

Innovations in Implementation of Trauma-Informed Care Practices in Youth Residential Treatment: A Curriculum for Organizational Change

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Children in the child welfare system frequently experience trauma within the caregiving relationship. These traumatic experiences may be compounded by system trauma and place these children at high risk of emotional disorders and placement in out-of-home (OOH) mental health treatment programs. This article reviews the literature on trauma and children in the child welfare system and discusses a study of trauma-informed practices in OOH treatment programs and the curriculum *Creating Trauma-Informed Care Environments*, which resulted from study findings.

Childhood traumatic stress refers to both physical and emotional responses of children to life-threatening events that cause or threaten injury, such as child sexual abuse, physical abuse, or family violence (Child Welfare Collaborative Group, National Child Traumatic Stress Network [NCTSN], and California Social Work Education Center, 2008). The types of trauma prevalent among children and families in child welfare include abuse and neglect, exposure to violence, and exposure to parental substance abuse. Child maltreatment also co-occurs with risk factors within disadvantaged environments, such as neighborhood violence and inadequate community resources (Edleson, 1999; Rudo, Powell, & Dunlap, 1998).

As children move through the child welfare and juvenile court systems, they often encounter additional stressful, frightening, and emotionally overwhelming experiences through “system-generated trauma” (Ryan, Bashant, & Brooks, 2006), such as multiple placements and frequent changes in schools and peer groups (Ko, Ford, Kassam-Adams, Berkowitz, Wilson, Wong, Brymer, & Layne, 2008). Because of the increased risk for emotional and behavioral challenges experienced by children in child welfare (Landsverk, Burns, Stambaugh, & Rolls Reutz, 2009), these placement changes often include out-of-home (OOH) mental health treatment programs, including residential treatment programs. Consequently, there are high rates of trauma exposure in the histories of youth in OOH settings (LeBel & Stromberg, 2004).

The high rate of dependent children and youth in OOH mental health treatment programs, combined with the recognition of the need for trauma-related training and resources from Florida’s service provider community, provided the impetus for evaluating the degree to which trauma-informed care was being implemented in Florida’s OOH mental health treatment programs. The findings from the eight nominated residential mental health settings in Florida who participated in the assessment were used to develop a comprehensive

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curriculum that highlights successful implementation and sustainability of cultural change within organizations that are adapting trauma-informed and trauma-specific care. This curriculum merges the current research on models of trauma-informed care with theories of organizational change and development (Hodges, Hernandez, Nesman & Lipien, 2002) and implementation research (Fixsen, Naoom, Blasé, Friedman, & Wallace, 2005).

Background

There is a growing recognition that chronic and complex trauma is at the core of many behavioral and psychological disorders of children and adolescents (Cook, Blaustein, Spinnazzola, Van der Kolk, & the Complex Trauma Task Force, 2003), and that research-proven practice is essential for effective treatment of this population. Complex trauma refers to problems from exposure to multiple traumatic events and the resulting short- and long-term effects of such exposure. This generally occurs within the caregiving system, which suggests that interventions that occur within the context of relationships are the desired avenue for healing (Perry, Pollard, Blakley, Baker, & Vigilante, 1995). Exposure to early, repeated, and multiple episodes of abuse increases the risk for complex trauma, affecting the self-regulatory, behavioral, and emotional systems of traumatized children (Cook et al., 2007). Therefore, the need for intervention within the caregiving relationship also extends to relationships between direct-care staff and children in mental health treatment programs. Residential programs that serve traumatized children and youth should be first and foremost a “sanctuary” with an abundance of environmental and relational safeguards to prevent further retraumatization (Bloom, Bennington-Davis, Farragher, McCorkle, Nice-Martin, & Wellbank, 2003).

The research literature distinguishes between two types of trauma treatment: trauma-specific and trauma-informed. Trauma-specific services directly address complex trauma and facilitate the child’s recovery through individual or group therapy specifically focusing on trauma recovery; central goals are achieving safety in one’s environment, developing skills in emotion regulation and interpersonal

functioning, making meanings about traumatic events, and enhancing resiliency and integration into a social network (NCTSN, 2007). Trauma-specific treatment approaches may include such interventions as psychological debriefing, psychological education, cognitive behavioral therapy, and psychotropic medication (Cohen, Mannarino, Berliner, & Deblinger, 2000).

Trauma-informed services address the dynamics and impact of complex trauma on youth through a focus on avoiding inadvertently retraumatizing them when providing assistance within the mental health system. For example, in agencies using trauma-informed practices, all staff that interact with youth may be trained to recognize and respond therapeutically to manifestations of trauma such as acting out behaviors. A trauma-informed organizational culture supports and sustains “trauma-specific” services as they are introduced (Jennings, 2004, p. 68).

Literature on trauma-informed care suggests that to implement trauma-informed care, there is a need for organizational readiness, assessment, and change (Harris & Falot, 2001; Rivard, Bloom, McCorkle, & Abramovitz, 2005). Several curricula highlight the principles and elements of trauma-informed care within schools, child welfare, juvenile justice, and residential care. The curricula discussed in this article focus specifically on facilitating cultural change within the organization, addressing gaps and barriers, and taking effective steps based on the science of implementation (Fixsen et al., 2005). Implementing trauma-informed practices is then based on using individualized organizational data to inform planning and implementation. Case studies that examined organizational factors related to successful implementation of trauma-informed practices at OOH treatment settings in Florida are discussed here.

Methods

Case Studies

Florida has three Medicaid-funded, OOH mental health treatment settings: statewide inpatient psychiatric program (SIPP), therapeutic group care (TGC), and therapeutic foster care (TFC). The SIPP

is a facility-based residential treatment designed for clinically eligible children who are high users of inpatient psychiatric services. TGC services are community-based psychiatric residential treatment services for youth with emotional and behavioral issues, and TFC services are intensive treatment services provided to youth with emotional and behavioral issues in a licensed therapeutic foster home. Youth served in OOH treatment are more likely to be male, slightly more likely to be white, and on average are 13–14 years old. Typical diagnoses include attention deficit disorders, mood and affective disorders, and disruptive behavior.

Through a statewide nomination process, this study identified Florida provider agencies representing three SIPP facilities, two TGC homes, and two TFC programs that were already using trauma-informed approaches (Armstrong, Dollard, Hummer, Vergon, Robst, Cobb, Clark, Li, & Reyes, 2008). The case study approach addressed whether and how organizational culture in the nominated agencies supported trauma-informed practice in addition to the clinical practice elements that specifically address trauma. Findings were based on 75 interviews, 33 clinical record reviews, 12 treatment team observations, and reviews of policy and procedure manuals at 8 sites nominated by peers as using trauma-informed care practices.

The findings from these site visits were analyzed using a trauma-informed framework adapted from the trauma-informed program self-assessment scale (Fallot & Harris, 2006), a measure originally developed for use with adult service-system agencies. The measure identifies six domains of trauma-informed care based on previous research with women survivors of trauma. These domains reflect program procedures and settings. This measure was adapted for use with agencies providing residential treatment services to children and youth with permission of the author. Key modifications included the addition of activities specific to residential care, such as transitioning to the next placement, as well as activities specific to children and youth (vs. adult clients), such as the frequency of caregiver involvement in treatment planning.

Using data collected through interviews, case record reviews, document reviews, and treatment team observations at the eight study

sites, ratings of high, moderate, or low trauma-informed care implementation were assigned to agency-level policies and practices. Agencies were assigned ratings in each domain based on the consensus score among a team of three reviewers to assure inter-rater reliability. At least two reviewers were present at the site review to record reviews, written treatment team observations, transcribed stakeholder interviews, and copies of policies, procedures, training materials, and formal documents.

Case Study Results

The results of the site visits identified organizational factors related to successful implementation of trauma-informed care and confirmed the importance of including an organizational self-assessment instrument and process in the trauma-informed care curriculum. The organizational factors identified from the case studies are summarized under each domain.

Domain 1: Program Procedures and Settings

Physical and Emotional Safety

In general, there were systematic debriefings of seclusion and restraint, including documentation of de-escalation attempts prior to a seclusion or restraint episode, youth debriefing with staff, and staff debriefing on the event and what might have prevented it.

Trustworthiness

Facilities had numerous policies and procedures that ensured children and youth knew program expectations and understood the role of each staff member. Program staff reported their agency staff did well at being honest and informative and made conscious efforts to avoid unnecessary disappointment with the youth. All sites included maintenance of physical and emotional boundaries as part of their ongoing training agenda. All sites reported challenges in managing staff-child boundaries, often around issues of favoritism, and particularly among direct service staff.

Child and Youth Choice and Control

Three programs demonstrated efforts to promote child and youth choice. For instance, children and youth have choices as to their clothing and food preference and some choice of which staff members help them cope during behavioral escalations. Children typically had a choice regarding preferences for how they chose to de-escalate. Youth were actively encouraged to participate in treatment teams and to invite significant others to attend. One program was working toward youth assuming leadership roles in their treatment team meetings.

Collaboration, Power Sharing, and Empowerment

In general, the power appeared to reside with staff rather than with youth. Three programs showed evidence of “house council” activities in which youth could exercise some control over their environment and activities. Where opportunities for program feedback did exist for youth and their families (e.g., through satisfaction surveys and suggestions), it was unclear whether suggestions were reviewed or acted on by the administration.

Caregiver Involvement

Many of the children and youth in these programs are dependent, and respondents reported that less than half have biological or adoptive caregivers involved for this reason. When families are involved in their children’s care, staff reported that families are invited to participate in service planning and participate in family therapy, psychoeducational opportunities about trauma, and discharge planning, although family engagement remains a challenge.

Preparation for Placement Transition

Most programs reported that they did prepare for transitions, but that with dependent children and youth, because of uncertainties with availability of appropriate postdischarge placements, the actual placement was not always foreseen or planned for by the multidisciplinary teams.

Domain 2: Formal Service Policies

Knowledge of issues related to trauma and recovery were most clearly articulated in policies and procedures regarding confidentiality, child and youth rights and responsibilities, and seclusion and restraint policies and procedures (including de-escalation). Children and youth were informed of the grievance procedures, including how children and youth can contact the state abuse registry. There were also policies in place to identify child and youth preferences regarding de-escalation and procedures for staff. Generally, these preferences are identified soon after admission and include intervening at low levels of agitation, complying with the youths' preferred responses pertaining to location, the staff member to intervene, and debriefing after a seclusion or restraint incident.

Domain 3: Trauma Screening, Assessment, and Service Planning

Physical and sexual abuse were frequently identified through program-wide screening, although broader trauma exposure was not always explicitly included in the screening measures, particularly with respect to exposure to natural disaster and history of grief and loss. Questions about exposure to physical and sexual abuse were included in in-depth assessments, and these issues were addressed in service planning through a focus on resolution of past trauma, identifying children and youth's preferences regarding safety and grounding, and allowing children and youth to specify the gender of the person(s) identified to work with them during crises when possible.

Domain 4: Administrative Support for Program-Wide Trauma-Informed Services

Institutional support for trauma-informed care was not evident in the mission and vision statements of any programs visited, nor were there specific written policies regarding development of an approach to systematically address trauma in administration or quality improvement. The two exceptions noted were the inclusion and planning of trauma-related topics in training and supervision and the direct-care practices described previously.

Domain 5: Staff Trauma Training and Education

Respondents had a wide range of perspectives about support in terms of trauma-related training. Cross-training of all staff and “open forums” in which staff participated in providing feedback, problem solving, and developing policies and procedures were an integral part of a culture of openness, learning, and teamwork. However, some respondents also reported that high levels of staff turnover impeded the agency’s ability to keep staff fully trained. There were no reports in interviews about supports for staff that might experience secondary traumatization or being retraumatized in the course of their work with children and youth.

Domain 6: Human Resources Practices

There was little evidence at any site that trauma was addressed either prospectively in staff recruitment or as a component of personnel evaluation in any program.

Creating Trauma-Informed Care Environments

Study findings suggested that, while some agencies had attained high levels of trauma-informed care implementation, there was wide variability in the degree to which agencies had fully embraced trauma-informed care. After completing the study, to support the curriculum development, a literature review was undertaken to identify promising and best practices in trauma-informed care. This review of the trauma-informed care literature identified a growing emphasis on the need for organizational readiness, assessment, and cultural change to support trauma-informed care (Bloom et al., 2003; Harris & Fallot, 2001; Rivard et al., 2005). Based on this review and the study findings, the curriculum *Creating Trauma-Informed Care Environments*, which combines study findings and other current research on trauma-informed care with theories of systems change and development (Hernandez & Hodges, 2005) and implementation research (Fixsen et al., 2005), was developed. The result was the development of a set of field-based standards for trauma-informed care developed for use in OOH mental health treatment settings for children and youth.

These standards were organized by organizational readiness, competent organizational and milieu practices, and youth and family involvement. A new organizational self-assessment was created as part of the curriculum that identifies practice components in need of change.

The curriculum is intended for use by teams from OOH mental health treatment provider agencies including administrative staff, behavior analysts, shift supervisors, direct-care staff, families, and others, if desired. Teams of five staff from each agency participate in the learning collaborative. With the training and support of facility leadership, each team then becomes “trainers” for the rest of the agency or facility.

The Learning Collaborative model was selected as the primary method for implementing the curriculum because it focuses on adopting best practices in diverse service settings and emphasizes adult learning principles, interactive training methods, and skill-focused learning. Learning Collaboratives use methods for accelerating improvement in settings and capitalize on shared learning and collaboration. A toolkit created by the NCTSN supports applying the concept to the implementation and sustenance of evidenced-based and promising practices (Markiewicz, Ebert, Ling, Amaya-Jackson, & Kisiel, 2006). The learning collaborative sets up a statewide community of practice that promotes sharing of specific strategies.

The Learning Collaborative is a yearlong process in which the provider teams use self-assessment to identify a trauma-informed practice to implement in one unit of their facility. The group then gathers information and data on the practice topic and identifies implementation strategies and potential barriers to implementation. These teams also identify or develop measures to assess progress toward implementation. Teams meet face-to-face three times during the year, have monthly telephone support calls, access to a listserv, and receive onsite consultation from the learning collaborative faculty. The curriculum has three modules.

Module #1: Understanding Trauma and Trauma-Informed Care

Module #1 provides a sequential process for team leaders to facilitate an orientation to trauma with agency staff. Trauma-informed care

principles encourage the need to train staff at every level of the agency. The estimated time for completion of this module is four hours. The goals of Module #1 are to help participants become familiar with trauma and the philosophy and strategies associated with trauma-informed care. Successfully completing this module ensures that participants will understand the role that safety, trustworthiness, choice, collaboration, empowerment, skills acquisition, empathy, and relationships play in healing the effects of trauma; can differentiate between trauma-informed practices in all settings from trauma-informed care in a mental health residential setting; and can identify trauma-specific interventions that are empirically supported. This module also introduces the core elements of culturally competent care. The case studies played an important role in the development of this module.

The exercises contained in Module #1 are designed to help leadership, staff, and families become attuned to the sensory aspects of trauma, plan and create comforting areas and materials that consumers can use for self-soothing, determine whether a particular trauma intervention is the best choice for the select consumer population, and create a plan for how to care for oneself as someone who works closely with trauma survivors. Throughout the curriculum, there are opportunities to challenge values and beliefs about trauma and to encourage participants to develop a personal philosophy and commitment to honoring what trauma victims and their caregivers have done to survive.

Module #1 could be used as “stand alone” training that provides an introduction to the effects of trauma and the principles and practices that exemplify trauma-informed care. The full training, however, is intended to be implemented with all three modules delivered through the learning collaborative process.

Module #2: Application of the Learning Collaborative Model to Florida Residential Treatment Settings for Youth

Module #2 includes content and materials to assist the teams with understanding the learning collaborative model and why it was selected for implementation of trauma-informed care in residential

settings in Florida. The goals of Module #2 are to understand the Florida context for trauma-informed care; recognize all elements of the learning collaborative model as they are defined by the NCTSN; understand how and why the learning collaborative model was selected for use with implementing trauma-informed care practices; and discover the specifics of what is expected of learning collaborative teams. This module also contains the materials necessary for participation in the learning collaborative and answers to frequently asked questions about the process.

The essential values discussed in Module #2 include the beliefs that organizations are dynamic communities that need to be able to change and grow to be successful; that good ideas are created both from the top down and bottom up; that there is benefit to ideas being tested quickly, with immediate change and feedback for purposes of improvement; that implementing change requires commitment, resources, and incentives; that youth and their families are a valuable part of the organizational team; and that individuals learn best from sharing experiences with each other. Participants are given the opportunity to practice skills related to collaborative learning.

Module #3: Getting Started: Metrics and Organizational Assessment Tools

Module #3 continues using the learning collaborative framework and builds on implementation research that suggests organizations must be prepared for change; self-assessments help promote positive change and a transparent culture; and changes in outcomes and practice, however small, need to be observed, recorded, and given as feedback to all levels of the organization (leadership, clinical, milieu) as frequently as possible.

In this module, participants are expected to gain or increase their appreciation for the importance of data collection when beginning a new practice, learn about best practice standards for trauma-informed care, understand trauma-informed care from a consumer and family perspective, and appreciate the role of readiness for organizational change. The materials include a self-assessment tool to assess organizational readiness to implement trauma-informed practices (see

Table 1

Creating Trauma-Informed Care Environments-Organizational Self-Assessment

I. Organizational Readiness for Trauma-Informed Care Change

1. Demonstrate a minimum threshold of organizational readiness and build the capacity to implement a new practice model
 - A. Leadership and staff at all levels express commitment to implementing trauma-informed care.
 - B. Agency leadership has addressed cultural and policy barriers, externally and internally, that may impede implementation.
2. Provide support and infrastructure to monitor and evaluate practices and outcomes on an ongoing and continuous basis
 - A. The agency has standardized and systematic approaches for compiling and monitoring data and outcomes.
 - B. Organizational incentives are in place to support staff as changes are made.
 - C. Agency leadership allows staff time necessary for focus on implementing trauma-informed care.
 - D. The agency can provide the resources (technology, staffing, and training) for implementation of trauma-informed care and the monitoring of data and outcomes.

II. Competent Trauma-Informed Organizational, Clinical, and Milieu Practices

1. Demonstrate organizational practice standards for implementation of trauma-informed care
 - A. The agency has a "trauma-informed care initiative" (i.e., workgroup/task force, trauma specialist) endorsed by the chief administrator.
 - B. The agency identifies and monitors trauma-informed care values (safety, trustworthiness, choice, collaboration, and empowerment).
 - C. Organization promotes a culture of program improvement based on quantitative and qualitative data.
 - D. The organization has one or more methods of debriefing that involve, at minimum, all staff that were involved in the incident.
 - E. Formal policies and procedures reflect language and practice of trauma-informed care.
2. Demonstrate program practice standards for implementation of trauma-informed care
 - A. Clinical and direct-care staff are integrated into treatment teams that allow for integrated training and supervision.

Continued on next page

Table 1 cont.

- B. There are opportunities for staff to recognize, acknowledge, and address their vicarious traumatization.
- C. Trauma screening, assessment, and service planning is designed to identify and address trauma while avoiding retraumatization.
- D. The program offers trauma-specific, evidenced-based practices.
- E. Treatment planning and interventions are individualized, include skill building, and are developmentally suited to each youth.
- F. Each youth has a safety or crisis management plan with individualized choices for calming, de-escalation, and avoidance of seclusion and restraint.
- G. The physical environment is attuned to safety, calming, and de-escalation.
- H. Milieu staff uses a strengths-based, person-centered approach in all their interactions with youth.
- I. Staff have systematic opportunities to seek support or assistance from their peers.

III. Youth and Family Engagement in Trauma-Informed Care

1. Staff are effective in engaging youth and families in trauma-informed care practices
 - A. The agency demonstrates, in philosophy and practice, intent toward increasing comfort, involvement, and collaboration of youth and caregivers.
 - B. The agency regularly trains all staff on how to engage caregivers and monitors extent of engagement.
 - C. Youth and their caregivers are active partners in the trauma-informed care initiative.
 - D. Clinical interventions with caregivers are aimed at addressing dynamics and building skills to effectively identify and address trauma related needs and symptoms.
 - E. Youth and caregivers are actively involved in treatment, discharge planning, and transition to the next placement.

Table 1). This self-assessment tool for residential care settings was developed using the case study results and in consultation with Roger Falot PhD and colleagues at the Traumatic Stress Institute of Klingberg Family Centers. The instrument measures organizational readiness for change; competence of trauma-informed care practices at the organizational, clinical, and milieu levels; and youth and family engagement in trauma-informed care practices. The packet also

includes a consumer and family perception of care scale. Additional tools help the provider teams begin to gather quantitative and qualitative data to assist their move toward improving practice through data collection and discovery.

The collaborative structure, change package, application, and training materials have been completed, and agencies are currently being recruited. Learning Collaboratives will be implemented and evaluated beginning in fiscal year 2009–2010 with approximately five OOH treatment programs.

Conclusions and Next Steps

The identification of trauma-specific interventions to address the needs of traumatized children and prevent retraumatization is only one aspect of the significant organizational culture change needed to fully implement trauma-informed care in OOH treatment settings. To realize the principles of trauma-informed care, organizations need sustainable strategies that assist providers in developing a culture that fosters change at the organizational level. The curriculum described focuses on the tools necessary to support cultural change within organizations such that evidence-based practices for trauma-informed and trauma-specific care can be successfully implemented. As part of the overall curriculum, a new organizational assessment tool was developed to assist providers with self-assessment of organizational climate and practice competence. While the curriculum is initially being used with residential treatment center staff, future modifications of the curriculum are expected for use in less restrictive OOH treatment programs and eventually community-based treatment settings.

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