A case study for applying therapeutic jurisprudence to policymaking: Assembling a policy toolbox to achieve a trauma-informed early care and learning system

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1. Introduction

Ava is a twelve-month old infant, with three older siblings. Three months ago, Ava's father was shot and killed in front of Ava and her siblings during a drive-by shooting. Her mother, Victoria, is in a new, physically abusive relationship. Victoria has a high school equivalency diploma, but few skills to help her advance her career, and is struggling to make ends meet after the death of Ava's father, who had provided some financial support. She is also dealing with her own trauma from his murder and her abusive new relationship. The family's current annual income is less than $25,000 USD, qualifying as below the US poverty threshold.[2] The family just moved into a more affordable two-bedroom apartment in the north part of the city, where the average child poverty rate exceeds 50%. The apartment has mold issues, and the lack of proper ventilation and dated HVAC systems leave the family with high electricity bills. Ava and two of her siblings are in a local child care center, where many of the children are in similar family and neighborhood circumstances. Victoria receives subsidies from the state to help cover the care. The center acts at capacity for ratios of adults/

children as the sole licensed center in the neighborhood. The facility's director graduated from college; however, most of the staff do not have any education post-high school. Initial staff training includes detection, notification, and prevention of parental abuse, but nothing specific to trauma and the developing brain or the importance of positive adult interactions.

Ava's case is emblematic of the experiences of far too many young children. "[D]ata from more than 10,000 cases of children receiving trauma-focused services from sites in the NCTSN [National Child Traumatic Stress Network] reveal that in this cohort, one-fifth of children are aged 0-6. The traumas these children most often received services for [are]… exposure to domestic violence, sexual abuse, neglect, and traumatic loss/bereavement."[3] With so much happening to so many at so young an age, a number of services, organizations, and agencies exist to address specific causes and effects of certain traumatic experiences; however, it can be easy to lose a holistic sense of what and who is at issue the experiences mount and possible interventions climb.

Let's visualize Ava's case using Matryoshka dolls, classic nesting dolls of Russian origin that split in the middle to reveal successively smaller dolls inside.[4] For our situation, the outer, most visible doll represents the programs and services, e.g., early intervention or nurse home visiting, that are available for children and families in Ava's situation. With a bit more investigating, we come to the organizations, agencies, and communities available to help mitigate and prevent trauma for Ava. The next doll reveals the policies, e.g., Medicaid funding of nurse home visitation programs, embedded within organizations, agencies, and across the community that support or impede effective, trauma-informed practices and services. This could include the existing data or data needed to inform these policies. Finally, we reach the innermost doll that represents the heart of the matter: the healthy development of Ava and children like her and the stability of families, so critical to well-functioning communities. These children and families are those on whom policy intervenes and whose dignity policy should, at the very least, not degrade through its interventions.

This article focuses on the policy and evidence-informing layers critical to building a truly "trauma-informed" system that considers the human lives affected by policies and policymaking. To effectively inform policy, we need to examine the connection between policymaking/

[3] National Child Traumatic Stress Network, n.d.
[4] Teslova, 2017.

policy analysis and the emotional consequences of these processes and resulting policies. Specific considerations include: What psychological factors influence policy approaches, populations, or issues targeted and outcome metrics endorsed? Even when we believe we have science, common sense, and political will behind us, do potential psychological consequences impact ultimate and/or enduring "success" of policies? If so, which ones? What emotions are triggered by the policymaking process itself—emotions that impact at least the perception of a proposed policy's need, merits, and/or fairness? Arguably, there is value in being more explicit in recognizing the psychological consequences of the policy endeavor, and in being proactive and purposeful in thinking through these potential consequences.

In searching for a way to reframe the policy process and its desired outcomes, it is important to utilize a framework or lens that recognizes the importance of all evidence, including narrative evidence of lived experience. Therapeutic jurisprudence ("TJ") presents one significant prism through which to view law and engage in this empirical work because TJ is "the study of the role of law as a therapeutic agent."[5] It recognizes that law and lawmaking "constitute social forces that, whether intended or not, often produce therapeutic or antitherapeutic consequences."[6] As a framing mechanism and empirical guide, TJ offers a preventive approach to policymaking and policy analysis that proactively and iteratively asks questions to reveal potential therapeutic consequences. Critically, TJ seeks engaged participation of those most affected by policy in its development, implementation, and evaluation.

Theoretical consideration of TJ's application to policy has been discussed elsewhere[7]; what is needed is a real-world policy example to test this application and see if this therapeutic frame and empirical approach adds value, as contended, to policymaking. That is, does use of a TJ frame and agenda lead to better, and more enduring, outcomes for all key stakeholders in the process by adding purposeful attention to therapeutic consequences? The engagement of the Institute for Health Law & Policy ("Institute" or "iHeLP") to address policy needs related to creating a trauma-informed early care and learning system offers such a real-world case study.

Over the past twenty years, science has advanced our understanding of brain development and the impact of adverse childhood experiences ("ACEs") on the developing brain, affecting health and risk behaviors throughout the lifespan. "Extensive research on the biology of stress now shows that healthy development can be derailed by excessive or prolonged activation of stress response systems in the body and the brain, with damaging effects on learning, behavior, and health across the lifespan."[8] Moreover, "[c]**hildren who grow up in conditions of economic hardship often exhibit elevated stress hormone levels.** This is especially true for children [like Ava] who live in chronic situations of poverty and experience an accumulation of adverse conditions (e.g., overcrowding, noise, substandard housing, separation from parent(s), exposure to violence, family turmoil)."[9]

The State of Tennessee has been proactive in addressing trauma through a statewide initiative to "build strong brains,"[10] which has informed and been informed by regional efforts across the state, most notably in Memphis/Shelby County. At the local level, the Institute is

partnering with key stakeholders to develop a policy agenda that advances trauma awareness in early care and learning settings, specifically through enhanced child care standards that reinforce healthy development of young children. At the "macro" level, Institute work involves construction of a policy toolbox to systematically and proactively address trauma prevention/mitigation in early care and learning. This effort presents an ideal testing ground for application of a TJ frame and principles to evidence-informed policymaking, recognizing policy's potential for therapeutic impact on trauma reduction, especially in the earliest years. Critically, this application moves beyond simply implementing "what works." Engaging in a thoughtful process to develop, determine metrics of success for, and implement the toolbox adds a participatory-oriented consideration of the *how, what, why,* and *for whom.* It seeks systematically to ground efforts to inform policy with evidence[11] in the messy, real world.

This article lays the foundation for the real world, real-time application of a TJ prism through which to develop, organize, implement, and evaluate policies toward the goal of trauma prevention/mitigation. Part 2 sets the context by illustrating the increasing demand for evidence-informed policymaking, describing the field of TJ, and applying TJ to evidence-informed policymaking. It also describes the science behind ACEs. Part 3 describes the policy response: the launch of the Building Strong Brains Initiative in Tennessee, and its coalescing to address trauma in early childhood years within Memphis/Shelby County. Part 4 explicates the Institute's role as policy partner in this work through launch of its iHeLP Policy Lab, with the chief task to address, comprehensively and proactively, the policy needs connected to trauma prevention/mitigation, including through development of a policy toolbox. Part 5 incorporates the TJ overlay to this work by adding a TJ-informed lens and empirical process to construction of the policy toolbox. The article concludes in Part 6 by discussing what can be learned from this "real time" application of TJ to enhance evidence-informed policymaking, including next steps for the local pilot. The ultimate goal for application of the TJ frame is to ensure policy better achieves its aims with more enduring effect by interacting more therapeutically on individual, family, and collective lives.

2. Context

2.1. The policymaking context: Evidence-informed policymaking

Policymaking is an admittedly complex endeavor, which often plays out in a political, ideological, cultural, and economically-sensitive context that carries with it historical "baggage." Confronted by this cacophony, policymakers are increasingly urged to consult researchers to block out the "noise" and instead support best practices, i.e., "what works?"[12] Evidence represents one of many contextual factors, e.g., economics, the socio-political culture, and justice, affecting policy, but it bears some weight, especially when evidence is strong.[13] The result is not so much an expectation of evidence-based policymaking, but rather that it be evidence-informed.[14] "Research evidence is not sought out to directly solve problems or justify policy decisions; rather, it helps policymakers debate where they should be concerned and how they should proceed."[15] This more modest approach accords with

[5] Winick, 1997, p. 185.

[6] Winick, 1997, p. 185.

[7] Campbell, 2010; Campbell, 2012.

[8] National Scientific Council on the Developing Child, 2005/2014, p. 1 (emphasis removed).

[9] National Scientific Council on the Developing Child, 2005/2014, p. 4 (emphasis removed). "In contrast to the earlier belief that early trauma had little impact on the child, it is now recognized that early trauma has the greatest potential impact, by altering fundamental neurobiological processes, which in turn can affect the growth, structure, and functioning of the brain. When trauma occurs in a chronic, persistent manner in the context of the young developing brain, the negative effects of such 'complex' or 'developmental' trauma have been shown to be cumulative, with damage from one stage of development affecting the successful navigation of developmental tasks at the next stage" (TDMHSAS, 2013, p. 50) (citation removed).

[10] See, Peck, n.d. (overview and mission of the statewide initiative).

[11] This is not simply an argument for more qualitative research and its application at the policy level, although it is important to include qualitative studies (Davies, 2000).

[12] Davies, Nutley, & Smith, 2000a. See also, Baron, 2014; Commission on Evidence-Based Policymaking, 2017; Goodvin & Lee, 2017.

[13] Amann, 2000; Nutley & Webb, 2000.

[14] Bowen & Zwi, 2005; Oxman, Lavis, Lewin, & Fretheim, 2009. "Yet the aims of many of those promoting the role of evidence are rather more modest than the term 'evidence-based' might imply. Many would argue that evidence-*influenced*, or even evidence-*aware* is the best that we can hope for. Some models of the policy process … make explicit recognition of this in that evidence is seen not as something on which decisions hinge, but more as pressure for a reframing of policy problems and potential solutions" (Davies, Nutley, & Smith, 2000b,p. 11).

[15] Campbell, 2010, p. 286.

incrementalist-type models of policymaking, instead of rational models that presume more mechanistic-like, technocratic approaches to identify or develop research to support predetermined ends.[16] For example, common arguments in developing legislation to enhance child care standards often include economic debates over costs of increased staffing or political debates over shifting money to the early years. An evidence-informed approach might also consider research that highlights positive impacts of early intervention[17] and innovative funding models,[18] or that documents the negative, long-term consequences of inattentive care providers[19] or chaotic or unstable environments on developing brains.[20] Moreover, an "evidence-informed" emphasis also applies to the process of policy formation, i.e., how we make policy—as intervention on people's lives—should also follow a research-like method: ask question, construct hypotheses, experiment, analyze results, share results, and affirm hypotheses or ask new questions/hypotheses.[21]

These are not revolutionary claims. It seems intuitive that policy should support more of "what works" and at the very least not endorse what doesn't work. Thus, it is important to consider the conditions under which something "works," e.g., the training, resources, or political will required. But what does this mean? How do we determine that something is working, for whom, and why/how? Policymaking occurs in context: it affects people like Ava and Victoria, and is made by people who have a range of emotions and whose thoughts impact and are impacted by policy. Policymaking, especially in health and social contexts, is also an intervention that seeks to alter behaviors, priorities, knowledge, etc. It influences and is influenced by the daily experiences of individuals and communities. At any point during its development, implementation, and analysis, these human, "living" factors impact the "success" of policy.

In sum, in so complex a process as making policy and so messy a context as the "real world," what hope have we of somehow matching policy goals with evidentiary supports in a systematic way? Is there a different frame for policymaking to address this messy, emotion-laden context? Is there a data-driven method for policymaking that proactively addresses, without ignoring or diminishing, the importance of this human context in a systematic way, i.e., a thoughtful re-visioning? Could this re-visioning and the measuring of outcomes to define "success" be more holistic rather than a sum of its parts? Development of therapeutic jurisprudence ("TJ") with its application as a frame for policy and as an empirical guide to frame questions that drive an experiential-focused research agenda arguably represents the new vision.

2.2. Therapeutic jurisprudence 101

In the 1960s and 1970s, notwithstanding the positive intent behind moving persons with mental illness out of psychiatric institutions,[22] communities across the United States struggled with the cycling of persons with mental illness through the justice system.[23] In addition to concerns over the justice system as the new psychiatric hospital,[24] it became clear that court decisions and the court process itself were also negatively affecting persons with mental illness.[25] Could a new

approach better serve these individuals' needs? Answering yes, Professors Bruce Winick and David Wexler developed the field of TJ as a means to highlight the therapeutic consequences of court involvement with persons with mental illness, and the need for an additional prism through which to view its substance and process.[26] More generally, "[t]herapeutic jurisprudence is an interdisciplinary approach to law that builds on the basic insight that **law is a social force** that has inevitable (if unintended) consequences for the mental health and psychological functioning of those it affects. [It] suggests … that, consistent with considerations of justice and other relevant normative values, **law be reformed to minimize anti-therapeutic consequences and to facilitate achievement of therapeutic ones**."[27]

With its origins in mental health law,[28] application currently extends to substantive areas, including family,[29] child welfare,[30] domestic violence,[31] trusts and estates,[32] elder,[33] and special education law.[34] Application has also extended to military,[35] bankruptcy,[36] and worker's compensation law.[37] TJ's relevance goes beyond doctrinal applications, transforming the practice of law and lawyering, e.g., via connection to relational lawyering,[38] comprehensive law,[39] restorative justice,[40] and preventive law.[41] We also see its influence in problem-solving courts, e.g., the rise in mental health courts.[42] Finally, it also informs emerging "law and" fields, e.g., law and emotion.[43]

Some commentators have questioned TJ's empirical role and seeming prioritization of therapeutic values over others.[44] TJ has a more modest aim: for law to benefit from a "therapeutic design" and "therapeutic application,"[45] i.e., purposeful consideration of therapeutic consequences at a "system of law" level and as applied in practice in substantive areas by specific persons. That is, the proposal is not for a new normative construct for law, but rather a new framing device focused on "[l]aw as lived," and grounded in empirical inquiry and participatory processes that shift perceptions of law's role and law's metrics of success.[46] TJ does not involve picking the most important value[47]; rather, it pushes lawmakers to consider the consequences of conflicting values—as experienced and as expressed in law.[48]

Policy, too, reflects values and has real-world consequences. Thus, it would also benefit from evidence of therapeutic impact and inclusion of a social science approach that includes impacts on emotional well-being amongst the empirical means explored to test its efficacy. The TJ frame

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[16] Nutley & Webb, 2000, p. 25–28; see also, Weiss, 1979.

[17] See, e.g., Olds et al., 2014 (illustrating effectiveness of resource-intensive nurse home visiting model). Other, less costly models that can be applied more broadly have also been developed (See, e.g., Porter & Howe, 2008; Reese, Slone, Soares, & Sprang, 2012).

[18] See, e.g., American Academy of Pediatrics, 2016; Ollove, 2015.

[19] See, e.g., Perry & Pollard, 1997; Reck et al., 2018; Schmid et al., 2011.

[20] See, e.g., Anda et al., 2006; Perry, 2000; Perry, Pollard, Blakley, Baker, & Vigilante, 1995.

[21] See, Head, 2010; Nilsen, Stahl, Roback, & Cairney, 2013; Oliver, Innvar, Lorenc, Woodman, & Thomas, 2014.

[22] See, e.g., Kennedy, 1963; Rosenham, 1973.

[23] Steadman, Monahan, Duffee, Hartstone, & Robbins, 1984.

[24] Bonovitz & Guy, 1979; Kaufman, 1973.

[25] Wexler & Winick, 1996; Wexler, 1999, p. 273. For early work in this area, see, Wexler, 1986; Wexler, 1980.

[26] Both Professors Winick and Wexler have written numerous articles explaining and applying the field of therapeutic jurisprudence (See, e.g., Wexler, 1995; Winick, 1997).

[27] Stolle, Wexler, Winick, & Dauer, 2000, p. 7 (emphasis added).

[28] See, e.g., Perlin, 1994; Perlin, 1995.

[29] See, e.g., Babb, 1997; Gal & Shilli-Jerichower, 2017.

[30] See, e.g., Kierstead, 2011.

[31] See, e.g., Hartley, 2003; Simon, 1995; Winick, 2000.

[32] See, e.g., Glover, 2012; Glover, 2015.

[33] See, e.g., Kapp, 2001; Stolle, 1996; Winick & Perez, 2009.

[34] See, e.g., Peterson, 2010; Peterson, 2013.

[35] See, e.g., Seamone, 2009.

[36] See, e.g., Stines, 2005.

[37] See, e.g., Yamada, 2010.

[38] Daicoff, 1999.

[39] Daicoff, 2004.

[40] See, e.g., King, 2008.

[41] See, e.g., Goldman & Cooney, 1999; Stolle, Wexler, Winick, & Dauer, 1997.

[42] Wren, 2010; see also, Johnston, 2012; Kondo, 2001.

[43] See, e.g., Campbell, 2012; Schweppe & Stannard, 2013; Westaby & Jones, 2017.

[44] Johnston, 2012; Hoffman, 2002. "Therapeutic jurisprudence is inadequate to justify mental health courts because of its inability, by definition, to resolve significant normative conflict" (Johnston, 2012, abstract).

[45] Wexler, 2015.

[46] Des Rosiers, 2002, p. 444.

[47] TJ "proposes the exploration of ways in which, *consistent with principles of justice and other constitutional values*, the knowledge, theories and insights of the mental health and related disciplines can help shape the development of the law" (Winick, 1997, p. 185) (emphasis added).

[48] "[M]y proposition is that, at times, law reformers focused too much on the wording of the right and not enough on the context in which it was going to be implemented, too much on the formal enactment, not enough on the informal norms which created the context for the law reform" (Des Rosiers, 2002, p. 447).

emphasizes therapeutic consequences with an empirically-grounded call to action, i.e., to seek out and study law's (anti-) therapeutic consequences. It fits within evolving visions of policymaking, e.g., the evidence-informed policymaking agenda, as well as the use of forward-thinking approaches to policy, such as the use of health impact assessment tools[49] and application of a "nothing about us without us"[50] philosophy.

2.3. Therapeutic jurisprudence as frame and empirical guide for evidence-informed health policymaking

As with evidence-informed policymaking, application of TJ is similarly research-driven: using behavioral science to reform law to promote therapeutic, or mitigate anti-therapeutic, consequences of law and policy. Specifically, "the empirical task is to view the relevant law, rule, procedure, or legal role as an independent variable and to ascertain the therapeutic consequences that flow from alternative legal arrangements. Settling on appropriate measures of therapeutic outcome is an interesting and integral conceptual and methodological component of the overall task."[51] Coupling evidence-informed policy with TJ in the lawyering process resulted in a call to extend TJ to policymaking, whereby law facilitates solutions to vexing public policy problems by utilizing insights and processes of behavioral science, and with outcomes cooperatively defined with those affected.[52] A marriage of policymaking and TJ holds considerably more promise when considering the interdisciplinary thrust behind both. Policymakers benefit from the best and brightest across a range of disciplines—e.g., economics, early childhood development, psychology, history, social work, business, urban planning—when conceptualizing a "successful" outcome facilitated by policy. TJ similarly benefits from multidisciplinary contribution.

Conceptually, this policy process, as framed by TJ, is a question-generating and data-seeking endeavor, a search for "*psycho-policy soft spots*"[53] that suggest where tweaks in the policymaking process might support, or at least not antagonize, psychological well-being. Identification of these "soft spots" in the law, i.e., areas for therapeutic consideration, should follow a methodical, data-generating process. Questions to add to the empirical policymaking process include:

- What is the problem and can/should policy help address it?
- Might policymaking and/or its implementation create psycho-policy soft spots?
- Can we mitigate potentially anti-therapeutic consequences?
- Are other values at play that supersede a focus on therapeutic consequences?
- Does reflection and data generation indicate that policy intervention is premature, or perhaps calls for a narrower, time-limited, policy intervention?[54]

Hypothetical case studies have applied TJ framing questions to the emotional aspects of policy, e.g., policy proposals addressing gun violence and persons with mental illness,[55] in an effort to "systematize

consideration of emotional consequences."[56] "What is needed now is a fleshing out of how the process would flow in real-time and a visualization of the TJ-framing [question-and-answer] … approach in a more iterative format."[57] The State of Tennessee's desire to be a "trauma-informed state"[58] represents just such an interesting real-time case study, specifically as reflected in Memphis/Shelby County's efforts to create a trauma-informed early care and learning system. Assuming it is a good thing to enhance well-being through policy, if law intends to mitigate trauma in a child's life by allocating funds to science-backed parental support models, is it not preferable that the policymaking process and resulting policies not traumatize? First, consider the science behind the call to action.

2.4. The science of childhood trauma and the developing brain

A seminal article published in 1998 shared results of a study on adverse childhood experiences ("ACEs").[59] In the study, adult Kaiser Health Plan members completed a survey that asked questions about leading ACEs relating to abuse (psychological, physical, and sexual) and household dysfunction (substance abuse, mental illness, violent treatment of mother, and criminal behavior).[60] The study authors "found a strong …relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults…. The findings suggest that the impact of these adverse childhood experiences on adult health status is strong and cumulative."[61] The authors concluded with a call for efforts directed to prevent ACEs.[62]

Over the next 10 years, more research emerged on the importance of early childhood experiences, and the enduring, negative impact of toxic stress on children like Ava.[63] As evidence mounted about the negative impact of ACEs, parallel research in the neurosciences and developmental sciences highlighted how early intervention can prevent lifelong negative impact.[64] We now know that "[b]rains are built over time, and the foundations of brain architecture are constructed early in life."[65] Moreover, "[j]ust as in the construction of a house, certain parts of the developing brain must be built in a predictable sequence and what is built early must be strong enough to support the long-term structure. … [B]uilding more advanced cognitive, social and emotional skills on a weak foundation is far more difficult and less effective than getting things right from the beginning."[66] Research-backed early interventions demonstrate that there are things we can do to prevent/mitigate ACEs,[67] fueling the desire to change practices, programs, and the training of caregivers and program staff to reflect the evidence; hence, the growth in "trauma-informed" programs and services.[68] Funding has followed,[69] as has government notice.[70]

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[49] See, e.g., Pew Trusts, 2015; Lock, 2000; Hanney, Gonzalez-Block, Buxton, & Kogan, 2003.

[50] Charlton, 1998 (connected to the disability rights movement). This inclusiveness accords well with TJ's push for personal "voice" in constructing and applying law (See, Ronner, 2002; Ronner and Winnick, 2000, p. 499).

[51] Wexler & Winick, 1991, p. 985.

[52] Campbell, 2010.

[53] Campbell, 2010, p. 289 (drawing from the approach developed by David Wexler (1998)).

[54] Adapted from Campbell, 2010, Figure 1. Des Rosiers' (2002) explication of "law as lived" provides an excellent example of the importance of this sort of inquiry, e.g., how best to address financial exploitation of elders requires going beyond simply statutory reform.

[55] See, Campbell, 2012.

[56] Campbell, 2012, p. 698.

[57] Campbell, 2012, p. 699.

[58] See, Wadhwani, 2015.

[59] Felitti et al., 1998.

[60] Felitti et al., 1998, Table 1.

[61] Felitti et al., 1998, p. 251.

[62] Felitti et al., 1998, p. 254.

[63] Anda et al., 2008; Brown et al., 2009; Cannon & Hsi, 2016; Hillis et al., 2004.

[64] Kassam-Adams, 2014; McDonald, Kehler, Bayrampour, Fraser-Lee, & Tough, 2016; Perry & Conners-Burrow, 2016; Shonkoff, 2016.

[65] Center on the Developing Child, Harvard University, 2016, p. 9 (emphasis removed).

[66] Center on the Developing Child, Harvard University, 2016, p. 9.

[67] See, e.g., McKelvey, Whiteside-Mansell, Conners-Burrow, Swindle, & Fitzgerald, 2016; Olds et al., 2014; Porter & Howe, 2008.

[68] See, e.g., National Center on Substance Abuse and Child Welfare, 2015; Child Trauma Academy, n.d.; American Academy of Pediatrics, n.d.

[69] See, e.g., Building Strong Brains Initiative, 2017; Robert Wood Johnson Foundation, n.d.; The Kresge Foundation, n.d.

[70] See, Prewitt, 2017. ACEs were specifically referenced in 40 bills in 18 states in 2017, and 20 ACEs and "trauma-informed" statutes were enacted in 15 different states (Prewitt, 2017). Federal law makers have also taken action (See, Trauma-Informed Care for Children and Families Act of 2017, 2017; Violence Against Women Reauthorization Act of 2013, 2013.)

What does it mean to be "trauma-informed"? "Trauma-informed care (TIC) is a systems-focused frame of reference and operating model in the care of all children and youth. TIC impacts:

- Organizational culture
- Staff practices and approach
- Policy and processes …
- Screening and assessment
- Staff learning and development in each component of care.

TIC also impacts interfaces among systems"[71] Principles guiding creation of trauma-informed systems of care include: understanding trauma and its impact; promoting safety; ensuring cultural competence; supporting control, choice, and autonomy; sharing power and governance; integrating care; and recognizing that healing happens in relationships, and recovery is possible.[72]

This comprehensive and holistic vision and approach suggest that being "trauma-informed" at a policy level goes beyond simply providing support for—or privileging through enhanced or exclusive government support—services and programs that mitigate and/or prevent ACEs. To be truly trauma-informed requires policy action. Then, to be effective, policy itself should be informed by the latest in trauma science, early childhood brain development, and yes, effective evidence-informed policy making.

2.5. Connecting the dots

A trauma-informed approach to care results in understanding trauma and acting upon such understanding, as reflected in training, practice, and policy at the organizational, agency, and system levels. Evidence-informed policy results in amplifying the benefits of evidence through policy support and in applying best practices to the making of policy itself. TJ-framed evidence-informed policymaking walks policymakers, influencers, and analysts through a question-and-answer process to require more purposeful reflection on the (anti-) therapeutic consequences of policy and the policymaking process. In combination, building a TJ-framed trauma-informed system of care emphasizes the role of policy to ensure more enduring, *therapeutic* change.

The upshot: Trauma science informs stakeholder actions to create a trauma-informed system of care, which is in turn nurtured and sustained through the relational and evidence-informed elements of a TJ-framed policy response. In this vision, TJ moves policy from a discrete "bullet" in the work of creating a trauma-informed system of care to a cross-cutting influence on and supporter of creating a trauma-informed system and focuses attention on the therapeutic, relational consequences of this policy work. What might this look like on the ground? Notably, the State of Tennessee is taking a proactive, systemic approach in order to be a "trauma-informed state."[73]

3. Moving to the policy level: Evidence-informed policy in practice

3.1. The state of Tennessee: Building strong brains initiative

Armed with data about the consequences of ACEs within the state,[74] reflecting on the science on toxic stress, and with the hope of buffering potentially toxic stressors through early intervention, leaders in Tennessee launched the *Building Strong Brains: Tennessee ACEs Initiative* ("BSB Initiative") in November 2015, at a summit convened by the state's governor, first lady, and deputy governor.[75] A three-year initiative, it seeks

to become a "national model for how a state can promote culture change in early childhood."[76] Change occurs through explicitly envisioning policy action by government and private organizations[77] and through explicitly endorsing an evidence-informed approach through public/private, interdisciplinary collaboration on research.[78]

The BSB Initiative has at its core the diffusion of a trauma-informed philosophy through concentrated, coordinated investment in healthy childhood development in nurturing homes and communities.[79] Programs, services and practices are to reflect this philosophy, as supported by policy and funding streams. Critically, the BSB Initiative seeks culture change and a move from a deficit-based to an experiential-based philosophy[80] by emphasizing the why: human lives.

Much of the focus of the three-year initiative has been on educating public and private sector leaders and policymakers about the science, framing the work in a message that investing in early years advances the prosperity of all.[81] Critically, the emphasis on healthy environments and strengths-based approaches inclusive of the experiences and perspectives of children and families ground this work in those the State seeks to serve. As the initial three-year BSB Initiative winds down, local efforts for "testing" trauma-informed system approaches take on new vigor.

3.2. Trauma-informed early care and learning system in Memphis/Shelby County

As knowledge mobilization and funding shift to the local level, the focus is on how to build local trauma-informed systems. In Memphis/Shelby County, this mobilization occurs with support of a diverse range of leaders from government, courts, health systems, early care and learning providers, public schools, and the academy. What motivated local action? Even before the BSB Initiative began, a County-commissioned survey[82] identified that 52% of adults, or roughly 361,200 individuals, experienced at least one ACE; 20% experienced 2–3 ACEs; and over 10% experienced at least 4+ ACEs.[83] The study also expanded upon traditional ACEs to investigate emerging "adverse community experiences," such as witnessing violence, perceptions of neighborhood safety and trust, and experiencing racial discrimination: experiences also common among Shelby County adults.[84]

Armed with this data and the statewide push to address ACEs, attention at the local level shifted to early childhood. We know that in early childhood, the availability of safe and nurturing environments with caring adults can determine whether a child succeeds in school and in life.[85] A safe and nurturing environment is especially important in under-resourced neighborhoods across Memphis. Homes in Shelby County have a higher prevalence of violence between adults than in the state and nation.[86] Licensed early care provider coverage is less than 50% in two-thirds of the zip codes in Shelby County, an access gap most prevalent in the five zip codes with larger age 0–3 populations and lower median household incomes.[87] Early intervention and home

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[71] TDMHSAS, 2013, p. 53.

[72] TDMHSAS, 2013, p. 55–56 (explanatory text removed).

[73] Prewitt, 2016.

[74] Lucinski, 2016 (all results reached statistical significance).

[75] See, Peck, n.d. Notably, the effort's name links to the "building" and "brain architecture" analyses made prominent in leading analyses of brain development and positive early experiences (See, Center on the Developing Child, Harvard University, 2016).

[76] Peck, n.d.

[77] Peck, n.d.

[78] Peck, n.d.

[79] See, Building Strong Brains Initiative, 2016.

[80] As the BSB Initiative overview explains it, "the culture must shift from 'what is wrong with you' to 'what happened to you?'" (Peck, n.d.).

[81] Kendall-Taylor, 2016, slide 7.

[82] The Research and Evaluation Group, Public Health Management Corporation, 2014.

[83] The Research and Evaluation Group, Public Health Management Corporation, 2014, p. 7.

[84] The Research and Evaluation Group, Public Health Management Corporation, 2014, p. 6.

[85] Center on the Developing Child, Harvard University, n.d.

[86] The Research and Evaluation Group, Public Health Management Corporation, 2014, p. 11.

[87] People First Partnership, 2015a, December.

visitation services are similarly scarce in low-income areas.[88] In Memphis, 44.7% of children live in poverty.[89] All of these statistics reflect Ava's story.

The danger in these daunting statistics and a desire to "do something" is that we pile on a myriad of programs, services, or practices without coordination and without a coherent vision focused on, and informed by, those most impacted. There is a critical need for collaboration and purposeful implementation of best practices that utilize metrics to gauge success and direct support to what works. Creating upstream change is critical to sustain these efforts *and* have collective impact.[90] Development of a "policy toolbox" is one tangible means proposed to fill the gap in this evidence-informed, collective impact effort. That is, a systematic, comprehensive approach is critical to create a truly "trauma-informed" system.

4. Constructing a "policy toolbox"

4.1. The "Assist in Change" agent: The Institute for Health Law & Policy (iHeLP) policy lab

The Institute had the fortune to be an early participant in the State BSB Initiative, specifically through launch of the iHeLP Policy Lab as a resource for policy research, advising, and drafting. Essential in its work is interdisciplinary collaboration in service, education, e.g., through a policy skills practicum,[91] and scholarship. Completed or anticipated "products" of its work in using policy to address childhood trauma,[92] include policy briefs, letters to policymakers, draft contract language, updated procedure manuals and education materials, and suggestions for innovative funding models.

However, similar to piling up programs, services, and practices, the danger with policy interventions is losing sense of the forest through the trees. There are a myriad of policies and approaches to childhood trauma prevention/mitigation. Policies span public and private actors, systems, and localities. Policy approaches range from "mild" (e.g., support for education, capacity building), to "medium" (e.g., funding of different approaches to care), to "hot" (e.g., mandate coverage of new services). With so much at stake and given the significance of issue prioritization—and privileging of related evidence and endorsing of related policies—being comprehensive and coherent takes on great importance. Thus, the iHeLP Policy Lab is also piloting development of a "policy toolbox," i.e., a collective tool for actually doing the work—systematically and in alignment—to become a "trauma-informed" system.

4.2. The "policy toolbox"

4.2.1. Context: The idea takes root

Within this initial launch period, it is clear that policy plays a key role across interventions, and as an intervention itself, in the success of state and local efforts. For example, early childhood advocates in Memphis/ Shelby County argue that child care standards, for centers like those serving Ava and her siblings, should be stronger given the science behind the importance of the early childhood years and having trauma-informed caregivers.[93] To accomplish this, the iHeLP Policy Lab's

engagement includes: identifying national model best child care standards[94]; researching best practices for standards enhancement in other communities[95]; situating local/state standards on a national "best" to "worst" continuum, in terms of adherence to national standards reflecting research on trauma-informed practices in the early years; cross-walking current local and state standards against the "best;" and recommending how to improve local/state statutes and regulations in furtherance of "trauma-informed" goals. End products for targeted engagement include a policy brief, a "cross-walk" map, and policy recommendations for next steps at the state policy level, with tips for local advocacy.

4.2.2. Thinking more globally, comprehensively, and systematically

How might we turn Policy Lab "assignment"-based work for building a "trauma-informed" early care and learning system into more than the sum of these parts? On a parallel track to ongoing policy assistance for child care standards lies development of a trauma-informed, early care and learning policy toolbox.[96] The toolbox will contain resources around issue areas, e.g., trauma-informed child care standards, and be a resource for advocates, policymakers, and researchers to accomplish policy goals, e.g., to enhance standards. Within an issue area, the toolbox will be a one-stop shop for joining ideas, suggestions, tips, and other resources together in a coordinated fashion. For example, altering a child care standard might require additional education of child care providers, additional child care payment assistance, and more training of child care regulators. Thusly, policy might need to cover educational mandates, funding reallocations, and support for retraining, which, in turn, might impact anything from contracts and federal/ state block grant applications, to job descriptions, organizational training manuals, and inspection protocols. Thus, the "policy" within the policy toolbox consists of a diverse range of small-p (e.g., organization manuals) and large-P (e.g., statutes and regulations) policies, as part of an "interconnected map" to guide policy action and assessment.

Critically, the policy toolbox will also include steps to guide users through the effective use of materials, e.g., policy brief findings, cross-walk results, and policy recommendations. An informed stakeholder matters, but so too does one who knows how to apply that information in real world settings and for positive effect. Advances in technology allow this toolbox to be a "living," iterative, web-based resource, adaptable with gains in scientific understanding, increased understanding of effective or less-effective approaches to implementation, and changes to relevant federal or state policy. As an iterative, adaptable tool, inclusion of evaluation metrics that facilitate toolbox user feedback is also necessary to determine the toolbox's ability to meet the goals of coordination, comprehensiveness, ease of use, etc. Moreover, users will be able to make suggestions for additions to the toolbox or tips to make areas more user-friendly.

The driving hypothesis is that the policy toolbox adds value through its focus on coordination, comprehensiveness, instruction, and adaptability, with a broad vision for policy's engagement in the trauma-informed process. Its use, alteration, and feedback helps determine if the hypothesis is met and where/how adaptation would provide more value. The latter points to the overarching goal: enhancing the ability of systems and communities to be "trauma-informed" and ultimately create healthy environments in which children thrive. This core goal reinforces how much is riding on this work; however, considering all data, ideas, resources, and steps risks overwhelming stakeholders, and masking or devaluing the heart of this work. Ensuring that human lives remain the focus throughout requires careful attention.

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[88] People First Partnership, 2015a, December.

[89] Delavega, 2017. Additionally, Delavega (2017) found that 34.5% of Shelby County children live in poverty, and notably, the poverty rate for children has risen 4.0% in Memphis and 6.5% in Shelby County in one year.

[90] Tamarack Institute, n.d. See also, Hanleybrown, Kania, & Kramer, 2012.

[91] For more information on building this interdisciplinary skills course, see, Campbell, 2016.

[92] Anecdotally, the local experience has been that the language of ACEs may be too limiting, e.g., not looking at community factors as added in Shelby County. It is also alienating in certain segments of the community who see it as fatalistic and perhaps writing off certain children after a certain age. The language of "trauma" is seen as more inclusive and less determinative.

[93] The Urban Child Institute, 2013; People First Partnership, 2015b.

[94] See, e.g., Limardo, Sweeney, & Taylor, 2016.

[95] See, e.g., National Center on Child Care Professional, 2014; Griffey & Koski, 2016.

[96] For a potential visual for what is contemplated, see, Center for Community Progress, n.d.

5. Applying TJ to the "policy toolbox" approach/process

5.1. As frame

As described above, TJ offers a framework to enhance well-being via policy and policymaking, and adds an empirical approach to assess therapeutic consequences as part of the evidence-informed policymaking agenda. As applied to the trauma-informed early care and learning "policy toolbox" development process, this TJ frame assumes at a baseline all key stakeholders believe in the value of focusing on therapeutic consequences of policies and policymaking. Goals of creating a trauma-informed system and those for the early development of TJ are consonant: that laws and law-making not further traumatize persons with mental illness.[97] In light of the science highlighting long-term benefits of focusing on healthy early childhood development, TJ provides an important frame given its own dedication to a preventive approach. TJ recognizes how law and law-making, by intervening in lives, should also seek proactive ways to avoid negative consequences and rather create therapeutic ones. How ironic if our approach to creating a "trauma-informed" system or state causes trauma. If use of a different prism to view and approach our policymaking work will help prevent/mitigate this potential trauma, why not try it? For the toolbox, this means that what is included, and critically, the instructions provided, take account of the psychological consequences of preferred solutions and/or rejected approaches.

5.2. As empirical guide with applied agenda

This gets us to the "meat" of this work: the application of TJ to the evidence-informed policymaking process. The toolbox represents an attempt at making coherent that which is messy and complex, moving from science to real-world results. Critically, TJ situates the toolbox and the process of its "rationalizing" of the complex within a human context. Policies affect people, are made by people, and are assessed by people. People have a range of emotions that are triggered by their own unique set of circumstances. Behavioral science studies people and these emotions. Thus, bringing this evidence and highlighting emotional consequences via a TJ approach stands to better inform our policy work and policies.

5.2.1. Example: Child care center standards "tool" and TJ-framing questions

For the TJ-framed, early care and learning policy toolbox, determining what to include and how to describe its value, its correct use, and what "success" looks like in that use, requires each step to focus on human consequences—the "lived experience"—of this policymaking work. For example, as applied to the child care center standards "tool" within the toolbox, the Policy Lab team is initiating engagement with key partners to ask and seek answers to the following questions to inform the approach to making, implementing, and evaluating policy change[98]:

- What is the problem and can/should policy help address it?

  o Minimal educational requirements exist for child care center directors and staff in Tennessee. Existing requirements do not reflect what science tells us about the earliest years.
  o Given limited options and inadequate child care payment assistance, too many families rely on substandard care providers.
  o National standards exist. Other states are altering their approaches to

reflect best practices, providing actions from which key stakeholders in Memphis/Shelby County and Tennessee can learn.

- Might policymaking and/or implementation create psycho-policy soft spots?
  o Changing educational requirements might require retraining of many child care center workers, sometimes at their added expense. These workers may fear losing their jobs or going into debt to afford the additional education required. Some centers may close, causing fear and stress among providers and families.
  o Families might have to change child care providers, likely bringing short-term instability to their children's lives. For example, this might require traveling further, at their expense. Caregivers might worry that they will not be able to afford the newly-certified centers.
  o Some center staff might grow angry at being told to follow perceived "one size fits all" standards with limited local resources. Unfunded mandates might create further pressures.

- Can we mitigate potentially anti-therapeutic consequences?
  o By studying successful implementation of new standards in other communities or fields, state and local policymakers could consider phasing in educational requirements and partnering with local high schools and institutions of higher education to develop affordable certificate programs.
  o Retraining and job assistance could be provided to workers in centers that close.
  o Phasing in changes might alleviate immediate closures, limiting the scope and duration of instability on families. Policymakers could work with child care centers and transportation providers to identify ways to address transportation issues. Policymakers could work with centers and families to address financial barriers to seeking care. This could include drawing down the full amount of support available to trauma-informed child care centers via state block grants, or addressing time limits on payment assistance as tied to date of entry of first child.[99]

- Are other values at play that supersede a focus on therapeutic consequences?
  o Policymakers should monitor implementation of new standards to avoid disparities, e.g., racial, between which centers get certified and the demographics of families who can access certified centers.
  o Changes in federal and state administrations might alter the nature of state block grants, creating need to rethink unaccounted-for consequences of "low-funded" or unfunded mandates.

- Does reflection and data generation indicate that policymaking is premature, or perhaps call for a narrower, time-limited, policy intervention?
  o Sufficient data may not yet exist on other states' experience using heightened standards.
  o Status of funding and current limits on educational training programs might result in forgoing the "sticks" in mandates, but rather push use of "carrots" via tuition assistance and time-limited grandfathering of existing centers, particularly in low-resource communities with few center-based child care providers.

In practice, this exercise is not dissimilar to other efforts to inform policy with evidence, or calls for policymaking to follow a scientific method. It simply reframes this effort with attention to those persons and collections of persons who are affected by policies, and to consider those effects when transitioning from identifying "what works" to

[97] See, e.g., Winick, 1999.
[98] The main questions are adapted from Campbell, 2010, Figure 1. These questions draw from the psycho-policy soft spot question generating process described earlier (Wexler, 1998). The answers and areas for follow-up are meant to be illustrative, not exhaustive.
[99] Tennessee Department of Human Services, n.d.

rolling out best practices. It requires consideration of *how* things work, thoughtfully and through a therapeutic frame, by asking questions and gathering evidence about how policies affect, or are perceived or anticipated to affect, persons" targeted" by the policies, i.e., the *by* and *for whom*.

5.2.2. Example: The story of ava and Ava's mother, Victoria, and TJ-framing questions

Returning to the opening case study, the policy toolbox for Ava and her family could include legislative and regulatory action, organizational policy change, enhanced education, and redistribution of resources to enhance court participation. Each would include guidance on the *why*, *what*, and *how* of building the toolbox and using the tools within it, as well as tracking results. More concretely, potential tools include: new/amended statutes and regulations to expand state insurance coverage of trauma-informed services; local regulatory action to advance "healthy housing" standards; enhanced training of court actors about trauma's impact, and the role for the court in mitigating negative psychological impact; and a clarified process for fee waiver. With an overarching goal that law/policy itself not traumatize, asking the TJ-framing questions might help determine which tools to use, how, and with what intended effects.[100]

- What is the problem and can/should policy help address it?
  o Ava witnessed violence in the home: the homicide of her father and the physical abuse of her mother, Victoria, in a new relationship.
  o Victoria experienced trauma at the loss of her husband and in her abusive relationship.
  o The family is under great economic strain and also lives in a severely economically-challenged neighborhood.
  o The family lives in substandard housing.

- Might policymaking and/or implementation create psycho-policy soft spots?
  o The court process for allegations of domestic violence include not insubstantial court fees, waiting areas open to survivors and alleged perpetrators, and involve judicial officers with limited training in the science or impact of trauma.
  o The state Medicaid system covering Ava does not include coverage for emotional issues affecting Victoria.
  o Efforts to address poverty have been piecemeal and/or limited to zip codes other than that of Ava's family, which is seen as so resource-poor that it lacks intervention points.
  o Several different code sections, with different regulatory authorities, impact rental property housing standards, and include only a subset of health-impacting criteria (e.g., lead, asbestos).

- Can we mitigate potentially anti-therapeutic consequences?
  o The process for waiver of court fees could be made more "user" friendly and time-sensitive.[101] Waiting areas could be altered to keep separate accusers and the accused. Training in trauma-informed best practices could be integrated within routine judicial training,[102] with specific modules created to translate knowledge into practical application via relevant case-studies and role playing.[103]

  o The state Medicaid system could allow health providers to bill for services to address Victoria's psychological distress under Ava's insurance number.[104]
  o City and county leaders could partner with a diverse set of agencies, community organizations, health systems, and schools to develop asset maps and identify gaps, to highlight areas of greatest need. These partners could also work on community coalition-building and developing the "voice" of residents like Victoria, so "no community is left behind."[105]
  o The community could map the relevant housing code sections for greater coordination, integrate model "healthy housing code" provisions to capture the full array of policy supports for enhancing rental property standards,[106] and adopt a "good landlord program" to incentivize landlord compliance with updated standards.[107]

- Are other values at play that supersede a focus on therapeutic consequences?

  o Policymakers should be mindful of not assuming that challenges facing Ava and her family require paternalistic responses.
  o Policymakers should not assume that "one size fits all" for creating trauma-informed systems, or that education or a voluntary program is a sufficient response to trauma's impact.
  o Facing limited resources, allocation decisions might first target areas with sufficient "assets" to develop models for change. However, leaders could partner with communities to develop a specific process and timeline for rolling out the plan—with necessary refinement—across the community.

- Does reflection and data generation indicate policymaking is premature, or perhaps call for a narrower, time-limited, policy intervention?

  o Sufficient data might not yet exist in support of the feasibility of a "good landlord" program.
  o Sufficient trauma-informed services offering relational care to Ava and Victoria might not yet exist to which to refer them both, should the state expand coverage.

Importantly, those persons most affected also take center stage throughout the process. Using a proactive approach, data-generating and –informing questions will reveal potential emotions of those most affected at the outset, to guide policy formulation, implementation, and assessment. Persons "targeted" by policy will now become essential participants in—not targets of—this shared endeavor, fleshing out the "humanity" of policy by providing a critical but often missing narrative to evidence-informed policymaking.[108] The ultimate goal is stronger evidence that helps us understand *why* what research suggests should work does or does not work, as *informed by* the persons who are the focus of policymaker efforts. The contextualization added by the question-and-research-to-find-answers process, as informed by behavioral influences in and on the policymaking process, arguably enhances the odds policy will endure, inasmuch as it is explicitly mindful of potential (anti-) therapeutic consequences, and with an attendant duty to mitigate them based on person-centered feedback.

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[100] The main questions are adapted from Campbell, 2010, Figure 1. These questions draw from the psycho-policy soft spot question generating process described earlier (Wexler, 1998). The answers and areas for follow-up are meant to be illustrative, not exhaustive, and do not focus on child care center standards as such were the focus of the example in 5.2.1.

[101] Tennessee has eliminated fees, court costs, and litigation taxes for domestic violence, sexual assault, and stalking victims filing for an order of protection (T.C.A. § 36–3-617). In Memphis/Shelby County, Tennessee, the Family Safety Center, a non-profit, assists victims of domestic violence in partnership with local law enforcement and other service agencies (Family Safety Center, n.d., "Who We Are" and "How We Help").

[102] See, e.g., Tennessee State Courts, n.d.

[103] See, e.g., National Center on Domestic Violence, Trauma & Mental Health, n.d.; Substance Abuse and Mental Health Services Administration, 2017.

[104] See, e.g., Centers for Medicare & Medicaid Services, 2016; American Academy of Pediatrics, 2016. This builds upon a "2GEN" or the Two-Generation Approach to children and caregivers (See, ASCEND The Aspen Institute, n.d; Shonkoff & Fisher, 2013).

[105] This phrase builds on the push in education policy to leave "no child behind." For more information about the No Child Left Behind Act, see, Jorgensen & Hoffmann, 2003.

[106] National Center for Healthy Housing & American Public Health Association, 2014.

[107] Good landlord programs include training programs like the city-wide initiative in Milwaukee, crime reduction programs like CPTED or Mesa, Arizona's program, and financial incentives like the Good Landlord Program in Salt Lake City, Utah (Center for Community Progress, n.d., at Tool 6: Good Landlord Incentives).

[108] See, Ronner, 2002, p. 89; Glover, 2012.

6. Conclusion

6.1. Next steps

Currently, two law student research assistants are working on the policy brief and cross-walking map as related to child care standards. Another law student is fleshing out what to include in the child care standard portion of the "trauma-informed early care and learning system" policy toolbox.[109] A key next step is to identify, and provide support for, additional disciplinary partners, e.g., public health, public policy, child development, psychology, social work, early intervention, pediatrics, and education, to inform development of the toolbox, and, most critically, seek out the families and staff most intimately affected by proposed new policy. We need to query these individuals more systematically to flesh out the potential (anti-) therapeutic consequences of proposed revisions to standards. Their responses and the generation of additional "test-able" questions will inform metrics of "success" of the toolbox to gauge achievement of therapeutic-enhancing, value-added goals. To the latter's end, we also need the help of experts in not simply program evaluation, but also in process, policy, and collective impact[110] evaluation. Finally, we need to identify technical partners to help translate a two-dimensional map for action into the vision of a "living" adaptable toolbox via a web-based platform.

6.2. Lessons for others

Given such an expansive scope, it quickly became clear that the initial scope—to create a toolbox to help Tennessee become a "trauma informed state"—was far too broad. Narrowing to a local focus was necessary, as was narrowing the issue area of focus. Accordingly, we looked to develop a policy toolbox focused on the early care and learning environment, specifically with a pilot guide focused on child care standards. Starting local and narrow remains more faithful to the person-centered nature of this work, and its adaptability accounting for lessons learned. Also, this resource-intensive work has benefited from grant support, a statewide initiative to bring focus to the issues, a receptive local community, and a pre-existing network of engaged stakeholders and early champions who have built the trust of the communities of interest, and "space" to develop and test ideas.

This reframed work also benefits from specific qualities in those persons engaged in the process. Critical are humility in recognizing the limits of one's expertise, an openness to interdisciplinary engagement, and assuming a support role when necessary.[111] It requires comfort with the discomfort of unpredictable policy climates and of confronting negative emotions, like fear, anger, and suspicion, triggered by asking questions and piloting policy approaches. Also useful is an adaptive orientation that does not let the perfect become the enemy of the good, at least as an interim step. One must be prepared to be wrong, at least to those whose perspectives will and/or should have great weight, and to negotiate and at times "lose." Thus, meeting this challenge takes a diplomatic, culturally-sensitive, open-minded, humble, adaptive approach—evidencing an emotional intelligence[112] in recognition of the emotions involved, plus a commitment to transformational and servant leadership.[113]

Finally, the contention is that policy matters because it affects people—especially in their earliest years and most vulnerable contexts. So, too, do the therapeutic effects of policymaking matter. Utilizing a "human-faced" policy toolbox is a systematic means to address this importance. Being trauma-informed is more than a collection of best practices, and it's more than a set of policies supporting those practices. It's a reimagining of what it takes to raise healthy children, and the community's and government's obligations toward such, with a further reimagining of how and why policy can and should support this work. Therapeutic consequences are not the only concern, but they are a concern worthy of explicit analysis. Attention to them creates a sum greater than its parts. Ultimately, it is work with the potential to make a positive, enduring difference in the lives of children and families—what gives the work its meaning, value, and heart.

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[109] Notably, all law students are also seeking dual degrees in public health, and the fellow a master's in public health, providing for them a more holistic perspective on this work and understanding of the value of epidemiological, behavioral, and other research approaches to informing policy.

[110] Tamarack Institute, n.d. See also, Hanleybrown et al., 2012.

[111] "[D]iscourse and practice involving community-engaged scholarship must continue to pay attention to the notion of interpersonal skills in various aspects and across multiple cultural dimensions and disciplines" (Hatala, et al., 2017, p. 46).

[112] See, Goleman, 1995; Salovey & Mayer, 1990.

[113] See, Bass & Avolio, 1993; Hoch, Bommer, Bulebohn, & Wu, 2018; Stone, Russel, & Patterson, 2004.

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