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Mapping “Trauma-Informed” Legislative Proposals in U.S. Congress

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Abstract

Despite calls for translation of trauma-informed practice into public policy, no empirical research has investigated how the construct has been integrated into policy proposals. This policy mapping study identified and analyzed every bill introduced in US Congress that mentioned “trauma-informed” between 1973 and 2015. Forty-nine bills and 71 bill sections mentioned the construct. The number of trauma-informed bills introduced annually increased dramatically, from 0 in 2010 to 28 in 2015. Trauma-informed bill sections targeted a range of sectors, but disproportionately focused on youth (73.2%). Only three bills defined “trauma-informed.” Implications within the context of a changing political environment are discussed.

Traumatic stress has profound impacts on multiple domains of life and increases the risk of many adverse outcomes—such as mental and physical health problems (Felitti et al., 1998; Shonkoff et al., 2012), academic difficulties (Stein et al., 2003), arrest and incarceration (Abram et al., 2004; Messina & Grella, 2006), food insecurity (Chilton, Knowles, Rabinowich, & Arnold, 2015; Sun, Knowles, et al., 2016), and homelessness (Hopper, Bassuk, & Olivet, 2010; Kim, Ford, Howard, & Bradford, 2010). In response to the far-reaching effects of trauma, the construct of trauma-informed practice emerged in the 1990s to better meet the needs of trauma survivors (Baker, Brown, Wilcox, Overstreet, & Arora, 2016; Bloom, 2013; Bowen & Murshid, 2016; Harris & Fallot, 2001; Ko et al., 2008; Treatment, 2014).

Although many definitions of trauma-informed practice exist (Branson, Baetz, Horwitz, & Hoagwood, 2017; Marsac et al., 2016), the core tenets of a trauma-informed approach are captured by the Substance Abuse and Mental Health Services Administration’s (SAMHSA, 2016) *Four “Rs”* of: *realizing* the widespread impact of trauma and pathways to recovery,

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recognizing the signs and symptoms of trauma among consumers of services and staff, *responding* by integrating knowledge about trauma into practice and policy; and proactively *resisting* re-traumatization. Trauma-informed approaches to practice have demonstrated effectiveness in reducing the use of seclusion and restraint (Azeem, Aujla, Rammerth, Binsfeld, & Jones, 2011; Boel-Studt, 2015; Hodgdon, Kinniburgh, Gabowitz, Blaustein, & Spinazzola, 2013), improving substance use and mental health outcomes (Gatz et al., 2007; Greenwald et al., 2012; Morrissey et al., 2005), and enhancing the quality of treatment environments (Rivard, Bloom, McCorkle, & Abramovitz, 2005).

Trauma-informed practice initially gained traction in human and mental health service sectors at the local-level, but has recently been embraced by a wide array of sectors at multiple levels of government (Becker-Blease, 2017). For example, federal initiatives such as the White House's My Brother's Keeper and the Department of Justice's (DOJ) Defending Childhood Taskforce encouraged the widespread implementation of trauma-informed interventions. States (e.g., Washington) (Kagi & Regala, 2012) and cities (e.g., Philadelphia, PA) (Beidas et al., 2016) have made commitments to promoting trauma-informed practice in their public systems. Major philanthropies, such as the Robert Wood Johnson Foundation and The California Endowment, have established trauma-informed practice as a funding priority. Interest in trauma-informed practice has also increased in academic discourses. The number of new entries to PubMed annually that mentioned "trauma-informed" in the title or abstract increased from only 7 in 2010, to 46 in 2014, 81 in 2015, and 83 in 2016 (search conducted on February 22, 2017).

Within this context of growing interest in trauma-informed practice, mental health researchers and practitioners have called for the translation of trauma-informed practice into public policy (Ardino, 2014; Bloom, 2016; Bowen & Murshid, 2016; Fairbank & Gerrity, 2007; Gerrity, 2007; ISTSS, 2010; NCTSN; Shern, Blanch, & Steverman, 2016; Shonkoff & Fisher, 2013). As Bowen and Murshid (2016) describe, "Now, therefore, is an opportune time for public health and allied fields to expand on the shift toward trauma-informed care already underway in the service system and promote a parallel transformation in social policy." (p. 228) Despite enthusiasm about the notion of trauma-informed policy—and its potential to maximize the public health impact of traumatic stress research (Sorenson, 2002; Thoits, 2010)—no empirical studies have investigated if and how the construct of trauma-informed practice has been integrated into public policy proposals. Consequently, little is known about the current status of trauma-informed public policy and limited guidance exists to guide trauma-informed policy advocacy efforts.

Policy Mapping

We conducted a policy mapping study to begin to address this knowledge gap. Policy mapping is a methodology in which policies and/or policy proposals related to an issue are systematically identified and then analyzed using content analysis (Burris, 2015; Burris et al., 2010; Tremper, Thomas, & Wagenaar, 2010). By cataloguing the policies 'on the books,' mapping studies can identify policy gaps and provide a foundation for future research on policy implementation, enforcement, and impact (Burris et al., 2010). Through categorizing policy proposals according to their characteristics, mapping studies can inform policy

development activities (Burris, Hitchcock, Ibrahim, Penn, & Ramanathan, 2016). By assessing trends in the volume of policy proposals to address an issue, mapping studies can provide indication of changes in the amount of attention an issue is receiving from policymakers (Tremper et al., 2010; Wagenaar, Erickson, Harwood, & O'Malley, 2006). Mapping studies are frequently conducted for policies related to physical health (e.g., air quality and food safety), but are underutilized in the field of mental health (Peck & Scheffler, 2002; Purtle, 2014; Rowan, Duckett, & Wang, 2015). For example, The Policy Surveillance Program at Temple University conducts ongoing mapping studies for 58 health-related policies and only one is focused on mental health (i.e., involuntary commitment laws).

Study Purpose

This article presents the results of a policy mapping study of legislative proposals introduced in US Congress with the explicit intent of advancing trauma-informed practice. The objectives of the study were to: 1) determine if the volume of federal legislative proposals making explicit reference to trauma-informed practice has increased, 2) identify the sectors and populations targeted by these proposals, and 3) catalogue the policy instruments used to promote trauma-informed practice.

It is important to emphasize the parameters of our study and justify the rationale for our approach. First, we limited our study to legislative proposals that *explicitly mentioned* trauma-informed practice. Thus, we did not attempt to determine if tenets of trauma-informed practice (e.g., screening for trauma exposure, preventing re-traumatization) were implicit in legislative proposals that did not explicitly mention the term. We operationalized trauma-informed narrowly to ensure construct validity and adhere to the recommendation that policy mapping studies focus “on measuring the apparent characteristics of legal texts, rather than interpreting their meaning.” (Burris, 2015) (p. 119).

Second, we limited our study to *legislative proposals* at the *federal-level*. Our study was not designed to capture trauma-informed policy activity in the executive branch of government (e.g., policies of SAMHSA or the Administration for Children and Families), judiciary decisions related to trauma-informed practice, or identify state or local policy proposals that mentioned the construct. We limited our study to federal legislation because state policies are often modeled after federal legislative proposals (Goodman, 2007) and because federal legislation served as a logical starting point given the paucity of trauma policy research. In summary, our study was not an exhaustive review of how public policy has been used to address the needs of trauma survivors; but rather begins to map the uncharted territory “trauma-informed” federal legislation to provide direction for future research and policy development activities.

Method

Data Collection

Congress.gov—a comprehensive, publicly available database containing information about all bills introduced in US Congress since 1973—was used to identify legislative proposals

introduced between January 1, 1973 and December 31, 2015 that included mention of trauma-informed practice. The *Word and Phrase* option within the Congress.gov *Advanced Search* function was used to identify all bills that contained the term(s) “trauma-informed” and/or “trauma informed” in the *Title or Text* fields. An Excel sheet was created that listed the title and bill number of each legislative proposal and a hyperlink to where its full text could be accessed on Congress.gov. For many of the bills, multiple versions existed because the text was iteratively revised through the legislative processes. In these instances, only the most recent version of each bill was analyzed.

Coding Categories

Both entire bills and the individual sections of bills that included trauma-informed language were units of analysis. The boundaries of bill sections were delineated by the headings “Sec.” before and after the mentions trauma-informed practice. In this article, bills that included trauma-informed language are referred to as “trauma-informed bills” and bill sections that included trauma-informed language referred to as “trauma-informed sections.” Preliminary coding categories and sub-categories were established *a priori* based on an earlier policy mapping study of federal legislative proposals to address post-traumatic stress disorder (PTSD) (Purtle, 2014) and scholarship about trauma-informed policy (Ardino, 2014; Bloom, 2016; Bowen & Murshid, 2016; Fairbank & Gerrity, 2007; Gerrity, 2007; ISTSS, 2010; Shern et al., 2016; Shonkoff & Fisher, 2013).

Trauma-informed bills were coded according to the mutually exclusive categories of: the Congressional chamber (i.e., House or Senate) in which the bill was introduced, the name of the congressperson who introduced the bill and their political party, the congressional committee to which the bill was first referred, the date when the bill was introduced, whether or not the bill became law, and whether or not the bill included a definition of “trauma-informed.”

Trauma-informed sections were coded according to the non-mutually exclusive categories of: the population that the trauma-informed practice targeted (e.g., youth in foster care, college students), the sector in which the trauma-informed practice was intended to be implemented (e.g., juvenile justice, health care), and the policy instruments used to promote trauma-informed practice. Policy instruments are the means by which public policy can be used to achieve goals; and policy instrument typologies are often used in mapping studies to describe how policies have been used to address issues (Howlett, 2010; Howlett, Ramesh, & Perl, 1995). Trauma-informed sections were coded as containing *symbolic* and/or *material* policy instruments. Symbolic policy instruments codify the perceived importance of an issue (e.g., designating an issue awareness day) whereas material instruments allocate resources or alter processes. Trauma-informed sections that contained material instruments were also coded as *substantive* and/or *procedural*. Substantive instruments affect the delivery of goods and services, whereas procedural instruments affect processes. Trauma-informed sections that contained material instruments were also coded according to the governing resources being used (i.e., *treasury*, which allocates financial resources, *authority*, which mandates behaviors and practices; *information/knowledge*, which educate policy targets; and *organizational structure*, which requires government employees to provide services).

Each trauma-informed section was also coded according to whether or not it exclusively targeted youth populations (i.e., did not target adults) because youth and adults are often served by separate systems that are affected by different policies. We defined ‘youth’ as people between the ages of 0 and 18 and thus did not include college students in this category. Trauma-informed sections that targeted families (i.e., both children and adults) were not coded as exclusively targeting youth. Trauma-informed sections were not coded according to the extent that they were evidence-supported because the details needed to make such assessments (e.g., the specific trauma-informed interventions that would be implemented) were typically not provided in the legislative texts.

Coding Process

First, two coders independently read all of the trauma-informed bills, wrote notes about themes observed in the legislative texts, and then revised the preliminary coding categories and definitions through discussions in which notes were compared. All of the bills were then independently coded again by the two coders using Qualtrics (a web-based survey platform; Provo, Utah). The two coded datasets were then exported, compared, and incongruent coding decisions (which did not exceed ten percent for any coding sub-category) were resolved through discussions. This produced the final legislative dataset.

Analysis

The dataset was imported into SPSS 24.0 (IBM, Armonk, NY) for analysis. Univariate statistics were generated to describe the proportion of trauma-informed bills and sections coded at each sub-category, with the total number of trauma-informed bills and sections as the denominators. Each bill and section was counted as a single unit regardless of the number of times that it referenced trauma-informed practice. The data were stratified to examine differences in trauma-informed bills and sections with varying characteristics. Fisher exact and χ^2 tests were conducted to determine the statistical significance of differences between trauma-informed sections that did and did not exclusively target youth.

Results

The first bill in US Congress that made explicit reference to trauma-informed practice was the Domestic Minor Sex Trafficking Deterrence and Victims Support Act of 2010 (S 2925) and was introduced on December 22, 2009. Between then and December 31, 2015, 49 bills were introduced that mentioned “trauma-informed” or “trauma informed” (complete list of bills available in online appendix). These bills contained 71 sections of legislative text that included trauma-informed language (per bill mean: 1.4, mode: 1, range: 1, 4). Of the 49 bills, 40 (81.6%) were introduced by Democrats, nine (18.4%) were introduced by Republicans, 27 (55.1%) were introduced in the Senate, and 22 (44.9%) were introduced in the House (Table 1). Thirty-nine different congresspersons introduced the 49 trauma-informed bills.

Two trauma-informed bills, containing two trauma-informed sections, became law. The Justice for Victims of Trafficking Act of 2015 (Public Law No: 114-22), signed into law on May 29, 2015, requires states and local governments to have a plan to provide “trauma-

informed, gender-responsive rehabilitative care to victims of child human trafficking” [Sec. 203(k)(4) (C)(ii)] to be eligible for funding from DOJ’s Victim-Centered Child Human Trafficking Deterrence Block Grant Program. The Every Student Succeeds Act (Public Law No: 114-95), signed into law on December 10, 2015, identifies training school personnel in “trauma-informed practices in classroom management” [Sec. 4107(5)(D)(ii)] and school-based mental health services that are “based on trauma-informed practices that are evidence-based” [Sec. 4107(5)(B)(ii)(II)(aa)] as two of the many activities that agencies can perform with funds allocated by the law.

Only three bills (S 2999, S 1169, and HR 2728) included a definition of “trauma-informed.” This definition was identical in each of these bills and read:

The term ‘trauma-informed’ means—(A) understanding the impact that exposure to violence and trauma have on a youth’s physical, psychological, and psychosocial development; (B) recognizing when a youth has been exposed to violence and trauma and is in need of help to recover from the adverse impacts of trauma; and (C) responding by helping in ways that reflect awareness of the adverse impacts of trauma.

Trend in Volume of Trauma-Informed Bills and Bill Sections

The volume of trauma-informed bills and sections introduced in US Congress increased dramatically between when the first bill was introduced and December 31, 2015 (Figure 1). The number of trauma-informed bills introduced annually ranged from 0 in 2010, 2011, and 2012 to 28 in 2015. The most trauma-informed sections were introduced in 2015 when 28 bills contained 39 trauma-informed sections.

Target Populations and Sectors of Trauma-Informed Bill Sections

The majority of trauma-informed sections exclusively targeted youth (52 sections, 73.2%) (Table 2). The specific youth populations targeted included those in primary and secondary schools (16 sections, 22.5%), juvenile justice facilities (ten sections, 14.1%), and foster care settings (seven sections, 9.9%) and those that were victims of sex trafficking (six sections, 8.5%) or experiencing homelessness (four sections, 5.6%). For example, the Youth Justice Act of 2015 [HR 2728, Sec. 101(4)] was introduced with the purpose “to support a trauma-informed continuum of programs (including delinquency prevention, intervention, mental health, behavioral health, and substance abuse treatment, and aftercare) to address the needs of at-risk youth and youth who come into contact with the justice system.” College students (14 sections, 19.7%) were the most common population targeted in trauma-informed sections that did not exclusively target youth. For example, the Campus Accountability and Safety Act [HR 1310, Sec. 2(5)] proposed to amend the Higher Education Act of 1965 (Public Law No: 101–542, i.e., ‘the Cleary Act’) to develop and administer an online survey for students about their experiences with sexual violence that uses “trauma-informed language to prevent retraumatization.” None of the trauma-informed sections targeted active duty military personnel or veterans.

Trauma-informed sections targeted a range of sectors. Sixteen sections (22.5%) targeted agencies in the child welfare and/or primary/secondary education sector, 14 (19.7%) targeted

institutions of higher education and/or criminal justice (e.g., juvenile justice facilities, courts), and ten (14.1%) targeted clinical health care settings. For example, the SOAR to Health and Wellness Act of 2015 [S 1446, Sec. 3(b)(4)(H)] proposed to establish a pilot program to train health care providers to identify potential victims of human trafficking and “provide such victims care that is... trauma-informed.” All of the trauma-informed sections that targeted the criminal justice sector exclusively targeted youth.

Policy Instruments Used to Promote Trauma-Informed Practice

Twenty-eight (39.4%) trauma-informed sections contained at-least one symbolic policy instrument (Table 3). Symbolic instruments were often used to make proclamations about the potential of trauma-informed practice, such as the Improving the Juvenile Justice System for Girls Act of 2013 [HR 1833, Sec. 1(b)(6)], which stated that “Current research and data have shown that gender-responsive, strength-based programming providing trauma-informed care and trauma-specific services is the most effective means of preventing juvenile offenses.”

Fifty (70.4%) trauma-informed sections contained at least one material instrument, with 40 (56.3%) containing at least one substantive instrument and 32 (45.0%) containing at least one procedural instrument. Many substantive instruments targeted the SAMHSA National Child Traumatic Stress Initiative (NCTSI), such as the Gun Violence Prevention and Reduction Act of 2013 [HR 2910, Sec. 223(4)] which directed NCTSI to disseminate “evidence-based and trauma-informed interventions, treatments, products, and other resources to appropriate stakeholders.” Procedural instruments required executive branch agencies perform activities such as prepare reports for Congress about the provision of trauma-informed services and consider grant applicants’ trauma-informed service capacity when making funding decisions. For example, The Family Unification, Preservation, and Modernization Act of 2015 [S 2289, Sec. 201], required that consideration be given to “whether an eligible applicant utilizes evidence-based practices and trauma-informed care models to serve families” when evaluating grant applicants.

Treasury governing resources were most frequently used to promote trauma-informed practice (42 sections, 59.2%). Treasury resources were primarily used in proposals that would have provided grants to deliver trauma-informed services, such as the Strengthening Mental Health in Our Communities Act of 2014 [HR 4574, Sec. 601(b)(2)] which proposed to “provide financial support to enable local communities to implement a comprehensive culturally and linguistically appropriate, trauma-informed, and age-appropriate, school mental health program.” Authority resources were used in 25 (35.2%) sections and mandated trauma-informed practices. For example, the Campus Accountability and Safety Act [S 2692, Sec. 4(a)] required that any institution of higher education that receives federal funds designate a confidential advisor for victims of crime and that they “be trained to perform a victim-centered, trauma-informed (forensic) interview, which shall focus on the experience of the victim.” Information/knowledge resources were used in 14 (19.7%) of sections and provided trainings on trauma-informed practice, such as the Children’s Recovery from Trauma Act (HR 2632, Sec. 2) that proposed to provide funding for NCTSI

to “oversee the continuum of interprofessional training initiatives in evidence-based and trauma-informed treatments, interventions, and practices offered to NCTSI grantees.”

Discussion

The volume of federal legislative proposals making explicit reference to trauma-informed practice increased dramatically between when the first bill was introduced on December 22, 2009 and December 31, 2015. This increase, coupled with the fact that these proposals were introduced by many different congresspersons on both sides of the aisle, is an indicator of heightened interest in trauma-informed practice within US Congress (Tremper et al., 2010; Wagenaar et al., 2006). This finding is consistent with evidence that traumatic stress is increasingly recognized as a problem in mainstream public and political discourses (Houston, Spialek, & Perreault, 2016; Purtle, Lynn, & Malik, 2016; Wu, 2016). Increases in legislative attention to trauma-informed practice signal a need for a trauma-informed workforce and integration of knowledge about trauma into the core curricula of clinical (e.g., psychology, psychiatry, primary care social work) and non-clinical (e.g., public health, education, criminal justice) training programs (DePrince & Newman, 2011; Ko et al., 2008). Increased enthusiasm for trauma-informed legislation also reinforces the importance of strategies to ensure that trauma-informed initiatives are implemented with fidelity when they are adopted across different sectors (Becker-Blease, 2017).

Trends in legislative proposals to promote trauma-informed practice should be considered within the political context in which they occurred; and implications of our study should be considered within context of the current political environment. Increases in legislative attention towards trauma-informed practice occurred during the presidency of Barack Obama, a Democrat whose administration overtly supported trauma-informed practice (Jarrett, 2016). In contrast, the agenda of President Donald Trump—a Republican whose administration plans to drastically reduce the size of the federal workforce (Trump, 2017)—raises questions about the extent to which trauma-informed bills could be effectively implemented if they become law during his presidency.

Despite changes in federal leadership, there are at least three reasons why attention to trauma-informed practice might be sustained in US Congress during the Trump presidency. First, it should be noted that the most trauma-informed bills were introduced in 2015 when Republicans had majority control of both the House of Representatives and the Senate—as they will until at least January 3, 2019. Furthermore, both of the trauma-informed bills that became law were introduced in 2015. Second, it should be reiterated that nine (18.4%) of the trauma-informed bills were introduced by Republicans, suggesting some bi-partisan support for trauma-informed practice. Also, a search of Congress.gov reveals that eight trauma-informed bills were already introduced in US Congress as of February 22, 2017—one (12.5%) by a Republican congressperson.

Third, although Democrats and Republicans are deeply divided on several health policy issues (Gollust, 2016; Kindig, 2015; Purtle, Goldstein, Edson, & Hand, 2017), bi-partisan support exists for mental health and substance abuse issues—which are the focus of many trauma-informed initiatives (Gatz et al., 2007; Greenwald et al., 2012; Morrissey et al.,

2005). For example, a survey of US state legislators found that a similar proportion of Democrats and Republicans identified behavioral health a top policy priority (46.4% vs 52.8%, $p = .795$) (Purtle, Dodson, & Brownson, 2016). A 2016 survey of US adults found that a similar proportion of Democrats and Republicans felt that government spending on opioid addiction treatment was too low (45% vs 37%, $p > .05$) (Blendon, McMurty, Benson, Sayde, 2017). Advocacy efforts to promote trauma-informed legislation might be successful if they frame trauma-informed initiatives as a strategy to address issues for which bi-partisan support exists.

Although the volume of trauma-informed bills introduced in US Congress increased dramatically, only two of these bills (4.1%) became law—slightly less than the proportion of bills (9.3%) that became law in a mapping study of federal legislative proposals to address PTSD (Purtle, 2014). By identifying these two trauma-informed bills, however, our study raises empirical questions about their implementation, enforcement, and potential impacts. One of the trauma-informed sections, Sec. 103 of The Justice for Victims of Trafficking Act of 2015 (Public Law No: 114-22), requires that grant recipients have a plan to provide “trauma-informed, gender-responsive rehabilitative care to victims of child human trafficking” to be eligible for funding from DOJ’s Victim-Centered Child Human Trafficking Deterrence Block Grant Program. Policy monitoring activities should evaluate whether the criteria used by DOJ to assess this are aligned with evidence-supported recommendations for trauma-informed practice with victims of human trafficking (Ahn et al., 2013; Clawson, Salomon, & Grace, 2007; Macy & Johns, 2010) and whether these plans are actually implemented by grant recipients.

The other trauma-informed section that became law, Sec. 4108 of The Every Student Succeeds Act (Public Law No: 114-95), lists training school personnel in “trauma-informed practices in classroom management” and mental health services that are “based on trauma-informed practices” as two of the many options that local education agencies can choose from to comply with requirements for the receipt of funds. Future studies could evaluate the proportion of funded agencies that selected these options, the trauma-informed training curricula school personnel have completed to satisfy these requirements, and the extent to which these practices have been implemented and are consistent with evidence about trauma-informed practice in school settings (Ngo et al., 2008; Perry & Daniels, 2016; Walkley & Cox, 2013; Wiest-Stevenson & Lee, 2016).

The sectors and populations that were the targets of trauma-informed sections should be considered within the context of research about the epidemiology of traumatic stress and evidence on trauma-informed interventions. The finding that trauma-informed sections targeted a wide range of sectors is consistent with evidence on the effects of trauma across multiple domains of life and that trauma-informed interventions offer promise in these areas (Baker et al., 2016; Bowen & Murshid, 2016; Marsac et al., 2016). However, the finding that youth were the exclusive target population of the majority (73.2%) of trauma-informed sections does not reflect research on the incidence of trauma exposure over the life course and potential of trauma-informed interventions for adult military populations (Dinnen, Kane, & Cook, 2014; Kelly, Boyd, Valente, & Czekanski, 2014; Norman, Wilkins, Myers, &

Allard, 2014) and civilian populations (Endres, Keller, Wong, & Krahn, 2015; Machtinger, Cuca, Khanna, Rose, & Kimberg, 2015; Sun, Patel, et al., 2016).

The finding that explicit mentions of “trauma-informed” were largely absent from legislative proposals targeting adults should not be interpreted as a lack of legislative attention to the needs of adult trauma survivors, as many bills have targeted these populations—such as the Violence Against Women Reauthorization Act of 2013 (Public Law No: 113-4) and the Veterans Access, Choice, and Accountability Act of 2014 (Public Law No: 113-146). Rather, this finding suggests that trauma-informed practice has largely been defined as a youth-specific construct in US Congress. Political science research indicates that this often happens as issues become defined in policy discourse within the context of a specific population (Schneider & Ingram, 1993, 2005). For example, an ethnographic content analysis of the language used in federal legislative proposals to address PTSD found that the disorder had been defined as a military-specific problem (Purtle, 2016). Advocates might consider engaging in activities to increase congresspersons’ awareness about the potential of trauma-informed interventions for adult populations.

We found that only three (6.1%) of the trauma-informed bills provided a definition of the construct. Given that trauma-informed practice is a relatively new construct and open to a range of interpretations (Baker et al., 2016), advocates might try to ensure that a definition of trauma-informed is included in legislative proposals to increase the likelihood that “trauma-informed” mandates are operationalized as intended when implemented by executive branch agencies (Becker-Blease, 2017). It should also be noted that over one-quarter (29.6%) of trauma-informed sections were symbolic and did not include provisions that would have instrumental impacts on trauma survivors. This is more than twice the proportion of bill sections that were symbolic in the mapping study of federal legislative proposals to address PTSD (13.7%) (Purtle, 2014). This finding could reflect the fact that trauma-informed practice is a newer construct than PTSD and that these symbolic sections served to educate congresspersons about the notion of trauma-informed practice.

Limitations

It should be re-emphasized that our study was limited to federal legislative proposals that explicitly mentioned trauma-informed practice. Future studies that map *explicitly* trauma-informed policy proposals across the executive and judiciary branches of federal government and at state and local-levels would enhance understanding of the trauma-informed policy landscape. There would also be benefits to research that mapped policy proposals that were *implicitly* trauma-informed—such as those that promoted safety, transparency, and empowerment (Bowen & Murshid, 2016). We did not categorize trauma-informed bills or sections according to the extent that they were likely to produce positive impacts for trauma survivors. As noted above, we were unable to assess the extent to which trauma-informed sections were evidence-supported because the legislative language was typically too broad to make such assessments.

Conclusion

Trauma-informed practice has received an increasing amount of attention in US Congress. Trauma-informed bills have been introduced by a diversity of congresspersons, referred to an assortment of congressional committees, and targeted a range of sectors. These findings indicate political will and signal an opportunity to institutionalize trauma-informed practice through federal legislation. The policy instruments and legislative language identified in this mapping study offer guidance for mental health researchers and practitioners who seek to advance trauma-informed policies.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Figure 1.
Trend in legislative proposals introduced in US Congress between December 22, 2009 and December 31, 2015 that mentioned “trauma-informed” and/or “trauma informed.”

Table 1

Characteristics of legislative proposals introduced in US Congress between December 22, 2009 and December 31, 2015 that mentioned “trauma-informed” and/or “trauma informed.”

Bill characteristic	<i>n</i>	%
Congressional chamber introduced		
House	22	44.9
Senate	27	55.1
Congressional committee first referred		
Senate Health, Education, Labor, and Pensions	14	28.6
House Energy and Commerce	9	18.4
House Education and the Workforce	8	16.3
Senate Judiciary	7	14.3
Senate Finance	5	10.2
House Judiciary	4	8.2
Senate Banking, Housing, and Urban Affairs	1	2.0
House Ways and Means	1	2.0
Political party of congressperson		
Democrat	40	81.6
Independent	0	0
Republican	9	18.4

Target sectors of legislative proposals introduced in US Congress between December 22, 2009 and December 31, 2015 that mentioned “trauma-informed” and/or “trauma informed.”

Table 2

Target sector	All sections <i>N</i> = 71		Did not exclusively target youth <i>n</i> = 19		Exclusively targeted youth <i>n</i> = 52		<i>p</i> ^a
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	
Child welfare	16	22.5	3	15.8	13	25.0	.410
Primary/secondary education	16	22.5	0	0	16	30.8	0.003
Higher education	14	19.7	14	73.7	0	0	.0001
Criminal justice	14	19.7	0	0	14	26.9	0.007
Health care	10	14.1	1	5.3	9	17.3	.151
Public health	1	1.40	1	5.3	0	0	0.267

Note. Chi-square and Fisher's exact tests used to compare differences in the proportion of trauma-informed sections with the characteristic according to whether or not the section exclusively targeted youth populations. *df*=1.

Policy instruments used in sections of legislative proposals introduced in US Congress between December 22, 2009 and December 31, 2015 that mentioned “trauma-informed” and/or “trauma informed.”

Table 3

Section characteristic	All sections <i>N</i> = 71		Did not exclusively target youth <i>n</i> = 19		Exclusively targeted youth <i>n</i> = 52		<i>p</i> ^a
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	
Instrument used							
Symbolic only	21	29.6	3	15.8	18	34.6	0.151
Material only	43	60.6	10	52.6	33	63.5	0.152
Both symbolic and material	7	9.9	6	31.6	1	1.9	.0001
Material substantive only	28	39.4	15	78.9	13	25.0	.0001
Material procedural only	10	14.1	1	5.3	9	17.3	0.151
Both material substantive and material procedural	12	16.9	0	0	12	23.1	0.028
Governing resource used							
Treasury	42	59.2	9	47.4	33	63.5	0.103
Authority	25	35.2	6	31.6	19	36.5	0.207
Information/knowledge	14	19.7	5	26.3	9	17.3	0.177
Organizational/structure	0	0	0	0.0	0	0.0	-

Note. Chi-square and Fisher's exact tests used to compare differences in the proportion of trauma-informed sections with the characteristic according to whether or not the section exclusively targeted youth populations. *df*=1.