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# Creating Trauma-Informed Systems: Child Welfare, Education, First Responders, Health Care, Juvenile Justice

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Children and adolescents who are exposed to traumatic events are helped by numerous child-serving agencies, including health, mental health, education, child welfare, first responder, and criminal justice systems to assist them in their recovery. Service providers need to incorporate a trauma-informed perspective in their practices to enhance the quality of care for these children. This includes making sure that children and adolescents are screened for trauma exposure; that service providers use evidence-informed practices; that resources on trauma are available to providers, survivors, and their families; and that there is a continuity of care across service systems. This article reviews how traumatic stress impacts children and adolescents' daily functioning and how various service systems approach trauma services differently. It also provides recommendations for how to make each of these service systems more trauma informed and an appendix detailing resources in the National Child Traumatic Stress Network that have been produced to meet this objective.

*Keywords:* service systems, trauma, schools, health care, juvenile justice

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*(Author notes continue)*

Although many children who come in contact with the educational, health care, child welfare, first responder, and juvenile justice systems have experienced significant psychological trauma, there has not been a systematic approach within these systems to develop evidence-based services that address the impact of trauma on the children they serve. In this article, we describe a federally sponsored national effort to assist these systems in creating and sustaining evidence-based interventions for traumatized children. The article concludes with a table (see the Appendix) detailing resources created for each child-serving system through the National Child Traumatic Stress Network (NCTSN) and recommendations for practitioners on how to extend these programs to continue to make all child-serving systems increasingly trauma informed.

## The NCTSN

The NCTSN is a group of 70 (45 current and 25 previous grantees) treatment and research centers from across the United States, funded by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, through the Donald J. Cohen National Child Traumatic Stress Congressional Initiative. This network is a groundbreaking initiative that seeks to integrate academically grounded best practices drawn from the clinical research community with the clinical wisdom of frontline community service providers. The NCTSN is committed (a) to therapeutically addressing a full spectrum of childhood trauma types on the basis of a conceptual foundation that draws on developmental psychopathology, family systems, and community-based perspectives and (b) to helping children from every ethnic, racial, sociocultural, and economic background.

The mission of the NCTSN is to raise the standard of care and improve access to services for trauma-exposed and traumatically bereaved children, their families, and their communities across a diversity of treatment settings, professional disciplines, and targeted populations. Essential to this mission is partnering with established systems of care, including health, education, first responder, child welfare, and juvenile justice systems, to ensure that there is a comprehensive continuum of care available and accessible to all traumatized children and their families.

## Why Should Child- and Family-Serving Systems Care About the Impact of Trauma on Children?

Approximately 25% of children and adolescents in the community experience at least one potentially traumatic event during their lifetime, including life-threatening accidents, disasters, maltreatment, assault, and family and community violence (Costello, Erkanli, Fairbank, & Angold, 2002). Although some children and adolescents may recover quickly after adversity, traumatic experiences can result in significant disruptions in child or adolescent development, with profound long-term consequences (Pynoos, Steinberg, Schreiber, & Brymer, 2006). Repeated exposure to traumatic events can alter psychobiological development and increase the risk of low academic performance, engagement in high-risk behaviors, and difficulties in peer and family relationships. Traumatic stress is also associated with increased use of health and mental health services and increased involvement with other child-serving systems, such as the child welfare and juvenile justice systems (Chapman, Ford, Albert, & Hawke, in press; Garland et al., 2001).

Reviews of studies of children's access to mental health services indicate that schools and health care settings are the primary portal of entry. For example, children are more likely to access mental health services through primary care and schools than through specialty mental health clinics: Seventy-five percent of children under age 12 see a pediatrician at least once per year, whereas 4% see a mental health professional (Costello, Pescosolido, Angold, & Burns, 1998). Similarly, a longitudinal study of children in the community found that services were most often provided by the education system (Farmer, Burns, Phillips, Angold, & Costello, 2003).

Each child-serving system approaches trauma differently; has different levels of awareness, knowledge, and skill about trauma; and varies in perceptions of the utility of gathering information about trauma. Child-serving systems also differ in their responsibilities for meeting children's needs. However, the goal for all systems is to improve outcomes for children and to maintain excellent standards of care. Addressing the impact of trauma on children and families therefore is a crucial—although often overlooked—priority for all child-serving systems. Creating and sustaining trauma-informed child-serving systems requires a knowledgeable workforce, committed organizations, and skilled professionals. This article describes approaches mental health professionals are taking to achieve these goals in several child-serving systems.

## The Child Welfare System

Perhaps no other child-serving system encounters a higher percentage of children with a trauma history than the child welfare system. Almost by definition, children served by child welfare have experienced at least one major traumatic event, and many have long and complex trauma histories. Children in the child welfare system, especially those in foster care, have a higher prevalence of mental health problems than the general population

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(Garland et al., 2001; Halfon, Zepeda, & Inkelas, 2002; Leslie, Hurlburt, Landsverk, Barth, & Slymen, 2004; Taylor, Wilson, & Igelman, 2006). Abuse and neglect often occur, with concurrent exposure to domestic violence (Graham-Bermann, 2002; Hartley, 2002), substance abuse (Kelley, 2002), and community violence (Guterman, Cameron, & Hahm, 2003). These children also often face the additional stressor of removal from the home, multiple placements in out-of-home care (foster homes, shelters, group homes, residential treatment facilities, kinship placements), and different schools and peer groups (Halfon et al., 2002). The multiplicity of traumas can lead to polyvictimization (Finkelhor, Ormrod, Turner, & Hamby, 2005) or complex trauma (Cook et al., 2005), with increased likelihood of adverse traumatic symptoms.

Although child welfare professionals may be acutely aware of the traumatic events that brought the child to the system's attention, they may be far less cognizant of the complete trauma history the child has experienced or of the connection between that history and the child's current behavior or emotional response to stresses (Taylor & Siegfried, 2005). For example, foster children often present with very complex trauma histories and related behavioral or emotional problems (Halfon et al., 2002). The role played by traumatic stress in these problems often is overlooked, and even when it is recognized, many communities lack trauma-informed service providers who are skilled in evidence-based treatment for traumatic stress disorders (Chadwick Center for Children and Families, 2004; Chaffin & Friedrich, 2004).

For the child welfare system to become increasingly trauma informed, effective trauma screening and assessment protocols are needed at every level. When children are identified through trauma screening and assessment, it is not enough to offer general mental health services (Leslie et al., 2004); child welfare systems need service providers with expertise in research-based trauma treatment services (Taylor et al., 2006). In addition, child welfare workers, foster and adoptive parents, and courts can play an important role in facilitating posttrauma recovery. The NCTSN *Child Welfare Trauma Training Toolkit* identifies essential elements of trauma-informed child welfare practice to guide caseworkers: (a) maximize the child's sense of safety, (b) assist children in reducing overwhelming emotion, (c) help children make new meaning of their trauma history and current experiences, (d) address the impact of trauma and subsequent changes in the child's behavior, development, and relationships, (e) coordinate services with other agencies, (f) utilize comprehensive assessment of the child's trauma experiences and their impact on the child's development and behavior to guide services, (g) support and promote positive and stable relationships in the life of the child, (h) provide support and guidance to the child's family and caregivers, and (i) manage professional and personal stress.

## The Education System

Schools have long been identified as an ideal entry point for access to mental health services for children. However, most school-based mental health programs do not systematically screen, assess, or provide counseling or referrals for traumatic stress problems. Trauma confronts schools with a serious dilemma: how to balance their primary mission of education with the reality that many students need help in dealing with traumatic stress to attend regularly and engage in the learning process. For example, Stein, Jaycox, Kataoka, Rhodes, and Vestal (2003) found that among 769 students sampled in the Los Angeles Unified School District, the average number of violent events experienced in the previous year was 2.8, and the average number of witnessed events was 5.9. In addition, 76% of students had experienced or witnessed violence involving a gun or knife. Another study, by Flannery, Wester, and Singer (2004), found that between 56% and 87% of adolescents had witnessed someone being physically assaulted at school in the past year.

Violence exposure is associated with decreased IQ and reading ability (Delaney-Black et al., 2002), lower grade point average, increased days of school absence (Hurt, Malmud, Brodsky, & Giannetta, 2001), and decreased rates of high school graduation (Grogger, 1997). Low-income and ethnic minority youths are particularly vulnerable to the adverse effects of trauma because they disproportionately experience violence and academic failure (Thernstrom & Thernstrom, 2003) as well as insufficient access to mental health care (Kataoka, Zhang, & Wells, 2002).

Teachers, school psychologists, counselors, and school social workers typically receive little formal training or continuing education about the impact of trauma on students and ways they can help traumatized students achieve better educational outcomes. Educational systems largely have tried to mitigate the impact of trauma on the school community through school crisis plans and the development of resources to assist administrators and crisis teams when students are affected by tragic events. Crisis response programs provide an opportunity for schools to develop early interventions to detect youths who are experiencing more than transient traumatic stress reactions and to help them acquire coping strategies and positive peer and parent support (Jaycox, Kataoka, Stein, Wong, & Langley, 2005). For example, Cognitive Behavioral Intervention for Trauma in Schools (Jaycox, 2004) is a program that has been shown to reduce traumatic stress and depression symptoms and to increase the grade point average of traumatized students (Stein, Jaycox, Kataoka, Wong, et al., 2003).

Current education laws and federal legislation (e.g., No Child Left Behind Act of 2001; Individuals With Disabilities Education Improvement Act, 2004) have provided opportunities to augment national programs with trauma-informed elements. The President's New Freedom Commission on Mental Health (2003) recommended that school mental health programs be expanded and enhanced throughout the nation. To address this recommendation, the Office of Safe and Drug Free Schools within the U.S. Department of Education sponsors a number of initiatives and grants that support the development of trauma-informed services in schools, including Project SERV, Emergency Response and Crisis Management Initiative, elementary and secondary school counseling discretionary grants, grants for the integration of schools and mental health systems, and Safe Schools/Healthy Students Grant (see www.ed.gov for more information). Similarly, significant changes in the Individuals With Disabilities Education Improvement Act (2004) suggest that special education educators are potential partners in developing trauma-informed assessments and interventions. Educational organizations, guilds, unions, and education preparation programs are excellent partners in the effort to create trauma-informed programs.

## First Responder Systems

First responders, including law enforcement, firefighters, emergency medical services, and disaster response teams, encounter traumatized children and families on a daily basis. First responders are the first professionals to interact with victims and witnesses, often long before hospital emergency personnel, victim advocates, and mental health professionals. By virtue of their acknowledged expertise and authority, first responders are in a unique position to diminish the immediate traumatic stress of the survivors and witnesses whom they encounter. By addressing survivors and witnesses supportively and clearly, providing clear information about the status of the situation, developing safety plans, and helping traumatized survivors and witnesses to access trauma-informed professional services or peer support, first responders can provide a psychological scaffolding that is crucial to enabling traumatized children and families to regain hope and reorganize to deal with crises.

Police officers provide a clear illustration of the role that first responders may play. For children who are direct victims, police officers have established protocols for investigation, reports to Child Protective Services, forensic interviewing, and access to medical and psychological intervention. Child advocacy centers are an excellent example of a collaborative effort of various agencies and providers to address the needs of child survivors for both criminal and emotional issues. However, few police officers have formal training to address the complexities of children's psychological development and needs or to assist children in dealing with trauma.

When provided with support and training from trauma specialists, police officers often are able to decrease children's exposure to further upsetting incidents, provide them with containment and structure, and make referrals to providers within the course of their regular activities. The Child Development Community Policing (CD-CP) program is a model program for creating trauma-informed police systems (Marans & Cohen, 1993). The CD-CP program was initiated by the Yale Child Study Center and the New Haven, Connecticut, Department of Police Service in 1991. In an effort to correct the historical isolation of mental health providers from law enforcement and justice personnel, the CD-CP program places mental health professionals in the community side by side with the police to intervene early when children are exposed to violence or other forms of trauma (Marans, Murphy, & Berkowitz, 2002).

Many national organizations support the practice of trauma-informed policing, including the Police Executive Research Forum, the International Association of Chiefs of Police, the National Crime Prevention Council, and the Child Welfare League. In previous years, the U.S. Department of Justice was a major supporter of these efforts and, in 1999 in conjunction with the White House, named the CD-CP program the National Center for Children Exposed to Violence, in part to extend and develop the CD-CP model. The CD-CP model demonstrates that, through active partnerships with trauma-informed mental health professionals, police and other first responders are able to effectively attend to the needs of traumatized children and families.

## The Health Care System

The pediatric health care system encompasses a wide range of service settings, including outpatient, inpatient, and rehabilitation facilities as well as the home and community. In most health care settings, multiple professional disciplines, subspecialists, and trainees work in hierarchically structured teams in which the pace of information flow and decision making is rapid and provider–patient interactions are often very brief. However, pediatric health care provides the potential for continuity and ongoing relationships between providers and both children and families, which can serve as a base for identifying and initiating specialized care for traumatized children.

Difficult, painful, or frightening medical experiences are potentially traumatic for children and their families and affect millions of children each year. Traumatic stress reactions have been documented in children and parents in relation to a range of pediatric medical experiences, including burns, cancer, diabetes, unintentional and violent injury, and painful or frightening medical procedures (see Saxe, Vanderbilt, & Zuckerman, 2003; Stuber, Schneider, Kassam-Adams, Kazak, & Saxe, 2006, for reviews of this literature). Phases of medical traumatic stress with concomitant prevention and intervention options have been described (Kazak, Kassam-Adams, Schneider, Zelikovsky, & Alderfer, 2006), and the first generation of randomized prevention and intervention studies for pediatric medical traumatic stress is underway (e.g., Kazak et al., 2004).

Aside from medical experiences, health care settings are also among the first to see children exposed to acute, potentially traumatic events such as traffic accidents, residential fires, natural disasters, or violent mass trauma. Pediatric providers often are faced with the challenge of evaluating children who have been maltreated or exposed to domestic violence. Because traumatized children may require emergent medical assessment or treatment, the health care system can be an important front for identification of acutely traumatized children who are at risk for persistent traumatic stress (Horowitz, Kassam-Adams, & Bergstein, 2001; Ruzek & Cordova, 2003). Finally, routine health care encounters can be a primary gateway for identification of any type of child trauma exposure or traumatic stress reactions, especially for ethnic minority children and adolescents (Alegría et al., 2002).

Numerous studies have described poorer health or increased health care utilization over the long term in trauma-exposed individuals (Schnurr & Jankowski, 1999). Posttraumatic stress disorder (PTSD) in children has been associated with increased risk for circulatory, endocrine, and musculoskeletal conditions (Seng, Graham-Bermann, Clark, McCarthy, & Ronis, 2005). PTSD symptoms in transplant recipients have been associated with medication nonadherence, perhaps because of parent or child avoidance of traumatic reminders of the transplant experience (Mintzer et al., 2005; Shemesh et al., 2000). The impact of traumatic stress on physical health, and the possibility that addressing children's traumatic stress may reduce the utilization and increase the effectiveness of health care, provides an incentive to health care organizations and payer systems to seek trauma-informed service models.

Most health care personnel receive minimal training in traumatic stress or trauma-informed approaches. Two recent studies with regard to pediatric injury and traumatic stress illustrated the difficulty of identifying traumatic stress in the course of usual medical care (Sabin, Zatzick, Jurkovich, & Rivara, 2006; Ziegler, Greewald, DeGuzman, & Simon, 2005). A lack of training does not denote a lack of interest or concern. Health care providers often recognize the distress of ill and injured patients and parents yet are

aware of the paucity of mental health referral resources for patients. Brief evidence-based strategies that can be integrated seamlessly into care and administered directly by the health care team are often welcomed. The trauma-related task most familiar to many pediatric health care providers is their role in identifying and reporting suspected child abuse or maltreatment. There is an opportunity to expand on this better established skill set to enable providers to competently address a wider range of trauma exposure in their patients.

There are important ways trauma-informed care can mesh well with the goals and culture of health care service settings. Concepts such as family-centered care and the growing move toward parent presence during emergency and critical procedures for children (Lewis, Holditch-Davis, & Brussen, 1997; Sacchetti, Lichtenstein, Carraccio, & Harris, 1996; Woodward & Fleegler, 2001) have been the focus of research and have led to practice innovations in pediatric health care. These represent potentially fruitful avenues for finding common ground with others who advocate shifts in health care practice consistent with a trauma-informed approach. Many aspects of trauma-informed health care are in keeping with current efforts to promote family-centered pediatric care (Baren, 2001; Loyancono, 2001), which is increasingly seen to be associated with improvements in health outcomes (American Academy of Pediatrics Committee on Hospital Care & Institute for Family-Centered Care, 2003; Hanson, De Guire, Schinkel, & Kolterman, 1995). National organizations such as the Institute for Family-Centered Care (2004) and the National Association of Emergency Medical Technicians (2002) have produced training and advocacy materials for parents, providers, and health care systems interested in promoting family-centered care.

Health care organizations also are well positioned to adopt evidence-based traumatic stress interventions within the context of the quality improvement and quality assurance processes already used for integrating and assessing promising new practices. Traumatic stress screening and interventions may find additional footholds in health care systems by becoming incorporated in existing quality improvement–assurance initiatives, such as those mandated by the Joint Commission on Accreditation of Healthcare Organizations for pain assessment and pain management.

## The Juvenile Justice System

The juvenile justice system is a multifaceted array of interconnecting organizations, including law enforcement agencies, the courts, detention centers and prisons or "training schools" (including the schools and health care services in these facilities), probation and parole officers, residential centers and group homes, and community rehabilitation programs. Personnel in the juvenile justice system range in training and expertise from correctional staff and administrators, who may have extensive street experience and education ranging from a high school diploma to a postgraduate degree in criminal justice, to legal and health care professionals, who typically have more extensive academic training and credentials but less real world expertise.

Trauma is widely recognized within the juvenile justice system as a critical factor in the origins and rehabilitation of delinquent youths but also widely feared as a Pandora's box of problems that may intensify the behavioral and legal challenges of delinquent youths if opened up (Chapman et al., in press). When provided with well-validated tools for screening, assessment, education, and rehabilitation of traumatic stress problems as well as with accessible evidence-based services for youths whose functioning is impaired by traumatic stress, juvenile justice settings readily embrace a trauma perspective for behavior management and rehabilitation as well as for mental health services (Chapman et al., in press).

The major gap standing between traumatic stress specialists and the juvenile justice system is the absence of a shared understanding of the role of trauma in delinquency and rehabilitation. Although some delinquent youths have not been traumatically victimized (Dodge, Lochman, Harnish, Bates, & Pettit, 1997), traumatic victimization may tip the scales for many youths and put them on—or lock them into—a path to delinquency. Clinical (Cauffman, Feldman, Waterman, & Steiner, 1998) and epidemiological (Abram et al., 2004) studies indicate that at least three in four youths in the juvenile justice system have been exposed to traumatic victimization, and 11%–50% of youths in the juvenile justice system have PTSD (Abram et al., 2004; Arroyo, 2001; Garland et al., 2001; Teplin, Abram, McClelland, Dulcan, & Mericle, 2002; Wasserman, McReynolds, Lucas, Fisher, & Santos, 2002). Brosky and Lally (2004) reported high rates of trauma exposure in children who were referred to a court clinic—especially girls—and most of their sample reported significant behavioral health problems, with one in nine (11%) meeting criteria for PTSD. Many justice-involved youths also are or have been involved in the family court system as a result of victimization (Barth, 1996).

The delinquent behavior of a youth who is attempting to ward off victimization or who is reacting to reminders of past victimization may be no less dangerous than that of a youth who is callously indifferent to the law or the harm inflicted on people. Yet the sanctions and services needed for these youths may differ greatly. To ensure fair application of procedure throughout the juvenile justice system, authorities representing the legal system have to recognize that they have a responsibility to society and to youths and their families to base their judgments on a full understanding of the role that trauma and victimization play in youths' lives (Ford, Chapman, Mack, & Pearson, 2006). When exposed to coercion, cruelty, violence, neglect, or rejection, a child may cope with indifference, defiance of rules and authority, or aggression as a self-protective counterreaction. These defensive attempts to overcome or resist the helplessness and isolation caused by victimization often are motivated by the desire to regain the ability to feel safe and in control rather than by the callous indifference often assumed to be driving delinquency. Thus, traumatic stress, if not addressed in juvenile justice services, may contribute to a downward spiral of increasingly deviant and risky behavior, retraumatization, and chronic juvenile (and adult criminal) justice involvement.

A number of national organizations have welcomed this trauma-informed perspective. These include the National Commission on Correctional Healthcare, the National Council of Juvenile and Family Court Judges, the National Juvenile Defenders Center, and the National Center for Mental Health and Juvenile Justice (Ford, Chapman, Hawke, & Albert, 2007). State and county juvenile justice systems, departments of children and families, and children's advocates are sponsoring trauma initiatives across the country as well, such as in California, Connecticut, Florida, Massachusetts, and Pennsylvania. The Department of Justice and its Office of Juvenile Justice and Delinquency Programs and the National

Institute of Justice are funding policy and clinical research studies designed to develop evidence-based models for trauma services in juvenile justice. Partnering with these and similar organizations, advocacy groups, and initiatives offers trauma specialists many productive venues for public and professional education and collaborative development of models for evidence-based services for traumatized youths in the juvenile justice system

## Recommendations for Independent Practitioners

Recognizing that each system that serves children and families has unique needs, we conclude with recommendations regarding how independent practitioners can work with these systems to implement changes in practice and policy to create trauma-informed systems.

1. *Promote the integration of trauma-focused practices across formal mental health treatment and other service sectors.* Such efforts may promote a number of aims of common concern to many mental health and service sectors, including accurate risk detection and case identification; triage of clients to appropriate interventions; continuity of care across providers; and facilitation of staged, multisystemic, or flexible interventions for high-risk, treatment-refractory, or culturally diverse populations (see Perry, 2006).

2. *Identify changes in practice that providers and policymakers in each system view as important to achieving outcomes that matter to them* (e.g., school attendance, grades, recidivism, physical health outcomes, service utilization, cost-effectiveness) and then partner with these systems to assess the extent to which practice changes are effective in improving these outcomes. For example, practitioners in the Los Angeles Unified School District, an NCTSN site, have been able to collect data that support the effectiveness of the Cognitive Behavioral Intervention for Trauma in Schools in improving grade point averages (Stein, Jaycox, Kataoka, Wong, et al., 2003).

3. *Rigorously evaluate the benefits of implementing trauma-informed care.* Collaborations with child-serving systems are an opportunity to bring clinical and research skills to projects that demonstrate benefits to children, families, and the system. When these benefits include enhanced services or reduced costs, a synergy is created that can lead to sustained adoption of innovative trauma-informed services and policies and funding for their wider dissemination.

4. *Introduce trauma-informed services into the core education and training for every child- and family-serving system.* Working with those who train the next generation of practitioners, trauma-informed professional psychologists can integrate a knowledge base on traumatic stress and skills for trauma-informed practice into core educational experiences for professional psychology, mental health, and other human service and child-serving professions.

5. *Provide trauma-informed care and traumatic stress interventions early and strategically.* Professionals in child-serving systems need not be specialists in traumatic stress, but they should be sufficiently trauma informed to be able to identify and help traumatized youths and families understand traumatic stress and gain access to trauma specialists.

6. *Replicate specialized evaluation, assessment, and treatment services provided by programs within the NCTSN.* Initiatives enhancing community-based mental health and health care services, faith-based programs, community policing and violence prevention programs, individualized educational programs, and juvenile justice programs should explicitly include funding requests for evidence-based services for traumatized children and families. For example, practitioners in Delaware have used *Cops, Kids and Domestic Violence* (NCTSN, 2006; see the Appendix) in trainings statewide. As a result, they have received funding from the state to hire clinicians who can provide trauma treatment.

7. *Emphasize interdisciplinary collaboration and relationship-building.* Cross-training and cross-disciplinary integration between mental health practitioners and frontline workers and administrators in other child- and family-serving systems allows multiple systems to work together to seamlessly provide children with a continuum of care and reduce the risk that children and adolescents will be reexposed to traumatic material by being required to retell their story as they enter each new system.

In conclusion, we propose that the successful integration of trauma-focused information into systems that serve trauma-exposed and bereaved children and adolescents, combined with strong collaboration among systems and disciplines, constitutes one of the most powerful mechanisms by which the NCTSN may promote its mission of raising the standard of care and improving access to services for traumatized children and adolescents nationwide.

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*(Appendix follows)*

Appendix

NCTSN Initiatives in Child-Serving Systems

| System | Project/resource | Description/status |
|---|---|---|
| All child-serving systems | Service Systems Brief | *Creating Trauma-Informed Child-Serving Systems* (Ko & Sprague, 2007) |
| Child welfare | • *Child Welfare Trauma Training Toolkit*<br>• *Child Welfare Trauma Referral Tool* (Taylor et al., 2006)<br>• Additional resources are in the development phase: (a) Policy Guide for Child Welfare Administrators, (b) Foster Parent Training Materials, and (c) Guide to Trauma Mental Health for Child Advocacy Centers. | Components: (a) trainer's guide, (b) slide kit, (c) supplemental handouts, (d) LISA 9-1-1 call (audio file), and (e) comprehensive guide. |
| Education | • *Child Trauma Toolkit for Educators*<br>• Web resources on crisis response and recovery for school personnel | Components: (a) Trauma Facts for Educators, (b) Understanding Child Traumatic Stress: A Guide for Parents, (c) Psychological and Behavioral Impact of Trauma: Elementary School Students, (d) Psychological and Behavioral Impact of Trauma: Middle School Students, (e) Psychological and Behavioral Impact of Trauma: High School Students, (f) Self Care for Educators, (g) Suggestions for Educators, (h) Brief Information on Childhood Traumatic Grief, (i) Brief Information on Childhood Traumatic Grief for School Personnel, and (j) Students and Trauma DVD. |
| First responder | • *Cops, Kids and Domestic Violence: Protecting Our Future* (NCTSN, 2006b) | Components: (a) 20-minute video of police response to a domestic violence call, (b) perforated tip cards stating actions police officers can take on scene, (c) information on traumatic stress and resources. |
| | • *Psychological First Aid: Field Operations Guide, 2nd ed.* (NCTSN & NCPTSD, 2006) | An acute intervention used by disaster responders to assist survivors of mass trauma in the immediate aftermath of an event. |
| | • Service Systems Brief | *Creating a Trauma-Informed Law Enforcement System* (Widdoes & Merrick, 2008) |
| Health care | *Pediatric Medical Traumatic Stress Toolkit* (NCTSN, 2004) | Components: (a) practical tools for health care providers and information for parents, (b) a "D-E-F" framework to guide the practice of trauma-informed heath care, and (c) template for training and adoption of trauma-informed practice. |
| Juvenile justice | • Four briefs on childhood trauma in the juvenile justice system. | *1. Trauma Among Girls in the Juvenile Justice System* (Hennessey et al., 2004)<br>*2. Victimization and Juvenile Offending* (Siegfried et al., 2004)<br>*3. Assessing Exposure to Psychological Trauma and Posttraumatic Stress in the Juvenile Justice Population* (Wolpaw & Ford, 2004)<br>*4. Trauma-Focused Interventions for Youth in the Juvenile Justice System* (Mahoney et al., 2004) |
| | • Special issue of the *Juvenile and Family Court Journal* (Ruffin, 2006), which addressed childhood trauma within justice settings. Abstracts can be viewed on the NCJFCJ website at www.ncjfcj.org | |
| | • In development: Service Systems Brief | *Informing Judges about Child Trauma: Findings From the National Child Traumatic Stress Network/National Council for Juvenile and Family Court Judges Focus Groups* (Sprague, in press) |

*Note.* Resources are available for download at http://www.nctsn.org or can be obtained from the National Center for Child Traumatic Stress (NCTSN) at info@nctsn.org. NCPTSD = National Center for PTSD; NCJFCJ = National Council of Juvenile and Family Court Judges.

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