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The LINC Model: A Collaborative Strategy for Community Resilience

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Abstract

This article describes the Linking Human Systems (LINC) Community Resilience model, a theoretical framework for initiating and sustaining change in communities that have undergone rapid and untimely transition or loss. I argue that: 1) By accessing their individual and collective strengths, communities can overcome loss and trauma; 2) Professionals who are called upon to assist communities in times of major transition or trauma must be sensitive to and collaborate with community members to draw upon resources that are available in the community; and 3) Helping community members build and maintain connectedness with one another, with their shared histories, and with tangible community resources is essential for fostering community healing. This article describes the model and provides examples of its application around the world.

### **Enhancing Resilience: Families and Communities as Agents for Change**

Communities may experience upheaval stemming from a wide variety of circumstances, including war, terrorism or other violence; natural disaster; political oppression or unrest; widespread drug abuse; AIDS and other disease epidemics; urbanization and isolation of the nuclear family; and economic decline and poverty. Such rapid, untimely and unpredictable transition or loss often leaves a trail of devastation that extends far beyond those individuals who are most directly affected (Landau, 2001a; Landau & Stanton, 2004; Landau-Stanton & Clements, 1993; Walsh & McGoldrick, 1991). During times of stress or trauma, people tend to become disconnected from family or community relationships (Reilly, 2002; Reilly, McDermott, & Coulter, in press), causing the transitional pathway--the delicate connection between past, present and future--to become disrupted (Landau-Stanton, 1990). Major cultural transitions, natural disasters, and even natural life-cycle transitions can cause "transitional conflict" within communities, an asynchrony between the speed and direction with which different individuals adjust to change (Boss, 2001; Garmezy & Rutter, 1983; Figley & McCubbin, 1983a, 1983b; Landau, 1982; Landau-Stanton, 1990). Especially if the upheaval is extreme or if resources are insufficient to balance the stresses, this asynchrony can precipitate symptoms of dysfunction, such as depression and suicidality, addiction, violence, post-traumatic stress, and risk-taking behaviors that can lead to HIV/AIDS (Landau, Griffiths, & Mason, 1981; Landau & Saul, 2004; Landau-Stanton, Clements, & Stanton, 1993).

One of the key principles emerging from work on loss and transition is the importance of reconnection, recalibration, and continuity of the transitional pathway (Landau-Stanton & Clements, 1993). We now know that people who can access the resilience of past generations -- including the rituals, strengths, stories, scripts and themes of those who came before -- can

reconnect their transitional pathways, better understanding where they came from and where they are now (Landau, 1991, 2001b, 2002; Landau-Stanton, 1990; Seaburn, Landau-Stanton, & Horwitz, 1995). For example, at a concrete level, research indicates that strong social relationships and support and connectedness with one's family of origin can provide healthy protection, and that lacking these connections can compromise health (e.g., Boehmer, Flanders, McGeehin, Boyle, & Barrett, 2004; Fisher et al., 2000; House, Landis, & Umberson, 1988; Landau, Cole, Tuttle, Clements, & Stanton, 2000; Rankin & Fukuoka, 2003; Tuttle, Landau, Stanton, King, & Frodi, 2004).

### **The LINC Community Resilience Model**

Following extremely stressful events, communities often have difficulty accessing resources that might offer support and strength for healing (Hobfoll, 1998; Chemtob, 2002). When this is the case, mutual support efforts, facilitated by trained professionals, can mitigate the effects of community trauma and loss, allowing people to support themselves in their recovery process (Landau, 2004a, 2004b; Landau & Saul, 2004).

In mental health research and practice, the importance of identifying and cultivating individuals' and families' inherent strengths, rather than merely pathologizing weaknesses, has long been recognized (Attneave & Verhulst, 1986; Boss, 1991; Figley & McCubbin, 1983a, 1983b; Garbarino & Kostelny, 1996; Imber-Black, 1986; Johnson, 2002; Landau & Saul, 2004; Seligman & Peterson, 2003; Walsh, 2003; Walsh & McGoldrick, 1991). The Linking Human Systems (LINC) Community Resilience model (Landau, 2001b, 2002, 2004a, 2004b) extends the concept of resilience to the level of the community. I define community resilience as a community's capacity, hope and faith to withstand major trauma and loss, overcome adversity,

and to prevail, usually with increased resources, competence, and connectedness. The LINC model assumes that communities, like individuals and families, are inherently competent and healthy; thus, with appropriate support and encouragement, all communities can access individual and collective strengths to transcend loss and trauma.

### *Building On Transitional Family Therapy*

The LINC Community Resilience model evolved from my approach to family therapy, known as Transitional Family Therapy<sup>1</sup> (Landau-Stanton, 1986, 1990; Landau-Stanton & Clements, 1993; Horwitz, 1997; Seaburn et al., 1995). Four key principles, common to Transitional Family Therapy and to the LINC Community Resilience model, are briefly outlined below:<sup>2</sup>

- *Competence.* Transitional Family Therapy and the LINC Community Resilience model regard families and communities as intrinsically healthy and competent (Landau, 1982; Landau-Stanton, 1986; Watson & McDaniel, 1998). Professionals working within this theoretical orientation should approach individuals, families, and communities with the attitude that they are capable of accessing resources and designing effective solutions to their problems.
- *A systems approach.* Transitional Family Therapy and the LINC Community Resilience Model take a systems perspective, recognizing that to effectively address families' and communities' problems and concerns, family therapists must understand the historical context and broader social systems in which they exist (Auerswald, 1968; Boszormenyi-

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<sup>1</sup> This approach to therapy, which I began to develop in my research and practice in South Africa in the 1970s, was further honed with colleagues at the University of Rochester Division of Family Programs.

<sup>2</sup> A lengthier discussion of the theoretical tenets of Transitional Family Therapy and the LINC Community Resilience model is provided elsewhere (Landau, 2004b).

Nagy & Spark, 1973; Bowen, 1976; Byng-Hall, 1991; Imber-Black, 1988, 1999; Landau, Griffiths & Mason, 1981; Landau-Stanton & Clements, 1993; McDaniel, Hepworth, & Doherty, 1992; Papadopoulos, Losi, & Kuscu, 2004; Speck & Attneave, 1973).

- *Mapping.* Therapists using Transitional Family Therapy and the LINC Community Resilience model rely on a variety of mapping techniques to assess families' and communities' structures and histories and to identify resources for healing. These include the transitional genogram (Landau, 1982; Landau, Griffiths, & Mason, 1981; Landau-Stanton, 1986, 1990; Watson & McDaniel, 1998), an expansion of McGoldrick's original genogram (McGoldrick, Gerson, & Shellenberger, 1999); geographic maps; and sociological maps such as the Transitional Field Map, the Multisystemic Levels Map, and the Structural Pyramid Map (see Landau, 2004b for more detailed discussion of these maps).
- *Using natural change agents.* Therapists using Transitional Family Therapy identify and coach a family member, the "Link Therapist," who can serve as an effective "link" between the therapist and the family or larger network (Landau, 1981, 1982, 2001a; Landau, Cole, Clements, & Tuttle, 1995; Landau et al., 2004; Landau-Stanton, 1986, 1990). Likewise, LINC community interventions recruit community members to serve as "Community Links" (Landau, 2001b, 2002, 2004a, 2004b). In both family and community settings, links should be respected members of the group and should be able to view the situation from multiple perspectives.

*Building Connectedness: A Collaborative Approach to Community Healing*

The LINC Community Resilience model is a collaborative strategy to promote resilience and community healing. The model is grounded in the principle that communities are inherently competent to effect positive change. For professionals who are called upon to aid communities during times of major transition or loss, it is essential to work collaboratively with community members to uncover the resources, both tangible and intangible, that the community already possesses (Hobfoll, 1998; Klingman & Cohen, 2004; Kretzmann & McKnight, 1993; Laor, 2004; Papadopoulos, 2002; Rojano, 2004). One of the more intangible, but crucial, aspects of this process is fostering among community members a sense of connectedness with one another, with the people who came before them, and with the daily patterns, rituals, and stories that impart spiritual meaning (Imber-Black & Roberts, 1992; Reilly, 2000; Sluzki, 2003). Doing so requires that we deliberately highlight themes of resilience and connection rather than themes of vulnerability and disconnection (Landau et al., 2000; Suddaby & Landau, 1998).

LINC community interventions entail three stages, as shown in Table 1.

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Insert Table 1 about here

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Critical to the LINC model's success is its reliance on Community Links, natural change agents who provide a crucial connection between mental health professionals and the community. This is particularly important in closed communities such as highly educated, sophisticated communities or communities composed of traditional extended families and clans, where outside intervention is neither invited nor welcomed. The Community Links initiate,

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maintain and sustain change long after the outside "experts" have departed. Working with them signals a respect for the community's competence and strength to effect positive change and preserves its tradition, pride, and privacy to remain intact.

Community Links should be respected and trusted members of the community who can communicate effectively with community leaders as well as with grass roots community members, their families, and their natural support systems. They should be flexible around community issues; should not be allied with any particular coalition of community members; and should be effective without engendering resentment or opposition from others in the community.

Families are treated as the fundamental unit of community change in the LINC model. Thus, it's critical for LINC interventions to be attentive to how rapid, untimely transition affects families within the community--their adaptations to loss and upheaval and their rituals and patterns of communication.

Rather than creating artificial support structures within communities, LINC interventions deploy existing community resources and leave decision making to community members. Professionals who facilitate LINC community interventions -- LINK Facilitators -- are responsible for providing the context, the process, and the skills that will allow communities to access their strengths and resources. They do not assume responsibility for either the goals of the community or the content of the community's interventions. Their role is brief, and in many ways consultative in process rather than content, allowing them to move on once the community is beginning to meet its goals, and/or healing from trauma. Since this approach works through Community Links, it permits the LINK Facilitators to help forge culturally appropriate, sustainable solutions without becoming embedded in communities or intruding into their privacy.

*Assessment Tools*

LINC community interventions use several tools for assessing communities' resources and histories. Figures 1 and 2 show two such tools, the Transitional Field Map (Landau, 2004b; Landau & Saul, 2004; Landau-Stanton & Clements, 1993) and the Multisystemic Levels Map (Landau & Saul, 2004; Saul, 2000), were used in the context of major disaster relief effort in New York City in the immediate aftermath of the September 11, 2001 terrorist attacks.

The Transitional Field Map is a schematic representation of a community's members, problems, resources, events, themes, and histories that exist within every level of a community, including biological and individual psychosocial systems; natural and ancillary (artificial) support systems; and cultural and ecosystems. Further, the Transitional Field Map underscores that each level within a community affects the others. It provides a template for designing interventions, including selecting Community Links and other participants in the intervention; setting goals; identifying concrete, easily attained tasks; determining a timeline for change; and establishing who will be responsible for which tasks.

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Insert Figure 1 about here

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A second map commonly used in LINC community interventions is the Multisystemic Levels Map. This map examines each level of the Transitional Field Map (e.g., community events, resources) in further detail. The map helps elucidate problematic events in the community, providing an additional opportunity to brainstorm solutions.

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Insert Figure 2 about here

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Finally, the Structural Pyramid Map (Landau, 2001b, 2004b; this map and its use is discussed in greater detail in the LINC community resilience manual) represents all members of the community, including individuals, families, schools, neighborhoods, local authorities and political leaders, and professionals. Using this map in designing community interventions helps ensure that everyone across the system is informed and invited, that there are no secrets, that authority is given where needed, and that the LINC intervention takes advantage of special skills and leadership already available in the community. The Structural Pyramid Map represents the recruitment of community members and the dissemination of the intervention across the community. The map is particularly useful for observing progress across time to ensure that Community Links' efforts permeate every level of the community.

### **LINC Interventions Worldwide**

LINC interventions have been used successfully in communities around the world. A few examples are discussed below.

#### *Buffalo, New York*

In 1983, Catholic Charities of Buffalo, a large social services organization in western New York State, invited me and my colleagues on the faculty at the University of Rochester's Division of Family Programs to direct a formal family therapy training program (including coursework, seminars and clinical supervisions) for the organization's senior social workers. Following the three-year externship, we provided two years of

supervisory training to these senior therapists, enabling them in turn to train the rest of the organization's 400 social workers. During an intra-agency conference during this period, some of the organization's 100 paraprofessional case-workers noted that they received insufficient support and training for their work "in the trenches." Collaborating with my colleague Pieter leRoux<sup>3</sup>, I developed a plan to provide family therapy training to the case-workers for one day each month. The first time the group met, we couldn't persuade the case-workers to talk. With difficulty, we learned that their work left them terribly stressed. They worked in isolation, several in very dangerous neighborhoods, and some, for their own safety, had to work behind bars. They were working extraordinarily hard, had minimal contact with their supervisors or each other, and were miserable. After lunch that first day, nearly desperate to find some way to join with them, I suggested that there must be *something* they enjoyed. Music and dance, they said; so on the principle that we needed to join them where they were, we spent the next few hours dancing. Then they started to talk about how burned out they were, also revealing that they resented having to spend a day each month at the training because they weren't getting any relief on their caseloads. With this clearer understanding of what was at the root of the paraprofessional case-workers' problems, we decided to take a different tack. As a group, we went to the different neighborhoods, walking the streets together so that everyone could learn about what troubled different neighborhood and what made each one tick. We met with activist groups within the neighborhoods; and we established an infrastructure that allowed the case-workers to communicate with one other about their work. After two months, they started to identify why certain neighborhoods seemed to be forever engaged

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<sup>3</sup> He is now Director of Family Therapy Training in the University of Rochester's Department of Psychiatry.

in drug wars, why houses kept burning down in others. The group discovered a host of factors that contributed to the neighborhoods' problems. For example, the state had recently built a ring highway that sliced through some neighborhoods, cutting children off from grandparents who had provided after-school supervision and making it difficult for families to access resources such as schools, clinics, youth and sports clubs, and social services. These were precisely the neighborhoods that were experiencing the most problems with drug dealers, arson, gang warfare and violence. Likewise, it emerged that the area that was experiencing the highest rates of suicidality was an area where a steel mill had recently shut down, leaving residents poverty-stricken and feeling disempowered. To better understand the neighborhoods' plight, the group mapped out the neighborhoods' geographic and economic histories. When they did, they could plainly see how the loss of jobs and geographic disruption had made people demoralized and vulnerable to a wide array of problems. Most of the paraprofessionals in this group lived in the same blighted neighborhoods that they served, and they had many times expressed that they couldn't wait to get out of their own communities. But as they came to understand their communities better, they began to want to stay in the community and to feel that they could make a positive difference. They also began to appreciate that communities that once had seemed hopeless to them in fact possessed resources. They realized that, with their respectful support, community members could play an active role in their own healing. At the end of the year, when it was time for them to present their work, a marvelous transformation had occurred. As a group, they had created a living genogram that filled an entire room: Suspended from the ceiling on hangers, meticulously arranged in a pattern of streets and alleys, were neighborhood maps, photographs of

families and shops: a colorful, twirling representation of the city that they had come to embrace. They walked through the genogram telling stories about developments in particular neighborhoods, how this neighborhood had had a community meeting and had been able to make a plan to collaborate with the community leaders and police (with whom they would previously not even communicate) to evict the drug dealers, deal with the gangs, and take back their streets, their homes and their community. After we completed the paraprofessional case worker training program, Catholic Charities of Buffalo asked us to follow up by taking social workers into the community, to help them gain a better understanding of the neighborhoods and circumstances that the families they worked with were coming from.<sup>4</sup>

### *Buenos Aires, Argentina*

Starting in 1990, I had the opportunity to fine-tune the LINC Community Model at a wider level, in the politically and economically ravaged province of Buenos Aires, Argentina<sup>5</sup>. Following a lengthy period of severe political unrest and upheaval in Argentina, a wide-scale survey had shown that there was an increase in the prevalence of addiction and HIV/AIDS in Buenos Aires Province (with an urban and rural population of 12 million). To combat these problems, health officials invited us to help develop a province-wide, community-based program focused on both

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<sup>4</sup> According to Catholic Charities of Buffalo director Diane Greenaway (Greenway, 2004, personal communication), the program's success has continued; more than 20 years after we began training the Catholic Charities social workers, the training program continues and thrives today, using the same methods.

<sup>5</sup> I served as a Fulbright Scholar in Argentina, with M. Duncan Stanton, Ph.D., consulting to Dr. Juan Yaria, Director of Addiction and HIV/AIDS in the Department of Health, Buenos Aires Province, Argentina, on the development of prevention and treatment services for addiction and HIV/AIDS.

prevention and intervention. We first trained professionals and paraprofessionals to use the assessment and intervention protocols of the LINC model. Then, we developed pre- and post- program surveys and used a series of maps to assess demographics, attitudes and customs, family structures, and important events in the communities. Following this assessment, we organized community forums, each representing a comprehensive cross-section of the population. There, members of the community (sometimes as many as 5,000) developed their own concept of resilience, using such words as *trust, faith, confidence, hope, loyalty, spirituality, and survival*. Following LINC protocol guidelines, they divided into small discussion groups, each representing a cross-section of the community. Each group developed overarching goals for the future, embracing those set by the ministry but also adding several of their own. The groups then worked as collaborative teams to select their Community Links -- people from within their own group that they trusted and with whom they could easily communicate, whom they thought would make good leaders, or links between their community and us as outside professionals. They then identified workable tasks from their goals and arranged work groups to achieve them. Some of the activities and groups that developed in different communities in Buenos Aires Province included: A partnership of police, school personnel, parents, and community residents to expel drug dealers from the neighborhood; support of a pre-existing formal organization, *Padre a Padre*, designed to serve parents of children struggling with issues of substance abuse or addiction (this organization grew into a nationwide initiative that continues to meet); a program for evening education for literacy, business skills, and handcrafts; and a social group for children and families of the

military to become integrated into the communities in which they were stationed.

Within two years, there was a 400% increase in the admission to treatment of young people struggling with alcohol or drug abuse--most of whom were brought to and supported in their treatment by family members.

### *Kosova*

Following the end of the 1999 war in Kosova, colleagues and I from the Kosovar Family Professional Education Collaborative<sup>6</sup>, have been consulting to the newly emerging government on building health and mental health systems that are closely tied to the culture and draw upon the strengths of family, community and culture (Agani, 2000; Agani, Cardozo, Vergara, & Gotway, 2000; Pulleyblank-Coffey, Griffith, & Ulaj, in press; Weine & Agani, 2002; Weine et al., 2004). The initial goal was to develop a services-based training initiative directed towards establishing a collaborative group of Kosovar professionals trained in family and systems approaches. Our work has prepared these professionals to work with Kosovar families and their communities to establish sustainable systems for prevention and intervention. Because the culture stresses the importance of the extended family and the community, the overall strengths-based design views families as the most important unit of change and communities as the primary units of both prevention and care. Adhering to the belief in family strengths (Landau-Stanton, 1986; Walsh, 1998, 2002, 2003) and the LINC model's underlying principle of inherent community resilience, all services are embedded in the communities, and the

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<sup>6</sup> Program initiated by S. Weine, J. Rolland & F. Agani. Supported by the Emergency Fund for Kosova; the American Family Therapy Academy; University of Illinois, Chicago; University of Prishtina; LINC Foundation; Linking Human Systems; International Trauma Studies Program, New York University;

communities participate in designing the systems of delivery and prevention. As a result, the inherent competence and resilience of the individuals, families and communities and their cultural heritage are mobilized, and we are seeing the emergence of a truly resilience-based health and mental health care system poised to develop effective mechanisms for dealing with trauma, grief and loss, violence, addiction, HIV/AIDS and other serious and chronic illness and mental illness.

### *Hualien, Taiwan*

In 2001, I was invited to Tzu Chi Buddhist University to help establish a catastrophe center there,<sup>7</sup> following a series of devastating earthquakes and floods. The disasters had precipitated a 60% increase in depression and suicidality, and much of the population were being treated for psychiatric illness, including anxiety, depression, suicidality, and psychosis (M.B. Lee, personal communication, 2002). As part of this effort, I taught a group of mental health therapists and medical school faculty members, graduate students, and undergraduates about enhancing resilience and health in individuals, families and communities during times of trauma. For the practical clinical part of the course, the students brought members of the community with them. Among them were members of a minority group that lived on an island off the coast and in a coastal region near that island. Following the catastrophic earthquakes and floods, these people were completely isolated; many didn't know where their family members were. There was a pervasive sense in the nearest village that they were "different," and that they would and could find their own way, and didn't require outsiders' help. The therapists who worked with them

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<sup>7</sup> During this same time, I was also working with Ministry of Health to establish a national catastrophe center.

talked about how they themselves struggled with the "we/they" dichotomy. I led the therapists and community members through an assessment exercise, in which they mapped out who was missing. A role-playing exercise helped the therapists and community members break down the we/they dichotomy, appreciate each other's histories and traditions, and understand the trauma from each other's perspectives. Using the Transitional Field Map, they identified strengths and resources that were available within families and within communities, as well as the traumas that had occurred. This process, which underscored the collective nature of community, helped counter a sense of dichotomy between those who lived in a closed traditional extended family community that had never asked before asked for outside help, and those who were not badly affected by the disasters and found it easier to distance themselves by relying on their sense of class or cultural superiority. Soon, the groups began to develop common goals and plans and establish workgroups to enact those plans. For example, they organized a building group to rebuild housing; established babysitting groups so that the families in which grandparents had been lost would still have caregivers to turn to; and started a kitchen to serve families that had lost homes. The process of developing these shared goals and plans to enact those goals enabled the groups to begin to connect with each another, reconstructing the transitional pathway that, already obscured by what seemed to be a cultural chasm, had been severed in the aftermath of the natural disasters. Transitional conflict began to subside and a new, more unified community, oriented toward healing, began to form.

## **Conclusion**

The LINC Community Resilience model describes a collaborative approach to community interventions. At both philosophical and practical levels, the model recognizes communities' inherent competence to find their own way to healing. The model adopts a systems perspective, viewing communities as a tightly interwoven collection of social networks, each dependent on the others. The implication of this systems orientation is that attempts to effect change in communities must bridge community hierarchies and involve as many networks as possible. Like Transitional Family Therapy, LINK Facilitators using LINC interventions recruit and coach trusted members of the community, known as Community Links, to bridge the various levels of the community (from the grass-roots level to the official level). In this way, Community Links serve as natural agents for change in the community; their central role ensures that the community "owns" its solutions and gets credit for change, maximizing the likelihood that change will be sustained over time.

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Table 1. The LINC Community Intervention Process in Detail

Stage 1: Town Meetings

- Ensure invitation and permission.
- Map the community.
- Assure cooperation and collaboration across all components of the community (using Transitional Field Map, Multi-Systemic Levels Map, and Structural Pyramid Map).
- Establish clear goals.
- Derive realistic and workable tasks.
- Develop and assign sustainable work groups.
- Establish clear time frames for each task and goal.

Stage 2: Weekly and Monthly Meetings of Work Groups. Our role in regular work-group meetings includes several "behind-the-scenes" activities:

- Assist in coordination of work groups, then withdraw to an observer role.
- Ensure continuity of the work groups by comprehensive representation in each group, with no spurious leaders.
- Facilitate individual, family, and community pride.
- Build on existing resources.
- Use natural change agents wherever possible to assume leadership roles in community and neighborhoods.
- Ensure that each endeavor relates directly to goals, future directions, and best interests of the community.

Stage 3: Create and Evaluate a Replicable Program of Community Support. By facilitating the initial town meetings and the subsequent work-group meetings, we strive to build a program that:

- Responds to immediate crisis.
- Offers a variety of interdisciplinary programs and services for trauma intervention.
- Simultaneously develops long-term family and community services to prevent the sequelae of trauma (e.g., substance and alcohol abuse, gambling, HIV/AIDS, depression, suicidality, and family violence).
- Creates an exportable plan to be prepared for future crises or situations of longer term or sustained stress.