

Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services

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Introduction

This report identifies criteria for building a trauma-informed mental health service system, summarizes the evolution of trauma-informed and trauma-specific services in state mental health systems, and describes a range of trauma-based service models and approaches implemented by increasing numbers of state systems and localities across the country. A summary of current state activities meeting 16 Criteria for Building a Trauma-Informed Mental Health System (see Appendix) is contained in the document *Trauma Informed Mental Health Service Systems: Blueprint for Action* (Jennings, in press). This technical report is focused on the trauma service models which were reported by states and organizations to meet the *Blueprint's* Criteria 15, Trauma-informed services and service systems, and Criteria 16, Trauma-specific services, including evidence-based and emerging best practice treatment models.

Who Are the Models Designed For?

All of the models described in this document are designed for persons receiving public mental health and/or substance abuse services who have been traumatized by interpersonal violence and abuse during their childhood and/or adolescence. Many of the models were designed specifically to address the kinds of complex traumatic stress issues and problems common in the lives of individuals seen in public service sector settings today. These individuals often have severe and persistent mental health and/or substance abuse problems and are frequently the highest users of the system's most costly inpatient, crisis, and residential services. They may carry any psychiatric diagnosis, and frequently do carry varied diagnoses over time such as Posttraumatic Stress Disorder (PTSD), borderline personality disorder, schizophrenia, depression and other affective disorders, anxiety disorder, eating disorder, psychotic, dissociative disorder, addictive, somatoform, and sexual impairment—all diagnoses which have been related to past trauma (Ford et al., 2004; Read et al., 2001; Felitti et al., 1998; Mueser et al., 2002).

Many of the individuals described above have developed extreme coping strategies to manage the impacts of overwhelming traumatic stress, including suicidality, substance abuse and addictions, self-harming behaviors such as cutting and burning, dissociation, and re-enactments such as abusive relationships (Saakvitne et al., 2000). Although the trauma they experienced in their formative years as children may be core to their illness and central to their healing, it has seldom been asked about or viewed as an issue central to treatment in the public mental health settings. For the most part these individuals have never received screening, assessment or treatment for trauma. (Mueser et al., 1998; Frueh et al., 2002)

What Kinds of Trauma are Experienced by Persons Who Develop Serious and Persistent Mental Illness and Addiction?

The kinds of trauma experienced by persons who are recipients of public mental health services are usually not associated with “single blow” traumatic events (Terr, 1991) such as natural disasters, accidents, terrorist acts, or crimes occurring in adulthood such as rape and domestic violence (Giller, 1999). Rather, the traumatic experiences of persons with the most serious mental health problems are interpersonal in nature, intentional, prolonged and repeated, occur in childhood and adolescence, and may extend over years of a person’s life. They include sexual abuse or incest, physical abuse, severe neglect, and serious emotional and psychological abuse. They may also include the witnessing of violence, repeated abandonments, and sudden and traumatic losses.

As adults, these individuals often experience trauma and re-victimization through domestic violence, sexual assaults, gang and drug related violence, homelessness, and poverty (Saakvitne, 2000). They are traumatized further by coercive interventions (Cusack et al., in press; Frueh et al., 2000) and at times sexual and physical abuse in inpatient or institutional settings, jails, and prisons. They frequently have serious and disabling health problems (Felitti et al., 1998). As parents, individuals with mental illness may participate in or witness the intergenerational effects of violence and abuse, and women in particular are vulnerable to revictimization, ongoing exploitation and abuse (Frueh et al., 2000; Rosenberg et al., 2001; Russell, 1986; Browne, 1992).

What Percentages of Mental Health Clients Have Histories of Trauma?

Individuals with histories of violence, abuse, and neglect from childhood onward make up the majority of clients served by public mental health and substance abuse service systems.

- 90% of public mental health clients have been exposed to (and most have actually experienced multiple experiences of trauma (Goodman, Rosenberg et al., 1997; Mueser et al., 1998)
- 75% of women and men in substance abuse treatment report abuse and trauma histories (SAMHSA/CSAT, 2000)
- 97% of homeless women with mental illness experienced severe physical and/or sexual abuse, 87% experienced this abuse both as children and as adults (Goodman, Dutton et al., 1997)

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- 55% of consumers and former consumers with a dual diagnosis of both mental illness and substance abuse reported histories of physical and/or sexual abuse (Maine Department of Behavioral and Developmental Services, 1998)
 - Teenagers with alcohol and drug problems are 6 to 12 times more likely to have a history of being physically abused and 18 to 21 times more likely to have been sexually abused than those without alcohol and drug problems (Clark et al., 1997)
 - 82% of all adolescents and children in continuing care inpatient and intensive residential treatment programs in the state of Massachusetts were found to have histories of trauma as reflected by a point-in-time review of medical records (LeBel J, Stromberg N, 2004)
 - Nearly 8 out of 10 female offenders with a mental illness reports having been physically or sexually abused (Smith, 1998)

Evolution of Trauma-Informed and Trauma-Specific Services in State Mental Health Systems

As awareness of the prevalence and impacts of trauma increases, the individuals for whom the trauma-informed and trauma-specific services described in this report were designed are increasingly viewed not as a subgroup or an anomalous or special population of clients, but as encompassing nearly *all* persons served by public mental health and substance abuse service systems. This increasing awareness is reflected in the rising number of states taking significant steps toward integrating knowledge about trauma into existing services and developing and/or implementing new “trauma-specific” services.

In 2001, about 12 states formed an informal network (State Public Systems Coalition On Trauma [SPSCOT]) to share ideas and support the development of trauma-informed systems of care. State mental health policymakers including Commissioners and senior staff, trauma experts, advocates, and mental health consumers with histories of sexual and physical abuse trauma (Consumer/Survivor/Recovering persons [C/S/Rs]) formed a listserv as a vehicle for on-going communication. A list of criteria for building trauma-informed mental health service systems was compiled, and a report entitled *Trauma Services Implementation Toolkit for State Mental Health Agencies* was prepared, listing trauma-related activities initiated and resources created by 15 state public service systems. This report, published as an appendix to *The Damaging Consequences of Violence and Trauma: Facts, Discussion Points, and Recommendations for the Behavioral Health System* (Jennings, 2004), was 28 pages in length.

In 2004, an update of the original *Trauma Services Implementation Toolkit*, entitled *Trauma-Informed Service Systems: Blueprint for Action*, has increased in size from 21 to over 130 pages, reflecting a dramatic increase both in the number of states now reporting trauma-related activities (from 15 to 31) and the multiplicity of strategies and programs they have adopted, initiated, or in some way support.

Trauma-related activities reported by states fall within 3 areas: 1) administrative policies or guidelines regarding the service system; 2) administrative policies and guidelines regarding services; and 3) trauma services. They meet one or more of the following sixteen *Criteria for Building a Trauma-Informed Mental Health Service System* (see Appendix for criteria descriptions). Many of the criteria are related to recommendations made in the President’s New Freedom Commission on Mental Health’s *Achieving the Promise: Transforming Mental Health Care in America*.

1. A designated trauma function and focus in the state mental health department
2. State trauma policy or position paper

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3. Workforce orientation, training, support, competencies and job standards related to trauma
 4. Linkages with higher education to promote education of professionals in trauma
 5. Consumer/Trauma Survivor/Recovering person (C/S/R) involvement and trauma-informed rights
 6. Trauma policies and services that respect culture, race, ethnicity, gender, age, sexual orientation, disability, and socio-economic status
 7. Systems integration/coordination among systems of care serving persons with trauma histories and including life-span perspective
 8. Trauma-informed disaster planning and terrorism response
 9. Financing criteria and mechanisms to pay for best practice trauma treatment models and services
 10. Clinical practice guidelines for working with people with trauma histories
 11. Procedures to avoid retraumatization and reduce impacts of trauma
 12. Rules, regulations, and standards to support access to evidence-based and emerging best practices in trauma treatment
 13. Research, needs assessments, surveys, data to explore prevalence and impacts of trauma, assess status of services, and support more rapid implementation of evidence-based and emerging best practice trauma treatment models
 14. Trauma screening and assessment
 15. Trauma-informed services and service systems
 16. Trauma-specific services, including evidence-based and emerging best practice treatment models

Factors Contributing to the Growth of Awareness and Activity in State Mental Health Service Systems

A number of factors are shaping and influencing increased awareness of trauma as a key public health and policy issue while promoting growth in trauma related activities within state mental health systems and localities. It has become evident to a critical mass of mental health leaders in decision making positions that:

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- a majority of persons served in public mental health and substance abuse systems have experienced repeated trauma since childhood;
 - they have been severely impacted by this trauma;
 - ignoring and neglecting to address trauma has huge implications for use of services and costs incurred;
 - evidence exists for effectiveness of trauma-based integrated treatment approaches and emerging best practice models designed for (and providing renewed hope of) recovery to clients with complex, severe, and persistent mental health and addiction problems; and
 - these trauma-informed and trauma-specific models are applicable and replicable within public service sector settings.

With increased awareness and commitment to a trauma paradigm on the part of policy makers, the kind of change and transformation of the existing mental health system called for by the President's New Freedom Commission on Mental Health report will follow.

The following factors provide both impetus and support for changes leading to a large-scale transformation of mental health service systems and their core services to a trauma-informed paradigm.

- **Leadership of the Substance Abuse and Mental Health Services Administration (SAMHSA).** SAMHSA has designated trauma a cross-cutting issue in its formal matrix of SAMHSA Priorities: Programs & Principles and has consistently supported local, state, and national level initiatives addressing trauma in the lives of both adults and children with mental health and substance abuse problems. In the 1990s, SAMHSA's Center for Mental Health Services (CMHS) developed a specific agenda on women's issues and gender-specific treatment, and in 1994 held a landmark conference, Dare To Vision. The conference brought together over 350 consumers, practitioners, and policy makers and created a national momentum on trauma and violence. This momentum led to the creation of a series of national "technical expert groups" on trauma and stimulated the development and testing of innovative approaches. In the 2000s, SAMHSA's Center for Substance Abuse Treatment (CSAT) published the first Treatment Improvement Protocol (TIP) on Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues. Several major studies and initiatives focused on trauma have also been initiated by SAMHSA/CMHS including the Women, Co-Occurring Disorders and Violence Study and the National Child Traumatic Stress Network.
- **The Women, Co-Occurring Disorders and Violence Study (WCDVS).** This landmark five-year multi-site study, launched by SAMHSA in 1998, was the first federal effort to address the significant lack of appropriate services for women with co-occurring substance abuse and mental health disorders who experienced trauma, and their children. During the first two years of the program, 14 organizations located in ten states developed and documented integrated service models and agreed upon site-specific and cross-site research protocols. A separate

study focusing on the children in these families was also developed. In the second phase of the study, nine study sites developed and tested manualized trauma-specific service intervention models integrating trauma, mental health, and substance abuse issues. Preliminary cross-site findings indicated significantly positive outcomes for the women and their children who received these integrated services. Further, the study indicated that interventions are cost effective. This study has impacted on service delivery, both within the states where study sites were located and nationally, by contributing a group of emerging best practice models which are applicable to public sector service settings and relevant and appropriate to clients served by public mental health service systems. The models are increasingly being adopted by state systems and adaptations of some models have made them appropriate for other genders and a variety of ethnic groups (www.nationaltraumaconsortium.org).

- **Leadership of the National Association of State Mental Health Program Directors (NASMHPD).** NASMHPD, along with its National Technical Assistance Center for State Mental Health Planning (NTAC), has utilized its established reputation and considerable networking capacity with federal and other national agencies, state mental health authorities (SMHAs), researchers, service providers, and mental health service consumers across the country to promote the development, dissemination, and implementation of new scientific knowledge and to bring emerging best practices in the field of trauma to state mental health systems. In 1998, the NASMHPD membership of state mental health Commissioners unanimously passed a *Position Statement on Services and Supports to Trauma Survivors* (NASMHPD, 1998). In 1998, NASMHPD held the first national trauma experts meeting, created an annotated bibliography on trauma and mental health, and declared NASMHPD to have a strategic role in keeping trauma at the forefront of a national mental health agenda. Plenary panels and other major presentations on trauma have been held at biannual NASMHPD Commissioners meetings. From 2002 to 2004, additional expert meetings were hosted by NASMHPD, a major initiative was undertaken by NASMHPD/NTAC to reduce seclusion and restraint practices and the retraumatization of such practices (see below), and a technical assistance project was produced to bring emerging best practice models to NASMHPD Division directors, the NASMHPD Research Institute, Inc., and SMHAs across the country. NASMHPD/NTAC produced several documents including, *Developing Trauma-Informed Behavioral Health Systems* (Blanch, 2003), *The Damaging Consequences of Violence and Trauma: Facts, Discussion Points, and Recommendations for the Behavioral Health System* (Jennings, 2004), *Trauma Informed Mental Health Service Systems: Blueprint for Action* (Jennings, in press), and this document.
- **The National Trauma Consortium (NTC).** Dedicated to improving the lives of trauma survivors and their families, the NTC was founded in 2003 by a group of individuals who had played key roles in the SAMHSA WCDVS study. NTC has three primary goals: to strengthen the interaction of research and practice; to increase the impact of our growing knowledge about trauma through activities in

the public arena, including advocacy, public policy, and public education and awareness; and to enhance the capacity of individuals and organizations to plan, implement, and oversee effective service approaches by offering high quality training and technical assistance, including leadership development. NTC is collaborating with SAMHSA/CMHS to organize the second landmark national conference on trauma: “Dare To Act: Trauma Survivors, Practitioners, Researchers and Policymakers Creating a Blueprint for Change.” The event is intended to provide a forum for practitioners, researchers, survivors of physical and sexual abuse with histories of mental health and substance abuse problems, and decision makers to encourage and support the applicability of the trauma paradigm (centrality of trauma) in mental health, substance abuse, and family and children’s service systems (www.nationaltraumaconsortium.org).

- **National Child Traumatic Stress Network (NCTSN).** The NCTSN is a coalition of 54 treatment centers from all over the United States, funded by SAMHSA/CMHS within the U.S. Department of Health and Human Services through a Congressional initiative, the Donald J. Cohen National Child Traumatic Stress Initiative. This coalition recognizes the profound, destructive, and widespread impact of trauma on American children’s lives. NCTSN’s purpose is to improve the quality, effectiveness, provision, and availability of therapeutic services delivered to all children and adolescents experiencing traumatic events by developing and disseminating effective, evidence-based treatments; collecting data for systematic study; and helping to educate professionals and the public about the effects of trauma on children. The 54 sites work collaboratively to address the issues of child trauma in the nation. The NCTSN was created in 2001 (www.nctsnet.org).

- **National Executive Training Institute for the Reduction of Seclusion and Restraint: Creating Violence Free and Coercion Free Mental Health Treatment Settings** (see description below). This trauma-informed approach has reduced seclusion and restraint (S/R) practices in mental health settings, practices often experienced as retraumatizing by consumers with histories of sexual and physical abuse. A training curriculum designed for executive and middle management staff, it has been implemented in a number of states. Evaluation studies of states submitting data pre- and post-training demonstrated significant reductions in hours of restraint, consumers restrained, restraint events, seclusion hours, clients secluded, and seclusion events. This initiative has been instrumental in raising awareness and knowledge of trauma in numerous state systems, particularly in mental health facilities (www.nasmhpd.org/ntac.cfm).

- **The Adverse Childhood Experiences (ACE) Study.** ACE is a decade-long and ongoing collaboration between Kaiser Permanente’s Department of Preventive Medicine in San Diego and the Centers for Disease Control and Prevention (CDC). The ACE study was designed to assess the relationship between the childhood experiences and the current health status and health risk behaviors of 30,000 mainly middle-class adult members of Kaiser Permanente. To date, data

have been collected from 19,000 cooperating adults. The study indicates that childhood abuse and household dysfunction lead to the development—decades later—of the chronic diseases that are the most common causes of death and disability in this country, including heart disease, cancer, stroke, diabetes, skeletal fractures, chronic lung disease, and liver disease. A strong relationship is shown between the number of adverse childhood experiences and reports of cigarette smoking, obesity, physical inactivity, alcoholism, drug abuse, depression, suicide attempts, sexual promiscuity, and sexually transmitted diseases. Furthermore, persons who reported higher numbers of adverse childhood experiences were much more likely to have multiple health risk behaviors. Similarly, the more adverse childhood experiences reported, the more likely the person was to develop chronic and disabling illnesses. Traditionally viewed as public health or mental health problems, these behaviors appear to be coping mechanisms for people who have had adverse childhood experiences, the study found. Authors suggest the behaviors may also reflect the effects of the adverse experiences on the developing brain chemistry—effects that may lead to the adoption of the coping behaviors (www.acestudy.org).

- **The Institute of Medicine *Crossing the Quality Chasm* Report.** In 2001, the Institute of Medicine published the report of the Committee on the Quality of Health Care in America, *Crossing the Quality Chasm, A Report on the Quality of Health Care in America*. The report identifies critical problems within the American health care system and begins to lay out a strategic direction for the redesign of systems for the 21st century. A 2002 summit was held on the “translation” of the *Quality Chasm* report for the Mental Health and Addictive Disorders fields. Ongoing work of the Quality Chasm Initiative includes collaborating with the Institute of Medicine; meeting with policy and payer stakeholder groups such as SAMHSA, NASMHPD, and CMS to explore collaborative initiatives; development of best practice model programs; and field testing results (Institute of Medicine, 2001).
- **President’s New Freedom Commission on Mental Health Report (2003).** Like the *Quality Chasm* report, this report calls for a complete transformation in the delivery of mental health care and articulates goals and recommendations that can serve as measurable outcomes for service systems. The Commission report explicitly draws attention to the seriousness of childhood traumatic stress and the need to better address the mental health needs of children. It also stresses the importance of implementing evidence-based practices and emerging best practices such as those developed and under development in the field of trauma. In addition, the report identifies the research and treatment of trauma as an important focus of mental health reform (President’s New Freedom Commission on Mental Health, 2003).
- **9/11 and Disaster Planning.** Following an immediate response to 9/11 by providing resources to the state of New York, SAMHSA convened a pre-summit, where nine of the most directly affected jurisdictions shared their experiences and

set an agenda for a national summit 3 weeks later. At that national summit, almost 700 individuals representing 42 states, 5 territories, the District of Columbia, 2 Tribal Governments, and over 100 other key stakeholder organizations participated. As a result, states have made progress toward finalizing their own disaster/emergency plans that include both mental health and substance abuse, and SAMHSA, the National Institute of Mental Health (NIMH), and the National Institute on Drug Abuse (NIDA) issued grants to move new knowledge about the effects of trauma to service programs nationwide. Though not directly addressing complex stress disorders such as those found in clients of public mental health services, this and other disaster planning and response initiatives have helped to raise the level of public and professional knowledge regarding the impacts of trauma and appropriate responses.

- **Development of Evidence-Based Practices and Emerging Best Practices with Applicability for Public Mental Health and Substance Abuse Systems.** As a result of all or some of the above factors, there has been a significant increase in the number of trauma-informed and trauma-specific services and models which are applicable, replicable, and appropriate for use in public sector service settings. Some of the models have been researched and they demonstrated positive client outcomes. The following section of this report outlines and describes over 50 service models and examples reported to be implemented within state mental health and substance abuse service systems.

Trauma-Informed and Trauma-Specific Models

Definitions of “Trauma-Informed” and “Trauma-Specific”

To address the treatment and support needs of survivors of trauma within the public system requires a systemic approach characterized both by trauma-specific diagnostic and treatment services and a “trauma-informed” environment capable of sustaining these services and supporting the positive outcomes to clients who receive these services.

Change to a trauma-informed organizational or service system environment will be experienced by all involved as a profound cultural shift in which consumers and their conditions and behaviors are viewed differently, staff respond differently, and the day-to-day delivery of services is conducted differently. The new system will be characterized by safety from physical harm and re-traumatization; an understanding of clients and their symptoms in the context of their life experiences and history, cultures, and their society; open and genuine collaboration between provider and consumer at all phases of the service delivery; an emphasis on skill building and acquisition rather than symptom management; an understanding of symptoms as attempts to cope; a view of trauma as a defining and organizing experience that forms the core of an individual’s identity rather than a single discrete event; and by a focus on what has happened to the person rather than what is wrong with the person (Saakvitne, 2000; Harris & Fallot, 2001). Without such a shift in the culture of an organization or service system, even the most “evidence-based” treatment approaches may be compromised.

“Trauma-informed” services are not specifically designed to treat symptoms or syndromes related to sexual or physical abuse or other trauma, but they are informed about, and sensitive to, trauma-related issues present in 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 (Harris & Fallot, 2001). A “trauma informed” system uses that understanding to design service systems that accommodate the vulnerabilities of trauma survivors and allows services to be delivered in a way that will avoid inadvertent retraumatization and will facilitate consumer participation in treatment. It also requires, to the extent possible, 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” (Harris & Fallot, 2001).

“Trauma-specific” services are designed to treat the actual sequelae of sexual or physical abuse trauma. 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 behavioral therapies which teach skills for the modulation of powerful emotions (Harris & Fallot, 2001). Treatment programs designed specifically for survivors of childhood trauma are consistent on several points: the need for respect, information, connection, and hope for clients; the importance of recognizing the adaptive function of “symptoms;” and the need to work in a collaborative empowering way with survivors of abuse (Saakvitne, 2000).

All trauma-specific service models, including those that have been researched and are considered emerging best practice models, should be delivered within the context of a relational approach that is based upon the empowerment of the survivor and the creation of new connections. The betrayal and relational damage occurring when a child is repetitively abused and neglected sets up lifetime patterns of fear and mistrust which have enormous impacts on his or her ability to relate to others and to lead the kind of life he or she wants. Recovery cannot occur in isolation. It can take place only within the context of relationships characterized by belief in persuasion rather than coercion, ideas rather than force, and mutuality rather than authoritarian control—precisely the beliefs that were shattered by the original traumatic experiences (Herman, 1992).

The trauma-informed and trauma-specific models described below are manualized models that have been reported in use by SMHAs and agencies serving public mental health and substance abuse consumers (see reference for “Jennings, in press” for more information). They are listed alphabetically and organized in the following categories.

- Models for Developing Trauma-Informed Service Systems and Organizations
- Individual Trauma-Informed Service Models
- Trauma-Specific Service Models for Adults
- Manualized Adaptations to Trauma-Specific Service Models for Adults
- Trauma-Specific Models for Parenting
- Trauma-Specific Service Models for Children
- Trauma-Specific Peer Support and Self Help Models

Information on research studies and findings regarding specific service interventions are indicated for each service example or model.

Based on the experiences reported by state service systems and organizations, the trauma-informed and trauma-specific emerging best practice models and services described in this report are applicable and replicable within public mental health and substance abuse service system settings.

Models for Developing Trauma-Informed Service Systems and Organizations

Developing Trauma-Informed Organizations: A Tool Kit

Developed by members of the Massachusetts State Leadership Council of the WCDVS Women Embracing Life and Living (WELL) Project of the Institute for Health and Recovery, this Toolkit is geared toward directors of organizations and policymakers. It is designed to help organizations develop plans to improve the quality of care offered to women with co-occurring substance abuse and mental health difficulties and histories of experiencing violence. It includes: principles for trauma-informed treatment of women with co-occurring mental health and substance abuse disorders; self-assessment for provider organizations; organizational assessment (for non-service providing organizations); and instructions for using the assessments to move toward providing trauma-informed, integrated care.

Status of Research: No research to date.

To obtain the Tool Kit, materials, and training information, contact: www.healthrecovery.org, or Laurie Markoff at wellproject@healthrecovery.org or 617-661-3991.

National Executive Training Institute for the Reduction of Seclusion and Restraint: Creating Violence Free and Coercion Free Mental Health Treatment Settings

This is a trauma-informed approach to reducing seclusion and restraint (S/R) practices in mental health settings, practices often experienced as retraumatizing by consumers with histories of sexual and physical abuse. In developing this model, the National Association of State Mental Health Program Directors worked with national experts in the field and completed an extensive literature review on seclusion and restraint, culture change, leadership, trauma-informed care, recovery-oriented systems of care, the public health prevention approach, the principle of continuous quality improvement (CQI), and all steps involved in a seclusion/restraint event. Using this information, substantiated by other literature reviews by objective and unrelated professionals, NASMHPD developed the first comprehensive curriculum to reduce the use of seclusion and restraint in mental health facilities.

The 17-module, 2-day NASMHPD training curriculum is designed to assist adult and child mental health facilities to reduce the use of seclusion and restraint. It is founded on the theoretical principles inherent in the public health prevention approach, leadership theory, trauma-informed care, the neuro/bio/psychological effects of trauma on human beings, consumer and staff experiences and self reports of S/R, and CQI. The training is designed for executive and middle management staff and leads to the creation of an individualized facility prevention plan to reduce S/R use. The plan needs to be designed

around the *Six Core Strategies for the Reduction of Seclusion and Restraint*®. These include: leadership toward organizational change; use of data, workforce development; use of S/R reduction tools; consumer roles in inpatient settings; and debriefing activities.

Status of Research: One evaluation study has been done on the first eight states that sent in data pre- and post-training and it demonstrated significant reductions in hours of restraint, consumers restrained, restraint events, seclusion hours, clients secluded, and seclusion events. S/R hours were reduced by as much as 79%, the proportion of consumers in S/R was reduced by as much as 62%, and the incidents of S/R events in a month were reduced by as much as 68%.

To obtain information about the Draft Training Curriculum for the Reduction of Seclusion and Restraint or how to participate in current or future trainings and evaluations, contact: Kevin Huckshorn, R.N., M.S.N., C.A.P., Director, Office of Technical Assistance, NASMHPD, via e-mail at kevin.huckshorn@nasmhpd.org

Risking Connection: A Training Curriculum for Working with Survivors of Childhood Abuse

Created by Karen W. Saakvitne, Ph.D., Sarah Gamble, Ph.D., Laurie Anne Pearlman, Ph.D., and Beth Tabor Lev, Ph.D, Risking Connection is a comprehensive, manualized, 20-hour, 5-module curriculum program which is used in multiple states as a resource for workforce development. Its objectives are to further implementation of trauma-informed service systems, to enhance trauma-specific service delivery to trauma survivors, and to improve all staff interactions with consumers, including the most difficult-to-treat, suicidal, and self-injuring consumers. This curriculum model was developed by the Sidran Institute and authored by trauma specialists at the Trauma Research, Education, and Training Institute, Inc. (TREATI) with input from helping professionals and trauma survivors with extensive experience in state mental health systems, clinical treatments of traumatic stress conditions, curriculum design, and the law. Risking Connection provides a basic (“Trauma 101”) framework for understanding and responding to trauma survivors. It is used with all levels of public mental health, health, and substance abuse staff—from inexperienced non-degreed front-line workers to highly trained personnel, mental health, and medical professionals—to create a trauma-informed environment and to empower both client and helper to work more effectively together.

Risking Connection has been adapted for use in multiple settings and fields including correctional, substance abuse, and developmental disabilities. Modules may be used flexibly and selectively, as may time-frames. The curriculum addresses common questions, concerns, and skepticism about trauma treatment; provides a theoretical framework to guide work with survivors of traumatic abuse; offers specific intervention techniques to use with survivor clients; and addresses internal needs of staff as well as clients. Modules include: Understanding Trauma is the First Step; Using Connections to Develop Treatment Goals with Survivor Clients; Keeping a Trauma Framework When Responding to Crises and Life-Threatening Behaviors; Working with Dissociation and

Staying Grounded; Self-Awareness as a Tool for Clients and Helpers; Vicarious Traumatization and Integration; and Putting It All Together. Client/provider worksheets are interspersed throughout the document as well as assessment, self-reflection, group discussion, and clinical practice exercises.

Status of Research: Unpublished one-year post training satisfaction survey of Risking Connection users in New York and Massachusetts was completed in August 2002.

Evaluation is ongoing for Risking Connection use in a trauma-informed HIV prevention project in partnership with the University of Maryland School of Psychiatry, Center for School Mental Health Services, Maryland State Department of Education, and Maryland State AIDS Administration.

Evaluation has been designed and is pending local grant funding in partnership with St. Vincent's Center, a Catholic Charities residential treatment facility for children and adolescents who are suffering from the trauma of child abuse and neglect.

Evaluation has been designed and is pending National Institutes of Health (NIH) funding in partnership with University of Maryland School of Social Work, School Mental Health Program for public school-based implementation of Risking Connection.

To obtain a Risking Connection curriculum, materials, and training information, contact: www.sidran.org, or Esther Giller at Sidran Institute, 410-825-8888, 410-337-0747 fax, or e-mail esther.giller@sidran.org

Sanctuary Model[®]

The Sanctuary Model[®] represents a trauma-informed method for creating or changing an organizational culture in order to more effectively provide a cohesive context where healing from psychological and social traumatic experience can be addressed. The Sanctuary Model[®] was originally developed in a short-term, acute inpatient psychiatric setting for adults who were traumatized as children. It was later extended to the longer-term treatment of adults in a state hospital setting and in a private psychiatric hospital in Canada (see below). Recently it has been adapted for use in three residential settings for children, all in New York State, with an NIMH research project based in one of the centers (MH62896). It has also been employed in an acute care setting at Salem Hospital in Salem, Oregon with a dramatic reduction in seclusion and restraint (see below). The model has been used in other settings as a method of organizational change, including domestic violence shelters, group homes, outpatient settings, substance abuse programs, and parenting support programs.

Status of Research: Homewood Hospital, Guelph, Canada. The Program for Traumatic Stress Recovery (PTSR) is a 28-bed, 6-week inpatient treatment program for adult survivors of childhood abuse with posttraumatic stress disorder that merges the concepts of the Sanctuary Model with that of the therapeutic community. In a study designed to

examine this comprehensive inpatient treatment program, 132 formerly abused individuals completed clinician-administered and self-administered measures of PTSD symptomatology at admission and discharge. All participants experienced a range of physical, sexual, and/or emotional abuse as children prior to the age of 17. Approximately 1/3 of these individuals also completed measures at 3-months post-discharge and 1-year post-discharge. Data were collected using a clinician-administered PTSD measure and self-administered PTSD measure at admission and discharge. On admission, all participants met criteria for a diagnosis of PTSD.

Analyses revealed that the program was effective in reducing symptoms from admission to discharge. Additionally, treatment gains were maintained at 1-year post-discharge. The findings of this investigation suggest that the current intensive inpatient group treatment program appears to reduce PTSD symptoms effectively for a sample of adult survivors of abuse (Wright et al., 2003).

Status of Research: Salem Hospital, Salem, Oregon. This hospital is a 400-bed community general hospital serving a catchment area of approximately 350,000 people. The adult inpatient psychiatry unit is in a freestanding building on the edge of the hospital campus. The program has been open for 13 years. Capacity is 22 patients (16 general adults and 6 geriatric adults), and the unit is usually full. Salem Hospital is one of several regional acute care units that replaced the state hospital system in Oregon nearly a decade ago. The unit accepts all patients in need of psychiatric care, with approximately 70% being involuntary. The average length of stay is nine days. More than 95% of patients are discharged into the community, though a small number are transferred for longer-term state hospitalization or to step-down units.

In consultation with Dr. Sandra Bloom, founder of the Sanctuary Model[®], Salem Hospital Psychiatry initiated a new environment of adult inpatient hospitalization using the basic tenets of Sanctuary in early 2001 with the goal of reducing coercion. Seclusion and restraint rates were used as measures of progress. Use of mechanical restraint has been virtually eliminated with the last episode occurring in October of 2002. Use of locked seclusion decreased from 150 episodes in 1999 to one episode in the past 11 months. Time in locked seclusion decreased from an average of 10 hours per episode in 1999 to 10 minutes during the last episode. There has been no increase in the use of psychotropic medications; in fact, there is an overall decrease in the use of emergent and “forced” medication injections.

There has been no change in patient selection. Emergency departments, police, jails, and crisis centers all refer patients regularly. Many patients have co-occurring substance abuse disorders along with symptoms of a major mental illness. Patient satisfaction scores have improved. There are significantly decreased staff and patient injuries, decreased time off due to work-related injuries, increased staff retention, and very little staff turnover since the full implementation of the mode. There has been an overall slight decrease in staff numbers due to more efficient use of time. Physician recruitment and retention has been extremely successful due to the model.

For more information, please contact Maggie Bennington-Davis, M.D., or Tim Murphy, M.S., administrative director, Psychiatry, Salem Hospital: 503-561-5761 or Dr. Sandra L. Bloom, M.D., www.sanctuaryweb.com, S13132020@msn.com, 215-248-5357.

A Training Manual for implementation of the Sanctuary Model[®] is in development. A Leadership Training Institute will begin in 2005. An elective graduate course has begun at the University of Pennsylvania School of Social Work. There is also a book on original inpatient work, *Creating Sanctuary: Toward the Evolution of Sane Societies* (Bloom, 1997).

To obtain further information on the manual, the institute, and training and consultation services, contact: Sandra L. Bloom, M.D., www.sanctuaryweb.com, S13132020@msn.com, 215-248-5357.

Using Trauma Theory to Design Service Systems

Used by state service systems and provider organizations, this small (103 pp.) book edited by Maxine Harris, Ph.D., and Roger Fallot, Ph.D. (2001) presents a step-by-step model for state mental health, substance abuse, and other public human service systems, provider agencies, and individual services and programs to become “trauma-informed.” The model provides guidelines for evaluating and modifying all system and service components in light of a basic understanding of the role that violence plays in the lives of people seeking mental health and addictions services, most of whom have been traumatically impacted by unaddressed histories of sexual and physical abuse.

Using Trauma Theory to Design Service Systems identifies essential elements necessary for a system to integrate a basic understanding about trauma into its core service programs so that the vulnerabilities of consumers with histories of sexual and/or physical abuse are accommodated, retraumatization is avoided, and participation in treatment is facilitated. It identifies fundamental characteristics of a trauma-informed system, guidelines for transforming an existing system of services, and necessary supports for bringing about system change. The book also examines and makes recommendations for modifying core service components (assessment and screening, inpatient treatment, residential services, addictions programming and case management) and addresses changing roles of consumers and providers in a trauma-informed system.

A self-assessment and planning protocol accompanies implementation of this model. Created by the authors of *Using Trauma Theory to Design Service Systems*, the “Trauma-Informed Services Self-Assessment and Planning Protocol” is used to assess the degree to which service systems or organizations are trauma-informed and to identify steps to take that can be incorporated into planning. The protocol includes key questions and possible indicators of trauma-informed approaches in areas such as administrative commitment to change; trauma screening; staff trauma training and education; hiring practices; formal policies; and formal and informal service procedures.

Status of Research: One formal pilot project has implemented this trauma-informed model in a mental health agency and evaluated responses from administrators, clinicians, and consumers to the services modifications. Qualitative responses from all three groups were positive. Administrators emphasized the value of: their increased collaboration with both clinicians and consumers; recovery skills-oriented services; an emphasis on physical and emotional safety; and enhanced trauma assessment. Clinicians noted the increased openness of their work with consumers; the value of focusing services on recovery skills, and the emphasis on vicarious traumatization and clinician self-care. Consumers reported having a more significant “voice” in services, especially via a Consumer Advisory Team established for the agency. In addition, they described an enhanced sense of safety and collaboration with agency staff. Quantitative evaluation focused on new consumers who entered services after the trauma-informed systems change was in process. Clinician ratings at baseline and three or six months indicated increases in overall functioning and recovery skills along with decreases in mental health symptoms, physical health concerns, consumer risk behaviors, and use of hospitalizations and crisis services. Consumer satisfaction ratings were very high, with 84% of the consumers giving their “overall experience” with the agency the scale’s highest rating.

To obtain the book, contact Aisha Meertins, M.S.W., at 202-608-4734 or ameertins@ccdc1.org or order it through Community Connections’ Web site at www.ccdc1.org To obtain the assessment and planning protocol and training or consulting information, visit www.ccdc1.org or call Rebecca Wolfson Berley, M.S.W., director of Trauma Training, at 202-608-4735 or rwolfson@ccdc1.org

Individual Trauma-Informed Service Models

Domestic Violence Group Intervention

This ten-session manualized group intervention helps women who have experienced domestic violence to break the cycle of abuse. Intervention is written as a leader’s manual, with a rationale, goals, questions to prompt discussion, and experiential exercises for each topic. Topics include: the relational context of domestic violence; the cycle of violence; power and control; multi-generational violence; the impact of domestic violence on children; anger; assertiveness; communication skills; and stopping the cycle.

Status of Research: No research to date.

To obtain a leader’s manual (Domestic Violence: A 10 Session Group Treatment Intervention) and more information, visit www.ccdc1.org or call Aisha Meertins, M.S.W. at 202-608-4734 or ameertins@ccdc1.org

Economic Success in Recovery

An educational group curriculum for women in recovery developed by the Boston Consortium of Services for Families in Recovery, Boston Public Health Commission and Institute on Urban Health Research at Northeastern University. *Exito Con Mi Dinero y Mi Recuperacion: Un curriculo educativo y grupal para mujeres en recuperacion.* (Spanish). The curriculum (Spanish and English) is for women with histories of trauma, mental illness, and substance abuse. This group model focuses on the options in planning for the future and financial success. Within a trauma-informed context, the women explore their strengths, skills, job and educational opportunities, decision-making, and understanding of their past and present experiences with money.

Status of Research: The Economic Success in Recovery was part of the intervention package offered to women participating in the Women, Co-Occurring Disorders and Violence Study in the Boston site. The study used a non-randomized comparison group design with comparison agencies providing services as usual and intervention sites providing the trauma integrated model. Analyses to date have focused on the overall differences in outcomes among intervention participants who received the ‘package’ of services and comparison group participants who received services as usual rather than on the specific outcomes related to exposure to this particular component of the intervention treatment ‘package.’ Two documents have been submitted for publication indicating that women in the intervention stay in treatment longer and also have lower sexual HIV risk behaviors than those in the comparison condition. Other analyses not yet published indicate positive outcomes in addiction severity, mental health, and trauma symptomatology at follow-up.

To obtain curriculum and additional information, contact Dr. Hortensia Amaro at h.amaro@neu.edu or Rita Nieves, R.N., M.P.H. at Rita_Nieves@bphc.org

Trauma Informed Addictions Group Intervention

This is a 20-session (75 minutes per), psycho-educational group intervention designed to address substance abuse issues within a trauma-informed perspective with survivors in the active treatment phase of recovery from substance addiction. Intervention used with all male, all female, or co-ed group membership. The group is aimed at helping survivors understand the connections between family history and addiction, substance use, and violence; the role of behavioral and emotional triggers in patterns of substance use; the emotional, interpersonal, and behavioral consequences of abuse; and re-victimization patterns. The final several topics are focused on empowerment, rebuilding relationships, achieving balance, and envisioning a dream for the future. The leader’s manual, *Trauma-Informed Addictions Treatment: A 20-Session Psycho-Educational Group Intervention Designed to Address Substance Abuse Issues Within a Trauma-Informed Perspective*, is written with a rationale, goals, questions and exercises to facilitate discussion and exploration for each session topic.

Status of Research: No research to date.

To obtain the leader's manual, materials, and more information, visit www.ccdc1.org or contact Aisha Meertins, M.S.W. at 202-608-4734 or ameertins@ccdc1.org

Trauma Issues Associated with HIV Infection: A Group Intervention

This is an 11-session group intervention designed for women trauma survivors who have also been diagnosed with HIV infection. Intervention is written as a leader's manual, with a rationale, goals, questions to prompt discussion, and experiential exercises for each topic. The group helps HIV positive individuals view the infection itself as an additional trauma. Issues to be discussed include disclosure and stigma; hopelessness and fear; dealing with the system; creating collaborative relationships; sexuality and future relationships; and acceptance and spirituality. Members have a chance to explore how their trauma histories might be affecting their management of the HIV infection and to design healthy approaches for dealing with the illness.

Status of Research: No research to date.

To obtain the manual, *Trauma Issues Associated with HIV Infection: An 11-Session Group Treatment Intervention*, and more information, visit www.ccdc1.org or call Aisha Meertins, M.S.W. at 202-608-4734 or e-mail her at ameertins@ccdc1.org

Trauma-Specific Service Models for Adults:

Addictions and Trauma Recovery Integration Model (ATRIUM)

Developed by Dusty Miller, Ed.D., and Laurie Guidry, Psy.D., ATRIUM is a manualized, sequentially organized, 12-week curriculum designed for people who are survivors of sexual and physical abuse, those with substance abuse and other addictive behaviors, those who are actively engaged in harmful relationships, who self-injure, have serious psychiatric diagnoses, and for those who enact violence and abuse against others.

ATRIUM is designed to work as a peer-led (as well as professionally led) group model and can be used for individuals working with therapists or counselors, or in group or peer support settings. ATRIUM is implemented within substance abuse and mental health treatment settings as well as in peer group environments. The model has primarily been used with single-sex groups.

Informed by Miller's personal knowledge of the mental health system and addiction recovery, and based on the premise that trauma impacts survivors on the physical, mental, and spiritual levels, ATRIUM is designed to intervene at all three levels. Integrating cognitive-behavioral and relational treatment, ATRIUM blends psycho-educational, process, and expressive activities. The curriculum provides information on the body's response to addiction and traumatic stress as well as the impact of trauma and addiction on the mind and spirit. Information is also included on anxiety, sexuality, self-harm,

depression, anger, physical complaints and ailments, sleep difficulties, relationship challenges, and spiritual disconnection. New ways are also presented for thinking about self-care, self-soothing (relaxation response, mindfulness training), and self-expression.

The ATRIUM manual, *Addictions and Trauma Recovery: Healing the Body, Mind and Spirit*, may be used in conjunction with 12-step or other addiction treatment programs, as a supplement to trauma-focused psychotherapy, or as an independent model for healing. Each treatment component includes explanations and interventions to be used collaboratively by professionals and consumers in groups or individual treatment. Handouts allow consumers to work on coping skills between sessions.

Status of Research: ATRIUM was selected as one site of the 9-site SAMHSA Women, Violence and Co-occurring Disorders study. Results of that cross-site study show positive effects for trauma treatment and indicate that participation in integrated counseling that addresses treatment issues related to trauma, mental health, and substance seems to be the key ingredient in achieving better outcomes.

To obtain the manual, and for information on training and technical assistance (in English and Spanish), visit www.dustymiller.org, e-mail dustymi@valinet.com, or call Dusty Miller at 413-584-8404.

Beyond Trauma: A Healing Journey for Women

Developed by Stephanie S. Covington, Ph.D., L.C.S.W., co-director of the Institute for Relational Development and the Center for Gender and Justice, *Beyond Trauma: A Healing Journey for Women* (Covington, 2003) is a manualized curriculum for women's treatment based on theory, research, and clinical practice. While the materials are trauma-specific, the connection between trauma and substance abuse is recognized and integrated throughout the curriculum. The program is designed for use in outpatient, residential, and criminal justice settings. *Beyond Trauma* has a psycho-educational component that teaches women what trauma is, its process, and its impact on both the inner self (thoughts, feelings, beliefs, values) and the outer self (behavior and relationships, including parenting). The major emphasis is on coping skills with specific exercises for developing emotional wellness. The curriculum includes a facilitator manual, participant workbook, and three instructional videos (two for facilitators, one for clients).

The facilitator's manual has two parts. The first part gives group leaders background information about trauma. Having a basic understanding of the depth and complexity of the issues helps the facilitator work more effectively with the group. The second part of the manual includes session outlines that are like lesson plans. There are 11 sessions total in the 3 modules: a) Violence, Abuse, & Trauma; b) Impact of Trauma; and c) Healing from Trauma.

The women in the group will go through a process of understanding what has happened to them by learning what abuse is and how wide spread it is in women's lives; exploring

how abuse and trauma have impacted them; focusing on safety and learning coping mechanisms, including exercises to help them feel grounded and safe; and learning strategies for symptom reduction.

Beyond Trauma promotes a strength-based approach that seeks to empower women and increase their sense of self. The exercises are designed to give them a corrective experience of connecting with others in a safe environment. In using this model, the facilitator helps the women in the group to see the strengths they have and to increase the skills they need. The curriculum also focuses on emotional development. Dealing with the expression and containment of feelings (fear, loss, grief, anger, shame) is a critical part of trauma work. The program uses cognitive-behavioral techniques (CBT), expressive arts, and is based on the principles of relational therapy. *Beyond Trauma* can also be used with *Helping Women Recover: A Program for Treating Addiction* (see below) to extend and deepen the trauma work introduced in *Helping Women Recover*.

Status of Research: Beyond Trauma is in the process of being evaluated at several sites, including an outcome study funded by the California Endowment. The site for this study is a residential substance-abuse program for women and children. Pre- and post-tests are being used with 50 women in Year 1 and 100 women in Year 2 to evaluate the following domains: relapse, mental health symptoms related to trauma (anxiety, depression, PTSD), and family functioning (parenting skills and reunification). Follow-up will be done 6 months and 12 months after program completion.

To obtain the *Beyond Trauma* program curriculum (facilitator's manual, participant's workbook, instructional videos) and for information on training and consultation, contact Stephanie S. Covington, Ph.D., L.C.S.W., 7946 Ivanhoe Avenue, Suite 201B, La Jolla, CA 92037, 858-454-8528 or via e-mail at sscird@aol.com Visit www.stephaniecovington.com or www.centerforgenderandjustice.org

Cognitive-Behavioral Treatment for PTSD Among People with Severe Mental Illness

Developed by B. Christopher Frueh, Ph.D., and colleagues, this is a manualized, multi-component cognitive-behavioral treatment model appropriate for chronic and severe PTSD among people with serious mental illness who are treated in public-sector mental health clinics. All components are designed for administration in a group format with the exception of Exposure Therapy which takes place in 6-12 individual therapy sessions. Group work takes place in 10–14 (1-hour) sessions. This treatment model should serve as an intervention guide to be administered with flexibility. The exact sequencing, implementation, and dose of components may vary across settings and among clients, but clinicians and investigators may use this model as a starting point for developing, delivering, and evaluating treatment with this population.

The model includes a comprehensive treatment designed specifically to target various aspects of the clinical syndrome associated with PTSD in persons with SMI, particularly

emotional and physiological reactivity to traumatic cues, intrusive symptoms and avoidance behavior, impaired interpersonal skills and emotion modulation (e.g., anger control), and reduced range of enjoyable social activities. It incorporates the PTSD psychosocial treatment approach with the most empirical support (exposure therapy) with a social skills and anxiety management training component that has been shown to work for other clinical populations.

The model consists of three phases: education/motivation/anxiety management skills; exposure; and coping/social skills. The major components of the model are: Education; Anxiety Management Skills Training; Social Skills Training; Social Environment Awareness; Social Skills Enhancement; Anger Management; Trauma Issues Management; Exposure Therapy; “Homework” Assignments; Long-term Follow-up Care.

For further information refer to *Cognitive-Behavioral Treatment for PTSD among People with Severe Mental Illness: A Proposed Treatment Model* (Frueh et al., 2004).

Status of Research: The project is in Year Two of a three-year NIMH treatment development grant. Open trials are currently being conducted with two groups, with plans for randomized trials to begin following revisions to the manual. For information about the model and obtaining a draft manual and materials, contact B. Christopher Frueh, Ph.D. at 843-789-7967 or via e-mail at fruehbc@musc.edu

Eye Movement Desensitization and Reprocessing (EMDR)

EMDR is an integrative structured treatment for Posttraumatic Stress Disorder (PTSD) during which the client is asked to hold in mind a disturbing image, an associated negative cognition, and bodily sensations associated with a traumatic memory while tracking the clinician’s moving finger in front of his or her visual field. Variations of the procedure are repeated until distressing aspects of the traumatic memory are reduced and more adaptive cognitions emerge regarding the trauma. Similar procedures are used to install alternate positive cognitions, coping strategies, and adaptive behaviors. EMDR processes historical events, current incidents that elicit distress, and future scenarios that will require different responses. The overall goal is to produce the most comprehensive and profound treatment effects in the shortest period of time, while simultaneously maintaining a stable client within a balanced system. The number of EMDR sessions should be consistent with the complexity of the trauma and the number of traumatic memories (Foa et al., 2000; Shapiro, 1995).

Status of Research: In seven published, randomized, controlled studies with overall large effect sizes, one of which included children, EMDR was found to be an efficacious treatment for PTSD. The evidence is stronger for the beneficial effect of EMDR on persons with single-event trauma than on multiply traumatized individuals with severe and persistent mental health problems.

To obtain information and materials on EMDR and training and consultation in this model, contact: EMDR Institute, Inc. at 831-761-1040 or online at www.emdr.com or via e-mail at inst@emdr.com

Growing Beyond Survival: A Self Help Toolkit for Managing Traumatic Stress

Created by Elizabeth G. Vermilyea, M.A., this manualized approach teaches skills that empower survivors to take control of and de-escalate their most distressing trauma-related symptoms. The workbook is intended for use in therapist-run symptom management therapy groups. It can also be used effectively by survivors for managing trauma symptoms between therapy sessions and for individual survivor self-help. It teaches trauma survivors to recognize, contextualize, and understand distressing dissociative and posttraumatic reactions. It also creates a structure in which to learn and practice skills for self-regulation of the troublesome thoughts, feelings, and impulses related to traumatic experiences. Developed in part and extensively field tested at Trauma Disorders Programs at Sheppard Pratt Hospital in Baltimore, *Growing Beyond Survival* offers tools enabling survivors who suffer from trauma-related symptoms (including poor concentration, sleep disturbances, panic attacks, nightmares, flashbacks, and other physical responses) to find relief. It also examines the relation between trauma and self-harming behaviors, difficulties with sexuality, and substance abuse.

Status of Research: No research to date.

To obtain this resource and for additional information, contact the Sidran Institute at 410-825-8888 or online at www.sidran.org/catalog/vegb.html or via e-mail at orders@sidran.org

Helping Women Recover (HWR): A Program for Treating Addiction

Developed by Stephanie S. Covington, Ph.D., L.C.S.W., co-director of the Institute for Relational Development and the Center for Gender and Justice, *Helping Women Recover: A Program for Treating Addiction* (with a special edition for criminal justice settings entitled *Helping Women Recover: A Program for Treating Substance Abuse*) is an integrated, manualized curriculum for treating women with histories of addiction and trauma. It is designed for use in a variety of settings including outpatient and residential substance abuse treatment programs, domestic violence shelters, and mental health clinics, as well as jails, prisons, and community corrections. *Helping Women Recover* is grounded in research, theory, and clinical practice. The foundation of the treatment model is the integration of three theories: a theory of addiction, a theory of women's psychological development, and a theory of trauma. The therapeutic strategies include psycho-educational, cognitive-behavioral, expressive arts, and relational approaches.

The facilitator's manual for the 17-session program is a step-by-step guide containing the theory, structure, and content needed for running groups. *A Woman's Journey*, the

participant's workbook, allows women to process and record the therapeutic experience. The program model is organized into four modules: self, relationships, sexuality, and spirituality. These are the four areas that recovering women have identified as triggers for relapse and as necessary for growth and healing. The materials are designed to be user-friendly and self-instructive. This allows the *HWR* program to be implemented by a staff with a wide range of training and experience.

Each session is organized in the following way.

- The objectives, general topics to be covered, and materials needed are listed at the beginning of each session.
- There is a check-in with the women in the group at the beginning of each session.
- Each session contains a teaching component—a segment in which the key topic(s) for the session are presented to enhance the women's understanding of the topic(s).
- Each session contains an interactive component in which the women discuss the issues, ask questions for clarification, and process the new information.
- Each session contains an experiential component in which the women do exercises to try out new skills, based on the information just presented, in a safe, supportive environment.
- Closure includes questions for the women to think about until the next session.

The groups are designed to be 90 minutes in length and to include 6 to 10 women with one facilitator. It is recommended that the curriculum be implemented sequentially in closed groups, but this is not a requirement. It can also be adapted for work with individuals.

Status of Research: *HWR* is currently being evaluated at several sites. One site is a residential substance-abuse program for women and children. Pre- and post-tests are being used with 50 women in Year 1 and 100 women in Year 2 to evaluate the following domains: relapse, mental health symptoms related to trauma (anxiety, depression, PTSD), and family functioning (parenting skills and reunification). Follow-up will be done 6 months and 12 months after program completion (this study is evaluating both *Helping Women Recover* and *Beyond Trauma*). One prison-based pilot (funding pending) uses an experimental design with 100 women randomly assigned to *HWR* or to a standard prison TC program. The study will test the impact of *HWR* on program performance, aftercare participation, and recidivism for women offenders, compared to the impact of a standard TC. It will also qualitatively assess treatment staff and client perceptions of the elements of the program. It is anticipated that this pilot will be expanded to a 5-year randomized study of 400 women using specific post-treatment outcome measures including recidivism, substance abuse and relapse, and social adjustment (e.g., employment, parenting behaviors, psychological improvement, relationship issues), compared to the impact of standard treatment.

In addition, there is approximately 4 years of anecdotal clinical data and self-report showing increased treatment retention, stronger therapeutic alliance, and lower rates of

relapse, as well as high client and staff satisfaction. *HWR* (criminal justice version) has been selected by the Correctional Services of Canada as the basis of their female offender programming. They are also doing quantitative and qualitative research.

HWR has also been adapted for adolescent girls in a program entitled *Voices: A Program of Self-Discovery and Empowerment for Girls* (see Models for Children, below).

To extend and deepen the trauma work introduced in *HWR*, *Beyond Trauma: A Healing Journey for Women* (described earlier in this section) can be used with *HWR*.

To obtain the *HWR* facilitator's manual and a *Woman's Journal* and for information on training and consultation, contact Stephanie S. Covington, Ph.D., L.C.S.W., 7946 Ivanhoe Avenue, Suite 201B, La Jolla, CA 92037 or at 858-454-8528, via e-mail at sscird@aol.com or online at www.stephaniecovington.com or www.genderforgenderandjustice.org

Seeking Safety Model

Developed by Lisa Najavits, Ph.D., at Harvard Medical/McLean Hospital, Seeking Safety is a manualized 25-topic, flexible, integrated treatment designed to address safety and recovery for persons with the dual diagnosis of PTSD and substance abuse (as well as persons with a trauma history who do not meet clinical criteria for PTSD). Seeking Safety is designed to be used in a wide variety of settings including substance abuse treatment (outpatient, inpatient, residential), correctional facilities, health and mental health centers, etc., as well as for both group and individual format, females and males. Flexible and adaptable, topics can be conducted in any order, the number of topics covered can be changed depending on a client's length of stay, and groups can be facilitated by a wide variety of counselors. It can be implemented by a very wide range of counselors, including those without a degree in mental health (e.g., substance abuse counselors, case managers). Seeking Safety recognizes establishing safety as the most urgent clinical need for persons with PTSD and substance abuse problems, and teaches a range of more than 80 "safe-coping" skills to work toward discontinuing substance use, letting go of dangerous relationships, and gaining control over dissociation and self-harm (e.g., grounding, self-nurturing, asking for help, setting boundaries in relationships). Rethinking is used to challenge demoralizing or risky beliefs, including distortions specifically related to PTSD and addiction, and to restore ideals that have been lost, including respect, care, protection, and healing.

The treatment manual, *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse*, (Najavits, 2002) includes client handouts and clinician guidelines. It offers 25 topics to address cognitive, behavioral, interpersonal, and case management domains: Introduction/Case Management; Safety; PTSD; Taking Back Your Power; When Substances Control You; Honesty; Asking for Help; Setting Boundaries in Relationships; Getting Others to Support Your Recovery; Healthy Relationships; Community Resources; Compassion; Creating Meaning; Discovery; Integrating the Split Self;

Recovery Thinking; Taking Good Care of Yourself; Commitment; Respecting Your Time; Coping with Triggers; Self-Nurturing; Red and Green Flags; Detaching from Emotional Pain (Grounding); Life Choices; and Termination. A Spanish-language version of the manual will be available by the end of 2004.

Status of Research: Seeking Safety is the most empirically studied treatment thus far for trauma/PTSD and substance abuse, and was designed from the start as an integrated treatment for both domains. Seeking Safety was selected by four sites of the 9-site SAMHSA Women, Violence and Co-occurring Disorders study. Results of that cross-site study show positive effects for trauma treatment and indicate that participation in integrated counseling that addresses treatment issues related to trauma, mental health and substance abuse seems to be the key ingredient in achieving better outcomes. In addition, Seeking Safety has shown positive results in seven outcome studies including two randomized trials. The studies were: outpatient women using group modality; women in prison, in group modality; low-income mostly minority women, in individual format; adolescent girls, in individual format; outpatient men traumatized as children, in individual format; women in a community mental health setting, in group format; and finally, men and women veterans, in group format. In all six studies that reported on substance abuse, improvements were found in that domain. Similarly, all six studies that included assessment of PTSD and/or trauma-related symptoms found improvements in those areas. Improvements were also found in a variety of other areas, such as general psychiatric symptoms, social adjustment, suicidal thoughts and plans, problem-solving, sense of meaning, quality of life, and depression.

Treatment attendance and satisfaction were high. Four of the studies had follow-up periods after treatment ended and showed maintenance of some key gains. Five of the studies were pilots, while two were randomized controlled trials. In the trial by Hien et al, (under review), *Seeking Safety* performed as well as *Relapse Prevention* treatment, and both significantly outperformed a non-randomized treatment-as-usual control condition (standard substance abuse and mental health treatment). In the Najavits, Gallop et al. study [Najavits LM, Gallop RJ, Weiss RD (under review). *Seeking Safety* therapy for adolescents with PTSD and substance abuse: A randomized controlled trial. (Email seekingsafety@netzero.com to obtain.), *Seeking Safety* outperformed treatment-as-usual in the community for outpatient adolescent girls. Finally, it can be noted that two of the studies combined *Seeking Safety* with other manual-based approaches. The study of men combined *Seeking Safety* with *Exposure-Therapy-Revised*, an adaptation of *Exposure Therapy* for PTSD specifically for substance abuse clients. The study of women in a community mental health center combined *Seeking Safety* with Linehan's *Dialectical Behavior Therapy*. Seeking Safety is currently being evaluated in several national trials.

To obtain a manual and for information on training and consultation, visit www.seekingsafety.org or e-mail info@seekingsafety.org or call Lisa Najavits, Ph.D. at 617-855-2305, McLean Hospital, 115 Mill Street, Belmont, MA 02478.

Spirituality and Recovery Curriculum

This is a 7-session group manual and curriculum that helps women in recovery from addiction and trauma explore their spiritual roots, assess the impact of religion and spirituality in their lives and make choices about how to grow and develop their chosen spiritual traditions to support recovery and healing from trauma. The curriculum was developed by the Boston Consortium of Services for Families in Recovery, Boston Public Health Commission, the Institute on Urban Health Research, Northeastern University.

Status of Research: The Spirituality and Recovery Curriculum was part of the intervention package offered to women participating in the Women, Co-Occurring Disorders and Violence Study in the Boston site. The study used a no-randomized comparison group design with comparison agencies providing services as usual and intervention sites providing the trauma-integrated model. Analyses to date have focused on the overall differences in outcomes among intervention participants who received the ‘package’ of services and comparison group participants who received services as usual rather than on the specific outcomes related to exposure to this particular component of the intervention treatment ‘package.’ Two documents have been submitted for publication which report on findings indicating that women in the intervention stay in treatment longer and also have lower sexual HIV risk behaviors than those in the comparison condition. Other analyses not yet published indicate positive outcomes in addiction severity, mental health, and trauma symptomatology at follow-up.

For more information or copies of these materials, please contact Dr. Hortensia Amaro at h.amaro@neu.edu or Rita Nieves, R.N., M.P.H., at Rita_Neives@bphc.org

Spirituality in Trauma Recovery Group

This manualized group intervention of 11 sessions addresses spiritual and religious resources for empowerment and recovery from physical and sexual abuse. Group topics include: What It Means To Be Spiritual; Spiritual Gifts; Spiritual Coping Strategies; Anger; Fear and Powerlessness; Shame and Guilt; Loneliness; Despair; Forgiveness and Letting Go; Hope and Vision; and Continuing the Journey of Healing.

Status of Research: No research to date.

To obtain a manual and for training and consultation information, visit www.ccdc1.org or contact Aisha Meertins, M.S.W., at 202-608-4734 or via e-mail at ameertins@ccdc1.org

Trauma Adaptive Recovery Group Education and Therapy (TARGET)

Developed by Julian Ford, Ph.D., TARGET is a manualized gender-specific group or individual treatment that begins with 3 to 12 sessions of self-regulation skills based on the neurobiology of complex trauma, and may continue for up to 26 sessions. The model is more commonly implemented in versions of different lengths: 3 to 5 sessions, 12 sessions for groups in addiction treatment programs, and 26 sessions for groups in community mental health or inpatient/residential psychiatric programs, and 16 sessions for one-to-one outpatient psychotherapy. Adaptations of the model have been implemented in Spanish, Dutch, and Hebrew; and with Deaf women and men; women in domestic violence shelters; women in prison and in community re-entry programs following incarceration; men and women in partial hospital treatment; men and women committed involuntarily to forensic inpatient programs; men and women following emergency medical care for acute assault or accidental injury; and pre-adolescents, adolescents, and parents in community-based juvenile justice programs.

TARGET teaches a practical 7-step sequence of skills for processing and managing the trauma-related components of current stressful experiences (e.g., PTSD symptoms, rage, traumatic grief, survivor guilt, shame, interpersonal rejection, and existential/spiritual alienation). The skills are designed in a sequence mirroring the three phases of trauma treatment, summarized by an acronym (FREEDOM): self-regulation via **F**ocusing; trauma processing via **R**ecognizing current triggers, **E**motions, and cognitive **E**valuations; and strength-based reintegration by **D**efining core goals, identifying currently effective responses (**O**ptions), and affirming core values by **M**aking positive contributions. A creative arts portion of the therapeutic curriculum—the Lifeline—is used throughout the group or individual sessions in order to facilitate nonverbal learning, self-expression, and social problem solving, as well as to engage narrative self-definition and autobiographical memory. Trauma memories often, but not always, are processed using the FREEDOM skill set, but this is done only when and if requested by the client and not as a required element of treatment. In group sessions, trauma memory processing is done primarily with a containment rather than exposure or exploration focus in order to provide group members with the experience of self-regulating when flooded by intrusive re-experiencing or witnessing another group member do so. In individual sessions, trauma memory processing is not done as an “exposure” protocol, but to provide the client with guided experience in using information processing and affect regulation skills to identify personally meaningful aspects of memories and to integrate memories into narrative autobiographical memory. Most trauma memory processing in TARGET involves processing recent traumatic experiences or assisting clients in making explicit and manageable any recurrent intrusive memories which are largely implicit (e.g., felt in the body or re-experienced without conscious awareness through recurrent anxiety, anger, or dissociative reactions).

The TARGET manual outlines a strengths-based model that explains PTSD in terms of the body’s survival/alarm system and teaches a set of practical skills to enable participants to gain control of PTSD symptoms. Self-regulatory skills approach and experiential exercises are used to address topics including self-esteem, anger, grief, shame, revictimization, and spirituality.

Status of Research: Results of a randomized controlled effectiveness study of TARGET compared to trauma-informed outpatient addiction treatment were reported most recently at the 2003 American Public Health convention (contact ford@psychiatry.uchc.edu for presentation summary) and are being prepared for publication by the study principal investigator, Dr. Linda Frisman. Results of open trials of TARGET with women in parenting, correctional diversion, residential addictions treatment, and outpatient psychiatry and community mental health programs, and with youths in juvenile justice programs, are being prepared for publication (see www.ptsdfreedom.org for updates). In field trials with 4 groups with 33 low-income women in residential, intensive outpatient, or criminal justice diversion treatment for substance abuse disorders or domestic violence (80% Black or Latina), 50% reported symptoms sufficient to warrant a diagnosis of PTSD prior to TARGET. Following 10 TARGET group sessions, only 20% continued to warrant a PTSD diagnosis. PTSD symptom severity levels dropped 33%, from an average of 48 (Standard Deviation = 19) on the PTSD Checklist before TARGET to an average of 32 (Standard Deviation = 15) after TARGET, a statistically significant reduction ($F = 11.6, p < .005$), and a clinically significant reduction from symptoms averaging at a moderate level (near the cut-off for classifying PTSD=51) to an average of mild level symptoms.

To obtain a manual and for information on training and consultation, contact Eileen Russo, M.A., L.A.D.C., at Russo@psychiatry.uchc.edu or online at www.ptsdfreedom.org

Trauma, Addictions, Mental Health And Recovery (TAMAR) Trauma Treatment Group Model

Developed as part of the first phase of the SAMHSA Women, Co-Occurring Disorders and Violence Study, TAMAR Trauma Treatment Group Model is a structured, manualized 14-week, 13-module trauma-specific group intervention combining psycho-educational approaches with expressive therapies. It is designed for women and men with histories of trauma in correctional systems. Groups are run inside detention centers, in state psychiatric hospitals, and in the community. Group sessions meet twice weekly for 90 minutes, an interval that fits smoothly into the daily schedules of county detention centers. Women taking part in groups while detained in the detention center complete it on-site or continue in a community group if released before completion.

The Trauma Addictions Mental Health and Recovery Treatment Manual provides basic education on trauma, its developmental effects on symptoms and current functioning, symptom appraisal and management, the impact of early chaotic relationships on health care needs, the development of coping skills, preventive education concerning pregnancy and sexually transmitted diseases, sexuality, and help in dealing with role loss and parenting issues. The modules integrate education about childhood physical and sexual abuse and its impact on adult development and functioning with cognitive-behavioral and expressive therapy principles and activities. In 2001, the Mental Hygiene Administration partnered with the Maryland AIDS Administration to fund two sites. Modules on HIV

and AIDS (including condom use, communication, and negotiation skills) were added to the manual. The TAMAR manual incorporates work by Maxine Harris, Marsha Linehan, Elizabeth Vermilyea, Barry Cohen, and Andrea Karfgin. Expressive Art Therapy exercises are often used.

Status of Research: The TAMAR Program is currently being evaluated by the Maryland AIDS Administration. Participants are given pre-tests when starting the group and post-tests after they have completed the program. The AIDS Administration is conducting the evaluation to demonstrate potential benefits of the program. One such benefit is that TAMAR builds participants' self-efficacy, and improves self-esteem and coping skills. Another potential benefit is the reduction of the incidence of contracting HIV and STD's for this high-risk population.

Initial research by the University of Maryland during the Women and Violence study found that prior to the TAMAR program, 72% of the women had a history of at least one prior incarceration. After the program was initiated, recidivism back to detention centers was 3%.

To obtain the manual and for information on training and technical assistance, contact Joan Gillece, Ph.D., at 410-724-3238 or gillecej@dhmh.state.md.us, or contact Jenny Howes, L.G.S.W. at 410-724-3180 or howesj@dhmh.state.md.us

Trauma Recovery and Empowerment Model (TREM)

Developed by Maxine Harris, Ph.D., and the Community Connections Trauma Work Group, TREM is a manualized, sequentially organized, 24–33 session group approach to healing from the effects of trauma. It is designed for women with major mental health, PTSD, and/or substance abuse problems. The TREM model for women was developed and refined over a period of five years by 27 clinicians and more than 500 participants.

TREM combines elements of recovery skills training, psychoeducation, and other cognitive-behavioral techniques, and emphasizes peer support, which has proven to be a highly effective approach with survivors. TREM is co-facilitated by female clinicians. TREM focuses initially on the survivor's personal and relational experience, with emphasis on empowerment and skill building. At this stage, members learn strategies for self-comfort and accurate self-monitoring as well as ways to establish safe physical and emotional boundaries. TREM then provides a supportive (gender-separated) group peer environment in which each survivor can explore current life problems as they relate to past or present experiences of physical, sexual, and emotional abuse. Some group members may disclose personal stories of trauma, though each woman has her own path to healing, and disclosure is not required. The model helps women overcome fear, grief, and shame while reintegrating trauma experiences into a personal life narrative and reframing the connection between their experiences of abuse and other current difficulties including substance use, mental health symptoms, and interpersonal problems. Several sessions focus on skills building, emphasizing self-awareness, self-soothing,

communication style, decision-making, problem solving, regulating overwhelming feelings and emotional modulation, and establishing safer, more reciprocal, relationships. Throughout, TREM addresses substance abuse problems and relapse prevention. In conjunction with their participation in a TREM group, participants may use the self-help workbook *Healing the Trauma of Abuse* by Mary Ellen Copeland (see below).

The TREM model for women and its adaptations for men and for girls have been implemented in multiple states in a wide range of settings including residential and non-residential substance abuse and mental health programs, correctional institutions, health clinics, and welfare-to-work programs, among others. Although fidelity to the manualized model is likely to produce the most positive results, it has been provided with benefit to public mental health and substance abuse clients in a variety of ways including selected sessions and in combination with other models and programs.

Participants largely have been recipients of publicly funded mental health, substance abuse and other human services, and have been diverse in terms of overall life skills and functioning. They include the most disenfranchised clients who often are homeless and make heavy use of inpatient, crisis, and other high cost services. TREM was developed in Washington, D.C., with a predominately African American population, and has been used with Caucasian and Latina women (see below for Spanish Cultural and Linguistic Adaptation) who have trauma and other mental health and/or substance abuse problems, and who may have had contact with the criminal justice system.

Status of Research: TREM was adopted by three sites of the nine-site SAMHSA-funded Women, Co-Occurring Disorders and Violence (WCDVS) project. TREM groups explicitly address trauma, mental health, and substance abuse concerns, using an integrated approach that seems to be a key ingredient in achieving better outcomes for project participants. TREM-specific studies to date have focused on the group's retention of participants, consumer satisfaction, fidelity of implementation, and effectiveness. TREM groups have shown a very high rate of retention, even among women with multiple vulnerabilities and few supports. At the D.C. site of the WCDVS, over 70% of the women enrolled completed over 70% of the group sessions. Pilot studies have indicated a high level of participant satisfaction with the group, with over 90% finding it helpful on a number of trauma-related dimensions, including recovery skill development. Results from studies using a formal TREM Fidelity Scale have demonstrated that trained leaders can implement the TREM group with high fidelity to the manual's content and leadership process. Preliminary studies of TREM have found improvement in overall functioning; mental health symptoms (including anxiety and depression); and trauma recovery skills (e.g., self-soothing, emotional modulation, and self-protection). In addition, these evaluations found decreased high-risk behaviors and reduced use of intensive services such as emergency room visits and hospitalizations. Quasi-experimental study results showed advantages for TREM over services as usual in both PTSD symptoms and drug and alcohol abuse. An NIMH-funded randomized controlled trial of TREM is currently in progress, jointly conducted by the New Hampshire-Dartmouth Psychiatric Research Center and Community Connections.

The TREM model has been adapted for men (M-TREM) and has been translated into Spanish and culturally adapted for Latina women (see descriptions below). It has also been adapted for adolescent girls and young women ages 12-18 (G-TREM) (see Trauma-Specific Service Models for Children).

TREM Manual: *Trauma Recovery and Empowerment: A Clinician's Guide to Working with Women in Groups*, by Maxine Harris, Ph.D. and the Community Connections Trauma Work Group, is a step-by-step leader's guide covering 33 group sessions. Each topic includes a rationale and goals for the session, specific discussion questions, a sampling of typical responses, and experiential exercises.

TREM Instructional Video: *Trauma Recovery and Empowerment: A Clinician's Guide to Working with Women in Groups*, by Maxine Harris, Ph.D. and the Community Connections Trauma Work Group, is an 8.5-hour instructional video designed for clinicians to learn the rationale and philosophy behind the TREM intervention, with focus on the content and format of each of the 33 sessions. The video provides general information about sexual and physical abuse and can be used as part of a curriculum on trauma.

To obtain the manual or the instructional video, visit www.ccdc1.org or contact Aisha Meertins, M.S.W., at 202-608-4734 or ameertins@ccdc1.org For information on training and consultation, contact or contact Rebecca Wolfson Berley, M.S.W., director of Trauma Training, at 202-608-4735 or rwolfson@ccdc1.org

Healing the Trauma of Abuse: A Women's Workbook, by Mary Ellen Copeland, M.A., M.S. and Maxine Harris, Ph.D. Used by women participants in conjunction with their work in the TREM group, this workbook can also be used by a woman on her own, or with a therapist or supportive friend. The manual assists women recovering from the effects of physical, sexual, and emotional abuse. It is divided into four parts: Empowerment, Trauma Recovery, Creating Life Changes, and Closing Rituals. Each part has a number of topics to work on, helps women develop individual goals for the recovery work, and addresses self-care while doing recovery work. To obtain the workbook and for more information, visit www.mentalhealthrecovery.com

Trauma Recovery and Empowerment Profile (TREP) and Menu of Strategies for Improving a Woman's Trauma Recovery and Empowerment Profile

Developed by Maxine Harris, Ph.D., and Roger D. Fallot, Ph.D., this skills rating scale and menu of skill building strategies may be used in conjunction with the TREM group program or individually as clinical tools for clinicians and survivors to evaluate skill levels and work toward development of skills. TREP is a rating instrument with eleven dimensions. Each dimension describes a skill that is central to coping effectively with the impact of emotional, physical, and/or sexual abuse. Completed by a clinician who knows the consumer/survivor well, or by the survivor him/herself, the TREP is designed to

provide an assessment of the consumer/survivor's recovery skills at a particular point in time. The manual, *Menu of Strategies for Improving a Woman's Trauma Recovery and Empowerment Profile*, contains interventions designed to develop skills in the eleven domains of trauma recovery. The interventions are used in conjunction with a case manager, counselor, therapist or peer advocate, and are in some circumstances used in a self-help format. Exercises are categorized into beginning and intermediate level exercises. Exercises may also be useful for individuals who are not trauma survivors but who desire skill development to deal with addictions or mental health problems.

Status of Research: No research to date.

To obtain copies of TREP and the Menu of Strategies, visit www.ccdc1.org or contact Aisha Meertins, M.S.W., at 202-608-4734 or ameertins@ccdc1.org For additional information, contact Rebecca Wolfson Berley, M.S.W., director of Trauma Training, at 202-608-4735 or rwolfson@ccdc1.org

The Trauma and Recovery Group: Cognitive Behavioral Therapy Approach for PTSD in People with Serious Mental Illness

Developed by Stanley Rosenberg, Ph.D., and Kim Mueser, Ph.D. of the New Hampshire Dartmouth Psychiatric Research Institute, the Trauma and Recovery Group model is a manualized, 16-session one-to-one psychoeducation intervention for women or men with chronic and persistent mental illness and PTSD. It is intended for use in community mental health or inpatient psychiatric settings. Offered individually and in groups, the model contains relaxation exercises, video facilitated psychoeducation about trauma and its effects, and cognitive restructuring to address unhelpful thoughts, beliefs and behaviors related to trauma. In addition to teaching clients to recognize specific PTSD symptoms and how they can exacerbate mental illness symptoms, this model uses cognitive restructuring (CR) to assist clients in challenging and revising distorted beliefs. Stress Inoculation Training (SIT) is used to instill skills for actively managing stress-reactions that can exacerbate mental illness or PTSD symptoms. This model does not utilize prolonged exposure, but instead focuses on here-and-now coping skills to assist clients in managing intrusive memories.

Status of Research: This model has not been tested in a controlled trial, but detailed psychometric outcome data are being collected for more than 50 community mental health center clients in several rural and urban settings. Individuals participating in all sessions of this intervention model show substantially greater improvement in PTSD and depression than people participating in fewer sessions or dropping out.

To obtain the manual, *The Trauma and Recovery Group*, the educational videotape, *Recovery From Trauma*, and for information on training and consultation, contact Kim.T.Mueser@Dartmouth.edu or Stan.Rosenberg@Dartmouth.edu

Trauma Safety Drop-In Group: A Clinical Model of Group Treatment for Survivors of Trauma

Designed by Pat Gilchrist of Ulster County Mental Health and Peri Rainbow of Women's Studies at New Paltz State University of New York, this model provides trauma survivors with basic safety skills. A low-intensity group model that requires no commitment from participants, the group is open to all survivors regardless of diagnosis, level of functioning, and place in the healing process. Goals of the group include increasing the survivor's ability to function and feel safe in a more intensive level of group treatment, to learn about the healing process and the after-effects of trauma, and to assess readiness for further treatment. The drop-in nature of the group is an essential and unique feature. Survivors who are beginning trauma-specific treatment are often not prepared to fulfill the commitment of consistent attendance required by traditional group therapy. The group is structured so that survivors can join at any point and complete the cycle at their own pace.

Status of Research: No research to date

Manuals are available from the New York State Office of Mental Health Trauma Unit at nominal cost from the NYS OMH Printing and Design Services. Their fax number is 518-473-2684.

TRIAD Women's Group Model

Developed by and implemented at one of the SAMHSA Women Co-Occurring Disorders and Violence Study sites, this manualized, 16-session (2-hours a week for 16 weeks) cognitive behavioral group model is based on the perspective that complex disorders arise from trauma and that particular fundamental issues must be addressed for long-term recovery to occur (Herman, 1992). It is designed for and takes an integrated approach to women who experience challenges around the three issues of trauma, mental health, and substance abuse.

TRIAD is structured into four phases: Mindfulness, Interpersonal Effectiveness Skills, Emotional Regulation, and Distress Tolerance, with four weekly sessions in each phase. This design allows for a "modified open" format in which women can join the group at the beginning of each of the four phases. Each session includes specific goals and objectives to facilitate short-term treatment planning. A leaders manual, *Triad Women's Project Group Treatment Manual*, was developed by the Clinical Interventions Committee of the Triad Women's Project. TRIAD's primary treatment goals are to reduce psychiatric and trauma-related symptoms associated with histories of violence/abuse and substance use for those with substance abuse disorders. Additional model goals are to increase abstinence for those with substance dependence and to support women in maintaining their personal safety. This cognitive behavioral model is based, in part, on Linehan's Cognitive-Behavioral Treatment model, Evans and Sullivan's work on substance abuse and trauma and Harris' work on trauma and serious mental illness.

TRIAD groups are implemented in outpatient or residential community mental health centers and substance abuse treatment facilities and a modified version of TRIAD is currently being offered in jails.

Status of Research: Triad was developed and implemented by one site of the 9-site SAMHSA WCVDS. Results of this cross-site study show positive effects for trauma treatment and indicate that participation in integrated counseling that addresses treatment issues related to trauma, mental health, and substance seems to be the key ingredient in achieving better outcomes.

To obtain the manual and for information on training and consultation, contact Colleen Clark, Ph.D., at 813-974-9022 or cclark@fmhi.usf.edu

Manualized Adaptations to Trauma-Specific Service Models for Adults

An Introduction to Trauma Issues for Women on Inpatient or Short-Stay Units

Created by Maxine Harris, Ph.D., Bronwen Millet, Ph.D., Lori Beyer, M.S.W., Jerri Anglin, M.S.W., and Rebecca Wolfson, M.S.W., this manualized, four-session (45-50 minute) group treatment intervention is drawn from the TREM model. It is made for women with histories of sexual and physical abuse who have been diagnosed as having a mental illness or a substance abuse disorder and are receiving treatment on a psychiatric, detoxification, or battered women's short-stay residential unit. The curriculum has a suggested order but is capable of being attended by a woman in any order as each session is designed to stand alone. The woman may attend one, two, three, or all sessions depending on her readiness and circumstances. A brief written version of the sessions is available for residents so they have a chance to benefit from sessions missed.

The curriculum is designed to introduce women to important connections between a history of physical, sexual, and /or emotional abuse and current difficulties and symptoms. It helps women assess their need for longer-term recovery work and identify community resources for doing trauma recovery work in an outpatient setting.

Status of Research: No research to date.

To obtain a manual and for additional information visit www.ccdc1.org or contact Aisha Meertins, M.S.W., at 202-608-4734 or ameertins@ccdc1.org

Men's Trauma Recovery and Empowerment Model (M-TREM): A Clinician's Guide to Working with Male Trauma Survivors in Groups

Developed by Community Connections with Roger D. Fallot, Ph.D., Maxine Harris, Ph.D., H. Urs Affolter, M.S.W., Jerri Anglin, M.S.W., Ellen Arledge, M.S.W., Richard Bebout, Ph.D., John Dende, M.A., David Freeman, Psy.D., Walter Green, M. Div., and Matthew Lee, M.S.W., this group is an adaptation of the original TREM for women tailored to the specific concerns of male trauma survivors. The men's 24-session group (75 minutes per session) is structured in three sections. Part I addresses the emotional readiness of male trauma survivors for trauma-focused discussions. Group members develop a shared emotional and relational vocabulary via sessions that center on both key emotions (anger, fear, hope, shame) and relationship characteristics (friendship, intimacy, trust, loss). Part I helps men to place their personal experiences in a larger context by exploring the cultural understanding of "what it means to be a man." In Part II, attention focuses more directly on trauma and its connections to emotional, addictive, and relationship difficulties. Part III adopts an explicitly skill-building emphasis with, among others, sessions on communication, problem-solving, and self-soothing. This program can be used with African American, Caucasian, and Latino men who have trauma, other mental health and/or substance abuse problems, and who may have had contact with the criminal justice system.

Status of Research: Pilot studies of M-TREM have recently begun. Initial results are promising, based on the feedback of group leaders and participants. In the initial group of six participants, changes from pre-group to six-month post-group follow-up were consistently positive, reflecting enhanced overall functioning and decreased mental health (including posttraumatic stress) symptoms.

To obtain the manual, visit www.ccdc1.org or contact Aisha Meertins, M.S.W., at 202-608-4734 or ameertins@ccdc1.org For information on training, call Rebecca Wolfson Berley, M.S.W., director of Trauma Training, at 202-608-4735 or rwolfson@ccdc1.org

Spanish Cultural and Linguistic Adaptation and Expansion of Trauma Recovery and Empowerment Model

Developed by the Boston Consortium of Services for Families in Recovery, Boston Public Health Commission and the Institute on Urban Health Research at Northeastern University, TREM is translated into Spanish and culturally adapted to make it more appropriate and accessible to Latina women. Multiple issues addressed by the TREM manualized group treatment are translated and contextualized within the Latino culture and the African American culture, and compared to the viewpoints of mainstream American culture and other cultures. The model has also been expanded to include strategies for reduction of HIV sexual risk behaviors.

Status of Research: The Spanish Cultural and Linguistic Adaptation and Expansion of Trauma Recovery and Empowerment Model was part of the intervention package offered to women participating in the Women, Co-Occurring Disorders and Violence Study in the Boston site. The study used a no-randomized comparison group design with comparison agencies providing services as usual and intervention sites providing the

trauma-integrated model. Analyses to date have focused on the overall differences in outcomes among intervention participants who received the ‘package’ of services and comparison group participants who received services as usual rather than on the specific outcomes related to exposure to this particular component of the intervention treatment ‘package.’ Two documents have been submitted for publication which report on findings indicating that women in the intervention stay in treatment longer and also have lower sexual HIV risk behaviors than those in the comparison condition. Other analyses not yet published indicate positive outcomes in addiction severity, mental health, and trauma symptomatology at follow-up.

To obtain a manual and for more information, contact Dr. Hortensia Amaro at h.amaro@neu.edu or Rita Nieves, R.N., M.P.H. at Rita_Nieves@bphc.org

Trauma-Specific Models for Parenting

Circle of Security

A psychoeducational, psychodynamic intervention protocol based on attachment theory, The Circle of Security (COS) is a Head Start model program designed to alter one component of the developmental pathways of at-risk parents and their children. As part of the Trauma, Addictions, Mental Health And Recovery (TAMAR) program with the Maryland Department of Health and Mental Hygiene Administration, The Circle of Security protocol is used with pregnant and post-partum women in the justice system. Focus of the intervention is upon “disorganized families with hidden resilience.” It was created for low-income parents and young children who had previously been unresponsive to intervention. The task of the intervention is to build on “resilience potential” and focus treatment toward developing healthy attachments. Intervention involves small groups of at-risk parents of infants (birth-12 months) who meet as a group with a psychotherapist for 15 months—three pre-natal though one year after birth. In the context of the group, each parent reviews edited video-vignettes of herself interacting with her baby. These video feedback vignettes, and the related psychoeducational and therapeutic discussions, are individualized to each dyad’s specific attachment-caregiving pattern, using a priori individualized treatment goals based on videotaped interactions recorded throughout the pre-intervention assessment. During the course of treatment, mothers learn to understand how their previous traumatic experiences (child abuse, poverty, and neglect) contribute to their parenting style. This is known as “shark music,” a sense of impending difficulty that influences their reactions to their children. The intervention has been used with mothers and their children up to the age of 9.

Status of Research: Pre-and-post intervention assessments of the attachment-caregiving pattern of each dyad track the effects of the intervention. Preliminary results on years 1 and 2 of a SAMHSA 3-year study indicate the protocol is effective in reducing rates of Disordered attachments, and increasing the rates of Ordered, and even Secure, attachments. Results suggest that the COS protocol has the potential to decrease one

important risk factor, disordered attachment caregiving bonds between child and parent, nearly to levels found in low-risk populations.

The TAMAR'S Children program is a research project looking at the effectiveness of the Circle of Security intervention on at-risk mothers and infants. Women in the justice system commonly have disorganized attachment styles resulting from their own experiences of abuse and neglect. After two decades of research, this pattern of disorganization has been found to contribute to the development of mental health and substance abuse disorders. In preliminary findings of the first 26 women to complete the 15-month COS protocol, all mother-infant dyads showed organized attachment patterns, some secure, some insecure with the majority assessed as secure attachment. No one participating in the TAMAR'S Children project has re-offended or violated parole. Although two mothers relapsed, their substance use was reported early and they returned to treatment. The project will be completed at an N=75 and findings will be reported in early 2006.

To obtain materials and more information, contact Andrea Karfgin, Ph.D., at 410-974-8968 or tamarinc@aol.com

Impact of Early Trauma on Parenting Roles

A 14-session group intervention for women whose traumatic experiences of early sexual and /or physical abuse have created symptoms and responses that make parenting tasks difficult. The intervention is designed to address the connections between trauma sequelae and parenting, and help a woman deal with her feelings and responses so that she can be maximally available to parent her children.

Status of Research: No research to date.

To obtain the manual *Non-Traditional Parenting Interventions*, which contains this group intervention, contact www.ccdc1.org or Aisha Meertins, M.S.W., at 202-608-4734 or ameertins@ccdc1.org For information on training or consultation, call Rebecca Wolfson Berley, M.S.W., director of Trauma Training, at 202-608-4735 or rwolfson@ccdc1.org

Nurturing Families Affected by Substance Abuse, Mental Illness and Trauma

This is a parenting curriculum offered in groups for women and children in recovery from substance abuse, mental illness, and trauma. The curriculum provides a first step in repairing the fractured parent-child relationship by helping families work toward a place where they can grow and heal together. Developed and piloted by the Institute for Health and Recovery as part of the Women Embracing Life and Living (WELL) Project—one of nine SAMHSA Women, Co-Occurring Disorders and Violence Study sites—the curriculum builds upon IHR's Nurturing Program for Families in Substance Abuse Treatment and Recovery, which was recognized by the Center for Substance Abuse

Prevention as a model program for best practices in strengthening families. The WELL Project adapted this curriculum to encompass the needs of families affected by substance abuse, mental illness, and trauma.

The model is based on the relational development principles of authenticity, mutuality and empathy, and emphasizes the critical role self-nurturing plays in the lives of women who are parenting and in recovery. It consists of three modules.

- Module 1. One-on-one mentoring and intensive skills building. Two sessions on setting goals, and building connections.
- Module 2. Nurturing families affected by substance abuse, mental illness and trauma group. Fourteen 90-minute sessions designed to increase parents' understanding of the effects of substance abuse, mental illness and trauma on their lives and the lives of their families.
- Module 3. Four sessions on parent-child skill-building activities, when parents and children engage in structured skill-building activities designed to repair and strengthen the bond between them.

The curriculum is intended to enhance coping strategies through concept presentations, practice sessions, role-plays, and activities, and it includes a skills-building component to apply techniques and strategies. Each session covers a different topic including hope; building trust; self-esteem; setting boundaries; family communication; feelings; managing stress; guiding behavior; schedules and routines; safety and protecting children; helping families grieve; and having fun.

Groups of no more than 12 participants are implemented in a variety of settings including inpatient, outpatient, and community-based service agencies. Women may join at any time throughout the series.

Status of Research: No research to date.

To obtain the manual *Nurturing Families Affected by Substance Abuse, Mental Illness and Trauma*, and for information on training and consultation, visit www.healthrecovery.org or contact Terri Bogage at family@healthrecovery.org or 617-661-3991.

Parenting at a Distance

A 10-session group intervention to address issues of parenting for women who are involved in some form of partial parenting, but who do not have full-time residential custody of their children.

Status of Research: No research to date.

To obtain the manual *Non-Traditional Parenting Interventions*, which contains this group intervention, visit www.ccdc1.org or contact Aisha Meertins, M.S.W., at 202-608-4734 or ameertins@ccdc1.org. For information on training or consultation, call Rebecca Wolfson Berley, M.S.W., director of Trauma Training, at 202-608-4735 or rwolfson@ccdc1.org.

Pathways to Family Reunification and Recovery (Caminos Para la Reunificacion y la Recuperacion): An educational group curriculum for women in recovery

Available in Spanish and English, this multi-session group intervention was developed by the Boston Consortium of Services for Families in Recovery, Boston Public Health Commission and the Institute on Urban Health Research, Northeastern University. The manual focuses on the different possible scenarios that women in recovery may encounter in the process of reuniting with their children. It has some focus on understanding the Department of Social Services regulations and policies but also explores other family dynamics when the children are in custody of the women's sister, grandmother, aunt or any other family members. Curriculum explores the different stages of reunification and the possible reactions and emotions children and mothers might experience when going through this period of transition coming from a foster home or any other environment. Contains tools for parents to develop nurturing relationships with children.

Status of Research: The Pathways to Family Reunification and Recovery was part of the intervention package offered to women participating in the Women, Co-Occurring Disorders and Violence Study in the Boston site. The study used a no-randomized comparison group design with comparison agencies providing services as usual and intervention sites providing the trauma-integrated model. Analyses to date have focused on the overall differences in outcomes among intervention participants who received the 'package' of services and comparison group participants who received services as usual rather than on the specific outcomes related to exposure to this particular component of the intervention treatment 'package.' Two documents have been submitted for publication which report on findings indicating that women in the intervention stay in treatment longer and also have lower sexual HIV risk behaviors than those in the comparison condition. Other analyses not yet published indicate positive outcomes in addiction severity, mental health, and trauma symptomatology at follow-up.

To obtain the curriculum and for further information, contact Dr. Hortensia Amaro at h.amaro@neu.edu or Rita Nieves, R.N., M.P.H., at Rita_Nieves@bphc.org

Recovering Families Parenting Curriculum

This curriculum is embedded as a standard service offered in many substance abuse treatment programs throughout San Joaquin County, California. Developed as a part of the SAMHSA Women Co-Occurring Disorders and Violence Study (WCDVS) Allies project, Recovering Families builds on a prior existing parenting curriculum based on the

work of Bavolek and Dellinger-Bavolek and the Nurturing Program for Families in Substance Abuse Treatment and Recovery curriculum developed by the Institute for Health and Recovery.

The Recovering Families Parenting Curriculum is a 13-week intervention designed to blend discussions and activities around parenting issues particular to parents with co-occurring disorders and trauma histories, with each session focusing on specific parenting skills.

Status of Research: No research to date.

To obtain the curriculum and for information on training and consultation, contact Frances Hutchins, division director of San Joaquin County Office of Substance Abuse, at fhutchins@sjgov.org

Strengthening Multi-Ethnic Families and Communities: A Violence Prevention Parent Training Program

A CSAP model parent-training curriculum for ethnic and culturally diverse parents of children ages 3 to 18 years, this program addresses violence against the self (drugs/alcohol), violence in the family (child abuse, domestic violence), and violence against the community (juvenile delinquency, crime, gangs). Information is presented within a “cultural framework” and instructors choose to either present the Parent Training Curriculum structured into an Orientation and 12 weekly 3-hour sessions or Parent Workshops (organized by component areas). The importance of ethnic/cultural/family/spiritual roots is emphasized. The curriculum includes five major components: Cultural/Spiritual Focus; Rites of Passage; Positive discipline; Enhancing Relationships; and Community Involvement. Positive communication and discipline strategies are presented to enhance child self-esteem, self-discipline and social competency. Anger management techniques and developmental information is integrated throughout the curriculum. The program is used with high-risk and hard-to-reach groups, including teens, foster parents, court-ordered parents, grandparents, parents of teens, migrant families, gay parents, single parents, fathers, etc., and with parents from a variety of ethnic/cultural backgrounds.

Status of Research: A pre-post test design had been used to evaluate over 100 parent classes using this model. Evaluation data from one report of 22 parent groups (N=357) show significant improvements in parents’ sense of competence, family/parent/child interactions, and child competence and behavior. Participation in the program had a direct impact on increasing parent involvement in the areas of “Community Activities,” “Political Issues,” and “School Involvement.” Reports show that the program helps with child rearing challenges, promotes family bonding, promotes pride in cultural heritage, promotes community bonding, and reduces life-threatening risks for children.

Five-day Facilitator Training Workshops, facilitator materials, and parent materials in six languages (US English, Spanish, Vietnamese, Korean, Cambodian, Russian, UK English) are available from Dr. Marilyn Steel, Ph.D., at 323-936-0343 or dr_mls@earthlink.net

Trauma and Triumph: Parenting Abused and Neglected Children

This is a 6-hour training from the Foster and Adoptive Parent Toolbox: Child Welfare Training Institute, Institute for Public Sector Innovation, Muskie School of Public Service. It is part of a series of six core topics designed for foster and adoptive parents new to parenting abused and maltreated children and youth. In this particular training, foster and adoptive parents learn the primary types of abuse and neglect experienced by children for whom a continuous series of traumatic moments have become a regular part of the child's existence. Parents are taught the short and long-term impacts of trauma on the child's development, interventions for working with these children, how to create a home environment that promotes emotional and physical safety for the children, and how to access community resources.

Status of Research: To date, no research has been done on this training series. As it has been in delivery for the past two years, it is the goal of the University to begin a training evaluation within the next year as the sample size is now sufficient for an evaluation.

For more information, contact Leslie Rozeff, C.W.T.I., co-director, at 207-626-5218 or Leslie.Rozeff@maine.gov

Trauma-Specific Service Models for Children

Group Intervention for Children of Mothers with Co-occurring Mental Health and Substance Abuse Disorders and Histories of Interpersonal Violence

This is a structured, children's skills-building group intervention that was developed as part of the SAMHSA Women, Co-Occurring Disorders and Violence Children's Subset Study. The group intervention has been modified from Einat Peled and Diane Davis' *Groupwork with Children of Battered Women: A Practitioner's Manual* to account for the presence of children in families without domestic violence, to address substance use and abuse and to meet developmental needs of two age groups (ages 5-7 and 8-10). The WCDVS modified Group Intervention for Children incorporated a variety of activities across sessions, including check-in, discussion, drawing, movement, skill practice, storytelling, videoclips, and free play. Core content includes teaching children to verbalize feelings, modeling expression of emotions in appropriate ways, educating the children about substance abuse and domestic violence, helping to identify good and bad touch, teaching assertiveness skills, learning relaxation exercises, and helping children develop a safety plan for themselves. The program consists of an hour-long orientation, nine core group sessions, and two booster sessions. Groups are conducted by a facilitator and co-facilitator, who can be a consumer/survivor/recovering (C/S/R) woman.

Status of Research: A preliminary summary of outcome effects as measured by the SAMHSA Women, Co-Occurring Disorders and Violence Study indicate that children who participated in this intervention sustained positive improvement when compared to children receiving treatment-as-usual, regardless of their mothers' outcome, with younger children showing a greater degree of positive change than older children.

To obtain the curriculum, *Groupwork with Children of Battered Women: A Practitioner's Manual* by Einat Peled and Diane Davis as adapted by The Coordinating Center and the Children's Subcommittee for the Women, Co-Occurring Disorders and Violence Study, visit www.wcdvs.com or www.domesticabuseproject.org For more information regarding the model, training, and consultation, visit the National Trauma Consortium online at www.nationaltraumaconsortium.org

Real Life Heroes: A Life Storybook for Children

Created by Richard Kagan PhD, this product helps traumatized children move from painful or fractured memories to a more positive perspective by drawing strength from the supportive people in their lives. The workbook uses a creative arts approach encouraging children to work with caring adults to develop autobiographies through drawings, music, movies, and narrative, to overcome difficulties such as divorce, separation, placement, learning problems, serious illness, and hospitalization, and highlight moments in their lives when "important" people—family, friends, and community members—showed kindness, caring, understanding and courage, giving the child a sense of value. For counselors, psychotherapists, teachers, parents, adoptive parents, foster parents, grandparents, and mentors who are working to help troubled children to overcome traumas and to rebuild hope and a positive identity.

Status of Research: The Workbook has been tested on a child-by-child basis for six years, primarily with chronically and severely traumatized children who have been at high risk of imminent placement or who have been living in foster families, residential treatment, and psychiatric hospitals due to dangerous behaviors, abuse, and/or neglect. Feedback from pilot testing has been excellent. A research study is currently underway to evaluate the effectiveness of this model with 40 children at Parsons Child and Family Center. Use of the Life Storybook is also being tested at other community practice sites of the National Child Traumatic Stress Network.

To obtain the workbook and additional information including training and consultation, contact Richard Kagan, Ph.D., at the Parsons Child and Family Center in Albany, NY at 518-426-2600.

Sanctuary Model for Children in Residential Settings

The Sanctuary Model[®] for Children in Residential Treatment is an intervention designed to address the special treatment needs of youth with emotional and behavioral disturbances and histories of maltreatment or exposure to domestic and community violence. The Sanctuary Model[®] integrates trauma theories, an enhanced therapeutic community philosophy, and recommended child treatment strategies that address post-traumatic symptoms, developmental disruptions, and unhealthy accommodations to traumatic experiences. A fundamental premise of the intervention is that the treatment environment is a core modality for modeling healthy relationships among interdependent community members. What has emerged from experience with residential treatment settings is a plan, process, and method for creating trauma-sensitive, democratic, nonviolent cultures that are far better equipped to engage in the innovative treatment planning and implementation that is necessary to adequately respond to the extremely complex and deeply embedded injuries that these children have sustained.

The Sanctuary Model[®] is being adapted for use in five residential settings for children, all in New York State (Goldsmith Center for Adolescent Treatment, Hawthorne Cedar Knolls Residential Treatment Center, Linden Hill School, Julia Dyckman Andrus Memorial Center, Parsons Child and Family Center), with an NIMH research project based in three of the centers (see below) (MH62896).

Status of Research: More information is available in: Initial Findings of an Evaluation of a Trauma Recovery Framework in Residential Treatment. *Residential Group Care Quarterly*, 5(1), 3-5. Summer, 2004.

An evaluation of The Sanctuary Model[®] was conducted as a partnership between researchers of Columbia University School of Social Work, the Center for Trauma Program Innovation of the Jewish Board of Family and Children's Services in New York City, and the model developer, Sandra Bloom. Dr. Jeanne Rivard was the primary investigator. The research component was funded through an exploratory/developmental research grant by the National Institutes of Mental Health as part of an initiative to promote research on interventions for youth violence. The project took place in a suburban community outside New York City where the Sanctuary Model[®] is being implemented in three residential treatment programs on one large campus. Results of the Sanctuary Model[®] units were compared to results of units with standard residential services. Although the Sanctuary Model[®] was in a very early stage of implementation, the evaluation was guided by hypotheses that projected which specific outcomes were expected to occur in the therapeutic communities and in youths. The evaluation emphasized an assessment of the processes of model implementation.

There was greater implementation among those units exposed to the model longer, those serving girls, and those with leaders who had greater enthusiasm and commitment to the model. The short form of the Community Oriented Programs Environment Scale (COPES) (Moos, 1996) (Moos, 1997) was used to assess the extent to which units were operating as therapeutic communities along selected dimensions. There were no significant differences between the Sanctuary Model units and the standard residential treatment units during the first two waves of measurement. By the final wave of

measurement, however, we found significant differences between the groups via independent t-tests, with the Sanctuary Model[®] units improving on the following constructs of the COPEs: support ($p < .05$), spontaneity ($p < .01$), autonomy ($p < .05$), personal problem orientation ($p < .05$), safety ($p < .05$), and in the total score ($p = .001$). There were also a few differences by time and group, favoring youth in the Sanctuary Model[®] units. These were on the incendiary communication/ tension management construct of the Youth Coping Index ($p < .05$), locus of control ($p = .15$), and the verbal aggression construct of the Social Problem Solving Questionnaire ($p = .15$). Results were modest and consistent with a newly implemented intervention, especially considering that rates of implementation varied across units. The positive youth findings offer promise that full implementation may yield greater youth benefits. The finding that the treatment environments of the Sanctuary units were functioning at significantly higher levels than the standard residential units by the final wave of data collection suggests that implementation was becoming stronger with time.

More information is available through Jeanne C. Rivard, Ph.D., a senior research analyst with the NASMHPD Research Institute, Inc. She can be reached at 703-739-9333, ext. 146 or at jeanne.rivard@nri-inc.org

For additional information on the model and on training and consultation services, contact Dr. Sandra L. Bloom, M.D., online at www.sanctuaryweb.com, via e-mail at S13132020@msn.com, or at 215-248-5357.

Seeking Safety

The Seeking Safety model, developed by Lisa Najavits, Ph.D., at Harvard Medical/McLean Hospital, is a manualized, 25-topic, flexible integrated treatment designed to address safety and recovery for persons with the dual diagnosis of PTSD and substance abuse, as well as for persons with a trauma history who do not meet clinical criteria for PTSD. Used widely with adults, it has been implemented with adolescent girls. The manual, *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse*, includes both client handouts and clinician guidelines. It offers 25 topics. A description of this model and manual is included in this document.

Status of Research: Seeking Safety (Najavits, 2002) is the only model for trauma/PTSD and substance abuse that thus far has been empirically studied in adolescents. In a randomized controlled trial with 33 adolescent girls comparing Seeking Safety to treatment-as-usual, positive outcome results were found in a variety of domains including substance use and associated problems, trauma-related symptoms, cognitions related to PTSD and SUD, psychiatric functioning, and several additional areas of pathology not targeted in the treatment (e.g., anorexia, somatization, generalized anxiety). Some gains were sustained at follow-up. The study used the existing treatment manual for Seeking Safety without substantial modification, indicating that—at least based on initial evidence—the model may be relevant and acceptable to adolescents.

To obtain the manual, the article on adolescents, and other materials related to Seeking Safety visit www.seekingsafety.org or contact Lisa Najavits, Ph.D. at 617-855-2305, McLean Hospital, 115 Mill Street, Belmont, MA 02478.

Trauma Focused Cognitive Behavioral Therapy (TF-CBT) for Children and Their Parents

This is a treatment intervention developed by Judith A. Cohen, M.D. and Anthony P. Mannarino, Ph.D, to help children, youth, and their parents overcome the negative effects of traumatic life events such as child sexual or physical abuse; traumatic loss of a loved one; domestic, school, or community violence; or exposure to disaster, terrorist attacks, or war trauma. It was developed by integrating cognitive and behavioral interventions with traditional child abuse therapies in order to focus on enhancing children's interpersonal trust and reempowerment. TF-CBT can be provided to children 3 to 18 years old and their parents by trained mental health professionals in individual, family, and group sessions in outpatient settings. TF-CBT targets symptoms of posttraumatic stress disorder (PTSD) that often co-occur with depression and acting-out behaviors (intrusive thoughts of the traumatic event; avoidance of reminders of the trauma; emotional numbing; excessive physical arousal/activity; irritability; trouble sleeping or concentrating). The intervention also addresses issues commonly experienced by traumatized children, such as poor self-esteem, difficulty trusting others, mood instability, and self-injurious behavior, including substance use.

Status of Research: TF-CBT is recognized as a Model Program by SAMHSA. Compared to traumatized children receiving therapy alone, children receiving TF-CBT experience significantly greater improvement in: PTSD symptoms, depression, negative attributions (such as self-blame) about the traumatic event, defiant and oppositional behaviors, social competency, and anxiety.

To obtain treatment manuals that address specific types of trauma events, a trauma screening guide, and information on model implementation, staff selection, and training, visit www.modelprograms.samhsa.gov or contact Judith Cohen at jcohen1@wpahs.org

Trauma Recovery and Empowerment for Adolescent Girls and Young Women Ages 12-18 (G-TREM): A Clinician's Guide for Working with Adolescent Girls in Groups

This guide was originally prepared in collaboration with staff from Community Connections, Inc. and Sasha Bruce Youthwork, Inc. in Washington, D.C. as two separate group leader's manuals for work with 12 to 14 year olds and 15 to 18 year olds. The guide was then revised, updated, and combined into one group leader's manual in summer 2004 by clinicians from Community Connections and the District of Columbia's Department of Mental Health School Mental Health Program. The guide was also re-titled as *Love and Life Group*, which appeals more to girls, especially those who may not

want to attend what is publicly known as a “trauma group.” This manualized model consists of 16 (75-90 minute) sessions addressing issues and approaches that make sense to adolescent girls. For groups of 8 to 10 girls who have experienced or witnessed physical, sexual, and emotional abuse and community violence with 2-3 leader/facilitators. Topics are adapted, learning approaches are modified, and overall tone respects the age appropriate struggles of adolescents. Each session begins with an icebreaker, continues with a series of discussion questions designed to accomplish the goals of the session, and concludes with an exercise. The format combines discussion and limited (optional) disclosure with experiential exercises and non-verbal modalities of expression. Also, the model is sensitive to the issue that many older adolescent girls in particular believe that they have put experiences of abuse behind them, and are focused on building relationships, seeking relationships, and becoming parents. The model engages girls and allows them to work through issues related to abuse without requiring disclosure of abuse experiences. Participants who complete the G-TREM program are given the book, *The Twenty-Four Carat Buddha and Other Fables* (see below for more information).

Status of Research: In the spring of 2004, the SAMHSA-funded Youth Violence Prevention Program, Project Hope in Washington, D.C., began to offer G-TREM groups in the public schools. Initial responses to these groups have been positive. In qualitative interviews, all the participants reported overall satisfaction with the group, and approximately 85% said they would recommend it to friends. They also reported increases in such skill areas as self-soothing, developing mutual relationships, self-awareness, self-protection, problem-solving, and goal-setting. Similarly, preliminary feedback from group leaders indicated that girls’ skills in these areas had increased. All of the seven group leaders said they would recommend the group to colleagues and other agencies.

To obtain the manual and additional information, visit www.ccdc1.org or call Aisha Meertins, M.S.W., at 202-608-4734 or ameertins@ccdc1.org

The Twenty-Four Carat Buddha and Other Fables, by Maxine Harris. Participants who complete the G-TREM program are given this book, a collection of original fairy tales set in imaginary space and time but with relevance for modern life. The stories explore themes of coming of age and learning to trust in one’s own judgment and intuition; dealing with experiences of profound loss; coming to terms with the demons of past abuses and trauma; and confronting the choices which must be made while trying to figure out how to live a meaningful life. An appendix includes observations about each story by the author on how the story might be useful to someone trying to grow or heal from hurt or disappointment, and a set of questions for each of the stories to facilitate self-exploration and to suggest potential directions. Visit www.ccdc1.org or call Aisha Meertins, M.S.W., at 202-608-4734 or ameertins@ccdc1.org

TRIAD Girls Group Treatment model

Manualized 18-session (2-hour sessions) group treatment for adolescent girls with histories of substance abuse, emotional problems, and violence/trauma/abuse, based on the Triad Women's Group and extensively revised for at-risk adolescent females experiencing difficulties in their academic and social functioning. The manual is intended to assist girls in discontinuing or avoiding substance use and abuse as well as other risky behaviors, to empower them to a state of improved mental health, to support their survival and healing from violence and trauma, to identify strengths that helped them survive, and to decrease chances they will become involved with or re-enter the juvenile justice system.

Status of Research: Formative research on this model was designed to capture the participants' ideas, feelings and opinions about the model and incorporate changes based on their feedback. Outcome research has not been done.

To obtain the manual, worksheets, and for further information, contact Colleen Clark at 813-974-9022 or cclark@fmhi.usf.edu

Voices: A Program of Self-Discovery and Empowerment for Girls

Developed by Stephanie S. Covington, Ph.D., L.C.S.W., co-director of the Institute for Relational Development and the Center for Gender and Justice, *Voices: A Program of Self-Discovery and Empowerment* addresses the unique needs of adolescent girls and young women between the ages of 12 and 18. The program model uses a trauma-informed, strength-based approach that helps girls to identify and apply their power and voices as individuals and as a group. The focus is on issues that are important in the lives of adolescent girls, from modules about self and connecting with others to exploring healthy living and the journey ahead. Given the pervasive impact of abuse and substance use in many girls' lives, these themes are woven throughout the sessions. *Voices* encourages girls to seek and discover their "true selves" by giving them a safe space, encouragement, structure, and support to embrace their important journey of self-discovery. In addition, skill-building in the areas of communication, refusal skills, anger management, stress management, and decision making is integrated across program topics. It can be used in many settings (e.g., outpatient and residential substance abuse treatment, schools, juvenile justice, and private practice).

Voices: A Program of Self-Discovery and Empowerment for Girls is based on the realities of girls' lives and the principles of gender-responsivity. It is also grounded in theory, research, and clinical practice. The following theories create the framework of thought for the development of the *Voices* model: psychological development, attachment, resilience, addiction, and trauma. This is the theoretical base on which the *Voices* program was developed. The various treatment strategies used in the program apply the theories to create the therapeutic process. The therapeutic approaches include psycho-educational, cognitive-behavioral, expressive arts, and relational theory. The psycho-

educational approach helps young women begin to link some of their current difficulties and experiences to larger social influences.

The first part of the facilitator's manual gives the facilitator background information about girls and about the formation of the *Voices* program. It includes information on the reality of girls' lives: socialization and identity, culture and class, sexuality, violence and aggressiveness. It also addresses expressions of risk: depression, substance abuse, relationship violence, eating disorders, teen mothers, and girls in juvenile justice settings. The second part includes the four modules (or themes), with a total of 18 90-minute sessions. The sessions may be arranged in a variety of ways, however, the curriculum is laid out in the suggested sequence.

Each group member is provided a *Voices* journal. This journal serves as a girl's personalized tool for exploring and recording her experiences, thoughts, and feelings as she progresses through the program in a safe space.

This program is designed for facilitation in a group setting but can be adapted for one-on-one use. The suggested number of participants per group is between 6 and 10. Ideally, the groups would be "closed," that is, the same girls would begin and end the program together. The curriculum can be adapted for larger groups and open groups, if either is essential to the program setting.

Status of Research: There are several grant applications pending for outcome studies in a variety of settings (schools, adolescent treatment, and juvenile justice). One is a multi-site project with court-ordered girls in a randomized study that compares outcomes from *Voices* to current practices. Outcomes will include reduction in risk factors associated with substance use, change in self-esteem and self image, increased knowledge regarding AOD issues and issues related to trauma, and involvement in the juvenile justice system (completion of probation, recidivism). The plan is to also have a follow-up to assess longer term outcomes. Both standardized tools for measurement and other developed instruments will be used.

Voices is an adaptation of *Helping Women Recover* for girls. To obtain the *Voices* curriculum materials and for training and consultation, contact Stephanie S. Covington, Ph.D., L.C.S.W., 7946 Ivanhoe Avenue, Suite 201B, La Jolla, CA 92037, at 858-454-8528 or sscird@aol.com Visit www.stephaniecovington.com or www.centerforgenderandjustice.org for more information.

Trauma-Specific Peer Support and Self Help Models

The Essence of Being Real: Relational Peer Support for Men and Women Who Have Experienced Trauma

Created by Jennifer L. Wilkerson, M.S., this is a manualized approach to creating, facilitating, and maintaining a peer support program for people who have experienced

traumatic events. It was developed in partnership with the consumer advocates of the TAMAR Project, the Maryland Women, Co-occurring Disorders and Violence Study Site and it provides the framework, methods, and techniques to facilitate the development of successful peer support and examine some of the obstacles likely to be encountered.

Status of Research: No research to date.

To obtain this resource and for additional information, contact the Sidran Institute at 410-825-8888 or visit www.sidran.org/catalog/sige.html or e-mail orders@sidran.org

Healing the Trauma of Abuse: A Women's Workbook

Created by Mary Ellen Copeland, M.A., M.S., and Maxine Harris, Ph.D., this workbook can be used by a woman on her own, or with a therapist or supportive friend. The manual assists women recovering from the effects of physical, sexual, and emotional abuse. It is divided into four parts: Empowerment, Trauma Recovery, Creating Life Changes, and Closing Rituals. Each part has a number of topics to work on, helps women develop individual goals for the recovery work, and addresses self-care while doing recovery work.

Status of Research: No research to date.

To obtain the workbook and for more information, visit www.mentalhealthrecovery.com

New Partnerships for Women Psychoeducational Groups with Consumer Curriculum

This program features trauma psycho-educational groups for consumers with histories of sexual and physical abuse trauma, to be co-taught by consumers and providers. Developed by a state-supported collaborative consumer/provider project in Wisconsin, the curriculum and manual include working with groups on understanding effects of trauma, symptom self-management, meeting basic needs, and self-advocacy.

Status of Research: No research to date.

To obtain the curriculum and for additional information, e-mail npw@choiceonemail.com

Trauma-No More Secrets

A video-based peer and/or professional led education/discussion/awareness-raising approach for consumer groups as well for groups of professionals. The 35-minute film features the stories of four women whose trauma experiences include domestic violence,

rape, loss, and physical, emotional, and sexual abuse. A facilitator's guide assists in discussions following showings of the film. Topics include Traumatic Experiences; Betrayal; Isolation; Stigma and the Need for Acceptance; Understanding Post Traumatic Stress Disorders and the Brain; the Vicious Cycle of Re-Victimization and Addiction; Recovery; and Regaining Positive Control.

Status of Research: No research to date.

To obtain the facilitator's guide, video, and additional information, contact Judith Ford, Connecticut Department of Mental Health and Addiction Services, at 860-418-6732 or Judith.Ford@po.state.ct.us

Well Recovery Groups

WELL recovery is a manualized approach intended for consumers who wish to establish peer-run mutual help groups specifically for women in recovery from substance abuse, mental illness, and trauma. The groups are run on the principle that a person's addiction, mental illness, and trauma need to be discussed together, for each plays off the other. With support from the Institute for Health and Recovery, the intervention and manual were created by Suzanne Garverich and Naomi Pinson, themselves recovering from the triple trouble of mental illness, addictions, and trauma.

Status of Research: No research to date.

To obtain the manual *WELL Recovery: Model for Peer Led Self/Mutual Help Groups for Women with Substance Abuse and Mental Health Problems and Histories of Trauma* and for further information, visit www.healthrecovery.org or contact Laurie Markoff or Christine LaClair at wellproject@healthrecovery.org or 617-661-3991.

A Woman's Addiction Workbook

This self-help book offers a step-by-step program to help women work on recovery from alcohol and drugs. It also addresses key issues that women face in relation to addiction, such as body image, trauma and violence, relationships, stress, and thrill-seeking. It explores how women differ from men in their addiction and recovery, and conveys a supportive tone for the journey to healing. A chapter on co-occurring emotional problems allows readers to evaluate whether they may have any of the key DSM-IV disorders common among women with addiction, such as depression, posttraumatic stress, eating disorders, and phobias. With a focus on building strength, women take steps to come to terms with their personal addiction stories. Healing exercises are offered in four areas—feelings, beliefs, action, and relationships—to help women build self-respect. Exercises include *Listen to That Small Quiet Voice*, *Extreme Self-Care*, *Self-Soothing*, *Become Friends with Women*, *Rethink*, *Take Charge*, *Share Responsibility*, and *Mourn*.

Throughout, recovery resources are provided. A clinician guide is in development by the author.

Status of Research: A pilot outcome study has been completed on this model in a public treatment program in Connecticut. Eight opiate-dependent women in methadone treatment attended a group therapy version of the model, led by a professional counselor in 12 sessions of 1.5 hours each. The women completed pre- and post-outcome evaluation on several measures. Significant improvements were found in the Addiction Severity Index drug composite, the Clinical Global Improvement Scale, the Basis-32 impulsivity subscale, and knowledge test of the material. Urinalysis data confirmed clients' self-report. Client satisfaction and attendance were high.

To obtain the workbook and for additional information, go to www.seekingsafety.org or contact Lisa Najavits, Ph.D., at 617-855-2305, McLean Hospital, 115 Mill Street, Belmont, MA 02478.

Women's Leadership Training Institute: "For and By Women in Recovery from Addiction, Mental Illness, and Trauma," Instituto de Entrenamiento para Mujeres Lideres en Recuperacion: Un curriculo educativo y grupal para mujeres en recuperacion

This 3-session, 16-hour training, run by women in recovery, promotes leadership skills development among women in recovery so they may use their own experiences and voices to advocate for services. The curriculum was developed by the Boston Consortium of Services for Families in Recovery, Boston Public Health Commission, the Institute on Urban Health Research, Northeastern University and Dorrington, Saunders and Associates.

Status of Research: The Women's Leadership Training Institute was part of the intervention package offered to women participating in the Women, Co-Occurring Disorders and Violence Study in the Boston site. The study used a no-randomized comparison group design with comparison agencies providing services as usual and intervention sites providing the trauma-integrated model. Analyses to date have focused on the overall differences in outcomes among intervention participants who received the 'package' of services, and comparison group participants who received services as usual rather than on the specific outcomes related to exposure to this particular component of the intervention treatment 'package.' Two documents have been submitted for publication that report on findings indicating that women in the intervention stay in treatment longer and also have lower sexual HIV risk behaviors than those in the comparison condition. Other analyses not yet published, indicate positive outcomes in addiction severity, mental health, and trauma symptomatology at follow-up.

To obtain a manual, contact Dr. Hortensia Amaro at h.amaro@neu.edu or Rita Nieves, R.N., M.P.H., at Rita_Neives@bphc.org

Your Surviving Spirit: A Spiritual Workbook for Coping With Trauma

Written by Dusty Miller, Ed.D., this workbook contains a series of exercises and vignettes designed to help trauma survivors transform their pain and despair into the practice of healthy well-being. The author guides readers through skill-building exercises, journal-writing activities, and the creation of their own stories and affirmations. They learn to identify the ways in which trauma has impacted their lives in mind, body, and spirit, and specific ways they can help on each level of experience.

Status of Research: No research to date.

To obtain the manual, and for information on training and technical assistance (in English and Spanish) and to obtain copies of the manual, visit www.dustymiller.org or e-mail dustymi@valinet.com or call Dusty Miller at 413-584-8404.

Recommendations for Moving Forward

The President’s New Freedom Commission on Mental Health final report has called for nothing less than “the transformation of mental health care in America,” and envisions a “future where everyone with a mental illness will recover, a future where mental illness can be prevented or cured, a future where mental illnesses are detected early, and a future where everyone with a mental illness at any stage of life has access to effective treatment and supports – essentials for living, working, being, and participating fully in the community” (President’s New Freedom Commission on Mental Health, 2003).

To make this vision a reality, A. Kathryn Power, director of SAMHSA’s Center for Mental Health Services, recommends that a Public Health Model be adopted. She describes this model as a community approach to preventing and treating illnesses, based on the premise that caring for the health of an individual protects the community—and in turn, caring for the health of a community protects the individual, with society at large reaping the overall rewards.

Power defines the characteristics of “transformation” as:

- a continuous process, without end, meant to create or anticipate the future;
- identifying, leveraging, and even creating new underlying principles for the way things are done;
- identifying and leveraging new sources of power; and
- once the process is begun, a profoundly different organization emerges, including changes in structure, culture, policy, and programs.

(Credited to Retired Vice Admiral Arthur Cabrowski, Special Assistant for Transformation, Department of Defense, in *Moving from Vision to Reality: Transformation of the Mental Health System.*)

Recognizing the centrality of trauma is key to accomplishing the overall mission of the President’s New Freedom Commission on Mental Health: A transformed mental health system with the goal of Recovery. Convergence of evidence from research studies, including neurobiological and epidemiological studies (Jennings, 2004), suggests that the effects of childhood trauma lead to an array of often co-morbid problems (health, mental health, substance abuse, and social). This calls for a transformed Mental Health system characterized by:

- an integrated, rather than separate or categorical, perspective on the origins of mental health, health, and social problems throughout the lifespan; and
- changes of, and modifications to, current mental health practices, organizational environments, policies, procedures, fiscal mechanisms, workforce development, and services which reflect a shift from an illness/symptom-based model to an

injury/trauma model—a shift from asking the question, “What is wrong with you?” to “What happened to you?”

Without such a shift in both perspective and practice, the dictum to “Do no harm” is compromised, recipients of mental health services are hurt and re-traumatized, recovery and healing are prevented, and the transformation of mental health care in America will remain a vision with no substance in reality.

There has been significant growth in the number of states addressing trauma and in the variety and number of trauma-focused activities initiated. However, state mental health systems vary markedly in the degree to which they have adopted emerging best practices in trauma-specific services and in the extent to which their service systems are trauma-informed. The initiation and sustainability of trauma-informed service systems based on an injury or trauma model are at present highly dependent on state mental health leadership and the appointment of senior staff with expertise, responsibility, and accountability for addressing trauma throughout the system. Without such leadership and single point of accountability, systems and practices tend to revert back to the traditional illness/symptom-based model.

The following recommendations for state mental health systems are based on the six goals of the President’s New Freedom Commission on Mental Health’s *Achieving the Promise* report (2003). Many of the recommendations listed here have been incorporated already in mental health organizations and state mental health service systems across the country, providing practical “real-life” examples of how they might be implemented (for a detailed description of states’ trauma-related activities, see Jennings, in press).

Recommendation #1: Understand and communicate the importance of the impacts of trauma as fundamental to health and mental health

- Conduct national and state educational campaigns which:
 - increase understanding of trauma and its impacts on health, mental health and social well-being;
 - raise awareness of the role of internal and external stigma as it affects the disclosure of childhood abuse experiences and as it exacerbates traumatic impacts over the life span; and
 - incorporate the stories of persons with lived experience of abuse and trauma
- Include keynotes and workshops on trauma in all national and state conferences tailored to the specific focus and goals of those conferences
- Collaborate with the ACE Study principals to develop and implement educational strategies that a) emphasize the strong relationship between trauma and health,

and b) impact on health and mental health groups who interface with and provide services to persons with lived experience of childhood abuse and trauma

- Appoint a single, high-level, clearly identified point of responsibility within a state’s administrative structure, charged with implementing trauma-informed service systems and use of emerging best practices in trauma throughout state supported services (i.e. a “trauma champion”)
- Develop a written statewide policy or position statement, signed by leadership, defining interpersonal violence and trauma; clearly stating the relationship between trauma, mental health, and recovery; and publicly declaring trauma to be a priority health and mental health issue for the state’s mental health system
- Support and sustain state leadership and trauma champions through convening groups at planned conferences and national meetings; development of a Web site resource, referral and information base; and consultation in developing trauma-informed service systems

Recommendation #2: Trauma recovery must be consumer-driven; be based on hope, self-determination, and empowerment; and stress the importance of listening to and hearing the lived experiences of trauma survivors

- Incorporate trauma into the development of individualized plans of care for every adult and child with serious mental health and/or substance abuse problems. The plan should be developed in collaboration with the consumer, and should address trauma; its impact on the individual; the prevention of re-traumatization; the provision of, or referral to, trauma-informed and trauma-specific treatment and supports; and the integration of trauma, mental health, and substance abuse (where present) in counseling and treatment programs
- Address trauma as a key element in comprehensive state mental health plans and planning by all community services, using guidelines such as the “Criteria for Building a Trauma-Informed Mental Health Service System” (see the Appendix) and the models for developing trauma-informed service systems and organizations described earlier in this document
- Involve and support the involvement of persons with lived experience of trauma who are mental health consumers at the core of all systems activities—from policy and financing, to training and services, to access and accountability. C/S/Rs (Consumer/Survivor/Recovering persons) should represent, whenever possible, a “critical mass” (at least 30%) of all those involved in orienting the mental health system toward recovery from impacts of trauma
- Advocate for the alignment of all relevant federal programs involved with developing, supporting, providing and regulating services used by individuals

whose lives have been impacted by trauma in order to improve access to, and accountability for, the full range of services needed by this population

- Facilitate the development of a national level and individual state level “Bill of Rights” specifically focused on the rights of persons impacted by trauma, e.g., the right to trauma treatment and freedom from re-traumatization

Recommendation #3: Eliminate Disparities among trauma, mental health, and social services

- Eliminate disparities in every aspect of system functioning—from screening, referral, diagnosis, and treatment to workforce training and deployment
- Address trauma and cultural competency in the national Strategic Workforce Development Plan and the National Rural Mental Health Plan
- Address cultural issues and issues of disparity regarding trauma for all populations including refugees, racial and ethnic minorities, and rural populations and with concern for gender, age and developmental phase over the life span
- Develop financing criteria and mechanisms and modify licensing, regulations, certification, and contracting mechanisms to eliminate disparities in mental health services by improving access to emerging best practices in trauma treatment
- Design service settings and develop collaborative arrangements that support the integration of services used by individuals that have an array of health, mental health, substance abuse, and social problems
- As part of a comprehensive treatment program, providers should offer integrated counseling services that are specifically designed to address all three issues of trauma, mental illness, and substance use

Recommendation # 4: Make early screening for trauma, assessment of impact of trauma, and referral for integrated trauma services common practice

- Incorporate screening for past and present experiences of abuse and trauma for all adults and children at the first point of contact when entering the system of care—regardless of which “door” they enter (primary health care, mental health, substance abuse, criminal justice)
- Implement effective identification of trauma, assessment of trauma impacts, and trauma treatment approaches for children in school mental health programs, throughout the children’s mental health system, and in primary care settings

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- Modify existing screening procedures for co-occurring mental health and substance use disorders to include screening for trauma
 - Conduct a trauma assessment of all those who report a history of trauma during initial screening as an integral part of the clinical picture, repeated periodically and used as part of all treatment, rehabilitation, and discharge planning. A life-span perspective should be adopted and, whenever possible, assessment and referral should be conducted by a multi-disciplinary team
 - Develop a comprehensive referral base of available, quality, trauma-informed, and trauma-specific services and supports for use in treatment and discharge planning

Recommendation #5: Deliver excellent trauma, mental health, and substance abuse integrated care and supplement trauma research

- Develop a body of useable knowledge on evidence-based and emerging best practice models in trauma treatment, and disseminate this information widely to multiple service systems, disciplines, and fields serving persons with histories of trauma and complex trauma disorders
- Develop an effective system to identify, disseminate, and apply proven treatments at the community level
- Link multiple forms of technical assistance to move evidence-based and emerging best practice knowledge into community practice to demonstration projects
- Expand the NREP to include mental health/trauma-specific interventions
- Conduct research, needs assessments, surveys, and data gathering at a state level to explore prevalence and impacts of trauma; to assess the status of services; to support more rapid implementation of evidence-based and emerging best practice trauma treatment models; and to use as part of an ongoing quality improvement and planning process
- Implement and evaluate trauma-informed services and service system models, and emerging best practice trauma-specific service models in state mental health systems
- Work with NASMHPD and NRI to convene a trauma research workgroup to identify next step intervention projects and to accelerate the conduct of research that has the potential to move emerging best practices into the category of evidence-based practices. This could increase the implementation of and access to such practices, especially to children, promoting recovery and resilience and

ultimately preventing the development of complex trauma disorders and major mental illnesses

- Involve clinicians (trained in recognizing, diagnosing, and treating disaster victims who develop signs of PTSD) in disaster planning and response activities to prevent the development of more complex trauma-disorders

Recommendation #6: Use technology that incorporates appropriate confidentiality safeguards for consumers' stories of violence in order to improve services integration

- Health technology and telehealth should be used to make promising and best practice-integrated trauma treatment model programs accessible for individuals in remote areas or in underserved populations
- Ensure that NASMHPD's user-friendly, consumer Web site contains information about, and referrals for, trauma services

Appendix: Criteria for Building a Trauma-Informed Mental Health Service System

The following elements should be in place in any public mental health system committed to meeting the needs of clients who have histories of trauma. Trauma is defined here as interpersonal violence, over the life span, including sexual abuse, physical abuse, severe neglect, loss, and/or the witnessing of violence.

Administrative Policies/Guidelines Regarding the System

- 1. Trauma function and focus in state mental health department.** A single, high-level, clearly identified point of responsibility should exist within the state administrative structure charged with implementing trauma-informed service systems and use of evidence-based and emerging best practices in trauma throughout state supported services. This could be a senior staffer, a unit or office within the department, and/or ongoing, high-visibility leadership on the part of the agency director.
- 2. State trauma policy or position paper.** A written statewide policy or position statement should be adopted and endorsed. This document should include a definition of interpersonal violence and trauma; make a clear statement about the relationship between trauma, mental health, and recovery; and publicly declare trauma to be a priority health and mental health issue. Ideally, the position statement should commit the state to meeting the essential elements of a trauma-informed service system, and a trauma-specific clinical system. The *NASMHPD Position Statement on Services and Supports to Trauma Survivors* (NASMHPD, 1999) serves as a model of such a position paper.
- 3. Workforce orientation, training, support, competencies and job standards related to trauma.** All human resource development activities should reflect understanding of, and sensitivity to, issues of violence, trauma, and coercion; incorporate relevant skill sets and job standards; and address prevalence and impact of traumatic events. All employees should receive basic education about the traumatic impacts of sexual and physical abuse and other interpersonal violence to increase sensitization to trauma-related dynamics and the avoidance of retraumatization. Direct care and clinical staff should be educated in a trauma-informed understanding of unusual or difficult behaviors, the maintenance of personal and professional boundaries, evidence-based and emerging best practices in the treatment of trauma, and in vicarious traumatization and self-care. Those whose clinical work includes assessment and treatment should be required to attend ongoing, advanced trauma training. (*See Recommendations 5.3 and 5.4 in the President's New Freedom Commission on Mental Health final report [2003]*)

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4. **Linkages with higher education to promote education of professionals in trauma.** Formal, ongoing efforts should be made to collaborate with institutions of higher education to create new trauma-based curriculum, revise existing curricula, ensure the teaching of evidence-based and emerging best practices in trauma, include consumer/survivors as trainers, and incorporate trauma and violence as a core part of the training of all future behavioral health care workers in all disciplines. (*See Recommendation 5.3 in the President's New Freedom Commission on Mental Health final report [2003]*)
 5. **Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights.** The voice and participation of consumers, including those who identify themselves as trauma survivors, should be at the core of all systems activities—from policy and financing to training and services. Trauma-informed individualized plans of care should be developed *with* every adult and child receiving mental health system services. Consumers with trauma histories should be significantly involved and play a lead role in the creation of State Mental Health Plans, the improvement of access and accountability for mental health services, and in orienting the mental health system toward trauma and recovery. Special attention should also be paid to the rights of people with trauma histories (e.g., right to trauma treatment, freedom from re-traumatization) and to the ways in which these rights may be systematically violated. (*See Recommendations 2.1, 2.2, 2.3, 2.4, and 2.5 of the President's New Freedom Commission on Mental Health final report [2003]*)
 6. **Trauma policies and services that respect culture, race, ethnicity, gender, age, sexual orientation, disability, and socio-economic status.** A commitment to all forms of diversity should be the bedrock on which trauma-informed systems of care are built. Cultural issues regarding trauma should be addressed for all populations, including refugees, racial and ethnic minorities, and rural populations. (*See Recommendations 3.1 and 3.2 of the President's New Freedom Commission on Mental Health final report [2003]*)
 7. **Systems integration/coordination between and among systems of care serving persons with trauma histories, and including life-span perspective.** Because abuse trauma may result in multiple vulnerabilities and affect many aspects of a survivor's life, coordination across systems is essential. Integration of trauma, mental health and substance abuse is absolutely critical. Systems integration should also include the health care system, educational system, criminal justice, social services, and the full range of human services. (*See Recommendations 4.2, 4.3, and 4.4 of the President's New Freedom Commission on Mental Health final report*)
 8. **Trauma-informed disaster planning and terrorism response.** Disaster planning should include clinical expertise on short and long-term trauma impacts. Mental health, trauma experts, and disaster response workers should work as a

coordinated team in emergency support and ongoing interventions in the aftermath of disasters. All workers should be trained and knowledgeable about mental health trauma issues from the initial assessment through the intervention process, including skills of recognizing and coping with trauma reactions. Clinicians should be trained in longer-term interventions for recognizing, diagnosing and treating those who develop PTSD or other stress responses and those whose existing history of abuse and trauma is further exacerbated by current disaster. *(See Recommendations 5.2 and 5.3 of the President's New Freedom Commission on Mental Health final report [2003])*

Administrative Policies/Guidelines Regarding Services

- 9. Financing criteria and mechanisms to pay for best practice trauma treatment models and services.** Funding strategies for trauma-specific services should be clearly identified, and should eliminate disparities in mental health services by improving access to evidence-based and emerging best practices in trauma treatment. Existing exclusions and barriers to reimbursement should be eliminated. Although new funds are not necessarily critical to developing a trauma-informed system, the development of sufficient trauma-specific services to meet the treatment needs of the high percentage of clients with histories of unaddressed sexual and/or physical abuse and trauma may require creative fiscal reimbursement strategies. Attention to reimbursement and funding issues is key to a successful change strategy. *(See Goal 3 of the President's New Freedom Commission on Mental Health final report [2003])*
- 10. Clinical practice guidelines for working with people with trauma histories.** Findings from studies, including SAMHSA's Women, Co-Occurring Disorders and Violence study, provide evidence that trauma treatment is effective. Several clinical approaches have been manualized and guidelines have been developed. Clinical approaches to trauma treatment should clearly identify trauma as the issue being treated, promote recovery, allow for survivors to tell their stories, include trauma-sensitive training and supervision, address secondary trauma and self-care for the caregiver, and be experienced as empowering by consumer/survivors.
- 11. Procedures to avoid retraumatization and reduce impacts of trauma.** A statewide effort should be made to reduce or eliminate any potentially retraumatizing practices such as seclusion and restraint, involuntary medication, etc. Training should cover dynamics of retraumatization and how some practices could mimic original sexual and physical abuse experiences, trigger trauma responses, and cause further harm to the person. Specific policies should be in place to create safety; acknowledge and minimize the potential for retraumatization; assess trauma history; address trauma history in treatment and discharge plans; respect gender differences; and provide immediate intervention to mitigate effects should interpersonal violence occur in care settings. *(See Goal*

5 of the President's New Freedom Commission on Mental Health final report [2003])

- 12. Rules, regulations and standards to support access to evidence-based and emerging best practices in trauma treatment.** Licensing, regulations, certification, and contracting mechanisms should all reflect a consistent focus on trauma. They should be modified periodically to conform to developments in knowledge of evidence-based and emerging best practice and to promote provision of and access to trauma-informed and trauma-specific services. (*See Goal 3 of the President's New Freedom Commission on Mental Health final report*)
- 13. Research, needs assessments, surveys, and data to: explore prevalence and impacts of trauma; assess status of services; and support more rapid implementation of evidence-based and emerging best practice trauma treatment models.** Data on interpersonal abuse trauma prevalence and impacts, service utilization and need, trauma treatment intervention outcomes related to recovery and resilience, and satisfaction with trauma services should be regularly collected and should be used as part of ongoing quality improvement and planning processes. (*See Recommendations 5.1 and 5.4 of the President's New Freedom Commission on Mental Health final report [2003]*)

Services

- 14. Trauma screening and assessment.** All adults and children who enter the system of care, regardless of which “door” they enter, should be screened for abuse and trauma at, or close to, admission. People with a positive response to the screen should have a trauma assessment as an integral part of the clinical picture, to be revisited periodically and used as a part of all treatment, rehabilitation, and discharge planning. Clients with trauma histories should be informed about and referred to quality, trauma-informed and trauma specific services and supports. (*See Recommendations 4.1, 4.2, 4.3, and 4.4 of the President's New Freedom Commission on Mental Health final report [2003]*)
- 15. Trauma-informed services and service systems.** A “trauma-informed” service system and/or organization is one in which all components of the 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” organizational environment is capable of supporting and sustaining “trauma-specific” services as they develop. A basic understanding of trauma and trauma dynamics—including trauma caused by childhood or adult sexual and/or physical abuse—should be held by *all* staff and should be used to design systems of services in a manner that accommodates the vulnerabilities of trauma survivors and allow services to be delivered in a way that will avoid retraumatization and facilitate consumer participation in treatment. (*Trauma-informed service systems increase capacity to address Goals 2, 3, 4 and*

5 of the President's New Freedom Commission on Mental Health final report [2003])

16. Trauma-specific services, including evidence-based and emerging best practice treatment models. Services designed specifically to treat the actual sequelae of sexual or physical abuse and other psychological trauma should be available in adequate numbers to serve the population and should be accessible to all consumers. As part of recent research studies including the SAMHSA *Women, Co-Occurring Disorders and Violence* study, several emerging best practice trauma treatment models applicable in public sector service systems have been manualized and are proven to be both cost effective and effective in reducing symptoms. These best practice models should be implemented by state mental health systems to treat trauma. Health technology and telehealth should be used to make these programs accessible for individuals in remote areas or in underserved populations. Although program models may vary widely, all should be recovery-oriented, emphasize consumer voice and consumer choice, and be fully trauma-informed. In addition, because of the numbers of trauma survivors with co-occurring disorders, and given significant positive findings from recent studies such as the WCDVS, trauma treatment programs should provide integrated trauma, mental health, and substance abuse services. Further, as part of a comprehensive treatment program, providers should offer integrated counseling services that are specifically designed to address all three issues (trauma, mental health, and substance use) simultaneously. (*See Recommendations 2.1, 3, 4.3, 5.2, and 6.1 of the President's New Freedom Commission on Mental Health final report [2003]*)

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