

**A Plan for Improving Behavioral Health Services for
Persons with Histories of Trauma**
Maine Department of Behavioral and Developmental Services
August 2001

INTRODUCTION

It is the policy of the Maine Department of Behavioral and Developmental Services to assure that quality mental health, substance abuse and support services are effectively provided to clients within our system of services who have experienced psychological trauma. Psychological trauma, as addressed by the Department, refers to interpersonal violence in the form of sexual abuse, physical abuse, severe neglect, and/or the witnessing of such violence. It is linked to such difficulties as serious mental illness, addiction, personality disorders, physical illness, suicide, self-injury, aggression toward others, and revictimization.

The scope of this problem is vast, impacting on all populations served by the department including children and adolescents, elderly persons, persons with mental retardation, substance abuse problems or physical disabilities such as deafness, persons who are homeless, refugees, or in the criminal justice system. Prevalence rates such as the following are significant: i.e. 50 to 70% of MH adult clients, (Carmen et al, 1984¹; Bryer et al., 1987²; Craine et al., 1988³), 74% of 2200 AMHI class members assessed in 1996, (13% of the 2200 indicating a need for trauma specific services), up to two-thirds of both women and men in substance abuse treatment (SAMHSA, CSAT 2000⁴), 42 to 90% of adolescent and teenage substance abuse clients (Rohsenow, 1988⁵), 90% of MR clients (Sobsey, 1994⁶; Valenti-Hein & Schwartz, 1995⁷), 97% of homeless mentally ill women (Goodman, Johnson, Dutton & Harris, 1997⁸). This clearly is not a “special population” separate from the majority of clients presently served by the Department. For nearly all Department clients, both children and adults, and particularly those making heavy use of

¹ Carmen E, Rieker P., and Mills T. Victims of Violence and Psychiatric Illness. *Am J Psychiatry* 141;3, March 1984

² Bryer JB, Nelson B, Miller JB, Krol P. Childhood Sexual and Physical Abuse as Factors in Adult Psychiatric Illness. *Am J Psychiatry* 144:1426-1430, November, 1987

³ Craine LS, Henson CE, Colliver JA, et al., Prevalence of a History of Sexual Abuse Among Female Psychiatric Patients in a State Hospital System, in *Hospital and Community Psychiatry*, 39, 300-304. 1988

⁴ Center for Substance Abuse Treatment. Substance Abuse Treatment for Persons with Child Abuse and Neglect Issues. *Treatment Improvement Protocol (TIP) Series*. Number 36. DDHS Publication No. (SMA) 00-3357, Washington DC: U.S. Printing Office, 2000

⁵ Rohsenow DJ, Corbett R, Devine D. Chemical Dependency Treatment Program, Mid-Maine Medical Center, Waterville, Maine. Molested as Children: A Hidden Contribution to Substance Abuse? *Journal of Substance Abuse Treatment*. Vol.5, pp.13-18, 1988

⁶ Sobsey D, *Violence and Abuse in the Lives of People with Disabilities: The End of Silent Acceptance?* Baltimore: Paul Brookes. 1994

⁷ Valenti-Hein D, Schwartz L. *The Sexual Abuse Interview For Those With Developmental Disabilities.* James Stanfield Company, Santa Barbara, CA 1995

⁸ Goodman L, Johnson M, Dutton MA & Harris M. Prevalence and Impact of Sexual and Physical Abuse. In Harris M & Landis (Eds) *Sexual Abuse in the Lives of Women Diagnosed With Serious mental Illness.* Pp. 277-299. Netherlands, Harwood Academic Publishers. 1997

high cost inpatient and crisis services, trauma is or will be a key treatment issue at some point in the process of their recovery.

To address the treatment and support needs of survivors of trauma within the public system requires a systemic approach characterized both by specialized diagnostic and treatment services and a “trauma-informed” environment capable of sustaining these services as they develop. A “trauma-specific” service is designed to treat the actual sequelae of sexual or physical abuse. Examples of trauma specific services include grounding techniques which help trauma survivors manage dissociative symptoms, desensitization therapies which help to render painful images more tolerable, and certain behavioral therapies which teach skills for the modulation of powerful emotions. “Trauma-informed” services are not designed to treat symptoms or syndromes related to sexual or physical abuse or other trauma. The commitment of a “trauma-informed system is to provide all services in a manner that is welcoming and appropriate to the special needs of trauma survivors. A “trauma-informed” system is one in which all components of a given service system have been reconsidered and evaluated in the light of a basic understanding of the role that violence plays in the lives of people seeking mental health and addictions services. A “trauma informed” system uses that understanding to design service systems that accommodate the vulnerabilities of trauma survivors and allow services to be delivered in a way that will avoid inadvertent retraumatization and will facilitate consumer participation in treatment. It also requires closely knit collaborative relationships with other public sector service systems serving these clients and the local network of private practitioners with particular clinical expertise in “traumatology”. Communication linkages must be maintained with the national network of clinical research and model trauma initiatives. These connections are vital as the field develops and new and promising trauma specific treatment approaches and innovative programs produce evidence of their effectiveness in assisting recipients of public mental health and substance abuse services who have histories of trauma.

BACKGROUND

In 1996-1997, informed by several statewide needs assessments of consumers and professionals, data from AMHI Consent Decree class members, 2 statewide invitational forums, state Medicaid data, state and national research findings, and new federal policy initiatives, BDS identified trauma as a key public health issue, established the Office of Trauma Services (OTS), and became first in the nation to develop and implement a strategic plan to build capacity within the existing system of care to respond more effectively to the needs of recipients of services with trauma related problems. It began by conducting an exhaustive needs assessment through written surveys and statewide focus groups involving approximately 130 recipients of public mental health services with histories of trauma and 140 professionals who were recommended by them. These groups identified what helps and hurts in existing public mental health treatment, and the Department prioritized its activities based on these findings. A comprehensive strategic plan was developed and submitted to the AMHI Consent Decree Court Master as a structured framework within which to plan and implement specific approaches to trauma survivor class members and others.

The Department's strategic plan took a multi-faceted approach addressing 4 major areas of focus pertinent to its role as a public mental health authority and reflecting in part the process necessary to produce lasting systemic and clinical practice change. These 4 areas were: 1) Awareness raising within consumer, professional and general public venues to increase understanding of the prevalence and effects of trauma, its implications for public policy, and the necessity to address it within the public system of services; 2) Professional training, education and support to enable providers of services to respond with specialized knowledge and skill to traumatized clients, increasing accurate diagnoses and appropriate treatment, and decreasing the retraumatization of clients caused by practices which inadvertently reenact original abuse experiences; 3) Trauma treatment, services and supports in the form of new services or modified existing services to directly address the clinical needs of traumatized clients; 4) Establishment or modification of policies and procedures which pave the way for public sector development and integration of promising and best-practice services and which increase access to existing services for clients with histories of trauma.

Although the Department can take pride in its pioneering role as first in the nation to recognize and take a systemic approach to addressing the needs of public sector clients with trauma related disorders, it has operated at some disadvantage due to lack of examples to follow and research data - such as trauma-based practice models, promising exemplary programs, evidence-based research, and training and education curriculums applicable to public mental health service delivery settings and fiscal structures. Only recently have promising treatment and professional training approaches begun to emerge and to be tested, some initiated by the Department, some developed by other state public systems and programs, some emanating from national demonstration and research initiatives, (SAMHSA Women and Violence Sites), and some adapted from the private practice sector.

In spite of these disadvantages, the Department dedicated significant resources toward the development of new programs and supports it thought would address some of the needs so eloquently stated in the survivor-based report "In Their Own Words". A specialized, twenty-four hour/7 day telephone support service, a warm line, was the first service to become available. The next focus was on residential services.

Maine's experience in this new territory was the concept of *Safe Houses*. Originally envisioned as one house in each of the Department's three regions, only two Safe Houses were ever actually up and running – Garland House in Bangor and Seasons in Sabattus. The Department conceived the Safe House programs for use by women with trauma histories who were consumers in the public mental health system. The homes were to provide a safe and supportive environment for those women experiencing particularly difficult periods in the individual recovery process, when living alone was not safe.

These were experimental programs for Maine. They were initiated in response to findings from initial needs assessments of recipients of public mental health services who suffered from the impacts of trauma. The Department originally meant them to serve as

“demonstration sites” or “Centers of Excellence” to assist the system to transition from a traditional psychiatric “medical model” to one more sensitive to trauma-related needs. However, several factors operated against their success, including no new funding. The resulting constraints on staffing and client mix, added to the lack of existing residential models nationally to look to for guidance, presented significant problems to those dedicated to the implementation of these services. But perhaps more significant were the difficulties inherent in initiating a new residential trauma-specific service within the context of an overall service delivery system still relatively uninformed and inexperienced in the implementation of a trauma model. During Maine’s struggle to make the Safe House programs work, the over-riding need for a more supportive systemic context in which increased clinical understanding and trauma expertise could be developed and sustained across services, became clear. This problem is being recognized nationally. Other states who have begun trauma initiatives are engaged in serious thought and discussion about how best to implement and integrate services based on a new trauma-based model for understanding and responding to mental health problems, within public mental health service systems where the dominant theoretical and environmental context does not include or even works in opposition to these new approaches to treatment.

In its position as “pioneer” within the context of state public mental health systems, the Department and its OTS have made significant contributions to the development of exemplary service, support and training models in Maine and have successfully implemented a number of nationally developed models to local settings. (See Accomplishment Section below.) While the Department has also pursued some paths that have proven to be unworkable within the organizational and fiscal context of the present system, these experiences have led it to the development of a second-stage approach designed to create a “trauma-informed” service system, committed to providing services in a manner that is welcoming and appropriate to the unique needs of trauma survivors. For trauma-specific services treating the actual sequelae of abuse to become available to the vast numbers of clients who have need of such services, a receptive, informed and supportive organizational systemic environment or context is necessary. This is the primary task of the Department’s new Trauma Design Team, described in the section “Next Steps” in this report.

SUMMARY OF ACCOMPLISHMENTS

The Revised Trauma Treatment Services Plan which was submitted to the Court Master on December 31, 1997, was designed to “facilitate a systemic transformation in ways in which persons with mental illness are viewed, understood and treated”, so that ways could be found to... “help trauma survivors as well as the professionals who work with them to recognize the impacts of traumatic abuse, and to use appropriate services which address trauma-based symptoms.” Several strategic areas and goals were outlined in the Plan, focusing on 1) awareness raising, communication networks, collaborations and constituency building with trauma survivors, professionals, other state agencies and disciplines, and the general public; 2) the development of new and modification of

existing policies to better facilitate addressing the needs of trauma; 3) the creation of trauma-based treatment options, services, supports and resources; and 4) the education and support of professionals who work with trauma survivors. The following activities have been accomplished and many are ongoing.

I. Awareness raising, communication networks, collaborations and constituency building with trauma survivors, professionals, other state agencies and disciplines, and the general public:

- An increased knowledge base about trauma combined with the locally connected regional organization of the Department has resulted in a higher level of responsiveness to input from consumer/survivors about their needs and their recommendations for services. (Refer to Section on Next Steps and Objectives, Action Steps and Timing)
- Over 80% of recently interviewed organizations serving mental health consumers now ask questions about trauma in their intake process. Most do so routinely. While we have no formal baseline data on the degree to which trauma related questions were asked prior to the Department's trauma initiative, our informal understanding based on needs assessments of consumers and providers was that inquiry into a trauma history was rare. That this has changed so dramatically should be considered an accomplishment and it is hoped will lead to an increasingly responsive system of services to individuals with trauma related disorders
- Comprehensive assessments of survivors and providers throughout the state via focus groups and surveys resulting in 2 reports: "In Their Own Words: Trauma Survivors and Professionals They Trust Tell What Hurts, What helps, and What is Needed for Trauma Services" (1997 Report of 1996 Trauma Advisory Group Assessment findings, Ann Jennings Ph.D. of the Department Office of Trauma Services and Ruth Ralph, Ph.D., Edmund S. Muskie School of Public Service), and "Maine Mental Health Services Provider Survey Report: Trauma Training and Service Needs (August 1997, Ruth Ralph, Ph.D. Edmund S. Muskie School of Public Service). The book "In Their Own Words" was selected by the National Journal of Government Information as one of the most notable state documents of the year 1997. Over 6,000 copies have been distributed statewide and nationally and requests continue to be responded to.
- Quarterly Survivor/Consumer Newsletter, by and for survivors. This continues to be published and distributed in collaboration with the Augusta Sexual Assault Crisis Support Center.

- A library of 130 Survivor-Recommended books is available for consumers in all areas of the state, through state and University inter-library loan systems. Annotated bibliography is also available. This library has also been used by professionals.
- A Public Education Pamphlet “Break the Silence, Support the Healing: What Happens to Abused children when They Grow Up?” has been distributed statewide with the purpose of increasing public understanding of the effects of childhood abuse and its implications for public policy.
- A public information paper of statistics from the research entitled: “What Can Happen to Abused Children When They Grow Up – If No One Notices, Listens or Helps?” was created for use across various systems of services and as a public education tool with the general public. This is a 5-page document of statistical information linking childhood physical and sexual abuse to a variety of serious adult difficulties. It communicates the serious repercussions of childhood abuse and the implications of those consequences for public policy.
- Major conferences and forums have been held annually attended by hundreds of consumer/survivors, providers of services, policy makers and educators throughout the state. These conferences have facilitated the formation of informal networks and widespread discussion about what survivors need for recovery and promising approaches to assisting them.

II. The development of new and modification of existing policies to better facilitate addressing the needs of trauma survivors:

- Core competency trauma education and training criteria have been established throughout the Department. Basic training in trauma is now a “core competency” for all Department employees who have direct contact with clients. Employees must attend “Risking Connections”, a 20 hour Training curriculum for Understanding and Working with Survivors of Childhood Abuse.
- The Department’s Clinical Protocol for Prevention of Seclusion and Restraint Informed by the Clients History of Trauma, August 31, 1998, and its accompanying assessment and personal safety forms, have been implemented at BMHI by the inclusion of the personal safety form as an optional part of patient evaluations and at AMHI through 1) the modification of suggested forms for use within their setting and to be more user friendly, 2) the completion of the Personal Safety Form as soon as possible after admission (within 72 hours), and 3) the completion of the Trauma Assessment form within 10 days of

admission. AMHI uses the Personal Safety Form as an assessment tool to assist individuals with histories of trauma in identifying options and developing skills for the future.

- The Department's Out of State Treatment (OST) policy was modified to clarify steps necessary to request OST without unnecessary delays. This year, this improvement has resulted in quick responses to 12 requests for OST for clients needing treatment for trauma disorders and approval of 7 of those requests.

III. The creation of trauma-based treatment options, services, supports and resources

- A 24 hour Trauma Support Line for clients with complex mental health and/or substance abuse problems who have histories of sexual abuse trauma is now in its 3rd year of operations. Through this joint effort between the Department and the Maine Coalition Against Sexual Assault (MeCASA) an estimated 600 clients received phone support last year, totaling over 7,000 phone calls, many of which averted crisis. Communication and coordination with mental health crisis services is an essential component of this service and is a priority for all 10 local MeCASA Centers.
- MeCASA's 10 local centers have formed a variety of Trauma Support Groups for men and women sexual abuse survivors including individuals with mental health and/or substance abuse problems. Groups have also been developed by the Department for deaf clients with histories of sexual abuse. A significant development in the field is the positive role peer support and psychoeducational group treatment approaches such as the Trauma Recovery and Empowerment Model (TREM), are being found to play in recovery. This development is being supported by the Department with trainings provided to the local centers.
- Trauma Clinical Consultation funds are allotted to each Regional office to assist providers in addressing special clinical needs of abuse survivors through case consultations, formal trauma assessments, psychiatric consults, diagnostic testing, second opinions, ancillary treatment modalities, targeted clinical supervision and mediation services. Each region has worked with the Office of Trauma Services to develop a list of over 50 professionals with trauma expertise willing to respond to the special trauma treatment needs of recipients of mental health and substance abuse services and to the consultation needs of their providers.

- Case or Site-specific trauma clinical consultation continues to be provided by Office of Trauma Services clinical staff in response to the many and often urgent requests received from regional Department staff, individual clients, state and private hospital and community-based providers, and others. These consultations take place about 2 to 3 times a month and are serving to increase the knowledge base of professionals and the effectiveness of services provided to trauma survivors.
- Safer Place: The Department provides trauma-based and other mental health services at no cost to consumers who were abused as children at Governor Baxter School for the Deaf. Funding may cover co-pay or unreimbursed mental health services to assist survivors in the process of healing.
- Trauma Information and Referral has been facilitated in all Regions through the OTS production of an updated Trauma Referral, Training and Consultation Resource Book, and a Trauma Sensitive Services Directory. With the stabilized regional organization of the Department and the increase of knowledge regarding the needs of clients with trauma related problems, there now exist both a structure and staff more cognizant of trauma and increasingly able to recognize and link clients with trauma disorders to the services they need.
- The Office of Trauma Services continues to link with national activities and other states through participation on national trauma expert groups, multi-state trauma coalitions and relationships with approximately 18 individual states' public service delivery systems' trauma initiatives. Through this ongoing involvement, the Department is able to stay in touch with the development of promising practices, treatment models and other clinical and support services found to be effective in assisting individuals with trauma disorders. Keeping in touch with promising practices in this developing field of traumatology, has led the Department and its contract agencies to increasingly adopt more effective approaches to treatment, such as for example the use of a Dialectical Behavioral Therapy (DBT) treatment model designed for people diagnosed with Borderline Personality Disorder in conjunction with approaches which recognize and address trauma issues in persons with a variety of diagnoses, the adaptation of the Trauma Recovery and Empowerment Model (TREM) for working with Women and with Male trauma survivors in groups as well as individually, and the Risking Connections training curriculum and model now being adapted for providers who serve various client populations. (See IV.)

- The increasingly routine inquiry about a trauma history during intake and assessment throughout the service system has decreased the level of re-traumatization caused by ignoring the consumers traumatic experiences and therefore reenacting the secrecy and silencing experienced as a part of the original abuse.
- Increasingly, many providers are framing client problems differently – rather than solely asking “what is wrong with this person”, the question “what happened to this person” is increasingly being asked, and the answers to that second question frequently lead to better relational and treatment responses which avoid unintentionally repeating the dynamics of the original trauma.

IV. The education and support of professionals who work with trauma survivors

- Statewide Trauma Train-the-Trainer Program has been implemented to build capacity within Maine’s public mental health and substance abuse service system. A cadre of trauma trainers has been formed in each region, totaling 90 to 110 trainers and clinicians across the state who were selected by Department contract mental health agencies, state hospitals and each of the regional offices, to participate in the Sidran conducted “Risking Connection” Train-the-Trainer program. In a number of agencies the clinicians have gone back to their agencies and trained other direct-care staff. This program has been expanded to train providers from other fields and disciplines such as mental retardation and substance abuse.
- Follow-up review and consultations have been provided after Train-the-Trainer programs to discuss implementation of direct staff trainings, and clinical and organizational issues. Trainers are also being invited to participate in a developing Trauma Provider Coalition listserv for communication and problem solving
- Risking Connection Curriculum and Trainings, a training program for working with survivors of childhood abuse, is a 5 module basic trauma curriculum for use in public mental health, substance abuse and human services fields. It is being used throughout the system in Maine for in-service and other direct care staff trainings. This program was developed in collaboration with the New York Office of Mental Health, the Sidran Foundation and the Traumatic Stress Institute, and gives the Department unlimited rights to reproduce the curriculum and materials for use within the State of Maine. It provides a framework for understanding and working with recipients of services who are survivors of childhood abuse and has been instituted by the Department as a core competency for all employees who interact directly with clients.

- Risking Connection trainings have been and continue to be offered continually throughout the year for clinicians and other field staff who work with persons with trauma disorders and for all state employees who interact with these clients as fulfillment of Department core competency requirements. Thus far, a total of 272 direct-care staff have received this training.
- The Risking Connection curriculum is being adapted to the field of Mental Retardation, Substance Abuse and Residential Treatment. This adaptation is a collaborative process with providers and recipients of services in each of those fields
- Risking Connection trainings have also been given for supervisors of staff who work with trauma survivors, and to specific provider groups such as case managers and crisis workers.
- Crisis system trainings by nationally renowned trauma clinician, consultant and author Dusty Miller in how to respond and work with clients with histories of trauma who are self-injurious, suicidal or otherwise at risk, have been presented to all staff from the various components of the crisis systems in York and Cumberland Counties. A new model has been developed based on the success of these trainings and will continue to be implemented throughout the State's other crisis systems, using Dusty Miller's expertise. This new training model will be adopted with the assistance of Muskie Institute Center for Learning, and consists of: 1) a didactic and experiential training workshop, followed by 2) a group case consultation session applying learnings from the workshops to specific problems being experienced in working with clients, followed by 3) participation of trainees on a listserve where they can continue to communicate with one another and with the trainer/consultant Dusty Miller and others. Over 85 providers attended the workshop and approximately 48 crisis system staff attending the case consultation sessions in York and Cumberland Counties.
- Women's Trauma Recovery and Empowerment Training Model (TREM) Programs have been conducted in Region I. The TREM model is a psychoeducational approach to working with groups of women who have histories of trauma and serious persistent mental health and/or substance abuse problems. The trainings have been conducted by Community Connections Washington D.C. staff who developed the group approaches, curricula and materials in collaboration with clients of their organization. All participants receive the book "Trauma Recovery and Empowerment: A Clinician's Guide to Working With Women in Groups". Several groups have

been implemented by agencies in Region I including Maine Medical Center (MMC) ACCESS Team (an ACT Team for persons with serious mental illness and substance abuse problems), Community Services Inc., and private providers serving public system clients. The Maine Medical Center ACCESS Team has presented the TREM model, their experience using it and the outcomes for the women who took part in the group. One statement exemplifies the very positive outcomes from this exemplary program and was said by a clinical group leader: "For the first time I feel hope for these women". MMC ACCESS Team is now participating in a TREM training to facilitate TREM groups for male survivors this September, 2001, with plans to begin groups for their male clients this year.

- A Third Annual Clinical Trauma Conference took place in 2000 and had a focus on Trauma, Children and Adolescents. This conference was "sold out" early on and offered keynotes and workshop presenters with national reputations for their understanding, work and research related to the problems of children who were traumatized by sexual abuse, physical abuse, the witnessing of violence and/or severe neglect. It was co-sponsored by the Department with the Department of Human Services. Conferences continue to be offered each year. The next one will take place November 2001 and will focus on trauma, substance abuse and mental health.
- A survivor workbook "Growing Beyond Survival: A Self Help Tool Kit for Managing Traumatic Stress" was developed through a collaborative venture with the Department Office of Trauma Services, the NY Office of Mental Health, the Sidran Foundation, and the Department's Office of Consumer Affairs. This arrangement gave the Department unlimited rights to reproduce the workbook for use within the State of Maine. It can be used as a peer or self-help tool or with a professional. It presents methods of gaining mastery over effects of trauma (such as flashbacks, overwhelming rage or grief, loss of control, addictions, self injury, aggressiveness/assaultiveness, repeated victimization, dissociation, etc.)
- OTS Trauma Research Literature Library continues to accumulate training materials, trauma research literature and books, making them available to providers upon request and disseminating materials when appropriate. OTS is developing a system of dissemination to maximize the availability of these resources.
- A "Tool Kit" of Written Resources and Information available through the OTS has been developed and distributed to assist the Department and its contract agencies and others in building capacity to address trauma issues

NEXT STEPS AND FUTURE ACTIVITIES

The Department has learned some hard lessons and is incorporating those learnings as we continue to refine our service development for trauma survivors. It has become clear that unless mental health and substance abuse services are delivered in a system where trauma knowledge is thoroughly integrated into existing policy and practice, specialized trauma services such as the Safe House programs would not be sustainable over time.

Recognizing the difficulties, constraints and operational problems being experienced by each of the 2 existing Safe Houses, the Department in conjunction with the providers decided to close both programs. At the same time, the Department began a “second-stage” planning process with the goal of quickly moving forward with activities designed to achieve the comprehensive integration of trauma into all aspects of the service system.

The need for a more “trauma-informed” service system as a necessary context for sustaining “trauma specific” services within the system, and the importance of integrating trauma knowledge throughout all components of the system, is now a priority of the Department. Since the inception of the trauma initiative in late 1995, the Department has re-organized, developed and stabilized a new regionally based structure for a more effective delivery of services generally. It is now, therefore, in a position to engage in rethinking and redesigning the trauma services initiative with broad central and regional support and with the full involvement of all parties crucial to the development of this “trauma-informed” system.

In January 2001 a Trauma Services Design Team was convened, consisting of the Regional Directors and Mental Health Team Leaders of Regions I, II and III, the Medical Director of Region III, the Director of the Office of Program Development (co-chair), the Director of Adult Mental Health Services (co-chair), the Director of Community Systems Development, the Director of the Office of Trauma Services, the Clinical Specialist for Adult Mental Health, the Consent Decree Operations Manager, and the Treatment Services Manager for the Office of Substance Abuse. As initial planning took place, new members were added from Tri-County Mental Health Services, the agency which will participate in a model project described later in this document. These new members included the Tri-county MHC Clinical Director and Director of Housing and the Director of the Rumford Tri-County Office. This team pulls together representation from all the various components of the Department necessary to develop a receptive, informed and supportive organizational environment where trauma and its effects become central to the way in which all services are thought about and delivered. Its ultimate mission is to create a system where trauma survivors receiving services have ready access to services treating the actual sequelae of abuse and where they can avail themselves of all the services and supports they need without being re-traumatized. This system will build on existing expertise and continually integrate the developing understanding of trauma and the treatment of traumatized individuals into the full array of services and supports.

The Trauma Design Team has developed a series of next steps and future activities focused on the goal of developing a trauma-informed system: They are described below:

Overall Systems Development

- Continuation and re-formation of the Department Trauma Design Team as a “Trauma-Informed System Implementation Team” with broad based involvement of all key Department staff.
- Discussions regarding the creation of a trauma-informed system statewide will be continued using the Mentor groups as a forum. This activity will be facilitated as an on-going agenda item with the Mentor groups by OTS through the Regional Mental Health Team Leaders.
- OTS will continue to link and participate with national activities and with other states, to stay informed about 1) promising and evidence-based practices, treatment models, other trauma-based clinical and support services, curriculums and training programs being implemented in the field as well as research finding regarding the effectiveness of these services and trainings, and 2) state public systems’ approaches to developing and sustaining trauma-informed services and organizational environments. This communication is facilitated through OTS Director’s membership in the State Public Systems Coalition On Trauma (SPSCOT) consisting of representatives from 13 states with trauma initiatives who have formed a network, meet nationally at conferences and other events, and communicate regularly over a listserv facilitated by OTS. An intra-state system of websites is being created to increase the sharing of written documents pertaining to the development of trauma-specific and trauma-informed services in public mental health and substance abuse service delivery systems. Information and learnings obtained through this activity will be disseminated through the Trauma Informed System Implementation Team to inform the field.

I. Awareness Raising, Communication Networks, Collaborations and Constituency Building

- Trauma Provider Coalition and Listserv: Facilitated by a statewide listserv, trauma service providers, staff who take part in various trauma training programs, administrators and others involved and interested in both trauma-specific services and in the formation of a trauma-informed system of services, will be able to use the technology of an email group listserv to share their experiences, keep up with promising practices, provide each other support, and communicate and problem solve.

- A quarterly Survivor/Consumer Newsletter will continue to be published and distributed in collaboration with the Augusta Sexual Assault Crisis Support Center
- Both public education documents: the pamphlet “Break the Silence, Support the Healing: What Happens to Abused Children When They Grow Up?”, and the white paper of statistics from the research entitled “What Can Happen to Abuse Children when They Grow Up, If No One Notices, Listens or Helps?” the book “In Their Own Words” and other articles and materials collected through OTS, will continue to be widely distributed throughout the state at Department sponsored events, in a variety of settings involving Department participation and through mailings to professional groups, other state systems of services, and the general public.
- Major conferences and forums will continue to be held annually with invited participation of key community leaders and professionals from an increasing variety of related fields such as substance abuse, mental retardation and corrections.

II. Development of new and modification of existing policies to better facilitate addressing the needs of trauma survivors

- A mechanism for administrative support for new ways of services delivery will be developed to review and address such issues as: improved rate setting options, seeking funding for new programs as identified, addressing licensing limitations or rulemaking if needed, requirements in contracts with providers to make explicit that all new services (such as supported living) must demonstrate how these services are or will be made to be trauma-informed, etc.

III. Trauma-informed and trauma-based treatment options, services, supports and resources

- A model project with Tri-Co Mental Health Center, will implement a trauma-informed system of services within a single geographically contained program unit of Tri-County. This program unit contains a network of multiple services, including most of the core services required by clients as well as ancillary services and other community based supports commonly used by recipients of services. This project is described in more detail below. (See Model Project)
- Region I Integrated Trauma Treatment Team to incorporate promising practices within a multi-disciplinary context as a model for their application to the rest of the service system. The concept for this approach was developed in collaboration with survivor/consumers and

will include the TREM model of group work described in the Accomplishment section of this document. (See Section: Objectives, Action Steps and Timing, and Budget)

- Safer Place: Trauma-based and other mental health services are provided by the Department at no cost to consumers who were abused as children at Governor Baxter School for the Deaf. Funding may cover co-pay or unreimbursed mental health services to assist survivors in the process of healing.
- As an alternative to traditional hospitalization, the Department has included in the new psychiatric facility plans for the development of trauma-informed inpatient services within the existing programs of AMHI (See Section: Objectives, Action Steps and Timing, and Budget)
- Intensive Residential Treatment Services and Supports which operated under an agency no longer in business, will be RFP'd, with the new operator required to deliver trauma-informed residential services. This service includes a residence for 6 women, a residence for 6 men, and 6 supported apartment beds. (See Section: Objectives, Action Steps and Timing, and Budget)
- Enhanced MeCASA support line and support groups through provision of training to staff of MeCASA local centers in the Trauma Recovery and Empowerment Model (See Section: Objectives, Action Steps and Timing, and Budget)
- Continuation of the Trauma Clinical Consultation Service in each Region (See Section: Objectives, Action Steps and Timing, and Budget)

IV. Education and Support of Professionals Who Work With Trauma Survivors

- Enhanced Clinical Supervision for Intensive Case Managers who frequently have persons with trauma histories on their caseloads will be implemented through monthly problem-solving meetings with small area groups of ICMs and one monthly case-oriented meeting co- led by OTS Trauma Clinical Specialist Mary Jean McKelvy and by Mary Auslander, Clinical Specialist for Adult Mental Health. This model of supervision/consultation will be considered for replication throughout the state wherever the Department provides direct services
- Crisis System training and ongoing consultation in how to respond and work with clients with histories of trauma who are self-injurious,

suicidal or otherwise at risk, using a the training, consultation and follow-up model developed in Region I crisis system training with Dusty Miller and described under Accomplishments. Training will take place with the crisis systems in Region II and III

- TREM (Trauma Recovery and empowerment Model) training program will be conducted in Regions II and III as a psychoeducational approach to working with individuals and with groups of women who have histories of trauma and mental health and substance abuse problems.
- Men's Trauma Recovery and Empowerment Training Program to take place statewide on September 24 and 25, 2001. This is a two-day statewide training for up to 40 clinicians who will then be available to lead recovery groups for and work individually with male trauma survivors with serious persistent mental health and/or substance abuse problems.
- Fourth Annual Clinical Trauma Training Conference on Trauma, Substance Abuse and Mental Health will be held at the Augusta Civic Center on November 29 and 30th. This conference will feature several nationally renowned keynote speakers and workshop presenters with trauma expertise in the fields of substance abuse and mental health. Presentation will be given by the SAMHSA sponsored Women and Violence sites and by other states who have developed innovative ways in which to create trauma-informed systems and services
- A group of Departmental staff are examining a variety of issues surrounding the treatment available to individuals diagnosed with Borderline Personality Disorder, the majority of whom research has shown have histories of trauma. The stages in this analysis are as follows:
 1. Review large number of professional citations on treatment issues - Completed
 2. Examine data from AMHI and BMHI – underway
 3. Follow individuals seen at AMHI and BMHI utilizing the MMDSS community Medicaid data base – Data base being developed
 4. Examine non hospitalized individuals with Borderline Personality disorder -utilizing the MMDSS community Medicaid data base – Data base being developed
 5. Survey Community Providers for treatment and other issues surrounding the care of individuals with Borderline Personality Disorder
 6. Prepare report for Commissioner

- Risking Connections Trainings will continue to be offered to a range of providers across a range of disciplines and fields including:
 - 1) 3 day long trainings, one in each region, for MH/ICM workers statewide,
 - 2) 2 day long trainings, one north and one south, for middle-management and supervisory Mental Retardation providers,
 - 3) 2 day long trainings, one north and one south, for Community Support programs,
 - 4) A 2 day training for dual-Diagnosis (MH & SA) providers statewide, co-facilitated with Office of Substance Abuse,
 - 5) 1 day training for clinical supervisory personnel statewide,
 - 6) 1 day training addressing “Borderline Personality Disorder” issues,
 - 7) 1 day training on vicarious traumatization and burnout issues,
 - 8) 1 day training for providers in residential settings,
 - 9) 1 day training for providers in partial hospital/day program settings

- All participants and trainers in the Department’s trauma trainings, consultations and conferences will be invited to participate in the Maine Trauma Provider Coalition and Listserve described earlier. This vehicle for sharing information and ideas will greatly enhance the learnings gained from trauma training experiences.

LOCAL SERVICE SYSTEMS

To establish a baseline for the Department Trauma Design Team’s “second state” planning process and trauma-service development (described in the section “Next Steps and Future Activities”) and to determine what activities need to be prioritized at this time, an assessment of the strengths and weakness of the existing service system was necessary.

To this end, information has recently been gathered from a total of 103 organizations across the state known to provide various services and supports to persons with mental health problems. Using a survey questionnaire designed by the Trauma Design Team, data about 1) existing services specifically designed to assist people with histories of trauma, 2) intake procedures which include inquiry about trauma, 3) trauma specific services identified as still needed and 4) perceived barriers to effectively serving individuals with trauma disorders, was collected in each local service system through phone and person-to-person interviews with 75 mental health, substance abuse and peer support and advocacy organizations across the state. Another 28 organizations have been contacted and scheduled to be interviewed but could not be interviewed in time for this report. However, information about the kinds of trauma-specific services these 28

organizations offer has been obtained from the OTS Trauma Sensitive Services Directory and is included in the data. A brief summary of findings is presented below:

- 80% (61) of the 75 recently interviewed organizations serving mental health consumers now ask questions about trauma in their intake and/or assessment process. Most do so routinely.
- Of the 103 organizations data was gathered about, 47 offer some kind of trauma-focused service or services they have found to be effective.
- 27 of the 47 organizations provide Outpatient and Community Support services specifically focused on trauma, including individual psychotherapy (9), psychoeducational counseling(2), group therapy (5), family treatment (1), psychoeducational groups (2), support groups for women survivors (10), support groups for male survivors (6), support groups for people with developmental disabilities (1), support groups for people with physical disabilities (1), support groups for lesbians survivors (1) psychoeducational support groups for women survivors (2), psychoeducational support groups for adolescents (1), psychoeducational support groups for male survivors (1), phone support services for persons with histories of sexual abuse (10), expressive therapies (3), assessment (2), relapse prevention groups (1), psychiatric treatment (1) , clinical community support (1), Eye Movement Desensitization and Reprocessing (EMDR) (4), Thought Field Therapy (TFT) (1),
- 13 out of 34 organizations designating “Other” types of services specifically mention Dialectical Behavioral Therapy (DBT) or a variation as a service offered. Although DBT was not designed specifically to treat persons with a history of trauma, aspects of DBT have been found beneficial for many trauma survivors.
- The most often cited need (23 out of all the needs identified) is for additional training and consultation to staff regarding trauma issues, followed by support groups (9), individual therapy (9), group therapy (9) and housing (8).

MODEL PROJECT

The Trauma Design Team, after much discussion and consideration, decided that the best course of action is to continue to develop a trauma-informed or trauma-sensitive system of services. With the recent publication of Maxine Harris’ book “Using Trauma Theory to Design Service Systems” (Maxine Harris Ph.D. and Roger Fallot, Ph.D). The Trauma Design Team became very excited about working with a community mental health agency to examine the process by which mental health agencies could become more trauma-informed. This is the best course of action and the logical next step to facilitating

an overall trauma-informed mental health service system (in conjunction with related systems such as domestic violence and sexual assault). Tri-County Mental Health Services (TCMHS) volunteered to accept this as a project in their Rumford office. On June 18, representatives from TCMHS and from the Department held an initial conference call with Maxine Harris, Co-Director of Community Connections in Washington, D.C. and Executive Director of the National Capital Center for Trauma Recovery and Empowerment, to understand where to begin and to solicit consultation from Dr. Harris and her colleague Roger Fallot, Co-Director of Community Connections D.C. The Department has committed resources to pay for additional “unbillable” staff time (TCMHS) as well as expert consultation. This project will also include an evaluation component pertinent to the transfer of learnings to other agencies throughout the State. The Office of Trauma Services role is to work with TCMHS and Community Connections to capture administrative, clinical and organizational learnings to be applied to future replication in other community agencies. The following outlines the basic requirements in developing a trauma-informed agency:

- Administrative commitment

To accomplish and sustain a trauma-informed organization, administrative commitment and support is necessary. Both Department administrative leadership and the Executive Director of the agency must make a commitment to integrating knowledge about violence and abuse into the service delivery practices of the organization. This does not necessarily mean direct trauma services. It means a trauma perspective will be integrated into how staff members understand people and their problems. It will involve all levels and kinds of agency personnel as well as the agency’s partners (hospitals, private practitioners, etc.)

- Tri-County Mental Health Services has made the commitment to examine its practices in the Rumford office utilizing Maxine Harris and Roger Fallot as expert consultants. The Department has agreed to work along with TCMHS to understand the process and procedures to undertake this kind of commitment.
- Telephone conference call with Maxine Harris occurred on June 18 with TCMHS staff and Department staff participating. Dr. Harris is enthusiastic about consulting in this effort.
- Department funds have been identified to support both the consultation costs and the additional staff time for TCMHS.
- Dr. Fallot is scheduled to consult at the end of September. The expected first phase of the project will include meeting with various focus groups to get a good sense of the existing knowledge and awareness of trauma perspectives of the Rumford staff.
- Based on the results of this first phase, specific action steps will be developed. We anticipate action steps in each of these areas.

- Universal screening for trauma history

Universal screening means brief, non-threatening screening for trauma history of all individuals seeking agency services. Universal screening begins to institutionalize trauma awareness throughout the agency, conveys the message that violence and victimization matter, communicates to consumers caring about the role that violence plays in their lives, leads to more thoughtful referrals for services and reduces stigma surrounding physical and sexual abuse.

- Training and consultation for all agency personnel

All personnel (agency and contracted services), regardless of the professional training, receive minimum basic level of training about trauma. This basic information is needed by all personnel to convey the message that making the agency a safe place for trauma survivors is not solely the responsibility of a few clinicians but of everyone who works for the agency and comes in contact with consumers.

- Hiring and Human Resource Development practice

Supported by agency directors, newly hired or existing staffs are designated as “trauma champions” who, in addition to his or her job responsibilities, will act as internal consultants in all agency activities to raise the issue of trauma and influence the perceptions and practices of others. This simple strategy can help to change the culture of an entire agency, making it the norm for staff to include considerations about trauma in their everyday practice.

- Review of policies and procedures

Establish a committee of administrators, clinicians and consumers to systematically review policies, procedures and current practices to make sure these do not create barriers or have negative consequences to trauma survivors. Another approach is to adopt a universal assumption of inclusion considering all consumers receiving services as trauma survivors.

- Outcomes

The project will include an evaluation component that captures the learning from the project and makes the results available to disseminate and replicate in other mental health agencies. Potential outcomes include 1) decrease in the utilization of inpatient services 2) decrease in the utilization of crisis services and 3) increase in consumer satisfaction with services.

- Further System Enhancement

The results of the model project will be used to further refine the actions needed to enhance trauma-sensitive mental health services in Maine. Project results will be widely disseminated and may have implications for training, consultation, funding, policy, procedure and practices. The learning that occurs during this project will be invaluable in informing the system as to next steps.

OBJECTIVES, ACTION STEPS AND TIMING, AND BUDGET

All funds are currently within the Department's budget. The following are organized according to goals as outlined in the 1998 plan approved by the Court Master.

I. Awareness Raising, Communication Networks, Collaborations and Constituency Building

II. Development of new and modification of existing policies to better facilitate addressing the needs of trauma survivors

IV. Education and Support of Professionals Who Work With Trauma Survivors

Trauma Design Team

Continuation and re-formation of the Trauma Design Team as a "Trauma-Informed System Implementation Team" which in addition to initial BDS members includes the Tri-County staff involved in the model project: the Tri-Co Clinical Director, Housing Director and the Clinical Director of the Rumford Office.

Costs: Model Project costs as described previously.

Timeline: Currently in place and on-going.

ICMs and ICM Supervisor training program

Region II has identified a need for enhanced clinical support and supervision for the Intensive Case Managers who frequently have persons with trauma histories on their caseloads. Mary Jean McKelvy and Mary Auslander have proposed co-leading a monthly process and support (problem-solving) meeting with small area groups of ICMs and supervisors to discuss general issues of how trauma manifests, how workers are affected, what approaches are most promising for both consumers and workers and strategies for self-care while maximizing therapeutic interaction with consumers. This model will be evaluated for replication in other regions.

Costs: No additional funds required as these positions are currently in the Department's budget. Costs are associated only with the allocation of staff time.

Timeline: Fall 2001

Crisis System training model implemented in Region II and III

This new training model consists of three components – 1) a didactic and experiential training workshop followed by 2) a group case consultation session applying learnings from the workshops to specific problems experienced in working with consumers, followed by 3) participation of trainees on a list-serve where they can continue to communicate with one another and with the trainer/consultant Dusty Miller and others.

Costs: \$21,000 contained with the OTS training allocation

Timeline: January – December 2002

Maine Trauma Providers Coalition list serve

An email listserv is created and will be coordinated by the Office of Trauma Services with technical assistance. This listserv will allow Department staff and agency providers who serve clients with trauma histories to share information, ideas and consultations, further enhancing their ability to work effectively with trauma survivors.

Costs: \$1,000 contained within the OTS training budget

Timeline: January – December 2002

Annual Trauma Conference

The fourth annual conference will feature several renowned speakers and workshops presenters with trauma expertise in the field of substance abuse and mental health.

Costs: \$50,000 contained within the OTS training budget

Timeline: November 29 and 30, 2001

Risking Connection Trainings

This training program for working with survivors of childhood abuse will continue to be offered to a range of providers across a range of disciplines and fields.

Costs: \$30,000 contained within the OTS training budget

Timeline: On-going through December 2002

Publications

Reprinting of publication education documents, such as “In Their Own Words” and “Break the Silence, Support the Healing: What Happens to Abused Children When They Grow Up?” for distribution.

Costs: \$10,000 contained within the OTS budget

Timeline: July 2001 – June 2002

Books, Material, Audio-visuals for Training

This item supports publications and materials needed to deliver training effectively.

Costs: \$5,000 contained within the OTS budget

Timelines: On-going through June 2002

Newsletter

Supports the continuation of a quarterly survivor/consumer newsletter that is published and distributed in collaboration with the Augusta Sexual Assault Crisis Support Center.

Costs: \$4,000 contained within the OTS budget

Timeline: On-going through June 2002

III. The creation of trauma-based treatment options, services, supports and resources

Model project with Tri-County. A fuller description of this project is contained in the Model Project section of this plan. Projected costs for FY 2002, Year One are as follows:

Planning Phase July – November 2001

TCMHS \$14,400

Consultation \$14,000

Implementation Phase December 2001 – June 2002

(including qualitative evaluation)

Specific action steps to be developed during the Planning phase

\$41,600

Evaluation \$20,000

Costs: Project total Year One \$90,000 contained within regional budgets

Timeline: See above

Region I Integrated Trauma Treatment Team

This is a community based interdisciplinary team focused on working with trauma survivors using an integrated treatment approach and providing specific trauma-based approaches to clients. Services will be inter-disciplinary and focus on program staff working closely with one another on a daily basis. Services will be delivered individually to clients as well as in group settings. Various groups, including psycho-educational, process, and activity related will be an essential component of the program. It is anticipated that these groups will include formats of Trauma, Recovery and Empowerment model, skills training, creative/alternative (i.e. movement, music, writing, meditation, yoga, etc.) groups, advocacy-skills development groups, as well as other groups focusing on addressing needs and interests identified by consumers and program staff. Concepts, skills and ideas presented in the "Risking Connection" curriculum will form a strong basis in this model. Projections are that this service will result in reduction in hospitalization days and in use of crisis services as well as increased consumer satisfaction in quality of life measures.

Costs: Grant \$50,000 seed \$235,710 contained within the regional budget

Timeline: Spring 2002

AMHI trauma-informed inpatient services.

Included in the new psychiatric treatment facility plans is the development of trauma-informed inpatient services within the existing programs of AMHI, with the initial goal of making treatment approaches non-retraumatizing for patients with trauma disorders. More specific actions will be determined during the program planning phase for the new psychiatric facility.

Costs: Currently contained within the budget

Timeframe: New facility scheduled to open in Summer 2003

RFP under development in Region I for Intensive Residential Treatment Services and Supports.

This RFP represents services that operated under the auspices of an agency that went out of business. The homes and apartments have consumers currently residing there. Proposals for creative, innovative services based on best practice standards, which include peer supports, a vocational component, and are trauma informed are also encouraged. This includes 1 residence for women (6 beds), 1 residence for men (6 beds) and 6 more beds in supported apartments.

Costs: On-going operational costs

Timeline: Proposals due October 2001

Enhanced MeCASA Services

MeCASA support line and support groups enhanced with TREM training to do trauma-based psycho educational groups for women survivors and for male survivors, statewide at the MeCASA local centers. This training would further enhance the services of the 10 Sexual Assault Centers.

Cost: \$8,000.00 contained within the OTS budget

Timeline: January – December 2002

Funds to Access Trauma Clinical Consultation Services in Regions

All three regions have a pool of funding (\$50,000 in total) available to purchase clinical consultation on an as needed, fee-for-service basis.

Cost: \$50,000 contained within the regional budgets

Timeline: On-going through June 2002

Trauma Telephone Support Line (ME Coalition Against Sexual Assault)

Provides 24 hour, 365 day a year statewide coverage to adults and adolescents with histories of sexual abuse trauma who have serious mental health or addiction problems and who are at risk of going into a state of crisis.

Costs: \$190,376 contained within the OTS budget

Timeline: Ongoing through June 2002

Safer Place

The Department provides mental health services at no cost to consumers who were abused as children at Governor Baxter School for the Deaf. Funding may

cover co-pay or unreimbursed mental health services to assist survivors in the process of healing.

Costs: \$65,000

Timeline: Ongoing through June 2002

MEASURES OF ACCOUNTABILITY AND EFFECTIVENESS

Goals as outlined in the 1998 plan approved by the Court Master

I. Awareness Raising, Communication Networks, Collaborations and Constituency Building

Trauma Provider Coalition and Listserve:

OTS will account for numbers of participating members

Survivor/Consumer Newsletter:

2000 copies will be distributed each quarter

Public and Professional Education documents:

List of publications will be included in OTS Tool Kit document

Updated mailing lists will be maintained by OTS

Conferences and forums:

Muskie Institute Center for Learning will evaluate and summarize results

II. Development of new and modification of existing policies

Mechanism for administrative support to review and address policy issues:

The Trauma Design Team Workplan will be based on findings from implementation of the Model Project with Tri-County Mental Health

III. Trauma-informed and trauma-based treatment options, services, supports and resources

Model Project with Tri-County Mental Health:

Project plan and budget includes evaluation of the following outcomes:

- 1) decrease in utilization of inpatient services
- 2) decrease in utilization of crisis services
- 3) increase in consumer satisfaction with services

Integrated Trauma Treatment Team:

Outcomes projected include:

- 1) reduced hospitalization days
- 2) reduced use of crisis services
- 3) increased consumer satisfaction in quality of life measures

Trauma-informed inpatient services within AMHI programs:

This will be measured by the AMHI on-going Quality Improvement system

Intensive Residential Treatment Services and Supports:

Residential Treatment program will be incorporated into the Housing Quality Improvement activities and recommendations

Enhanced MeCASA support line and support groups:

Training will be delivered in TREM model

Muskie Institute CFL will tabulate evaluation findings of the TREM training participants

Trauma Clinical Consultation Service in each Region:

OTS will summarize number and kinds of requests for consultation annually

IV. Education and support of professionals who work with trauma survivors

Enhanced Clinical Supervision for Intensive Case Managers:

Department will account for a. numbers of problem solving meetings and participants, and b. numbers of case-oriented meetings and participants

Crisis system training and on-going consultation:

Muskie Institute CFL will tabulate evaluation findings for the Crisis Trainings including number of participants

Findings will be incorporated into the Crisis and the Training Quality Improvement reports

TREM: Trauma Recovery and Empowerment Model training program for working with traumatized women and program for working with male survivors

Muskie Institute CFL will tabulate evaluation findings and number of training participants in a report

4th Annual Clinical Trauma Training Conference:

Muskie Institute CFL will conduct a participant evaluation of all workshops and keynote presentations, record number of conference and workshop participants, and will tabulate and summarize findings in a report

Analysis of issues surrounding treatment available to individuals diagnosed with Borderline Personality Disorder:

Report of findings to the Commissioner by December 2001.

Consideration for incorporating findings into the Trauma Design Team workplan

Risking Connections Trainings for providers from variety of disciplines and fields:

Muskie Institute CFL will tabulate and summarize evaluation findings in a report for each training, including numbers of participants

Trauma Provider Coalition and Listserve:

OTS will account for numbers of participating members