System of Care Trauma-informed Agency Assessment (TIAA)© Overview

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This manual is intended for a general audience interested in learning about the TIAA and how to implement it in communities and agencies. This manual does not include the actual TIAA. For a copy of the program manual and use of the copyrighted TIAA please contact Arabella Perez at aperez@thriveinitiative.org. You can also visit the THRIVE website for information on trainings and technical assistance: www.thriveinitiative.org

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–THRIVE Evaluation Committee, 2011

INTRODUCTION

THRIVE, Maine's trauma-informed system of care, provides child-serving agencies and community organizations a broad array of trainings and technical assistance that are trauma-informed, family-driven, youth guided, and culturally and linguistically competent. Family members and youth consumers may serve as co-trainers, and their valuable perspectives inform training materials as well as this TIAA.

Since 2005, THRIVE has educated and trained mental health agency staff and the state staff that oversee them on system of care principles and trauma-informed practices. THRIVE developed the TIAA to gauge current agency practices and see whether changes were making a difference. In 2010, Maine's Children's Behavioral Health Services[1] mandated that, starting with the TIAA's self-assessment; all children's behavioral health agencies contracting with it practice system of care principles and are trauma-informed. The tool is adaptable for other types of child-serving agencies, including, but not limited to, Child Welfare and Juvenile Justice. This manual describes the TIAA development and validation processes, as well as how to use it and score it, for those wanting to administer the TIAA themselves.

What the Research Says

It is estimated that three million children and adolescents in the United States are exposed to serious traumatic events each year. Nearly one out of three adolescents was found to be physically or sexually assaulted by the age of sixteen (Boney-McCoy & Finkelhor, 1995) and violent crime victimization among youth was twice as high as the rate for adults (Hashima & Finkelhor, 1999). High rates (50-70%) of Post-Traumatic Stress Disorder (PTSD) were found among child, adolescent and adult public service users, while PTSD rates among Medicaid enrollees were highest among children ages five to twelve, at 609.5 per 1,000 (Macy, 2002; Kessler, 2000; Switzer, et al., 1999). Child and adolescent trauma survivors had higher rates of mental health service use and were more likely to use acute mental health treatment services, including: inpatient hospitalization, crisis services, and residential treatment services at higher cost (Frothingham, et al. 2000; Macy, 2002; Newmann, et al., 1998; NTAC, 2003). Finally, the Adverse Childhood Experiences Study (Felitti, et al. 1998) found a strong relationship between exposure to trauma during childhood and many risk factors for health and social problems later in life. Other research shows a relationship between parental childhood trauma and how parents interact with their children.

[1] Located within the Maine Department of Health and Human Services, this agency guides all state-funded children's behavioral health services.

What is Trauma?

Trauma, as it relates to mental health, is a psychologically distressing event or exposure to a pattern of behavior that is outside the range of usual human experience. It creates intense fear and helplessness in the person directly experiencing or witnessing the violence. Physical or sexual abuse, exposure to substance abuse, serious physical and emotional neglect, domestic violence, other acts of brutality, war, and natural disasters are examples of traumatic events. Symptoms of trauma include: extreme anxiety, depression, anger, dissociation, sexual concerns and traumatic stress. The latter differs substantially from stresses that are an inevitable component of everyday life. Traumatic stress induces an abnormally intense and prolonged response, which overwhelms a person's ability to cope, and can be triggered unintentionally, especially by those perceived to be in a position of power and authority.

Why be Trauma-Informed?

Research shows that traumatic experiences are pervasive among youth receiving public mental health services, underscoring the importance of early trauma screening, identification and assessment. Having a trained trauma-informed staff not only reduces the potential for re-traumatizing youth and families, but also helps make their entire service experience less overwhelming and more effective, and potentially less costly in the long run.

Organizations also benefit internally from learning how trauma affects staff. Trauma-informed workplaces have the resources to reduce "burnout" and mitigate "vicarious trauma." Such support for employee well-being helps morale, retention and productivity, and strengthens the organization's reputation as a respectful workplace. The result should be an increased ability of the agency to attract high quality staff.

What Is Trauma-Informed Practice?

Trauma-informed practice is grounded in specific education and training supported by policies, included in, but not limited to the areas of: human resources, supervision and crisis management. Other components include:

- Integrated universal trauma screening, assessments and service planning;
- A strengths-based focus on resiliency, recovery and skills building; and,
- Continuous quality improvement

New clients screened for trauma receive an accompanying explanation as to what trauma is and why it matters. Paying attention to physical surroundings–such as well-lit parking lots, sufficient signage in waiting rooms, and secure, well-marked bathrooms–fosters a consistent sense of security. All staff who have contact with consumers receive general information as to the roles that violence and victimization play in the lives of a large number of families and how their own attitudes and behaviors can affect a client for the better or the worse.

Instead of asking "What is ***wrong*** with this child and family?" trauma-informed practitioners ask "What ***has happened*** to this child and family?" Trained to this simple shift in perspective, direct care staff recognize a "problem" behavior as a way of coping with painful circumstances or as a stress response related to past trauma.

To sustain treatment relationships and increase positive treatment outcomes, providers incorporate the following trauma-informed guiding principles into administrative and direct-care practices: **safety, trustworthiness, choice, empowerment, collaboration**, and **cultural and linguistic competency.**

Trauma survivors often report that past boundary violations have resulted in their inability to trust others, especially those in positions of power and authority. Trauma-informed staff gain trust by establishing and maintaining appropriate boundaries and communicating clearly. Trustworthy organizations demonstrate consistent policies and reasonable expectations. They share power with consumers and value all perspectives. Collaboration with family and youth lets their insights as to individual and family history, culture and needs inform all phases of service planning and delivery such as where, how and when services are provided.

Why Choose the TIAA?

The TIAA guides in-depth, data-driven decision-making to inform change efforts and sustain them through Continuous Quality Improvement (CQI) and evaluation. As a validated tool, the TIAA is designed to: identify areas where agencies are doing well and pinpoint areas for improving trauma-informed performance, thereby benefitting the overall system for youth and families. TIAA data guides change according to each organization's unique strengths and needs. Upon re-assessment, agencies can effectively gauge whether their CQI plans were successful and modify and re-implement them until they are.

THE DEVELOPMENT PROCESS

The development process for TIAA occurred over a two-year period. Youth and family members were instrumental partners during each phase. (See Appendix: Additional Resources, Trauma-Informed Guiding Principles.)

Planning

A group of key stakeholders, including youth and family members in Maine's System of Care, created the conceptual framework for the TIAA, as well as brainstormed methods for collecting the information needed to complete it. The initial content was based on Trauma-Informed Systems Theory (Fallot & Harris, 2006) and System of Care principles. The first major decision was which domains to include from the two conceptual bases. The planning group determined where the domains overlapped and which additional ones were critical to both trauma-informed practice and systems of care principles. The result was selection of six domains which are defined in the next section: physical and emotional safety; youth and family empowerment; trustworthiness; trauma competence; cultural competence; and commitment to trauma-informed philosophy.

A workgroup reviewed the literature, collected and examined existing tools, and drafted potential questions. Sets of questions were written for each perspective being assessed: managers, clinicians, family members and youth. The idea was that multiple perspectives would give agencies the most complete view of their trauma-informed performance. They then developed uniform standards which provided the basis on which to assign a score. A larger group of stakeholders reviewed and vetted the results of the planning phase.

Pilot Testing

Two agencies piloted the TIAA, as well as answered questions regarding the delivery method. Initially the stakeholders wanted people outside of the agency to administer and score the tool. Paired teams (an evaluator and a trained youth/family member) conducted interviews with agency administrators and supervisors, staff, family members and youth. Interviewers scored responses according to standards articulated during the planning phase. The information was analyzed, and the results presented to the stakeholder group.

Refining

Youth and family members helped interpret the results of the pilot and provided feedback about the data collection methods based on their field experiences. Taking into account all findings, the tool was modified and the standards were refined. Stakeholders also determined that it was overly labor-intensive to have external

evaluators conduct the assessment face to face. Moreover, this approach was not sustainable once funding was concluded. Therefore the group modified the tool into a self-assessment or, in the case of the youth and family, an assessment of the agency. In addition to simplifying the methodology and data collection, the tool was developed in a web-based version, which youth and family tested. They also provided invaluable guidance on the most compelling ways to present the data to various audiences. During the next phase people were given the option of completing the TIAA electronically through the web, or on paper.

Implementing

Once the pilots were completed, all of Maine's System of Care agencies participated, according to contract language implemented by Maine's Children's *Behavioral* Health Services. (See Appendix: Additional Resources, *Trauma-Informed Guiding Principles*.)

Essential Elements of the Assessment

The TIAA is designed for children's behavioral health agencies that offer clinical and targeted case management services. Plans are underway to modify the tool for Child Welfare and Juvenile Justice settings. *[Please note: The assessment should not be used as a family satisfaction questionnaire or an exit interview form.]*

Trauma-Informed Domains

The TIAA measures six elements (illustrated at right) from the perspectives of: agency staff, families served and youth served by the agency. These domains derive from select system of care and trauma-informed guiding principles. (See Appendix: Additional Resources, Trauma-Informed Guiding Principles.)

Physical and Emotional Safety assesses whether secure reception/waiting areas, non-judgmental treatment and flexible scheduling, among others, promote a sense of safety.

Youth and Family Empowerment is whether policies and practices empower clients through strength-based participation and/or community-based partnerships.

Trustworthiness is whether factors such as consistency, accessibility of staff and interpersonal boundaries foster trust between an agency and the consumer.

Trauma Competence is the extent to which staff, policies, procedures, services and treatment serve the unique experiences and needs of trauma survivors.

Cultural Competence is the extent to which staff, policies, procedures, services and treatment accommodate the cultures, traditions and beliefs of youth and family consumers.

Commitment to Trauma-Informed Philosophy is the extent to which *all agency staff with consumer contact* integrate a trauma-informed philosophy in everything they do.

Each of the TIAA domains is defined (see sample module below) so that respondents have a common understanding of what is being assessed.

IV. Trustworthiness

1. **Informed Consent**: Informed consent procedure contains: participant rights and responsibilities; when/how services will be terminated; limitations to confidentiality (e.g., mandated reporting); potential risks/benefits; goals of the service or treatment; and limitations of the service or treatment.

2. **Grievance Policy**: Grievance policy and reporting procedures are fully disclosed at the start of agency involvement; policy is explained orally and in writing in easily understandable language; policy includes a mechanism to address incidents or complaints short of filing a formal grievance; agency identifies trained individuals to help youth and families navigate process; grievances and complaints are reviewed by agency staff, youth and family member; results and reasoning and provided to youth and family in timely fashion.

3. **Consistent Communication with Youth and Families:** Written policies, procedures and practice support consistent communication with youth and families, including: agency mission; eligibility criteria; rights and responsibilities; services and treatments available; service and treatment practices; program or treatment expectations.

4. **Recognition of Power Dynamic:** Formal policy and practice recognizes the power dynamic of the service provider over the youth and family, particularly those with trauma history; defines professional boundaries that all employees are expected to uphold, including availability/ reachability; discusses consequences for failure to maintain proper boundaries.

5. **Family Informed of Staff Changes**: Policy requires that youth and family be informed of changes to their case manager or treatment provider and reasons for same in timely fashion. Process takes into account: the potential for re-traumatization due to the loss of a trusting relationship; youth and family preferences in selecting new provider (efforts to make appropriate match); adequate preparation for new staff to take over (e.g., “bridge” meeting, sharing case files).

Target Population

This tool is intended for use with children's behavioral health agencies that offer clinical and targeted case management services. Plans are underway to test and modify the tool for the Child Welfare and Juvenile Justice settings.

Initial Validation of the TIAA

The development process itself established the face validity of the tool. A panel of experts, including youth and family members, created the survey and provided multiple perspectives, including cultural and linguistic perspectives. Two additional validation analyses were performed once data was returned: Cronbach's alpha and Principal Component Factor Analyses.

Cronbach's alpha is a measure of internal consistency, and reliability: it is used to demonstrate how closely related a set of items is as a group and the extent to which the items "hang together" and contribute to the measurement of the same concept. Cronbach alpha coefficients above .70 generally indicate an acceptable level of internal consistency. When tests were performed on the data collected during the first statewide implementation, the results of the TIAA for each of the six domains ranged between 0.80 and 0.93, as illustrated below. This suggests that the TIAA domains have relatively high internal consistency reliability.

Table 1. Cronbach Alpha Scores by TIAA Module

Scale	Agency (n = 1,441)	Youth (n = 213)	Family (n = 574)
Physical and Emotional Safety	.855	.838	.882
Youth Empowerment	.832	.923	-
Family Empowerment	.823	-	.899
Trauma Competence	.887	.869	.876
Trustworthiness	.847	.911	.905
Commitment to Trauma-Informed Approach	.931	-	-
Cultural Competence	.906	.912	.912

The item analysis also found that most items in each domain area contributed to the overall scale score and exhibited moderate inter-correlations. This means that they are all measuring a similar concept (i.e., youth empowerment) but measure slightly different aspects of the concept or domain being measured. Upon review, the TIAA workgroup determined that in many of the instances where questions were related, they ultimately capture different aspects of the domain being measured and should be monitored separately. For example, having enough information about services and treatment to make a decision is directly related to whether staff inform consumers about available services and ask what a consumer prefers. However, all three of these aspects of trauma-informed service delivery should be monitored.

A series of exploratory Principal Component Factor Analyses were conducted to assess the underlying structure of the data and the extent to which the individual items corresponded to conceptual trauma-informed domains. All 42 items from the agency module were included in the initial principal component analysis. The results revealed seven independent groups of items.[2] These factor grouping were found to align closely with the TIAA conceptual domains, in some cases, exactly. The domains for youth and family empowerment were the least cohesive, although this makes sense because empowerment occurs in areas that relate to all the other domains. For example, that informed consent is reviewed with the consumer in easy to understand language is part of empowerment; that the consent process fully discloses agency expectations for services and grievance policies is a measure of trustworthiness.

The Factor Analysis results were less conclusive for with the youth and family modules. Exploratory Principal Component analysis on all 42 items contained in the Youth and Family modules produced 10 component factors which crossed the TIAA domains. When the analysis was limited to five factors, the same number of domains measured by the youth and family modules, the results continued to suggest that youth and family responses on the tool did not distinguish between the domains of safety, trustworthiness and empowerment. More validation work is needed on the youth and family modules to determine the extent that the items in each domain, as currently defined, measure singular traits of trauma-informed practice from the perspective of youth and families.

In summary, the preliminary validation analyses performed suggest that the scale items that make up each trauma domain show high internal consistency reliability for all three TIAA modules. The factor analyses provide preliminary support for the conceptual trauma domains used in the tool for the agency staff module. Further validation efforts are needed to determine the extent to which the youth and family module adequately captures each trauma domain.

The full of results from both validation analyses can be obtained on request by contacting THRIVE.

[2] All the groupings had eigenvalues over one.

ADMINISTERING TIAA: SINGLE-AGENCY

Appointing a Change Team of key stakeholders prior to implementing the TIAA is highly recommended. This group will help ensure that all subsequent actions undertaken as a result of the assessment's findings consider multiple points of view. This leads to greater success and buy-in throughout the process.

Single Agency Change Team
Evaluation, Data Administrator or CQI
Family Member
Youth Consumer
Executive Director
Clinical Supervisor
HR Director/Operations
Supervisor
Clinical Staff
Support Staff

Youth and family members are particularly important. They provide critical views on the importance of the assessment, in general, and the questions posed, in particular. They will help guide analysis of the results, and suggest ways to use the information to modify service practices.

Agency staff such as a supervisor, clinician and support staff member can help foster buy-in for other staff.

At a minimum, the Change Team ensures that the process is both culturally competent and youth- and family-guided, while remaining faithful to the assessment itself and implementation standards.

Timeframe

The timeframe represents when the assessment tools themselves are completed. It is recommended that the assessment be "open" for a period of 45 to 60 days, during which time intermediary reminders are sent. When selecting the timeframe, the Change Team would include agency, youth and family member input. Families may suggest that holiday seasons and school vacations be avoided. Staff will want to avoid dates of other agency-level reviews.

As specified below, the TIAA can be paper-based, so an extra 10-15 days grace period is recommended to allow for mail delays. Agencies may also want to set an internal deadline at least 10 days prior to the close of the survey so that supervisors can follow-up with staff, youth and families regarding response rates.

Methods of Administration

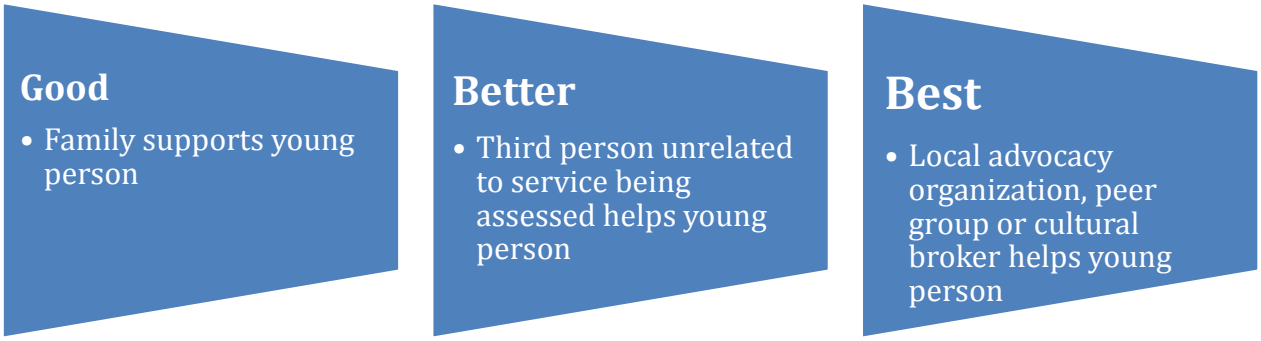
Local family and advocacy organizations could be invited to distribute information about the TIAA and encourage appropriate participation. A toll-free 800 line for people who are hearing impaired or who have trouble with reading comprehension or writing could also be used, as was piloted in Maine.

The tool can be administered through a web-based platform and/or paper-based format. The web minimizes data entry requirements and provides additional confidentiality and privacy. If an agency chooses only the web-version, it should provide youth and family with a web-enabled computer in a private area of the agency. Contact THRIVE for more information regarding the web-based platform.

If an agency opts to include the paper format, it would provide hard-copy surveys, as well as self-addressed, postage-paid envelopes, and/or a "TIAA return box" in the agency for completed surveys.

It is not recommended that agency staff be present while youth, family or even agency representatives complete the survey as this may impact results. However, the Change Team may allow exceptions, where agency staff or third-party providers, e.g., respite, behavioral health aide, help family and youth respondents overcome literacy challenges, language access, learning disabilities, mild mental retardation or developmental/behavioral challenges.

Youth Responses to Trauma-Informed Assessment



Target Response Rates

All agency staff should complete the assessment, including executive directors and administrators, clinical staff, case managers, behavioral health aides and other support staff, administrative support staff and facilities staff.

The number of family and youth (ages 12 to 20) who should participate is determined as a proportion of the number of children and youth served by the agency annually. The following table is a guide based roughly on 30 percent participation. The numbers should be considered a minimum target, meaning the fewest responses necessary to compile results that represent the agency. However, agencies are encouraged to get assessments for as many family and youth as possible, including those who have been discharged within the past three months, in order to obtain a sufficient number of responses.

Number of Clients Served Annually	Caregivers/ Parents	Youth (ages 12-20)
0-10	All	All
11-30	10	10
31-50	15	15
51-70	20	20
71-100	25	25
101-150	35	35
151+	50	50

Motivating Higher Responses

In general, regular updates during the administration period and follow-up during supervision can improve response rates. Otherwise, the Change Team has the charge of boosting them as needed. Ideas for discussion might include asking local family and advocacy organizations to distribute information about the TIAA and encourage appropriate participation; use of a toll-free 800 line for the hearing impaired or other learning needs (contact THRIVE for more information on access to the toll-free line provided by Hornby Zeller Associates, Inc.); a private area at the agency to take the survey on-line or on paper with a drop box handy, etc.

Incentive offerings might include:

- a raffle to win a gift card or certificate
- coupons or discounts to local businesses
- a contest, e.g., the department or unit with the highest proportion of respondents wins a pizza party, agency-wide recognition, etc.

Presenting the TIAA to Families, Youth and Staff

It is important that the intent and purpose of the assessment tool be communicated well. Families may be overburdened caring for their own needs and those of their child. Youth may have more immediate needs, such as where they are going to sleep that night or what they are going to eat. Families and youth are so used to being assessed themselves that a point to emphasize is that now they are doing an assessment of the agency (see family quote at right). It is not a clinical assessment. There are no questions about a diagnosis or treatment goals. As another family member stated, "They need to know that they are assessing the organization and its ability to meet their needs."

Likewise, staff who feel overburdened with paper work are not likely to respond to a voluntary survey. To be successful, the assessment needs to be known as an agency and/or state priority. Support and follow-up from supervisors during staff meetings and supervisions will help ensure that *all staff* complete the assessment.

> *I would encourage parents to complete the survey. Let them know that just a 30 minute investment carries a huge potential to change service delivery, and it is anonymous. This is not just a token attempt. It has included family and youth input throughout its creation.*
>
> ~Family Member

The following examples of talking points and the process established by an actual agency illustrate their approach to implementing the TIAA.

The examples demonstrate how they emphasized the importance of the assessment to their staff, provided clear standards and supplied a system for collecting the information. Although this particular agency was a large one that offers many different services and has multiple units, its approach employs many strategies that are useful for smaller agencies.

ADMINISTERING THE TIAA: MULTI-AGENCY

The TIAA may be administered on a multi-agency or a statewide basis. For example, if trauma-informed practices are being administered within several counties as part of a system of care project, the leaders may want to administer the tool to all agencies covered by the system of care and to analyze the scores collectively as well as individually. States may implement the TIAA consistent with a goal that all mental health agencies operating with state funding be trauma-informed.

Trauma-Informed Change Team

The membership of a multi-agency Change Team (see Box at right) guides not only the administration of the TIAA, but also the Continuous Quality Improvement process (CQI) that sustains it. The team should be culturally diverse and linguistically competent according to the demographics of the collective service population.

Multi Agency Change Team
Evaluation, Data Administrator or CQI
Family Member
Youth Consumer
Agency/Provider Administration
Agency/Provider Supervisor
Agency/Provider Staff
State-level Partner
State-level Change Agent
Support Staff

Timeframe

For multi-agency administration, allow at least 60 days with an additional 30-day extension, as needed, to increase the response rate.

When selecting the timeframe, the Change Team should heed agency, youth and family member input that might, for example, want to avoid holiday seasons, school vacations, or dates of other agency-level reviews.

As noted elsewhere, the TIAA can be paper-based, in which case an extra 10 to15 days grace period is recommended to allow for potential mail delays. Intermediary reminders should be sent between 45 and 60 days. Agencies may also want to set an internal deadline at least 10 days prior to the close of the survey so that supervisors can follow up with staff regarding both staff response rates as well as those of youth and families.

Method of Administration

The tool can be administered through a web-based platform and/or paper-based format. The web minimizes data entry requirements and provides additional confidentiality and privacy. A drop-down menu names all participating agencies, so each can receive its own scores as well as statewide averages. If an agency chooses only the web version, it should provide youth and family with a web-enabled

computer in a private area of the agency. Contact THRIVE for more information regarding the web-based platform.

If an agency opts to include the paper format, it would provide hard-copy surveys, as well as self-addressed, postage-paid envelopes, and/or a "TIAA return box" in the agency for completed surveys.

It is not recommended that agency staff be present while youth, family or even agency representatives complete the survey as this may impact results. However, the Change Team may allow exceptions, where agency staff or third-party providers, e.g., respite, behavioral health aide, help family and youth respondents overcome literacy challenges, language access, learning disabilities, mild mental retardation or developmental/behavioral challenges.

Target Response Rates

All agency staff should complete the assessment, including executive directors and administrators, clinical staff, case managers, behavioral health aides and other support staff, administrative support staff, and facilities staff.

The number of family and youth (ages 12 to 20) who should participate is determined as a proportion of the number of children and youth served by the individual participating agency annually. The following table is a guide based roughly on 30 percent participation. The numbers are a minimum target. However, agencies are encouraged to get assessments for as many family or youth as possible, including those who have been discharged within the past three months, to obtain a sufficient number of responses.

Target Response Rates by Clients Served		
Number of Clients Served Annually	**Caregivers/ Parents**	**Youth (ages 12-20)**
0-10	All	All
11-30	10	10
31-50	15	15
51-70	20	20
71-100	25	25
101-150	35	35
151+	50	50

Motivating Higher Responses

In general, regular updates during the administration period and follow-up during supervision can improve response rates. Otherwise, the Change Team has the charge of boosting them as needed. Ideas for discussion might include asking local

family and advocacy organizations to distribute information about the TIAA and encourage appropriate participation; use of a toll-free 800 line for the hearing impaired or other learning needs; a private area at the agency to take the survey on-line or on paper with a drop box handy.

A multi-agency administration could set up a contest or incentives between and among agencies to stimulate response rates. If the agencies vary in size, the incentives could be based on the proportion of people in a given category responding rather than absolute numbers. The winning agency could receive a certificate to an office supply store, a pizza party for staff, a plaque or other acknowledgment.

MODIFYING THE TIAA

Making substantive changes to the TIAA would compromise the validation of its results. However, modifying assessment language for cultural considerations or nomenclature (e.g., crisis plan vs. calm down plan) is appropriate.

Different programs can be added to the beginning of the survey that reflect the comprehensive service array offered by the state or agency (e.g., multi-systemic therapy, substance abuse, co-occurring or day treatment services.) A youth or family member's perceptions or a staff member's assessment of the agency could vary depending upon the type of service received or offered.

In short, the developers are willing to modify the web-based tool to meet your agency's requirements.

References

Boney-McCoy, S., & Finkelhor, D. (1995). Psychosocial sequelae of violent victimization in a national youth sample. *Journal of Consulting & Clinical Psychology*, 63(5), 726-736.

Developing Trauma-Informed Behavioral Health Systems. (2003). Prepared by Andrea Blanch, Ph.D. *Report from NTAC's National Experts Meeting on Trauma and Violence*. Alexandria, VA.

Harris, M. & Fallot, R. (2006). A Trauma-Informed Approach to Screening and Assessment. *New Directions for Mental Health Services*, 2001(89), 23-31.

Harris, M. & Fallot, R. (2001). Using Trauma Theory to Design Service Systems. *New Directions for Mental Health Services*; 29. Lamb, R. Ed. Jossey-Bass.

Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V.E., Koss, M.P., et al. (1998). The Relationship of Adult Health Status to Childhood Abuse and Household Dysfunction. *American Journal of Preventive Medicine*, 14, 245-258.

Frothingham, T.E., Hobbs, C.J., Wynne, J.M., Yee, L., Goyal, A., Wadsworth, D.J., (2000). Follow Up Study Eight Years After Diagnosis of Sexual Abuse. *Archives of Diseases in Childhood*, 83, 132-143.

Hashima, P., and Finkelhor, D. (1999). Violent Victimization of Youth Versus Adults in the National Crime Victimization Survey. *Journal of Interpersonal Violence*, 14(8): 799-820.

Kessler, R.C., Davis, C.G. & Kendler, K.S. (1997). Childhood Adversity and Adult Psychiatric Disorder in the U.S. National Comorbidity Survey. *Psychological Medicine*, 27, 1101-1119.

Macy, Robert D. (2002) On the epidemiology of posttraumatic stress disorder: period prevalence rates and acute service utilization rates among Massachusetts Medicaid program enrollees: 1993-1996 [dissertation]. Union Institute and University.

Newmann, J.P., Greenley, D., Sweeney, J.K. & Van Dien, G. (1998). Abuse histories, severe mental illness, and the cost of care. In B.L. Levin, A.K. Blanch, A. Jennings (Eds.). Women's Mental Health Services: A Public Health Perspective, Sage. P. 279-308.

Switzer, G.E., Dew, M.A., Thompson, K., Goycoolea, J.M., Derricott, T., & Mullins, S.D. (1999). Posttraumatic stress disorder and service utilization among urban mental health center clients. *Journal of Traumatic Stress*, 12, 25-39.