number of local, regional, and national efforts to develop programs that target children and youth impacted by traumatic events. For example, the Substance Abuse and Mental Health Services Administration (SAMHSA)'s Center for Mental Health Services (CMHS) has funded the National Child Traumatic Stress Network (NCTSN, 2007) since 2000 to improve services across the country for child trauma victims and highlighted trauma as one of its eight strategic initiatives (SAMHSA, 2011). The National Center for Trauma-Informed Care (NCTIC, 2016; http://www.samhsa.gov/nctic), also funded by CMHS, focuses on the provision of trauma training and technical assistance to a broad array of stakeholders across multiple service sectors and publicly funded systems. Other federal agencies, including the Administration for Children and Families, the Center for Medicare and Medicaid Services (Sheldon, Tavenner, & Hyde, 2013), the Department of Justice (Attorney General's National Task Force on Children Exposed to Violence, 2012), and the Department of Education (U.S. Department of Education, 2005), have recognized the impact of child trauma and funded a variety of trauma-focused

[1] National Crime Victims Research and Treatment Center, Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina, Charleston, SC, USA
[2] Child Health and Development Institute, Farmington, CT, USA

Corresponding Author:
Rochelle F. Hanson, National Crime Victims Research and Treatment Center, Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina, 67 President Street, Charleston, SC 250852, USA.
Email: hansonrf@musc.edu

programs and services for youth over the past decade. The Child and Family Services Improvement and Innovation Act of 2011 (P.L. 112-34) requires state child welfare agencies to report how they address trauma experienced by children in foster care.

An outgrowth of these initiatives is a heightened focus on ensuring that all service systems are aware, sensitive, and responsive to the potential impact of trauma. Often called trauma-informed care (TIC), but also referred to as a ''trauma-informed approach'' or ''trauma sensitive,'' the notion is that a child-serving service agency or system, including behavioral health, child welfare, juvenile justice, law enforcement, education, and medical settings, provides a safe, supportive environment to staff and consumers that reflects available research about the prevalence and effects of trauma exposure and the best methods for supporting children and families exposed to trauma. The rationale is that addressing child trauma earlier and more effectively (i.e., better screening to inform diagnoses and referral/receipt of appropriate trauma-informed mental health interventions) will result in improved outcomes, less need for more extensive and expensive services, and reduced long-term costs. TIC trainings, workshops, and programs are proliferating and, especially when aimed at entire agencies or systems, can be quite costly.

While such efforts to create more effective service systems are laudable, TIC is an amorphous concept that has been defined in a number of ways, making it difficult to evaluate TIC initiatives. Further, little is known about whether the various initiatives described as TIC actually result in improved outcomes for children and families or reduced costs. *Trauma informed* has become a standard term in our nomenclature and yet there does not appear to be clear consensus on what TIC actually means nor delineation of the specific components needed to achieve it. Similarly, the distinctions between TIC and good practice are not always clear. For example, in an article in the Clinical Psychiatry News, Vatel (2015) shares the following quote: ''there is nothing specific to trauma-informed care that is specific to a history of trauma. The need to be sensitive and humane . . . is just good psychiatric care''(Hanson, 2013).

Thus, in an initial attempt to clarify terminology and move toward consensus, we searched published literature, federal websites, and known national resources (e.g., NCTSN, SAMHSA, Child Welfare Information Gateway, NCTIC) and also solicited feedback from professional colleagues to identify the core components and overall definitions of TIC. Table 1 provides a summary of the definitions we found on TIC or closely related constructs. One of the first issues to emerge was inconsistent and unclear terminology and a surprisingly limited number of clear definitions of TIC, despite the burgeoning literature on TIC. For example, trauma-specific *services* or *practices* are typically defined as those designed to address the psychosocial impact of trauma (NCTIC, 2008). SAMHSA (2014) describes a trauma-informed *approach* as one that is ''inclusive of'' trauma-specific interventions and ''also incorporates key trauma principles into the organizational culture'' (SAMHSA, 2014, p. 13). While provision of a defined trauma-specific service is generally understood, defining how trauma principles are integrated into organizational culture is not clearly operationalized. Our review of existing resources and anecdotal reports led us to conclude that these various ''trauma-informed'' terms lack specificity, are frequently blended, and/or used interchangeably. Thus, there is a need to reach some consensus on terminology with clearly defined core components that can be applied among myriad service systems, professionals, laypersons, and consumers. Importantly, this type of consensus could then spur more careful measurement of the core components and overall construct and thereby facilitate empirical evaluation of TIC.

While the general aims of the various definitions of TIC are similar, the strategies for becoming TIC varied. In an attempt to operationalize these core components of TIC, we highlight those that were most commonly identified as important elements of TIC across the seven reviewed frameworks. As detailed in Table 2, this mapping yielded 15 components that target three primary domains: workforce development (training, awareness, secondary traumatic stress); trauma-focused services (use of standardized screening measures and evidence-based practices); and organizational environment and practices (collaboration, service coordination, safe physical environment, written policies, defined leadership). In order to get feedback regarding this conceptualization of TIC, we solicited input from child-serving professionals across various systems and job functions (Hanson & Lang, 2015). Briefly, an anonymous, web-based survey was disseminated through a snowball sampling approach to known trauma-focused researchers, practitioners, and intermediary organizations, such as the International Society of Traumatic Stress Studies (ISTSS) and the NCTSN. A total of 414 people responded to the survey. Participants were generally female (86%), had a graduate degree (70%), and had an average of 15.5 years of experience in the field. Most participants were from child welfare (28%) or behavioral health service systems (32%), with the remaining 40% representing education, juvenile justice, medical, public health, and other settings. Participants were mostly frontline staff (48%), with supervisors (12%), administrators (26%), and others (e.g., researchers, funders, attorneys, family advocates; 14%) also represented.

The survey included the following three primary questions related to the 15 TIC components: (1) How *important* was each to TIC, (2) To what extent had each *been implemented* within the respondent's agency, and (3) How *unique* was each to TIC, as opposed to reflecting good general standards of practice. Respondents rated each component on a 5-point Likert-type scale from 0 (*not at all*) to 4 (*very*). Additionally, we asked about methods being used to *evaluate* TIC initiatives in the respondent's agency. Results of the survey (Table 3) indicated that while most of the 15 components were viewed as important to the definition of TIC, not all were considered to be unique. Specifically, the components considered least unique to TIC were strengths-based/promotes positive development, having a positive, safe physical environment, consumer engagement, and collaboration within and across agencies. Additionally, the

Table 1. Definitions of Trauma-Informed Care.

Source	Definition
SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach (Substance Abuse and Mental Health Services Administration, 2011)	"A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization." (p. 9). Also notes that TIC is distinct from, but inclusive of, trauma-specific interventions.
National Child Traumatic Stress Network (2007) definition of a Trauma-Informed Child and Family Service System	"A trauma-informed child- and family-service 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 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."
NASMHPD Developing Trauma Informed Behavioral Health Systems (Blanch, 2002)	Note: Does not have a concise definition of TIC but refers to 15 essential elements of a trauma-informed system described in more detail as the starting point of a "basic 'checklist' for determining the extent that sensitivity to trauma has been embedded throughout a mental health system" (p. 9)
Attorney General's National Task Force on Children Exposed to Violence (2012)	"This is a new form of evidence-based interventions and service delivery, implemented by multiple service providers, that identifies, assesses, and heals people injured by, or exposed to, violence and other traumatic events." (p 210)
Hopper, Bassuk, & Olivet, 2010	"Trauma-Informed Care is a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment." (p. 82)
Fallot & Harris, 2001	"To be trauma informed means to know the history of past and current abuse in the life of the consumer with whom one is working . . . [and to] understand the role that violence and victimization play in the lives of most consumers of mental health and substance abuse services and to use that understanding to design service systems that accommodate the vulnerabilities of trauma survivors and allow services to be delivered in a way that will facilitate consumer participation in treatment." (p. 4)

Note. SAMHSA = Substance Abuse and Mental Health Services Administration; TIC = trauma-informed care.

extent to which the TIC components were implemented within the participant's agency varied, with the ones most commonly implemented being those that were generally not considered unique to TIC (i.e., a positive, safe physical environment, services that were strengths-based/promote positive development, and within agency collaboration/coordination). The least commonly implemented components were measuring staff proficiency in TIC, a defined leadership position, addressing secondary traumatic stress, and written policies that addressed trauma. Notably, only half of participants indicated that their respective agencies engaged in any type of formal evaluation of TIC efforts.

This brief survey has significant methodological limitations in terms of sample selection and generalizability of the findings. However, we are aware of virtually no other research delineating professionals' perceptions about the components of TIC and the extent to which TIC efforts are being implemented and evaluated nationally, which is consistent with our and our colleagues' perceptions that the movement and recent increases in funding to implement TIC have well outpaced the research. Specifically, there appears to be an absence of research defining and validating the core components of TIC, the methods and measures for evaluating large-scale TIC efforts, and most importantly, whether the child and family outcomes and future cost savings presumed by TIC advocates are in fact realized.

The apparent dearth of empirical research coupled with the broad interest from the practice community on TIC served as the impetus for this special issue. Our goal was to publish the most rigorous empirical studies available and to include those

Table 2. Core Domains and Components of Trauma-Informed Care.

Domain	Component	Source(s)
WD	Required training of all staff in awareness and knowledge on the impact of abuse or trauma	SAMHSA, NASMHPD, AG, NCTSN, JRI, NCTIC, H&F
WD	Measuring staff proficiency in defined criteria to demonstrate trauma knowledge/practice	NASMHPD, JRI
WD	Strategies/procedures to address/reduce secondary traumatic stress among staff	SAMHSA, NCTSN, JRI, H&F
WD	Knowledge/skill in how to access and make referrals for evidence-based trauma focused practices	SAMHSA, AG, NCTIC, JRI
TFS	Use of standardized, evidence-based screening/assessment measures to identify trauma history and trauma-related symptoms or problems	SAMHSA, NASMHPD, AG, NCTSN, JRI, NCTIC, H&F
TFS	Inclusion of child's trauma history in child's case record/file/service plan	Not specified (suggested by screening in SAMHSA, NASMHPD, AG, NCTSN, JRI, NCTIC)
TFS	Availability of trained, skilled clinical providers in evidence-based trauma-focused practices	SAMHSA, AG, NCTIC, JRI
ORG	Collaboration, service coordination, and information sharing among professionals *within the agency* related to trauma-informed services	Not specified (suggested by cross-system collaboration definitions from SAMHSA, NASMHPD, AG, NCTSN, NCTIC)
ORG	Collaboration, service coordination, and information sharing among professionals *with other agencies* related to trauma-informed services	SAMHSA, NASMHPD, AG, NCTSN, NCTIC
ORG	Procedures to reduce risk for client re-traumatization	SAMHSA, NASMHPD, AG, JRI, NCTIC, H&F
ORG	Procedures for consumer engagement and input in service planning and development of a trauma-informed system	SAMHSA, NASMHPD, AG, JRI, NCTIC, H&F
ORG	Provision of services that are strength-based and promote positive development	SAMHSA, NCTSN, H&F
ORG	Provision of a positive, safe physical environment	SAMHSA, AG, JRI, H&F
ORG	Written policies that explicitly include and support trauma informed principles	SAMHSA, NASMHPD, AG, JRI, NCTIC, H&F
ORG	Presence of a defined leadership position or job function specifically related to TIC	NASMHPD, NCTIC

Note. SAMHSA = Substance Abuse and Mental Health Services Administration (2011); NASMHPD = National Association of State Mental Health Program Directors (Blanch 2002); AG = Attorney General's National Task Force on Children Exposed to Violence (2012); JRI = The Trauma Center at the Justice Resource Institute (Hopper, Bassuk, & Olivet, 2010); NCTIC = National Center for Trauma-Informed Care, National Center for Mental Health Services (2008); NCTSN = National Child Traumatic Stress Network (2007); H&F = Harris & Fallot (2001); WD = workforce development; TFS = trauma-focused services; ORG = organizational environment and practices; TIC = trauma-informed care.

Table 3. Importance, Uniqueness, and Extent to Which TIC Components Were Implemented.

TIC Component	Importance to TIC, *M* (*SD*)	Extent Implemented, *M* (*SD*)	Unique to TIC, *M* (*SD*)
Required trauma training of all staff	3.74 (.66)	2.68 (1.28)	2.83 (1.27)
Positive, safe physical environment	3.72 (.59)	3.14 (1.17)	2.03 (1.55)
Availability of trained clinical providers of trauma EBPs	3.62 (.73)	NA	2.86 (1.25)
Within agency collaboration/service coordination	3.57 (.68)	2.85 (1.14)	2.39 (1.30)
Reduce risk of retraumatization	3.55 (.81)	2.23 (1.32)	2.67
Strengths-based/promote positive development	3.54 (.77)	2.88 (1.17)	1.93 (1.49)
Outside agency collaboration/service coordination	3.50 (.76)	2.62 (1.16)	2.38 (1.31)
Knowledge in how to access trauma EBPs	3.50 (.75)	2.70 (1.22)	2.54 (1.27)
Trauma history is always included in case/service plan	3.41 (.87)	2.65 (1.27)	2.58 (1.29)
Written policies that include trauma	3.37 (.90)	2.09 (1.45)	2.77 (1.23)
Use of standardized, trauma screening/assessment measures	3.36 (.94)	2.45 (1.43)	2.74 (1.29)
Address secondary traumatic stress	3.35 (.91)	2.05 (1.33)	2.59
Consumer engagement/input in system planning	3.2 (.94)	2.18 (1.36)	2.24 (1.30)
Measuring staff proficiency in defined criteria	3.16 (.91)	1.91 (1.37)	2.72 (1.24)
Defined leadership position for trauma services	2.96 (1.06)	1.94 (1.53)	2.73 (1.32)

Note. Scale: 0 = not at all; 1 = little; 2 = somewhat; 3 = mostly; 4 = very. TIC = trauma-informed care.

that utilized clear definitions and operationalization of TIC and empirical data. We sought to elicit papers that focused on systemic responses to trauma, rather than individual efforts to assess or treat trauma within a single agency, and also sought papers examining the costs or cost benefits of TIC.

The call for the special issue, distributed in Fall 2014 through *Child Maltreatment* and sent to trauma experts and researchers in ISTSS and the NCTSN, resulted in a total of 11 papers, 6 of which were accepted. These six papers were selected based on their inclusion of a definition of TIC, focus on one or more components of TIC in a child-serving system, and the availability of empirical data to demonstrate the effectiveness of their efforts. Three papers leverage data from ongoing statewide initiatives in Massachusetts (Bartlett, Barto, Griffin, Goldman Fraser, Hodgdon, & Bodian, 2016), Connecticut (Lang, Campbell, Shanley, Crusto, & Connell, 2016), and Minnesota (Donisch, Bray, & Gewirtz, 2016) to examine various aspects of TIC across youth service settings. Lang shares data about their statewide efforts to create and sustain a trauma-informed child welfare system and workforce. Donisch et al. specifically examined provider attitudes about TIC. Bartlett et al. describe the implementation of several different strategies to promote TIC in the child welfare and mental health service systems. Their initiative includes the use of learning collaboratives to train professionals in screening assessment and delivery of several targeted EBTs as well as development of Trauma-Informed Leadership Teams to build and sustain a structure for community-level integration of TIC. In the fourth paper, Kerns et al. (2016) provide findings from their study examining screening in the child welfare service system as a way to promote increased awareness of trauma and its impact to facilitate appropriate referrals and direct case management and monitoring activities. The final two papers examine the use of a promising practice (the Resource Parenting Curriculum; Sullivan, Murray, & Ake, 2016) to promote TIC among foster, adoptive, and kinship caregivers and the effectiveness of a well-established trauma-focused evidence-based practice (EBP) (Trauma-Focused Cognitive Behavioral Therapy (TF-CBT); Cohen, Mannarino, Jankowski, Rosenberg, Kodya, & Wolford, 2016) as delivered in residential treatment facilities. While the emphasis of the Cohen et al. paper is an effectiveness trial for TF-CBT in a residential treatment facility, it does demonstrate the benefits (including improved child outcomes) and challenges of implementing one important component of TIC—evidence-based practices—in a setting serving high risk and chronically traumatized youth.

The published papers provide a representation of the available empirical work being conducted on TIC. Perhaps not surprisingly, we did not receive an influx of papers for inclusion in the special section and speculate this could be due to our emphasis on empirical research rather than just broad descriptions of TIC efforts. It is also noteworthy that none of the papers received or accepted for publication provided data that specifically examined the relationship between TIC and youth outcomes nor the costs or costs benefits of TIC. Thus, these represent significant gaps in the research literature, with important implications for future work. If efforts to establish TIC are to continue, it is imperative that researchers systematically evaluate the effectiveness of this approach, specifically as it relates to outcomes for youth. Further, it is important to delineate the relative importance of the various core components of TIC to youth outcomes in order to identify the most cost-efficient strategies to improve care. Otherwise, we may continue down a path which intuitively makes sense and is filled with good intention but lacks empirical support of its need or impact on what is most critical—that is, the well-being of children impacted by trauma.

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References

Attorney General's National Task Force on Children Exposed to Violence. (2012). *Defending childhood*. Washington, DC: Department of Justice.

Bartlett, J. D., Barto, B., Griffin, J. L., Goldman Fraser, J., Hodgdon, H., & Bodian, R. (2016). Trauma-informed care in the Massachusetts child trauma project. *Child Maltreatment*. doi:10.1177/1077559515615700

Blanch, A. (2002). *Developing trauma-informed behavioral health systems*. Proceedings from NTAC's National Experts Meeting on Trauma and Violence, Alexandria, VA.

Carrion, V. G., Weems, C. F., & Reiss, A. L. (2007). Stress predicts brain changes in children: A pilot longitudinal study on youth stress, posttraumatic stress disorder, and the hippocampus. *Pediatrics*, *119*, 509–516.

Cohen, J. A., Mannarino, A. P., Jankowski, K., Rosenberg, S., Kodya, S., & Wolford, G. L. (2016). A randomized implementation study of trauma-focused cognitive behavioral therapy for adjudicated teens in residential treatment facilities. *Child Maltreatment*, *20*. doi:10.1177/1077559515624775

Corso, P. S., Edwards, V. J., Fang, X., & Mercy, J. A. (2008). Health-related quality of life among adults who experienced maltreatment during childhood. *American Journal of Public Health*, *98*, 1094–1100.

Donisch, K., Bray, C., & Gewirtz, A. (2016). Child welfare, juvenile justice, mental health, and education providers' conceptualizations of trauma-informed practice. *Child Maltreatment*, *20*.

Dube, S. R., Felitti, V. J., Dong, M., Giles, W. H., & Anda, R. F. (2003). The impact of adverse childhood experiences on health problems: evidence from four birth cohorts dating back to 1900. *Preventive Medicine*, *37*, 268–277.

Edwards, V. J., Holden, G. W., Anda, R. F., & Felitti, V. J. (2003). Experiencing multiple forms of childhood maltreatment and adult mental health: Results from the Adverse Childhood Experiences (ACE) study. *American Journal of Psychiatry*, *160*, 1453–1460.

Fang, X., Brown, D. S., Florence, C. S., & Mercy, J. A. (2012). The economic burden of child maltreatment in the United States and implications for prevention. *Child Abuse & Neglect*, *36*, 156–165.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., . . . Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: the adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine*, *14*, 245–258.

Finkelhor, D., Turner, H., Shattuck, T., & Hamby, S. L. (2015). Prevalence of childhood exposure to violence, crime, and abuse. *JAMA Pediatrics*, *169*, 746–754.

Hanson, A. (2013). Recovering from trauma-informed care. *Clinical Psychiatry News*. Retrieved from http://www.clinicalpsychiatrynews.com/index.php?id=2407&tx_ttnews%5Btt_news%5D=216863&cHash=1db42f288c48a4eeab06b09cc5ff0ec2

Hanson, R. F., & Lang, J. (2015). Defining trauma-informed care: A survey of child serving professionals. Unpublished survey data.

Harris, M., & Fallot, R. D. (2001). Envisioning a trauma-informed service system: A vital paradigm shift. *New Directions for Mental Health Services*, *89*, 3–22.

Hopper, E. K., Bassuk, E. L., & Olivet, J. (2010). Shelter from the Storm: Trauma-informed care in homelessness service settings. *The Open Health Services and Policy Journal*, *3*, 80–100.

Kerns, S. E. U., Pullmann, M. D., Negrete, A., Uomoto, J., Berliner, L., Shogren, D., Silverman, E., . . . Putnam, B. (2016). Development and implementation of a child welfare workforce strategy to build a trauma-informed system of support for foster care. *Child Maltreatment*, *20*.

Koop, C. E. (1982, November 28). *Violence and Public Health: A film lecture presented to the National Institute of law enforcement and criminal justice*. Washington, DC. Retrieved February 22, 2016, from https://profiles.nlm.nih.gov/ps/access/QQBCYK.pdf#xml=https://profiles.nlm.nih.gov:443/pdfhighlight?uid=QQBCYK&query=%28violence%20as%20a%20public%20health%20issue%29

Lang, J., Campbell, K., Shanley, P., Crusto, C., & Connell, C. (2016). Building capacity for trauma-informed care in the child welfare system: Initial results of a statewide implementation. *Child Maltreatment*, *20*.

National Center for Trauma-Informed Care, National Center for Mental Health Services. (2016). *Models for developing trauma-informed behavioral health systems and trauma-specific services: 2008 update*, Alexandria, VA: National Center for Trauma Informed Care.

National Child Traumatic Stress Network. (2007). *Creating trauma informed systems*. Retrieved from http://www.nctsn.org/resources/topics/creating-trauma-informed-systems

Price, M., Higa-McMillan, C., Kim, S., & Frueh, B. C. (2013). Trauma experience in children and adolescents: An assessment of the effects of trauma type and role of interpersonal proximity. *Journal of Anxiety Disorders*, *27*, 652–660.

Sheldon, G. H., Tavenner, M., & Hyde, P. S. (2013). *Tri-agency letter on trauma*. Retrieved from http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf

Shonkoff, J. P., & Garner, A. S., and the Committee on Psychosocial Aspects of Child and Family Health, Committee on Early Childhood, Adoption, and Dependent Care, and Section on Developmental and Behavioral Pediatrics. (2012). The lifelong effects of early childhood adversity and toxic stress. *Pediatrics*, *129*. Retrieved from www.pediatrics.org/cgi/doi/10.1542/peds.2011-2663

Substance Abuse and Mental Health Services Administration. (2011). *Leading change: A plan for SAMHSA's roles and actions 2011-2014. HHS publication No. (SMA) 11-4629*. Rockville, MD: Author.

Substance Abuse and Mental Health Services Administration (2014). *SAMHSA's concept of trauma and guidance for a trauma-informed approach. HHS Publication No. (SMA) 14-4884*. Rockville, MD: Author.

Sullivan, K. M., Murray, J. J., & Ake, G. S. (in press). Trauma-informed care for children in the child welfare system: An initial evaluation of a trauma-informed parenting workshop. *Child Maltreatment*, *20*. doi:10.1177/1077559515615961

U.S. Department of Education. (2005). *Tips for helping students recovering from traumatic events*. Washington, DC: Author. Retrieved from http://files.eric.ed.gov/fulltext/ED488995.pdf

Vatel, B. (2015). Unmasking trauma-informed care. *Clinical Psychiatry News: News and views that matter to psychiatrists*. Retrieved February 22, 2016, from http://www.clinicalpsychiatrynews.com/views/single-view/unmasking-trauma-informed-care/dfa0935dfbb07b1c60fc7c3bc3ed5fac.html