

Trauma-Informed Social Policy: A Conceptual Framework for Policy Analysis and Advocacy

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Trauma-informed care is a service provision model used across a range of practice settings. Drawing on an extensive body of research on trauma (broadly defined as experiences that produce enduring emotional pain and distress) and health outcomes, we have argued that the principles of trauma-informed care can be extended to social policy. Citing a variety of health-related policy examples, we have described how policy can better reflect 6 core principles of trauma-informed care: safety, trustworthiness and transparency, collaboration, empowerment, choice, and intersectionality. This framework conveys a politicized understanding of trauma, reflecting the reality that trauma and its effects are not equally distributed, and offers a pathway for public health professionals to disrupt trauma-driven health disparities through policy action. (*Am J Public Health*. 2016;106:223–229. doi:10.2105/AJPH.2015.302970)

In recent years, trauma-informed care has diffused as a model of service provision across a variety of health and social service settings.^{1–4} Trauma is broadly defined as experiences that produce intense emotional pain, fear, or distress, often resulting in long-term physiological and psychosocial consequences.^{3,5} For example, the landmark Adverse Childhood Experiences Study linked childhood experiences that are traumatic for many individuals, such as abuse and domestic violence, with adult health outcomes, including premature mortality, mental and physical health problems, and substance abuse.^{6–8} A trauma-informed care approach recognizes the intersection of trauma with many health and social problems for which people seek services and treatment, aiming to sensitively address trauma along with an individual's issues.

Trauma-informed care is conceptualized as an organizational change process centered on principles intended to promote healing and reduce the risk of retraumatization for vulnerable individuals.⁹ The literature indicates a growing interest in trauma-informed care among service providers, researchers, and government agencies, with this interest concentrating primarily on direct service settings.^{10–13}

Policy in the trauma-informed care literature is typically discussed only at the institutional level, for example in terms of ensuring that an agency's policies and procedures adequately promote clients' confidentiality and safety.^{1,14}

Because a social determinants of health perspective drives public health toward an emphasis on promoting “health in all policies,”¹⁵ we argue that the principles of trauma-informed care constitute a meaningful framework for analyzing social policy and guiding advocacy efforts. Such a framework builds on previous policy analysis models, such as Rapp, Petus, and Goscha's model of strengths-based social policy analysis.¹⁶ Although the notion of health in all policies suggests that virtually all policy is relevant to public health, we argue that trauma-informed policy analysis has the greatest salience for policies addressing social problems related to trauma, such as violence, homelessness, addiction, and chronic disease.

RATIONALE FOR A TRAUMA-INFORMED PERSPECTIVE ON SOCIAL POLICY

Because many health and social problems are interrelated as well as linked to trauma, a trauma-informed perspective is relevant to a range of local, state, federal, and international policies. For example, in 2011 the United States released its first National Prevention Strategy, which outlines priorities and strategic directions for preventing injury and disease and improving the nation's health and wellness.¹⁷ Because of the influence of trauma on many adverse physical and mental health outcomes,⁵ a trauma-informed care approach is relevant to this strategy as a whole as well as to many specific policies and initiatives referenced in the National Prevention Strategy. These range from large-scale federal efforts, such as the National Forum on Youth Violence Prevention, to state and local efforts, such as the variety of innovative health and prevention programs funded through the Centers for Disease Control and Prevention's Community Transformation Grant program.

Although no population is immune to experiencing trauma, some types of trauma are disproportionately experienced by certain groups because of deeply entrenched structural inequalities. Farmer and others have used the concept of structural violence to link social inequalities with trauma and related suffering, arguing that “suffering is ‘structured’ by processes and forces that conspire—whether through routine, ritual, or more commonly, the hard surfaces of economics and politics—to constrain agency.”^{18(p335)} Thus, to provide an example, people living in

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poverty and especially low-income racial minorities in the United States are disproportionately likely to experience contact with the criminal justice system, including police brutality and the use of excessive force—occurrences that are often traumatic at the level of the individual as well as the family and community.^{19,20} The unequal structuring of trauma across different segments of society has received relatively little attention thus far in the trauma literature, which tends to adopt a narrow medicalized focus.²¹ We argue that trauma-informed social policy should move beyond broad notions of trauma as a universal experience and address its specific sociopolitical and economic roots as well as its disproportionate impacts among marginalized populations.

PRINCIPLES OF TRAUMA-INFORMED SOCIAL POLICY

Researchers and government agencies such as the US Substance Abuse and Mental Health Services Administration have outlined core principles of trauma-informed care. Although there is some variability in the terminology used, there appears to be broad consensus in the literature that these principles include the following: safety, trustworthiness and transparency, collaboration and peer support, empowerment, choice, and the intersectionality of identity characteristics.^{1,2,9,13,14}

Safety in trauma-informed care refers to program efforts to ensure service users' physical and emotional safety, meaning reasonable freedom from harm or danger, and to prevent further traumas from occurring. Trustworthiness and transparency include the extent to which an organization maintains transparency in its policies and procedures, with the objective of building trust among stakeholders such as staff, clients, and community members.¹³ Collaboration in trauma-informed care means that agency staff view service users as active partners and experts in their own lives, an approach often operationalized through the formal and informal use of peer support, such as peer mentoring.^{1,9} Empowerment includes efforts to share power with service users, giving them a strong voice in decision making at individual and agency levels. Having meaningful choice and options gives service

users a level of control and is associated with better treatment outcomes in a variety of settings.^{22,23} Finally, intersectionality references awareness of identity characteristics, such as race, gender, and sexual orientation, and the privileges or oppression these characteristics can incur.

We have described the relevance of each of these principles to social policy. Although we believe the principles are relevant to health-related social policies at every level and in every national context, to illustrate we draw primarily on US federal policy in the following areas: illicit drug use, intimate partner violence (IPV), the use of community health workers (CHWs) in health care, HIV/AIDS, and food insecurity.

Safety

Trauma-informed social policy should make provisions for the basic safety of vulnerable populations. US drug policy is an area in which the notion of safety is often contested. Previous landmark legislation such as the Anti-Drug Abuse Acts of 1986 (Pub L No. 99-570, 100 Stat. 3207) and 1988 (Pub L No. 100-690, 102 Stat. 4181) emphasized harsh penalties such as mandatory minimum sentencing guidelines, under the rationale of keeping the public safe from drugs. A host of state and local policies, such as statutes banning drug offenders from residing in public housing or from receiving certain types of public benefits and services, followed suit.¹⁹ Often the question of “safety for whom?” must be asked in trauma-informed policy analysis, because many policies may privilege the safety—in rhetoric if not in actual outcome—of one group at the expense of the well-being of another. The philosophy of the US war on drugs suggests a prioritizing of the safety of the general public and in particular of young people, who might be lured into drug use, over the safety of drug users; arguably it has preserved the safety of neither, as drug use and sales have not appeared to decrease in response to these policies.^{24,25}

More recent drug policy developments move toward the notion that drug user safety is public safety, with greater emphasis on prevention, treatment, and recovery support over arrest and incarceration. For example, the 2014 National Drug Control Strategy

highlights community-level prevention strategies, early intervention, and expanded access to drug treatment via provisions in the Affordable Care Act (Pub L No. 111-148, 124 Stat. 119), while calling for a “smart on crime” approach to the enforcement of drug laws.²⁶ The strategy also calls for policy action to address immediate dimensions of drug user safety, such as expanding access to naloxone to prevent opioid overdose.

This shift in drug policy from a hardline, no tolerance philosophy to a harm reduction and recovery-oriented approach is largely consistent with the trauma-informed principle of enhancing safety for the vulnerable. Safety in drug policy could be further promoted through more explicit attention to the disparities in drug-related arrests and incarceration that continue to threaten the safety and well-being of particular groups of drug users. For example, it is well known that African Americans in urban areas are far more likely than are other groups to be arrested and incarcerated for drug-related crimes, despite comparable rates of drug use.²⁴

Incarceration is strongly associated with trauma in terms of the prevalence of violence and abuse in correctional settings and the family disruptions that occur when a family member is incarcerated.^{27,28} Therefore, strengthening safety in drug policy should include actions to reduce sentencing disparities and improve support for all drug users. One starting point would be to eliminate the sentencing standards under which harsher penalties are incurred for possession of crack cocaine versus powder cocaine, a disparity that has disproportionately affected African Americans.²⁹ This sentencing gap was substantially reduced but not eliminated by the 2010 Fair Sentencing Act (Public Law 111-220).

Trauma is also a concern for ex-offenders returning to their communities following incarceration, because they often struggle to secure stable housing and employment and may return to lifestyles that include violence, drug use, and high-risk survival behaviors such as trading sex for money.^{30,31} Trauma-informed drug policy should therefore include measures to support individuals transitioning from prisons and ensure that they have access to basic social safety net programs. For example, 13 states permanently prohibit

individuals convicted of drug felonies from accessing Supplemental Nutrition Assistance Program (SNAP) benefits, whereas 19 other states have partial bans.³² To be more trauma informed, drug policy should address such prohibitions and increase formerly incarcerated individuals' access to health and safety net programs that can support their recovery and well-being.

Trustworthiness and Transparency

In social policy, trustworthiness is tied to the transparency of the policy's intended goals or outcomes and the procedures by which these goals will be attained. Several factors have historically and presently limited transparency and trust in social policy. One is the notion of the street-level bureaucrat, the idea that the individual workers who administer public services exert considerable influence on how these benefits and services are distributed, effectively shaping policy through daily interactions.³³ Because of numerous structural challenges, including limited training and high caseloads, worker-client interactions in human services are typically characterized not by trust and transparency but by stigma and fear, often preventing eligible persons from seeking services in the first place.³⁴

This problem may be especially acute for policies targeting highly vulnerable and traumatized populations, such as survivors of IPV. For example, the Family Violence Option of the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (Pub L No. 104-193, 110 Stat. 2105) was created to address the economic needs of individuals experiencing IPV. This enabled states to screen for violence, waive federal requirements pertaining to work requirements and time limits on receiving Temporary Assistance to Needy Families (TANF) benefits, and refer individuals to community services. However, research indicates that women experiencing IPV tend to consistently distrust frontline caseworkers, who have limited training on this issue, thus underreporting violence and failing to receive potential benefits under this policy.³⁵

Increasing trust in social policy should include efforts to enhance the training of frontline workers and more clearly articulate and monitor the role and nature of worker

discretion in policy implementation.³⁶ Making the Family Violence Option more trauma informed would involve fostering an environment that encourages disclosure of IPV.³⁷⁻⁴⁰ The keys to creating such an environment of trust involve building good rapport with clients, ensuring and maintaining confidentiality, explaining the benefits of disclosure, asking clients about abuse, defining domestic violence broadly, using open-ended questions as well as behaviorally anchored questions, avoiding questions that may be stigmatizing, and providing multiple opportunities for disclosure.³⁶

Another factor limiting transparency in social policy is the widespread trend toward devolution in many policy areas. Devolution has allowed states more autonomy in policy design and implementation, including the ability to waive certain regulations for some federal policies. The Family Violence Option is also a good example of devolution hindering transparency, because not all states have chosen to implement this option and even when they do, there are implicit ambiguities about the definition of IPV as well as the information regarding this option. Devolution makes the goals and outcomes associated with the Family Violence Option less transparent because of the significant variation in implementation from state to state. For example, in Louisiana, the policy requires screening for domestic violence, referral to counseling services, and temporary waivers for TANF requirements, but there is no clear guideline or written policy regarding how eligibility should be determined.^{41,42}

Making the Family Violence Option more transparent, and thus trauma informed, would involve creating objective criteria for eligibility at the national level. The notion that individuals would have access to key benefits and services depending on which state they live in and which frontline worker they work with not only is nontransparent but also breeds mistrust that acts as a barrier between policy and its implementation.

Collaboration and Peer Support

Trauma-informed social policy can embody collaboration and peer support in the extent to which the policy prioritizes the indigenous knowledge and experiences of the policy's target population, in addition to

or instead of outside professional expertise. This principle is highly relevant to the issue of CHWs in health care policy. CHWs are members of the communities in which they work and deliver a variety of health-related services, from providing social support to advocating alongside other community members to address issues of poverty, racism, and other inequalities that drive health disparities.⁴³ The Affordable Care Act included funding structures to promote the role of CHWs in addressing health disparities in underserved communities through health education, outreach, and linkage to care.⁴⁴ Several states have enacted legislation to improve workforce development, working conditions, and job security for CHWs. For example, in 2010 Massachusetts passed legislation establishing a CHW-led certification board to create standards for best practice, continuing education, and training.⁴⁵

Integrating CHWs into health care practice alongside nurses, doctors, and other professionals is a clear example of how policy can promote indigenous knowledge to improve health outcomes, particularly for minority groups affected by health disparities.⁴⁶ This may have implications for addressing trauma and improving trauma care, especially as CHWs are integrated into mental health care teams.⁴⁷ However, policies promoting CHWs are not without their areas of contention. Efforts to regulate, standardize, and certify the work of CHWs may ultimately serve as barriers to entry for some individuals who have knowledge to contribute but may resist or lack the savvy to navigate the standards imposed. One can imagine a future in which CHWs function not as integral community members possessing local expertise but simply as a category of licensed paraprofessionals.

To be truly collaborative and trauma informed, it is therefore critical that developments in CHW policy be led largely by CHWs themselves. The account of Mason et al. of how the Massachusetts Department of Public Health collaborated with the Massachusetts Association of Community Health Workers to establish the certification board provides an example of how this collaboration might take shape. The authors noted that the policy success was achieved only through

the power of authentic collaboration, based on respect for the authority and necessity of community health workers to define their needs and determine the viability of different policy alternatives to advance the field.^{45(p2215)}

It may be beneficial for professionals with policy expertise to engage in capacity building with CHWs as well as with the populations that are their clientele (and the potential future CHWs among them) to promote their full participation in the different phases of the policymaking process.

Empowerment

The principle of empowerment may be reflected by the processes through which the policy is created as well as the policy objectives. Policymaking processes can be broadly characterized as reflecting both top-down and bottom-up elements, the latter referring to the active involvement of stakeholders who are directly affected by the target problem or issue in shaping the policy.^{16,48} Bottom-up policymaking is a compelling vehicle for empowerment. One policy area in which this principle is critical is HIV/AIDS policy.

The history of the HIV/AIDS epidemic in the United States includes many policy shifts. The first decade of the epidemic saw the rise of AIDS activist groups, such as the prominent AIDS Coalition to Unleash Power (ACT-UP). From New York City's lack of affordable housing for AIDS-affected individuals to the clinical trial guidelines at the National Institutes of Health, ACT-UP boldly (and often successfully) challenged the policies they perceived as not responsive to the needs of people living with AIDS.⁴⁹ Throughout its activism, the group popularized the slogan "nothing about us without us," demanding a voice in AIDS-related policy from the bottom up.

From a trauma-informed perspective, it is critical that empowerment in social policy reflect not only a rhetoric of liberation but actual shared power in terms of extending decision-making ability to the target populations of social policies. The legacy of ACT-UP is evidenced in the process through which the United States' first National HIV/AIDS Strategy was created, reflecting notable indications of shared power. In the early stages of the strategy's development in 2009, the White House Office on National AIDS

Policy held community policy discussions attended by more than 4000 people in 14 cities across the United States and solicited online written recommendations, a process that provided a broad constituent base with meaningful opportunities to help shape the policy.⁵⁰ The resulting national strategy included elements such as explicit support for needle exchange programs for injection drug users, an evidence-based prevention intervention long endorsed by many HIV-affected communities but for which federal political support was previously largely lacking.^{50,51} The strategy's implementation is now guided in part by the Presidential Advisory Council on HIV/AIDS, a diverse group that includes individuals living with HIV/AIDS.⁵²

Although the processes that created the National HIV/AIDS Strategy can be described as empowering, promoting genuine empowerment through HIV/AIDS policy objectives continues to be challenging. HIV policy, including the National HIV/AIDS Strategy, often emphasizes the idea of empowering vulnerable populations with knowledge, testing, and access to care. The seek-test-treat model has encompassed many significant advancements in HIV prevention and care, but it is unlikely to eliminate the spread of HIV unless the epidemic's structural drivers are also addressed.^{53,54}

To provide 1 example, although the National HIV/AIDS Strategy cites research documenting that homelessness and housing instability are associated with increased HIV risk behaviors and poorer HIV care outcomes, there has not been an adequate federal commitment to housing support for HIV-positive or high-risk HIV-negative groups, despite analysis suggesting that HIV-related housing assistance is a cost-effective intervention.⁵⁵ Trauma-informed HIV/AIDS policy would build on the groundwork of the National HIV/AIDS Strategy to actively address the structural conditions—including poverty, homelessness, discrimination, and mass incarceration—that are closely linked to both the occurrence of trauma and the perpetuation of the HIV/AIDS epidemic.^{56,57}

Choice

Promoting choice to the greatest extent possible has been recognized as a principle of

strengths-based social policy¹⁶ and is key to the trauma-informed policy perspective. Choice is a particularly salient concept in the area of food policy, as people make dozens of food-related choices on a daily basis and the ongoing cumulative effects of these choices have profound health impacts. Food policy, and specifically policies and programs designed to address hunger and food insecurity, have attempted to shape, expand, or contract food choices in various ways.

Basic food security safety net programs such as SNAP are trauma informed in that they are relatively easy to access and enable an individual to make a variety of food choices, because SNAP benefits can be used at many different types of establishments to purchase a broad (albeit not limitless) range of goods. Although several states have applied for waivers to further restrict SNAP recipients' choices, for example by excluding the purchase of soft drinks or other high-sugar beverages, historically these requests have been denied by the US Department of Agriculture.⁵⁸ Preserving the flexibility of the SNAP program is consistent with a trauma-informed approach.

The question of what conditions constitute meaningful choice is critical to social policy. The food choices of SNAP recipients, for instance, are limited if individuals encounter barriers to using their benefits. One example is that of food deserts; food choice remains restricted even for individuals with adequate resources if grocery stores are not easily accessible because of geographic distance, transportation barriers, or neighborhood crime and violence.⁵⁹ Another type of barrier exists for people who are homeless or unstably housed; these individuals rarely have access to facilities to store and prepare food and must rely on a patchwork strategy of purchased prepared foods, scavenged or stolen foods, and free meal programs.^{60,61}

To be more trauma informed, food policy should take action to remove barriers to food choice, for example by supporting mobile produce markets, working with convenience store owners to make more healthy foods available, or providing tax incentives for full-service grocery stores in food desert areas. Importantly, physical access is only 1 dimension of choice. Food policy must also strive to address the intersection of food insecurity with other social problems—such as

homelessness, poverty, family violence, and mental health issues—and how such intersections affect particular groups. For example, policy efforts to improve food security for homeless individuals might include support for innovative food outreach programs, such as community garden and community kitchen programs in which homeless people have the opportunity to participate in food production and preparation, along with concomitant action to address housing security.⁶⁰

Other research demonstrates an association between food insecurity, IPV and other types of violence, and depression for mothers of young children.^{62,63} Policies are therefore needed to address food insecurity in this syndemic context for low-income mothers. A starting point may be linking services and screenings for mental health, violence recovery, and food assistance, although ultimately the systemic inequalities that underlie food insecurity and gender-based violence must also be addressed.⁶³

Intersectionality

For social policies to be trauma informed, they need to take into account what Collins defines as intersectionality: “an analysis claiming that systems of race, social class, gender, sexuality, ethnicity, nation, and age form mutually constructing features of social organization.”^{64(p299)} This intersectionality must allow an understanding of discrimination, privilege, and human rights violations that occur as a consequence of the combination of the identities to which an individual may subscribe. For example, an undocumented immigrant from a low-income family in the Middle East may be discriminated against on the basis of race, ethnicity, social class, gender, and nationality. In addition to being a stressor with broad mental health implications, research indicates that instances of “everyday” discrimination and microaggressions related to multiple marginalized identities are significant predictors of posttraumatic stress.⁶⁵

Trauma-informed policies can address intersectionality by taking measures to prevent overt discrimination, for example through legislation such as the Civil Rights Act (Pub L No. 88–352, 78 Stat. 241) or the long-sought (yet to date unpassed) federal

Employment Non-Discrimination Act, and by addressing the structuring and social determinants of trauma. The social problems we have highlighted—including drug use, IPV, HIV/AIDS, and food insecurity—are evidenced across many segments of society yet disproportionately affect certain groups in terms of both prevalence and consequences. This notion of disproportionate impact is encapsulated in recent research and policy attention to health disparities.

To be trauma informed, policy should aim to address disparities regarding any health issue as close to the roots as possible, and not only in terms of more downstream indicators. For example, ideally HIV/AIDS policy should recognize and address factors influencing the persistently high prevalence of HIV among transgender women of color⁶⁶—such as widespread transphobia and the stigmatization of transgender identity within the context of racism and classism—and not target only disparities in access to care for this population. Trauma-informed policy should also make efforts to ameliorate the stigma associated with accessing some social programs, such as SNAP benefits or methadone treatment, recognizing that being the recipient of certain benefits and services can constitute its own marginalized identity and be a barrier to access.^{67,68}

In addition, it is important for policy to address the notion of historical trauma, “defined as cumulative emotional and psychological wounding across generations . . . which emanates from massive group trauma.”^{69(p283)} Historical trauma reflects the reality that policies themselves are sometimes the source of great trauma. Past policies—such as the collection of laws that inflicted genocide, displacement, and cultural erasure on indigenous Americans or that denied the humanity of African Americans through slavery and legalized discrimination—continue to affect the individual and community health of marginalized groups today.

Some such policies—such as the practice of removing Native American children from their homes and placing them in boarding schools or with non-Native foster families, or the urban renewal programs that decimated many African American urban neighborhoods in the 1950s—were endorsed in their eras by well-meaning health and social service professionals as being in the best interest of

these groups.^{70,71} Historical trauma is rarely directly acknowledged in policymaking. Today’s policies and policymakers would do well to recognize the impact of policies perpetuating historical trauma and apply this as a further reason to solicit the perspectives of marginalized groups in the policies that affect them so that the cycle of disempowerment and repeated trauma can be discontinued.

CONCLUSIONS

The trauma-informed care paradigm has diffused across a range of practice settings, reflecting the reality that trauma contributes to a multitude of health and social problems. We have provided a framework extending these principles to social policy. Policy is fraught with compromise, and just as trauma-informed social service programs may not fully actualize all principles of trauma-informed care at all times, it is unlikely that any single policy or article of legislation would fully reflect all the principles outlined in this framework. The framework instead provides a conceptual ideal whose aspects policies on the ground may reflect to varying degrees.

A commonality across all the principles of trauma-informed care is that their enactment implies a greater focus of attention and resources upstream in terms of the social determinants of health. Although there is a price tag attached to many of the upstream policy actions recommended by such analysis, it is possible that considerable financial savings—in addition to the prevention of human suffering—could be gained through policies that prevent trauma or mitigate its primary health consequences. Cost–utility analyses could be conducted of trauma-informed policy reforms in particular areas. Further analyses could use this framework to examine specific social policies in greater detail for their congruence with the principles we have outlined and to articulate directions for trauma-informed policy change. We believe that such subsequent analyses could yield valuable insight and directions for reform and implementation, whether applied to broad and expansive policies, such as the National Prevention Strategy, or more local and focused policies, such as university policies addressing sexual assault.

Perhaps the most important implication of the framework we have proposed is that it can serve as a basis for guiding policy advocacy. Public health professionals, especially those who work with trauma-affected populations and communities, should encourage social policy to integrate a trauma-informed focus. To shape policy so that it better reflects the realities of practice and lived experience, it is critical that policymakers hear directly from those on the ground, including service providers and service users.⁷² Therefore, trauma survivors, those who might be considered at high risk for trauma, and people who provide services to these populations can aim to educate policymakers about the importance of the principles of trauma-informed care and how social policies can manifest them. The current reality is that even service providers delivering the highest quality of trauma-informed care must draw their clients from and release them to a society and a social order that are largely not trauma informed. Trauma-informed policy advocacy offers an avenue for gradually shifting this reality.

Trauma and its repercussions are not equally distributed in society. Because marginalized populations are more likely to experience some types of current and historical trauma and generally have fewer resources with which to cope with trauma's negative effects, shaping policy to be more trauma informed may have an especially meaningful impact on disadvantaged communities. Public health practitioners may find community-based participatory research tools such as photovoice and community capacity-building strategies useful when engaging communities in evaluating policy shortcomings, generating trauma-informed policy alternatives, and advocating policy action.⁷³

Research interest in trauma and its consequences does not appear to be waning. With considerable recent media coverage, the link between trauma and many health and social problems appears to occupy a place of interest in the eye of the general public, researchers, and public health practitioners. 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. When social policy becomes more trauma

informed, it will be more participatory, transparent, and collaborative, and it will be better able to promote the safety and empowerment of its target constituents and, ultimately, disrupt trauma-driven disparities in health and well-being. **AJPH**

CONTRIBUTORS

E. A. Bowen and N. S. Murshid jointly conceptualized the article. E. A. Bowen led the writing and editing process, performing primary authorship of the introduction and discussion sections. N. S. Murshid contributed to refining the framework, elaborating on the 6 principles of trauma-informed care as applied to social policy, and editing the article.

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This work did not involve human participants; therefore, institutional review board approval was not required.

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