Evidence-Based Mental Health Treatment: A 25-Year Glance at Past, Present, and Future

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The 25th anniversary of the American Professional Society for the Abuse of Children (APSAC) calls us to reflect on how far mental health treatment for abused and neglected children and their families has come over this quarter century and the role of APSAC in shifting traditional thinking about children's mental health needs.

Advances in Treating Trauma

One of the most significant advances that has occurred over this time is the gradual move away from studying different types of abuse, trauma, and violence separately. It is now far more common for studies to assess a range of trauma and abuse experiences and the consequences of "polyvictimization" for child well-being (Turner, Finkelhor, & Ormrod, 2010). This shift has produced two of the key findings regarding trauma and its impact on children. First, trauma and abuse experiences are very common in the general population and even more common in clinical samples (Finkelhor, Hamby, Ormrod, & Turner, 2009; Copeland, Keeler, Angold, & Costello, 2007). Second, it is the accumulated burden of multiple traumas and adversities that is most predictive of negative outcomes, not the specific type or number of trauma experiences (Felitti et al., 1998). On the one hand, the good news is that not all children who have been exposed to trauma and abuse develop persisting mental health conditions (Bonanno, 2004; Bonanno, Westphal, & Mancini, 2011; Bonanno, Brewin, Kaniasty, & LaGreca, 2010; Copeland et al., 2007; Masten, 2001). On the other hand, there is a subset of children characterized by exposure to multiple forms of abuse and trauma and multiple adversities (e.g., insecure attachment, changes in living situation, parental incarceration, parental mental illness, and foster placement). These children are at the highest risk to develop persistent and severe behavioral and mental health problems, including trauma distress and depression (Felitti et al., 1998; Dube, Anda, Felitti, Chapman, Williamson, & Giles, 2001; Danielson, de Arellano, Kilpatrick, Saunders, & Resnick, 2005).

Twenty-five years ago there was scant empirical knowledge about the specific types of mental health interventions that would be most beneficial for children and families affected by abuse, violence, and neglect. Mental health professionals treating maltreated children would use their best judgment and clinical skills based on their training and experience in the field. They tended to use treatment approaches that were familiar and comfortable. For example, "treatment as usual" for abused children and their families in the late 1980s was not evidence-based (Chadwick Center for Children and Families, 2004). Sexual abuse treatment approaches originally developed out of the rape crisis movement that emerged in the early 1970s and established the conceptualization that the children were innocent victims who would likely suffer negative impacts. Mental health professionals who were active in APSAC during the early years were mostly involved with treating child sexual abuse (CSA) victims and their nonoffending parents. These treatments contained what we now consider the key elements of trauma-focused therapies, such as directly focusing on the CSA and addressing maladaptive cognitions. APSAC's interdisciplinary mission that promoted the coordinated system response emphasized child protection and holding offenders accountable through criminal prosecution. These two perspectives were highly compatible and likely related to the fact that CSA does not just involve parents as offenders.

In the past, physical abuse was not traditionally considered victimization but was viewed as a family problem and a failure of parenting. Physical abuse victims were not usually referred for mental health treatments because the impact of their experiences was not recognized. There was widespread recognition that the key for helping physically abused families was improving parenting. Consequently, interventions tended to be parenting programs that did not attend directly to the children's mental health. The treatment approaches were primarily didactic, involved voluntary support groups for parents, and rarely addressed the possibility that the child may have developed posttraumatic stress or depression. Again, it is likely that the interdisciplinary nature of APSAC helped promote the shift toward perceiving physical abuse as victimization, without abandoning the recognition that a focus on parenting is important.

The Role of APSAC Members

There has been tremendous growth in our field over the past 25 years developing and testing interventions for children and families affected by CAN. Treatment approaches are now conceptualized in terms of the target for clinical intervention and are based on well-accepted principles for bringing about change. Currently, we have sophisticated randomized clinical trials and proven interventions for the impact of traumatization (e.g., posttraumatic stress, depression), behavior problems in abused children, bonding-attachment disruptions, physically abusive families, and neglecting families. Some of the seminal empirical studies of trauma-specific and abuse-specific treatments were published in *Child Maltreatment* and other scientific journals in the mid-1990s and involved APSAC members (Cohen & Mannarino, 1996; Cohen & Mannarino, 1998; Lanktree & Briere, 1995; Berliner & Saunders, 1996; Kolko, 1996b), many of whom had served on the Board and as prior Presidents. A new generation of APSAC-affiliated researchers is now refining evidence-based treatments (EBTs) for this population and evaluating enhancements to EBTs (e.g., Rochelle Hanson, Monica Fitzgerald, Shannon Dorsey, Michael deArellano, Elissa Brown).

APSAC has clearly played a key role in the evolution of the field. Many of the most influential researchers in this area have been active APSAC members and Board members, such as David Finkelhor, Ben Saunders, Judy Cohen, Tony Mannarino, Esther Deblinger, Howard Dubowitz, Diane DePanfilis, Des Runyan, David Kolko, Elissa Brown, Rochelle Hanson, Mark Chaffin, Beverly Funderburk, Dee BigFoot, Anthony Urquiza, Cindy Swenson, Barbara Bonner, John Briere, Steven Ondersma, and many others. APSAC efforts to advance knowledge of CAN and skills have been achieved through product development and dissemination for its publications, educational colloquiums, and training and consultation activities. The annual APSAC Colloquium provides a platform for disseminating knowledge to an interdisciplinary audience. *The APSAC Handbook,* which is in its third edition, has summarized the empirical research on prevalence, impact, and interventions and is a widely used and highly regarded text. *Child Maltreatment* is a scientific journal for CAN-related research and is now the premier journal in the field. The *APSAC Advisor* is a quarterly news journal that provides data-based, practice-oriented articles that keep professionals informed of the latest developments in policy and practice, and APSAC's interdisciplinary guidelines task forces regularly develop data-based Practice Guidelines on key areas of the field. APSAC's cross-disciplinary approach affords the opportunity for other key professionals such as medical providers, child advocates, child protection, law enforcement, and prosecution to become aware of effective interventions for the children and families and to serve as brokers with their communities for policy changes to increase availability of evidence-based treatments.

Current State of the Field

In 2012, the prevalence and negative impact of child abuse and neglect (CAN) on children's mental health and behavioral, cognitive, and interpersonal functioning is better understood by professionals serving children in medical, community, and mental health child-service setting than it was 25 years ago. This is due to a large body of empirical knowledge based on increasingly rigorous methodologies that has accumulated over this period. We now have general population epidemiological surveys of the children, their caregivers, and adults (Finkelhor et al., 2009; Finkelhor, Turner, Ormrod, & Hamby, 2010; Copeland et al., 2007; Felitti et al., 1998). Prospective studies of birth cohorts (Jaffe, Caspi, Moffit, Taylor, Polo-Thomas, & Arsenault, 2007; Briggs-Gowan, Carter, & Ford, 2012) and samples of abused children and carefully matched controls (Widom, 1999) have allowed conclusions to be drawn about abuse-specific impacts. Prospective investigations with high-risk and abused samples, such as *Longitudinal Studies of Child Abuse and Neglect* (*LONGSCAN*; http:www.irpc.unc.edu/longscan), have provided the opportunity to measure impacts over time (Widom, Dumont, & Czaja, 2007; Putnam & Trickett, 1993). In addition, there have been many studies conducted examining the effects of CAN and various aspects of child welfare system intervention on children. Numerous studies have documented the high rates of mental health and behavioral problems in child-welfare-involved children (Leslie, Hurlburt, James, Landsverk, Slymen, & Zhang, 2005), and the lack of mental health services delivered to this high-need population (Landsverk, Burns, Stambaugh, & Reutz, 2009).

As knowledge has clarified the variability in the effects of CAN on children and families, the need for standardized methods of assessing impacts has emerged. APSAC has played an important role in bringing attention to the dearth of, and need for, evidence-based standardized assessments in the field to carefully assess abuse and trauma-related consequences to guide case conceptualization, treatment planning, and monitoring of treatment progress. Several of the first measures that advanced the field were developed by APSAC members 20 years ago, such as the *Trauma Symptom Checklist for Children* (*TSCC*) by John Briere, PhD (a former APSAC Board member), was published in 1988 to evaluate posttraumatic symptomatology and other symptom clusters found in abused and traumatized children and adolescents. He continued working throughout the 1990s and developed a parent report assessment tool to learn about younger children's posttraumatic stress symptomatology (ages 3-12), the *Trauma Symptom Checklist for Young Children* (*TSCYC*, Briere, 2005). Another example of APSAC members' leadership in advancing mental health assessment is the work of Bill Friedrich, PhD, ABPP (prior Board member) who began developing the *Child Sexual Behavior Inventory* (*CSBI*) in the 1990s. The *CSBI* was published in 1997 and became the first psychometrically sound measure of sexual

behavior problems (e.g., boundary issues, sexual interest, self-stimulation, exhibitionism, sexual intrusiveness) in 2–12-year-old children (Friedrich, 1997). All of these measures continue to be widely used by practitioners today and have been translated into several other languages. An important use of these measures has been to assess treatment outcomes in treatment trials with abused and trauma-exposed children.

While the idea that standardized assessment of child and family problems is an essential first step for mental health treatment has taken hold, routine screening for trauma exposure and abuse-related conditions (e.g., posttraumatic stress, depression, anxiety, behavior problems) is uncommon in most mental health, medical, social service, and school settings (Farmer, Burns, Phillips, Angold, & Costello, 2003; Costello, Pescosolido, Angold, & Burns, 1998; Jaycox, Morse, Tanielian, & Stein, 2006). This is problematic because children tend not to report trauma or abuse experiences unless they are directly asked using specific questions. The high rates of polyvictimization in childhood (Finkelhor et al., 2010; Finkelhor et al., 2009) call for professionals to ask about several common types of victimization (beyond the primary referral abuse-trauma type) when assessing trauma exposure, including physical abuse by caregivers, sexual assaults and victimization, violence witnessed inside and/or outside of the home, death of a family member, natural disasters, and accidents. The evidence is strong that children and families respond to routine screening, especially when it is accompanied by strategies including normalizing exposure and associated symptoms, addressing common misconceptions, and providing validation and support. This approach to assessment facilitates open communication about trauma, communicates clinician comfort in discussing difficult events, minimizes child avoidance, and incorporates gradual exposure to talking about the trauma in a safe environment.

Beyond learning whether children have experienced trauma or abuse, it is a necessary prerequisite for effective treatment to determine the specific psychological impact so that treatment can be matched to the individual child and family situation. In addition to conducting a clinical interview, it is now recommended that clinicians consider using psychometrically sound assessment checklists. According to Kazak et al. (2010), standardized assessment achieves three critical aims: (1) accurate identification of children's problems and disorders, (2) ongoing monitoring of response to interventions, and (3) evaluation of outcomes.

Mental Health Treatment in an Evidence-Based Era

One of the major movements that has taken place with regard to mental health treatments in the past 2 decades is the advent of evidence-based interventions (EBT) as the recommended standard of care. EBT are intervention programs that have been shown to have overall better results compared to nonspecific or alternative interventions. Interventions may have varying levels of evidence and it may be useful to consider evidence-based outcomes from a dimensional continuum versus a categorical perspective (Weisz & Kazdin, 2010).

In addition to its role in helping develop sound assessment measures, APSAC has been a key player in the development of evidence-based mental health practice (EBP) for children affected by CAN. APSAC members were among the first researchers to rigorously test treatments targeting mental health and behavioral problems commonly displayed by abused and neglected children using sophisticated randomized control designs. As a national organization, APSAC has emphasized the importance of an evidence-based-practice approach to serving children in the varied settings we work within (e.g., social service, mental health, legal, and medical) to support APSAC's vision of "a world where all maltreated or at-risk children and their families have access to the highest level of professional commitment and service."

This principle applies to all aspects of CAN intervention from child abuse medical evaluations to forensic interviews to mental health interventions. In 2010, we refined our mission statement to reflect our evidence-based values: APSAC's mission is to "support professionals who serve children and families affected by child maltreatment and violence through providing expert training and educational activities, policy leadership and collaboration, and consultation that **emphasizes theoretically sound, evidence-based principles"** (www.apsac.org).

There have been substantive advances in developing and testing psychosocial treatments improving CAN-related child and family outcomes. There are three primary targets for mental health interventions: (a) child psychological-mental health difficulties (e.g., posttraumatic stress, depression, and anxiety), (b) child behavioral problems (e.g., oppositionality, defiance, and sexual behaviors), and (c) ineffective and harmful parenting behaviors and parent-child interaction (e.g., emotionally and physically harsh, coercive, abusive, and/or neglectful). In some cases all three targets may be addressed by a single intervention, whereas in other cases, separate interventions may be necessary. Determining the priority target and intervention approach is based on a systematic, abuse-focused assessment process.

Many organizations and other resources provide information on effective interventions. The best known Web resource that enumerates evidence-based interventions and provides detailed descriptions of their research outcomes and readiness for dissemination is the National Registry of Evidenced-Based Programs and Practices (NREPP) (www.nationalregistry.samhsa.gov), supported by the Substance Abuse and Mental Health Services Administration. Another such resource is the California Evidence-Based Clearinghouse for Child Welfare (CEBC) (www.cebc4cw.org/), a Web site providing child welfare professionals a forum where information and research data regarding evidence-based practices (EBP) relevant to child welfare are available. The National Child Traumatic Stress Network (http://www.nctsn.org/) is a specific resource for trauma-focused interventions.

Interventions for the Impact of Traumatic Events (Posttraumatic Stress, Depression, Anxiety)

Interventions that directly target the trauma or abuse experience and are based on the principles or contain the components of cognitive behavioral treatments have the greatest evidence for effectiveness. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT; Cohen, Mannarino, & Deblinger, 2006; Deblinger & Heflin, 1996; www.musc.edu/tfcbt) is a specific version of trauma-focused therapy that has been subjected to extensive empirical testing. It has been found effective with children of all ages (3–18 years), multiple types of trauma experiences, both genders, and various ethnic and racial backgrounds and is currently the most widely disseminated trauma-specific intervention in the field (Silverman et al., 2008). TF-CBT is a family-focused approach, as nonoffending caregivers and children are included equally in this intervention. Briere and Lanktree (2011) have recently published a description of a comparable approach targeting adolescents with complex trauma. This model pays specific attention to addressing the context and safety considerations for adolescents. There is also an effective school-based intervention available called Cognitive Behavioral Intervention for Trauma in Schools (CBITS; Jaycox, 2004; http://cbitspro gram.org/). CBITS is a skill-oriented, structured group-based trauma-focused intervention delivered in schools that incorporates educators and other school staff.

The primary components of CBT for CAN focus on (a) providing corrective information about CAN/trauma, (b) building child and parent coping skills to manage stress and regulate emotional distress effectively, (c) improving caregiver understanding of the child's CAN/trauma experiences and responses and the caregiver's optimal response to these, (d) achieving mastery over trauma-related memories and reminders reducing traumatic avoidance through the use of gradual exposure throughout treatment and specific exposure to the trauma memory, (e) cognitive processing to help children and families make meaning and contextualize the traumatic experiences through cognitive restructuring, and (f) enhancing safety to optimize future developmental outcomes.

Interventions for Disruptive Behavior and Parenting Problems

Effective interventions for child behavior problems are primarily behavioral and cognitive behavioral. They target changing environmental contingencies and teach parents and caregivers to respond to child behavior in more effective ways. The same principles apply to addressing the coercive, ineffective, and violent parenting practices that are associated with CAN. In addition, parenting interventions enhance parent-child relationships, promote secure attachment and bonding, and lower parental distress. Many of these interventions are brand named, which means that they have a particular packaged version of delivering the standard treatment elements. All of them contain common basic ingredients: increasing positive one-on-one time with children, selective attention that involves attending to positive behaviors and ignoring minor negative behaviors, setting reasonable expectations, and consistently following through using rewards and nonviolent consequences. Some interventions are fully parent-mediated, whereas others may involve parents and children together learning the new skills.

Parent-Child Interaction Therapy (http://pcit.phhp.ufl.edu/) is a well-established intervention that has been used extensively in CAN situations (Timmer, Urquiza, Zebell, & McGrath, 2005; Chaffin, Funderburk, Bark, Valle, & Gurwitch, 2011) and has specific evidence for its effectiveness in reducing subsequent child

maltreatment reports (Chaffin et al., 2004; Chaffin et al., 2011). PCIT has a unique delivery vehicle in that parents receive live coaching via a bug in the ear to practice their new skills. It is designed for younger children, although it is effective in reducing future child abuse reports for children up to age 12 who do not have serious behavior problems. Triple P (http://www.triplep-america.com) is another well-established parent management intervention that has been found to reduce child abuse reports. Triple P has levels of intensity of intervention from community awareness campaigns to brief focused behavior management to standard individual and group versions. The Incredible Years and the Parent Management Training—Oregon Model (PMTO) (www.incredibleyears.com; http://www.isii.net/index.html) are also well-established parent management interventions that have been used with CAN.

Multidimensional Treatment Foster Care–Adolescent (MTFC–A) (www.mtfc.com) and the young child version Multidimensional Treatment Foster Care–Preschool (MTFC–P) (Fisher, Kim, & Pears, 2009) are intensive parent management interventions for severely disturbed children and adolescents who require out of home placement due to behavior problems and/or severe delinquency. The foster parent serves as the therapeutic agent and is supported by a consultant who helps develop the behavior management plan and provides support and consultation carrying out the plan as well as additional therapies that may be needed. This intervention has been proven effective reducing outcomes such as runaways, criminal referrals, self-reported criminal acts, and fewer days in locked settings and associations with delinquent peers.

There are two tested interventions for young children that are primarily based on attachment theory and use a more reflective and interpretive approach than parent management training. Child Parent Psychotherapy (CPP) (Lieberman & Van Horn, 2005) was developed for situations in which young children (ages 0–5) were exposed to domestic violence. CPP emphasizes the importance of treating mental health problems within the context of the parent-child relationship to enhance parental responsiveness, attunement and consistency to their children. The trauma experience is directly addressed and processed jointly. Attachment and Bio-behavioral Catch-up (ABC) (Dozier, Lindhiem, & Ackerman, 2005) takes a similar approach to promoting secure attachment and nurturance via increasing parental or caregiver responsiveness in physically neglectful families with young children (ages 0–5), and also has a component increasing children's regulatory capabilities. Both have growing evidence supporting their effectiveness.

Combined Interventions

There are several interventions that are designed specifically to address child physical abuse situations that involve both children and parents. These interventions are cognitive behavioral or incorporate cognitive behavioral principles. Alternatives for Families Cognitive Behavioral Therapy (AF-CBT; www.afcbt.org) is a short-term intervention for physically abusive parents and children ages 5–15 years; some sessions are child only, some parent only, and others are conjoint. Because there has been violence in the relationship, safety planning and routine assessment of the use of force, hostility, and coercion are incorporated. It includes the standard CBT components of psychoeducation, including information about violence, teaching both children and parents skills for emotional regulation (especially anger), teaching positive parenting, and teaching both parents and children useful skills such as problem solving and communication. A unique component is the clarification process in which the parents explicitly take responsibility for the abuse and make amends to the child for the abuse. AF-CBT has shown to improve family functioning and reduce child-to-parent aggression, child behavior problems, parental abuse risk, and re-abuse among physically abusive parents (see Kolko, 1996a, 1996b, 2002; Chalk & King, 1998). A group version called Combined Parent-Child Cognitive Behavioral Therapy (CPC-CBT) (http://www.caresinstitute.org/services_parent-child.php) has also been tested for physically abusive parents and at-risk parents (Runyon, Deblinger, & Steer, 2010). In this model, the children and parents meet in separate groups initially and then later conjointly. This intervention also includes the children doing a trauma narrative as part of the clarification process. It has been shown to decrease posttraumatic stress as well improve behavior problems and reduce later violence.

Multisystemic Therapy for Childhood Abuse and Neglect (MST-CAN) (Swenson, Schaeffer, Henggeler, Faldowski, & Mayhew, 2010) is a child abuse specific version of MST, a multi-component intervention for treating youth ages 6–17 with serious behavior and conduct problems. It is a structured package of specific strategies based on a functional analysis of the child abuse behavior. Some of the intervention strategies involve environmental interventions (e.g., school, separation from deviant peers), whereas others are based on CBT and parent management training principles. MST-CAN has been shown to be effective in reducing behavior problems, improving child functioning and reducing future child abuse reports (http://www.mstcan.com/).

The Science–Practice Gap

Clearly, there have been substantive advances in psychosocial treatments for youth affected by child maltreatment and trauma over the past 25 years. However, despite the fact that effective EBTs exist for maltreated and trauma-exposed children, few children receive these treatments (Chadwick Center for Children and Families, 2004). The wide gap between science and practice is not unique to the CAN/child trauma field. For example, the Institute of Medicine (2001) found that there is a 17-year lag for scientific knowledge generated in randomized clinical trials to be routinely incorporated into everyday medical practices across the nation, and other research has highlighted the limited effective-

ness of services delivered "as usual" in community mental health settings (McLennan, Wathen, Macmillan, & Lavis, 2006; Weiss, Catton, & Harris, 2000; Weisz, Donenberg, Han, & Weiss, 1995). In 2004, the Kauffman Foundation and the Chadwick Center initiated the Kauffman Best Practices Project, and leading researchers and clinicians in the child abuse field joined a working group led by Ben Saunders, PhD (APSAC member and former Board member), to brainstorm ways to address the fundamental systems changes needed to close the chasm between best care and everyday care (Chadwick Center for Children and Families, 2004).

Some of the leading reasons for the lack of EBT adoption include the following: mental health providers' misconceptions about the applicability of practices; inertia and resistance to change; lack of effective training and ongoing education in EBT; lack of support, resources, and infrastructure; and lack of leadership among administrators, program managers, and supervisors in championing the use of ESTs and working to overcome administrative barriers (Chadwick Center for Children and Families, 2004; Fixsen, Naoom, Blasé, Friedman, & Wallace, 2005; Torrey et al., 2001). In addition, "brokers" of service (e.g., child welfare staff, Guardian ad Litems, victim advocates, and medical and educational service staff) also play a critical role in adoption of EBT because they identify and refer trauma-exposed children to treatment and ensure that they receive needed services. Unfortunately, brokers of service are often unfamiliar with EBTs and often view all mental health approaches as the same (Chadwick Center for Children and Families, 2004).

APSAC: Looking Forward in Mental Health

In the past 25 years, we have made incredible gains in our ability to identify and effectively treat the impact of child abuse and trauma. Recent clinical research on evidence-based assessment and treatment offers child service providers from multiple disciplines the tools needed to ensure children and their families are identified and provided the highest quality of mental health services. We now have well-developed, low-cost, or free standardized screening and assessment tools that provide comprehensive information about both trauma exposure and trauma-related mental health difficulties as well as research based clinical strategies for talking to children about abuse and trauma exposure.

Additionally, we have many highly effective, short-term psychosocial treatments that work for improving CAN-related child and family outcomes (child psychological–mental health difficulties, child behavioral problems, and ineffective and harmful parenting behaviors and parent-child interaction. Web-based resources provided by the CEBC, NREPP, and NCTSN help clinicians stay abreast of new treatments and development of promising practices in the field, and innovative clinical decision-making tools are now available to help clinicians select EBPs and track clinical progress (www.practicewise.com; Chorpita & Weisz, 2009; Weisz et al., 2011).

APSAC has led in the past and will continue to lead to improve the lives of children and families affected by abuse and violence and to increase workforce effectiveness and confidence in engaging and serving these families. APSAC has the opportunity to help lead and facilitate effective supportive implementation efforts in this country, such as by conducting learning collaboratives (http://www.nctsn.org/resources/training-and-education/learning-collaboratives; *The Breakthrough Series…,* 2003) to improve multidisciplinary professionals' ability to build community capacity to deliver high-quality mental health services to youth and families affected by abuse and trauma. APSAC also has a role in increasing awareness, knowledge, and training in evidence-based service planning for professionals working in child welfare, which begins first with favoring evidence-based interventions or services, evidence-based principles, and evidence-based service models (Stambaugh, Burns, Landsverk, & Reutz, 2007). Given the choice between selecting a well-supported evidence-based service (e.g., specific parent training programs) and relying on less supported models, service plans should favor the evidence-based service. The APSAC Task Force on Evidence-Based Service Planning in Child Welfare is currently developing Practice Guidelines for a new service planning perspective that we have called "evidence-based service planning" with families involved in the child welfare system. Other recent national efforts to pilot broker implementation models (e.g., Project FOCUS, Dorsey, Kerns, Trupin, Conover, & Berliner, 2012; Project BEST,

www.musc.edu/projectbest) have focused on improving the awareness of child trauma and evidence-based practice (EBP) among brokers (child welfare caseworkers, GALs) and brokers' ability to identify appropriate EBP referrals, and engage children and families with appropriate, evidence-based services. APSAC has an important opportunity to lead wide-scale efforts in raising awareness about the mental health impact of child abuse and trauma on children and their families, and in overcoming barriers to children and families receiving effective, evidence-based mental health interventions.

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