Greater Buffalo Trauma-Informed System of Care Community Plan

Trauma-Informed Community Initiative of WNY Coalition

Commissioned by:

Health Foundation for Western & Central New York
Investing in Better Health for People and Communities

2002-2012
10 YEARS

WHY IS THERE A NEED FOR EDUCATION AND TRAINING ABOUT THE EFFECTS OF TRAUMA, TRAUMA-INFORMED CARE, AND TRAUMA-SPECIFIC SERVICES IN THE GREATER BUFFALO AREA?

TRAUMA IS PERVASIVE — NATIONAL COMMUNITY-BASED SURVEYS FIND THAT BETWEEN 55 PERCENT AND 90 PERCENT OF ALL INDIVIDUALS HAVE EXPERIENCED AT LEAST ONE TRAUMATIC EVENT IN THEIR LIFETIMES. ON AVERAGE, INDIVIDUALS REPORT EXPERIENCING NEARLY FIVE TRAUMATIC EVENTS IN THEIR LIFETIMES.

According to The National Child Traumatic Stress Network, by age 16, approximately 25 percent of children and adolescents in the U.S. experience at least one potentially traumatic event.

The impact of trauma is very broad — it touches many areas of life not obviously or readily connected with the experience of trauma itself.

Trauma exposure increases a person's risk of experiencing a wide range of emotional, behavioral and physical health problems, including:

- **Higher rates of chronic disorders like cancer, diabetes, and cardiac disease among many others**
- **Depression**
- **Post-traumatic stress disorder**
- **Generalized anxiety**
- **Suicidal tendencies**

The total lifetime estimated financial costs associated with the number of confirmed cases of child maltreatment (physical, sexual and psychological abuse and neglect) in 2008 is estimated to be approximately **$124 billion.**

The lifetime cost for each non-fatal victim of child maltreatment in 2008 is estimated to be $210,102.

Trauma doesn't just affect victims — it deeply affects administrators, clinicians, and support staff working in human services.

Trauma is part of our social reality and should be regarded as a serious public health issue in need of attention.

Introduction

What is trauma? Who does it affect? How does it affect us? Why should we care?

Everyone, at one time or another, experiences stress. In fact, being 'stressed' is so common that many people do not realize the effect it could have on their physical and mental well-being, or when feeling stressed crosses over to being traumatized. When an individual experiences a situation that overwhelms his or her ability to cope, the event is said to be traumatic.

The adverse effects of trauma, especially trauma experienced as a child, have long been recognized as negatively affecting emotional well-being, increasing the likelihood of drug and alcohol use and abuse; school truancy and poor learning habits; and increasing the incidences of depression and anxiety. Recently, researchers have been able to demonstrate a direct link between trauma and physical well-being. Individuals who experience trauma are more likely to develop high blood pressure, diabetes, cardiac disease and other chronic ailments.

In late 2008, a small group of Health Leadership Fellows were interested in exploring how the community might develop a trauma-informed system of care. With the assistance of the Health Foundation for Central & Western New York, this small group has grown into a coalition of individuals from a wide range of organizations who are committed to the development and implementation of a *Greater Buffalo Trauma-Informed System of Care Community Plan.*

For more information about the Trauma-Informed Community Initiative of Western New York Coalition or the community plan, please contact:

THE INSTITUTE ON TRAUMA AND TRAUMA-INFORMED CARE
UNIVERSITY AT BUFFALO SCHOOL OF SOCIAL WORK
716.829.3745

CARE MANAGEMENT COALITION OF WESTERN NEW YORK, INC.
716.335.7500

Background

THE GREATER BUFFALO TRAUMA-INFORMED SYSTEM OF CARE PLAN BUILDS UPON WORK STARTED IN LATE 2008 BY A SMALL GROUP OF FELLOWS FROM THE COMMUNITY HEALTH FOUNDATION OF WESTERN AND CENTRAL NEW YORK (NOW THE HEALTH FOUNDATION FOR WESTERN AND CENTRAL NEW YORK) WHO WERE INTERESTED IN EXPLORING HOW THE COMMUNITY MIGHT PROVIDE BETTER TRAUMA-INFORMED SERVICES. THIS INITIAL GROUP INCLUDED JIM CASION, CEO, BAKER VICTORY SERVICES; KATE GRIMM, M.D.; AND DENNIS C. WALCZYK, CEO, CATHOLIC CHARITIES.

Over time, the membership in this loosely-organized volunteer group grew to become a coalition of representatives from Baker Victory Services, Catholic Charities, Buffalo Police Department, State University of New York at Buffalo Department of Family Medicine, The Institute on Trauma and Trauma Informed Care School of Social Work, State University of New York at Buffalo, Crisis Services, Care Management Coalition of WNY, Roman Catholic Diocese of Buffalo, American Red Cross, Child Care Resource Network, Network of Religious Communities, Every Person Influences Children, Boys & Girls Clubs of Buffalo and the Family Help Center.

In March 2010, the coalition, with the support of the Health Foundation, organized and hosted a two-day conference, "Trauma: A Public Health Crisis in Western New York," at the Erie County Medical Center that featured nationally-recognized experts in trauma Robert F. Anda, M.D. and Sandra Bloom, M.D.

At the conference, Dr. Anda spoke about the Adverse Childhood Experiences (ACE) Study, an ongoing collaboration between the Centers for Disease Control and Prevention and Kaiser Permanente. Led by Dr. Anda and co-principal investigator Vincent J. Felitti, M.D., the ACE Study is the largest scientific research study of its kind, analyzing the relationship between multiple categories of childhood trauma and health and behavioral outcomes later in life.[1]

Dr. Bloom presented information on the Sanctuary Model®, a theory-based, trauma-informed, evidence-supported whole culture approach that has a clear and structured methodology for creating or changing organizational culture.[2]

THERE IS AN UNMET NEED FOR EDUCATION AND TRAINING ABOUT THE EFFECTS OF TRAUMA...

Background

The conference attendance and community interest in the topic confirmed the coalition's belief that there is an unmet need for education and training about the effects of trauma, trauma-informed care, and trauma-specific services in the Greater Buffalo area. The group continued to meet in an effort to find a way to fulfill this need.

The March 2010 conference was followed in May 2011 with a SITCAP-ART educational session to members of the Buffalo Public Schools' Student Support Teams (SSTs). SSTs are social workers, counselors, and teachers who work with students with behavioral challenges. SITCAP-ART, recognized by the Substance Abuse and Mental Health Services Administration (SAMHSA) as an evidence-based practice, is a trauma intervention program for adjudicated and at-risk youth. SITCAP-ART, a modification of Structured Sensory Intervention for Traumatized Children, Adolescents and Parents, is based on structured sensory therapy, integrating sensory-based activities and cognitive-reframing strategies. The approach is grounded in the understanding that trauma is a sensory experience and that traumatic memories are experienced at a sensory level and must be reactivated in a safe environment in order to be moderated and tolerated with a sense of power and a feeling of safety.[3]

Encouraged by the excitement generated by the SITCAP-ART training, in August 2011, the coalition applied to the Health Foundation for funding to provide additional information about trauma-informed care and services, as well as training, to community organizations. While declining to fund the original proposal, the Foundation agreed to provide support for the development of a community-wide trauma-informed system of care plan.

What is Trauma?

TRAUMA IS UNIVERSAL. IT CAN IMPACT ANY PERSON REGARDLESS OF AGE, CULTURE, GENDER OR CLASS; IT DOES NOT DISCRIMINATE. WHEN AN INDIVIDUAL EXPERIENCES A SITUATION THAT OVERWHELMS HIS OR HER ABILITY TO COPE, THE EVENT IS SAID TO BE TRAUMATIC.

Traumatic stress can be caused by both acute and chronic situations.

Acute events include, but are not limited to, experiencing or witnessing:

- School shootings
- Gang-related violence
- Terrorist attacks
- Natural disasters (e.g., earthquakes, floods, tornados, hurricanes)
- Serious accidents (e.g., car or motorcycle crashes)
- Sudden or violent loss of a loved one
- Physical or sexual assault
- Bullying
- Out-of-home placement of children
- Divorce
- Medical procedures, hospitalization, surgery
- Suicide of a loved one, friend, or acquaintance
- Institutional re-traumatization
- Workplace harassment

Chronic traumatic situations are those that are repeated over long periods of time and can include:

- Physical abuse
- Long-standing sexual abuse
- Alcohol or substance abuse within the home
- Domestic violence
- Multiple medical hospitalizations, procedures, and surgeries
- Workplace harassment
- Wars and other forms of political violence
- Vicarious traumatization resulting from providing services to trauma survivors
- Slow pace of court system(s) that results in re-traumatization
- Malnutrition

Child Maltreatment

While certainly not the only source of trauma, child maltreatment is perhaps the most studied. According to The National Child Traumatic Stress Network (NCTSN), by age 16, approximately 25 percent of children and adolescents in the U.S. experience at least one potentially traumatic event. The effects of early childhood chronic or toxic stress (i.e. trauma) on behavioral health issues have long been established. The January 2012 American Academy of Pediatrics' technical report summarizes the growing evidence base that links childhood toxic stress to the subsequent development of unhealthy lifestyles (e.g., substance abuse, poor eating and exercise habits), persistent socioeconomic inequalities (e.g., school failure and financial hardship), and poor health (e.g. diabetes and cardiovascular disease).[4] These same unhealthy lifestyles contribute to costly health disparities in adults.

The total lifetime estimated financial costs associated with the number of confirmed cases of child maltreatment (physical, sexual and psychological abuse and neglect) in 2008 alone is estimated to be approximately $124 billion. The lifetime cost for each non-fatal victim of child maltreatment in 2008 is estimated to be $210,102.[5]

THE TOTAL LIFETIME ESTIMATED FINANCIAL COSTS ASSOCIATED WITH THE NUMBER OF CONFIRMED CASES OF CHILD MALTREATMENT IN 2008 ALONE IS ESTIMATED TO BE APPROXIMATELY $124 BILLION.

Child Maltreatment Risk Factors

A combination of individual, relational, communal, and societal factors contribute to the risk of child maltreatment. Risk factors are characteristics associated with child maltreatment — they may or may not be direct causes.

RISK FACTORS INCLUDE[6]

- **Caregiver lack of understanding of children's needs and/or child development**
- **Lack of parenting skills**
- **Caregiver history of child maltreatment in family of origin**
- **Substance abuse and/or mental health issues including depression in family**
- **Caregiver characteristics such as young age, low education, single parenthood, large number of dependent children, and low income**
- **Non-biological, transient caregivers in the home (e.g., mother's male partner)**
- **Caregiver thoughts and emotions that tend to support or justify maltreatment behaviors**
- **Family social isolation**
- **Family disorganization, dissolution, and violence**

Protective Factors

Fortunately, the literature also shows that some of the effects of childhood trauma can be prevented or ameliorated through the development of protective factors, trauma-informed care, and trauma-specific treatment.

Protective factors buffer children from being abused or neglected. These factors exist at various levels; however they have not been studied as extensively or rigorously as risk factors.[7]

PROTECTIVE FACTORS HELP TO BUILD RESILIENCY AND DECREASE THE PROBABILITY OF ALCOHOL, TOBACCO AND OTHER DRUG ABUSE LATER IN LIFE.

PROTECTIVE FACTORS INCLUDE

- **Good prenatal care**
- **A supportive and caring relationship with at least one adult**
- **Nurturing caregiver/parenting skills**
- **Stable family relationships**
- **Successful school experiences**
- **Access to health care and social services**
- **Safe environments**

What is Trauma-Informed Care?

Recognizing the centrality of trauma is key to establishing a multidisciplinary trauma-informed system of care; thus ensuring that service systems are not re-traumatizing already vulnerable populations. Trauma-informed systems provide an environment in which safety, trustworthiness, choice, collaboration, and empowerment are ensured so that re-traumatization can be avoided. In such an environment, one would ask, "What has *happened* to this person?" instead of "What is *wrong* with this person?"

Trauma-Informed Community Initiative of WNY Coalition members adopted the following definition of trauma-informed care in December 2011:

> **Care that is grounded in and directed by a thorough understanding of the physical, psychological, and social effects of trauma, and is informed by and acknowledges the role that trauma has played in people's lives.**

Trauma-informed care not only benefits clientele in the system. Evidence also suggests that service providers benefit from the approach. Greenwald et al., (2008) found that after receiving trauma intervention training, service providers reported decreased stress, increased empathy, and increased comfort and confidence when faced with a challenging case scenario.[8]

TRAUMA-INFORMED SYSTEMS PROVIDE AN ENVIRONMENT IN WHICH SAFETY, TRUSTWORTHINESS, CHOICE, COLLABORATION, AND EMPOWERMENT ARE ENSURED SO THAT RE-TRAUMATIZATION CAN BE AVOIDED.

Trauma-Specific Interventions

Trauma-specific interventions are designed specifically to address trauma and the consequences of trauma in the individual, and to facilitate healing.

Trauma-Informed System of Care

Trauma-Informed Community Initiative of WNY Coalition members adopted the following definition of a trauma-informed system of care in January 2012:

A TRAUMA-INFORMED SYSTEM OF CARE (TISC) IS A PROACTIVE, STRATEGIC APPROACH TO RECOGNIZING AND ADDRESSING THE IMPACT OF TRAUMA ON INDIVIDUALS, SERVICE PROVIDERS, AND THE COMMUNITY AS A WHOLE. TISC IS INCLUSIVE OF ALL COMMUNITY SECTORS AND COMMITTED TO PREVENTING GAPS IN SERVICE.

TISC recognizes both the long- and short-term impact of trauma, natural and man-made, and actively promotes a culture of sensitivity towards those who have experienced one or more traumatic events and towards those who provide care to those individuals.

A trauma–informed system of care consists of:

- **Coordinated, collaborative, and holistic care and services provided across all sectors that are informed by and responsive to the effects of trauma on individuals throughout their life cycles;**
- **The recognition that the effects of and responses to trauma, as well as individual needs, will vary between diverse populations within a community;**
- **The use of common definitions, language, and measures of evaluation and accountability.**

Greater Buffalo Trauma-Informed System of Care

Introduction

OVER THE PAST 15–20 YEARS, THERE HAS BEEN GROWING ACKNOWLEDGMENT OF SEVERAL INTERRELATED FACTS CONCERNING THE PREVALENCE AND IMPACT OF TRAUMA IN THE LIVES OF PEOPLE IN CONTACT WITH VARIOUS HUMAN SERVICE SYSTEMS, AND THE NEED FOR A SYSTEM OF CARE THAT RECOGNIZES AND INCORPORATES THE PRINCIPLES OF TRAUMA-INFORMED CARE.

The following is an excerpt from "Creating Cultures of Trauma-Informed Care: A Self-Assessment and Planning Protocol" by Roger D. Fallot, Ph.D. and Maxine Harris, Ph.D., Community Connections, April 2009:

Trauma is pervasive. National community-based surveys find that between 55 percent and 90 percent of all individuals have experienced at least one traumatic event. Individuals report, on average, that they have experienced nearly five traumatic events in their lifetimes. The experience of trauma is simply not the rare exception we once considered it to be. It is part and parcel of our social reality.

The impact of trauma is very broad and touches many areas in life. Trauma exposure increases the risk of a tremendous range of vulnerabilities: mental health problems like post-traumatic stress disorder, depression, excessive hostility, and generalized anxiety; substance abuse; physical health problems; interpersonal struggles; eating disorders; and suicidality, among many others. Trauma touches many areas of life not obviously or readily connected with the experience of trauma itself. This broad impact makes it particularly important to understand the less evident links between trauma and its sequelae.

The impact of trauma is often deep and life-shaping. Trauma can be fundamentally life-altering, especially for those individuals who have faced repeated and prolonged abuse and especially when the violence is perpetrated by those who were supposed to be caretakers. Physical, sexual, and emotional violence become a central reality around which profound neurobiological and psychosocial adaptations occur. Survivors may come to see themselves as fundamentally flawed and perceive the world as a pervasively dangerous place. Trauma may shape a person's way of viewing and being in the world; it can deflate the spirit and trample the soul.

Violent trauma is often self-perpetuating. Individuals who are victims of violence are at increased risk of becoming perpetrators of violence themselves. The intergenerational transmission of violence is well documented. Community violence is often built around a cycle of retaliation. Many of our institutions — criminal justice settings, certainly, but also schools, churches and hospitals — are too frequently places where violent trauma is perpetuated rather than eliminated.

Trauma is insidious and preys particularly on the more vulnerable among us. People who are poor, who are homeless, who have been diagnosed with severe mental health problems, who are addicted to drugs, or who have developmental disabilities – all of these groups are at increased risk of violent victimization.

THE NEED FOR A TRAUMA-INFORMED SYSTEM OF CARE IS EVIDENT.

Trauma has often occurred in the service context itself. Involuntary and physically coercive practices, as well as other activities that trigger trauma-related reactions, are still common.

Trauma affects staff members as well as consumers in human service programs. Stressors deeply affect administrators, clinicians, and support staff working in human services. Not only is "secondary" or "vicarious" traumatization common but direct threats to physical and emotional safety are also frequent concerns. Being asked to do "more and more with less and less" becomes a pervasive theme underlying work experiences that may threaten to overwhelm coping abilities.

Trauma-Informed Organizations

In order to have a trauma-informed system of care, a community must have trauma-informed organizations. The culture of a trauma-informed organization is built on core values of safety, trustworthiness, choice, collaboration, and empowerment for both staff and consumers.

The creation of a trauma-informed organization begins with a commitment by top leadership to achieve the following:[9]

CONSUMER DRIVEN SERVICES
The organization employs consumers in active, integral roles throughout all organizational levels. Consumers are involved in making informed decisions about their own care, with feedback actively solicited during the treatment process.

EARLY SCREENING AND COMPREHENSIVE ASSESSMENT
Procedures are in place and staff is trained to sensitively explore childhood and current traumatic experiences during intake and at other points during treatment.

WORKFORCE DEVELOPMENT
All staff receive orientation and training on their role in creating and maintaining a trauma-informed care organization, building trusting relationships and creating a safe, healing environment.

TRAUMA-INFORMED PRACTICES
The mission, values, and principles of trauma-informed care are applied to policies and procedures, orientation and training curricula, practice guidelines, the environment, and all other aspects of care.

SAFE AND SECURE ENVIRONMENTS
The organization employs a system to continually assess and improve policies and procedures, environmental conditions, activities, social climate, documentation, and treatment practices that are consistent with a safe, secure, and supportive environment. Efforts are directed toward avoiding re-traumatization and re-victimization such as restraint and seclusion or other coercive acts.

COMMUNITY OUTREACH AND PARTNERSHIP BUILDING
The organization assumes a leadership role in reaching out to and educating others about the impact of trauma and how to promote trauma-informed care.

In a trauma-informed system, services are designed to accommodate the needs of trauma survivors. In general, trauma-informed services or systems:

- **Incorporate knowledge about trauma in all aspects of service delivery**
- **Are hospitable and engaging for consumers and staff**
- **Minimize re-victimization**
- **Minimize vicarious or second-hand trauma**
- **Facilitate recovery**[10]

When an organization or system decides to become trauma-informed, every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma affects the lives of individuals seeking services. Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate so that these programs and services can be more supportive and avoid re-traumatization.[11]

A trauma-informed organization also recognizes the importance of self-care and the need for the organization to take care of its employees — especially those who experience second-hand trauma, i.e., individuals whose jobs are to provide care and services to individuals who experience trauma.

The following factors were identified by the coalition as being important to the successful transformation of an organization to a trauma-informed care mode:

- **Recognition that trauma-informed care is an organizational model and not just for use with consumers (e.g., recognition of self-care concept).**
- **Introductory/awareness educational sessions for all staff.**
- **Practice — every day and in every situation — is the single most important element to raise awareness and infuse principles.**
- **People need hope in order to change.**
- **Transparency is critical to building trust.**
- **Shared governance is important.**

Impact of External Environment

AS WITH ANY PLANNING PROCESS, IT IS CRITICAL TO RECOGNIZE HOW CHANGES IN THE EXTERNAL ENVIRONMENT MIGHT IMPACT SERVICE DELIVERY AND INFLUENCE THE DEVELOPMENT AND IMPLEMENTATION OF ACTION STEPS.

The following factors were identified as being important to the development of a trauma-informed system of care plan:

- **ECONOMY** Creates stress for family members; increases demand for services; depletes community resources.
- **CHANGES IN HEALTH INSURANCE/MEDICAID REFORM** Uncertainty regarding insurance coverage, provision and cost of care; long-and short-term consequences of the medical home model; stress for consumers and providers.
- **CHANGING COMMUNITY DEMOGRAPHICS** Increase in refugee and immigrant populations, with associated cultural differences.

- **UNEXPECTED NATURAL OR MAN-MADE DISASTERS** Costs associated with mobilizing the response system.
- **POLITICAL AND SOCIAL ENVIRONMENTS** Lack of empathy; widening wealth gap; effect of conservative political views on social service funding; media overload.
- **TECHNOLOGY** Effect, both good and bad, within service sector; communication channels; generational preferences.
- **SERVICE DELIVERY** Traumatized individuals working with traumatized individuals.
- **ATTITUDINAL BARRIERS** Philosophical differences; differing professional biases and perspectives.
- **POST-DEPLOYMENT INDIVIDUALS** End of Iraq conflict; ongoing conflict in Afghanistan; increase in the number of veterans returning to the community; post-traumatic stress syndrome; effects of multiple deployments on family members.

Trauma-Informed System of Care Plan Components

The development of a trauma-informed system of care represents a shift in thinking and requires a long-term commitment on behalf of first responders, community organizations, schools, law enforcement, service providers, etc. The first step in any change process is education and understanding of the issue at hand. Once individuals and groups have been educated, understanding and acceptance of the steps needed to effect change usually follows.

While the mental health community has recognized the need to offer trauma-informed and trauma-specific services, most of the other sectors in our community would benefit from a basic understanding of trauma and how it impacts people's lives. As individuals become better informed about trauma, the need for trauma-informed and trauma-specific services will likely increase.

The typical format for the development of a trauma-informed system of care plan is as follows:

I. **Community Education/Exposure of Trauma-Informed Care/Systems**
   A. Effects of trauma
   B. Principles of trauma-informed care
   C. Continuous service provider assessment

II. **Identification of Trauma**
   A. Screening
   B. Linkage to service

III. **Assessment and Service Planning**
   A. Systemic trauma assessment
   B. Conceptualization of intervention targets and intervention planning

IV. **Intervention**
   A. Delivery of empirically supported (i.e., evidence-based) trauma-informed or trauma-specific treatment

V. **Evaluation**
   A. What effect has the plan had on creating a trauma-informed system of care?

Trauma-Informed Community Initiative of WNY Coalition : Next Steps

Administrative Structure

The Trauma-Informed Community Initiative of Western New York Coalition is in the process of more clearly defining its administrative structure. Two organizations, the Care Management Coalition and The Institute on Trauma and Trauma-Informed Care, University at Buffalo School of Social Work have agreed to share responsibility for managing the coalition and providing administrative support. An Advisory Council, comprised of individuals from the coalition and community, has been formed to provide oversight and structure for the coalition. A governance structure is in place and an operations plan for 2013 will be developed by December 31, 2012.

The coalition will also be expanded to include representation from additional community sectors in 2013.

Education

The coalition has developed a Power Point presentation about trauma and its effects for use by community members and organizations. The presentation will be piloted and evaluated by coalition member agencies through December 31, 2012 and then made available to the public in early 2013.

Additional information specific to education, law enforcement, health care, and behavioral and mental health will be added to the presentation in 2013.

Intervention

The coalition is in the process of developing and administering a survey that will identify the trauma-informed, trauma-related, and trauma-specific evidence-based practices/treatments currently available in the Greater Buffalo area. A report of the findings will be released in 2013. In addition to identifying the trauma-focused services available, the report will also identify the gap in local service provision.

Evaluation

Also in 2013, the coalition will work on identifying measures to evaluate the effectiveness of its efforts to create a trauma-informed system of care in Greater Buffalo.

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Coalition members would also like to acknowledge **AMANDA NOBREGA, M.S.W.** for her role in the initial planning efforts.

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National Trauma-Informed Care Resources

ADVERSE CHILDHOOD EXPERIENCES STUDY
www.acestudy.org

THE ANNA INSTITUTE
www.theannainstitute.org

NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTOR
www.nasmhpd.org

NATIONAL TECHNICAL ASSISTANCE CENTER FOR STATE MENTAL HEALTH PLANNING FOR STATE MENTAL HEALTH AGENCIES
www.nasmhpd.org

NATIONAL CHILD TRAUMATIC STRESS NETWORK (NCTSN)
www.nctsn.org

NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE
www.thenationalcouncil.org

NATIONAL INSTITUTE FOR TRAUMA AND LOSS IN CHILDREN
www.starrtraining.org

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION
www.samhsa.gov

TRAUMA INSTITUTE AND CHILD TRAUMA INSTITUTE
www.childtrauma.com

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Resources

Community Health Foundation of Western and Central New York's November 8, 2011 Speaker Series session, *"Resilience to the Rescue! Conquering Kids' Trauma"*

"Creating Cultures of Trauma-Informed Care: A Self-Assessment and Planning Protocol" by Roger D. Fallot, Ph.D. and Maxine Harris, Ph.D., Community Connections, April 2009:

National Council for Community Behavioral Healthcare, National Council Magazine, 2011, Issue 2

Scared Sick: The Role of Childhood Trauma in Adult Disease, Robin Karr-Morse with contributions from Meredith Wiley. 2012

University at Buffalo, The Institute on Trauma and Trauma-Informed Care

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