

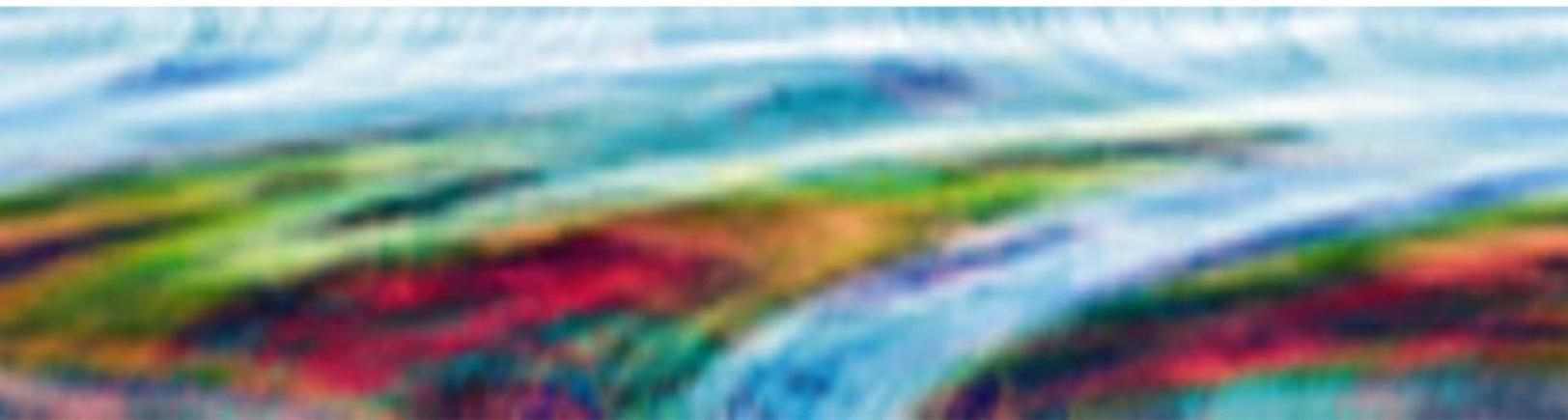


Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services

2008 Update

NCTIC Center for Mental Health Services
National Center for Trauma-Informed Care

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

Compiled by Ann Jennings, Ph.D.

This report is an update of the 2004 technical report describing trauma-informed and trauma-specific service models identified by state behavioral health service systems and organizations. All models in this report are designed and used specifically to address trauma in the lives of children, their parents or caregivers, and adults.

Acknowledgments

This document was compiled by the exhaustive efforts of Ann Jennings Ph.D. with her dedication to promoting awareness to the prevalence and effects of trauma as well as her hope in healing and systems transformation to a trauma-informed community. Abt Associates Inc., the National Association of State Mental Health Program Directors (NASMHPD), and the National Center for Trauma Informed Care (NCTIC) gratefully acknowledge the many individuals and organizations that contributed to the development of this updated report. In particular, we would like to thank Terry Cline, Ph.D. Administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA), A. Kathryn Power, M.Ed., and Susan E. Salasin of the Center for Mental Health Services (CMHS) within SAMHSA for their time, effort and continuing commitment to this issue.

Among the many individuals who contributed resources and time to this updated publication, we would like to especially thank those dedicated and talented people who created the trauma-informed and trauma-specific service models and treatment approaches contained in this report. Their response to our request for revised or new descriptions of their models according to a format easily reviewed by readers within state mental health and substance abuse service systems was generous and timely. They patiently and carefully summarized key aspects of their models, indicating the status of research and evaluative findings, identifying the specific settings and individuals for whom each approach was designed

and/or adapted, and providing contact information for readers to easily obtain more information and/or materials. Their commitment and continuing work in the field of trauma, especially with regard to the creation and research of models addressing the complex and deeply rooted types of childhood abuse trauma experienced by so many recipients of public mental health and addition services, has been essential to moving the field forward towards achieving the vision of recovery and transformation portrayed in the President's New Freedom Commission on Mental Health Final Report.

We would also like to acknowledge the contributions of Gail Robinson, Ph.D., Rebecca Tregerman, and Kenneth Morford of Abt Associates Inc. for their invaluable assistance contributing to the preparation of this manual.

Disclaimer

The data collection method used to prepare this report did not include specific questions about a particular model's "Approach," "Intended Setting," or "Special Focus," although many authors included such information in their descriptions. Authors were contacted to review the tables and to provide any missing information for the final publication of this report.

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Although childhood trauma experienced by individuals may be core to their condition and central to their healing, it has seldom been addressed or viewed as a central issue in the treatment of adults within public mental health settings.

—Cusack et al., 2007

Introduction

This 2007 technical report identifies revised 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 the increasing numbers and range of trauma-based service models and approaches available for implementation by state service systems, provider agencies and communities across the country. This report includes updated author descriptions of trauma service models identified by states and organizations for the 2004 technical report; author descriptions of evidence-based and promising practice models identified in SAMHSA's Model Programs and National Registry of Evidence-Based Programs and Practices; author descriptions of empirically supported treatments and promising practices identified by the National Child Traumatic Stress Network, and empirically supported treatment approaches and promising practices reported by state trauma-informed contacts. All models were designed explicitly to address trauma in the lives of children, their parents or caregivers, and adults.

Data Collection Method

The model descriptions included in this report were authored by the creators of the various models. A letter was sent to each author requesting a written description of their model that identified the following pieces of information:

- Name of the service model;
- Description of the content and process of the model itself, who it was developed by, and all accompanying manuals, PowerPoints, and/or other materials;
- Population(s) the model is designed for and used with (e.g., ages, genders, cultures, specific client groups, settings, language adaptations);

- Status of research; and
- Contact information including name of contact person or organization, phone number(s), email address, and website address.

The authors were provided a copy of the original 2004 document to use as a reference for examples of other written descriptions. Authors received a follow-up call several weeks after receiving the letter of request to address any questions or concerns. The completed author descriptions were collected via email and then included in this report.

Who Are the Models Designed For?

All of the models described in this document are designed for providers and persons receiving or at risk for receiving public mental health and/or substance abuse services who have been traumatized by interpersonal violence and abuse and other adverse experiences 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 children and adults seen in public service sector settings today. These individuals often have severe and persistent mental health and/or substance use problems and are frequently the highest users of the system's most costly inpatient, crisis, and residential services. As adults, they may be diagnosed with a broad array of psychiatric disorders, and often times, these diagnoses vary over time. Psychiatric diagnoses that have been related to past trauma include borderline personality disorder, schizophrenia, depression and other affective disorders, anxiety disorder, eating disorder, psychosis, dissociative disorder, addiction, somatoform, and sexual impairment (Ford et al., 2004; Read et al., 2001 and 2003; Felitti et al., 1998; Mueser et al., 2002; Mueser and Rosenberg, 2003; Sareen, 2005). As children and adolescents, a multiplicity of trauma-related behaviors and coping mechanisms may

lead to misdiagnoses such as attention deficit hyperactivity disorder, oppositional defiant disorder, conduct disorder, substance use disorders, juvenile or pediatric bipolar disorder, bipolar depression, borderline personality disorder, and major depression (Glad and Teicher, 1996; Perrin et al, 2000, Hodas, 2006). In spite of the prevalence of trauma and its severe impacts on the mental health of adults and children, a primary or secondary trauma-based diagnosis of Post-traumatic Stress Disorder is seldom given (NYS-OMH, 2001; Tucker, 2002).

Many of the individuals described above have developed extreme coping strategies in childhood, adolescence and adulthood, to manage the impacts of overwhelming traumatic stress, including suicidality, substance abuse and addictions, self-harming behaviors such as cutting and burning, hallucinations, emotional numbing and dissociation, hypervigilance, somatization, aggression and rage, re-enactments such as abusive relationships, and serious health risk behaviors (Saakvitne et al., 2000; Dube et al, 2001; Felitti et al, 2002; Felitti, 1998; Hammersley, 2004; Sareen, 2005; CDC, 2005).

Although childhood trauma experienced by individuals may be core to their condition and central to their healing, it has seldom been addressed or viewed as a central issue in the treatment of adults within public mental health settings (Cusack et al., 2007). For the most part, these individuals have never received screening, assessment or treatment for trauma (Cusack, Frueh, and Brady, 2004; Frueh et al., 2002; Mueser et al., 1998). This is unfortunate because data clearly now show that you can effectively assess PTSD and trauma, including the use of relatively brief screening measures (Cusack, Frueh, and Brady, 2004; Grubaugh et al., 2007). The situation is similar for children in the mental health service system. Although many have histories of severe interpersonal violence and multiple adverse childhood experiences, recognition of the trauma underlying their behaviors and diagnoses typically does not occur (Hodas, 2006; Perrin et al, 2000).

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 or who become recipients of public mental health services are not usually 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 adults, adolescents and children 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. They frequently include several different kinds of traumatic or adverse experiences resulting in cumulative traumas that have neurological impacts and that lead to health risk behaviors or symptoms adopted as attempts to ease the pain. In turn, these coping mechanisms can result in severe and sometimes chronic dysfunctions over the lifespan including disease, disability, and serious social and mental health problems (Felitti, 1998, Jennings, 2006).

As adolescents and adults, individuals abused in childhood 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 and unsafe psychiatric environments (Jennings, 1994; Cusack et al., 2003; Frueh et al., 2000; Frueh et al., 2005; Grubaugh et al.2008.; Robins et al., 2005), which can include sexual and physical abuse in inpatient or institutional settings, jails, and prisons. These individuals frequently develop serious and disabling health problems (Felitti et al., 1998). As parents, they may participate in or witness the intergenerational effects of violence and abuse. In particular, adolescent and teenage girls and women are vulnerable to

revictimization, ongoing exploitation and abuse (Browne, 1992; Frueh et al., 2000; Rosenberg et al., 2001; Russell, 1986). Models for improving patient safety and dignity within psychiatric hospitals and clinics now exist and indicate effective ways to improve mental health care for vulnerable people (Bloom, 1997; Borckardt et al., 2007), as do psychometric instruments for measuring aspects relevant to patient safety and dignity (Danielson et al., 2008).

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 population of clients, but as encompassing nearly *all* children, adolescents and adults 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.

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.

- 51 – 98% of public mental health clients with severe mental illness, including schizophrenia and bipolar disorder, have been exposed to childhood physical and/or sexual abuse. Most have multiple experiences of trauma (Goodman et al., 1999, Mueser et al., 1998; Cusack et al., 2003).
- 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, and 87% experienced this abuse both as children and as adults (Goodman, Dutton et al., 1997).
- Nearly 8 out of 10 female offenders diagnosed with a mental illness report histories of physical or sexual abuse (Smith, 1998).
- 93% of psychiatrically hospitalized adolescents had histories of physical and/or sexual and emotional trauma; 32% met criteria for PTSD (Lipschitz et al., 1999).
- In Massachusetts, 82% of all children and adolescents in continuing care inpatient and intensive residential treatment have trauma histories (NETI, 2003).
- 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 compared with teenagers without alcohol and drug problems (Clark et al., 1997).
- Among juvenile girls identified by the courts as delinquent, more than 75% have been sexually abused (Calhoun et al., 1993).
- 3 years of data from New York State Office of Mental Health showed that only 1 in 200 adult inpatients and only 1 in 10 child/adolescent inpatients carried either a primary or secondary diagnosis of PTSD (NYS-OMH, 2001; Tucker, 2002).

12 Criteria for Building a Trauma-Informed Mental Health Service System

1. A designated trauma function and focus in the state mental health department;
2. State trauma policy or position paper;
3. Workforce recruitment, hiring and retention;
4. Workforce orientation, training, support, competencies and job standards related to trauma;
5. Consumer/Trauma Survivor/Recovering person (C/S/R) involvement and trauma-informed rights;
6. Financing criteria and mechanisms to support development of trauma-informed service systems and implementation of evidence-based and promising practice trauma treatment models and services;
7. Clinical practice guidelines for working with children and adults with trauma histories;
8. Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop a trauma-informed system, and to avoid retraumatization;
9. Needs assessment, evaluation, and research to explore prevalence and impacts of trauma; assess trauma survivor satisfaction, service utilization and needs; and to monitor and make adjustments in trauma-informed and trauma-specific service approaches;
10. Universal trauma screening and assessment;
11. Trauma-informed services and service systems; and
12. Trauma-specific services, including evidence-based and promising practice treatment models.

In 2004, an update of the *Trauma Services Implementation Toolkit for State Mental Health Agencies* had grown from 21 to over 130 pages, reflecting a dramatic increase both in the number of states reporting trauma-related activities (from 15 to 31) and the multiplicity of strategies and programs they had adopted, initiated, or in some way support. In 2009, SAMHSA will publish

another update on state systems' activities in developing trauma-informed mental health service systems. Research for that document shows a continued increase in trauma-related activities, especially in the area of children's services. A total of 44 states and the District of Columbia now report trauma-related activities.

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 12 *Criteria for Building a Trauma-Informed Mental Health Service System* (Revised from Blanch, 2003). 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* (See Appendix for criteria descriptions).

What Factors have Contributed to the Growth of Trauma 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. It has become evident to a critical mass of mental health leaders in decision making positions that:

- 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 promising practice models designed for, and providing renewed hope of recovery to, clients with complex, severe, and persistent mental health or addiction problems; and
- Many of these trauma-informed and trauma-specific models are applicable and replicable within public service sector settings.

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

Leadership

■ **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 policymakers 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.

■ **Leadership of the National Association of State Mental Health Program Directors (NASMHPD).** NASMHPD, and 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 2005, reflecting increased scientific validation for the centrality of trauma in the lives of mental health clients, the NASMHPD membership unanimously passed a revised position statement: *NASMHPD Position Statement on Services and Supports to Trauma Survivors*.

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 undertaken by NASMHPD/NTAC to reduce seclusion and restraint practices and the retraumatization of such practices, and a comprehensive curriculum: *Creating Violence Free and Coercion Free Mental Health Treatment Settings*, was developed and implemented in numerous state systems. 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 has produced and implemented nationally a second curriculum "Creating Trauma Informed Systems of Care", and several trauma-related 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, 2004), *Models for*

Developing Trauma-Informed behavioral Health Systems and Trauma-Specific Services for Children (Jennings, 2004), *Responding to Childhood Trauma: The Promise and Practice of Trauma-Informed Care* (Hodas, 2006), and *Organizational Stress as a Barrier to Trauma – Sensitive change and System Transformation* (Bloom, 2006).

Studies

■ **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. It has contributed a group of evidence-based and promising 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 men and a variety of ethnic groups (www.nationaltraumaconsortium.org).

■ **The Adverse Childhood Experiences (ACE) Study.** The Adverse Childhood Experiences (ACE) Study, a decade long collaboration between the Centers for Disease Control and Prevention and Kaiser Permanente’s Health Appraisal Clinic in San Diego, is the largest epidemiological study ever conducted on the links between childhood maltreatment and trauma, and later-life health, mental health and social well-being. According to

data collected from over 17,000 Kaiser patients in this ongoing retrospective and prospective study, adverse childhood experiences, though well concealed, are unexpectedly common, and are major risk factors for the leading causes of death and disability in this country, including heart disease, cancer, stroke, diabetes, skeletal fractures, chronic lung disease, and liver disease.

Seven categories of adverse and potentially traumatizing categories of childhood experiences were explored with study participants, including: psychological abuse, physical abuse, sexual abuse, household member with substance abuse, household member with serious mental health problems, mother treated violently, and criminal behavior in household.

A strong graded relationship was consistently shown to occur between the number of categories of adverse childhood experiences and adult reports of health risk behaviors including smoking, obesity, physical inactivity, alcoholism, drug abuse, depression, hallucinations, suicide attempts, sexual promiscuity, and sexually transmitted diseases – all identified as leading causes of death and disability. These health risk behaviors, traditionally viewed as public health or mental health problems, are viewed by the ACE Study as coping mechanisms to ease the neurological impacts and psychological pain resulting from multiple childhood adverse and traumatic experiences.

The ACE Study has had a major impact on health and mental health care professionals both nationally and internationally, revealing the importance of routinely screening all patients or clients for adverse childhood experiences; and underscoring the fact that a childhood trauma history may be very relevant to both serious physical illness and mental health problems and that appropriate approaches to treatment must include dealing with childhood trauma. Additional data suggest that evaluating patients for ACEs is also cost-effective.

To date, over 30 scientific articles have been published and over 100 conference and workshop presentations have been made about ACE study findings and their implications for public health and health and mental health care professionals (www.acestudy.org; www.cdc.gov/nccdphp/ace/).

Reports

- **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; develop 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 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).

Centers

- **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. During the winter of 2004, NTC collaborated 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 provided 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. NTC continues to function as a clearinghouse of information about trauma and emerging best practices in trauma treatment and services, offering training and consultation services to mental health and substance abuse providers, hospitals, the criminal justice system, child-serving agencies, women’s organizations, community agencies, advocates, and others (www.nationaltraumaconsortium.org).

- **National Child Traumatic Stress Network (NCTSN).** Established by Congress in 2000, NCTSN is a unique collaboration of academic and community-based service centers whose mission is to raise the standard of care and increase access to services for traumatized children and their families across the United States. Combining knowledge of child development, expertise in the full range of child traumatic experiences, and attention to cultural perspectives, NCTSN is a national resource for developing and disseminating evidence-based interventions, trauma-informed services, and public and professional education.

The network comprises 70 member centers – 45 current grantees and 25 previous grantees – and is funded by CMHS, SAMHSA, US Department of Health and Human Services through a

congressional initiative: the Donald J. Cohen National Child Traumatic Stress Initiative (www.nctsnct.org).

- **Center on Women, Violence and Trauma (CWVT).** Created and funded by CMHS/SAMHSA in 2005, CWVT initially focused on work surrounding the Women and Co-occurring Disorders and Violence Study, the related Dare to Vision and Dare to Act conferences, and provided consultation and resources for state initiatives to develop trauma-informed service systems. Largely due to tireless work done by trauma champions and advocates across the country, interest in trauma exploded at the national and state levels, leading to a need for the Center to focus clearly on national policy issues, increase support for states in developing trauma-informed systems, and strengthen commitment to the leadership of people with lived experience of trauma. In 2006, CWVT was relocated to the Washington D.C. area and renamed the National Center for Trauma-Informed Care to reflect a national focus.
- **National Center for Trauma-Informed Care (NCTIC).** Funded by CMHS/SAMHSA, and in partnership with the National Technical Assistance Center at the National Association of State Mental Health Program Directors (www.nasmhpd.org), and with Witness Justice (www.witnessjustice.org), NCTIC provides free and low-cost trauma training and technical assistance to policymakers and administrators, caregivers, institutional workforces, consumers and survivors in the mental health, substance abuse, criminal justice, victim assistance, education, primary care, and other publicly-funded systems. NCTIC also offers an expert speakers bureau, resources, and education and outreach activities around the issue of trauma for these same target audiences. These and other activities stimulate and support change in publicly-funded programs and systems across the country in order to address the trauma experienced by survivors and consumers. <http://www.mentalhealth.samhsa.gov/nctic>

Notable Event

- **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. 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.

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 have demonstrated positive client outcomes. The following section of this report contains descriptions of over 80 service models and examples reported to be implemented within state mental health and substance abuse service systems or in use with public sector clients.

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

Trauma-Informed and Trauma-Specific Models

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 society; There will be open and genuine collaboration between provider and recipients of services 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.

The trauma-informed and trauma-specific models described in this report are manualized or packaged in a way as to make them accessible to review and implementation by State Mental Health Authorities and agencies serving adults, children and families/caregivers in

public mental health and substance abuse service systems. They are listed alphabetically and organized in the following categories.

- **Trauma-Informed Models for Service Systems and Organizations: Adults**
- **Trauma-Informed Service Models for Adults**
- **Trauma-Specific Service Models for Adults**
- **Manualized Adaptations of Trauma-Specific Service Models for Adults**
- **Trauma-Informed Models for Service Systems and Organizations: Children**
- **Trauma-Specific Models for Parenting**
- **Trauma-Specific Service Models for Children and Family/Parents/Caregivers**
- **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 reports of their creators and experiences reported by state service systems and organizations, many of 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, and in community settings where children and adults who are or who are at risk of being in need of public system resources, may receive services.

What are the definitions of “Trauma-Informed” and “Trauma-Specific”?

“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 adults, children and adolescents and families or caregivers seeking mental health and addictions services (Harris & Falot, 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 trauma and trauma recovery (Harris & Falot, 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 & Falot, 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).

Models for Developing Trauma-Informed Service Systems and Organizations: Adults

Guide to Models for Developing Trauma-Informed Service Systems and Organizations: ADULTS				
Name of Model	Intended Audience	Type of Services	Intended Setting	Special Focus
<i>Creating Cultures of Trauma-Informed Care</i>	Providers, State service systems	Book, Implementation and assessment guides, Consultation, Training	Public sector human service systems, Provider agencies, Individual services & programs	
<i>Creating Trauma-Informed Systems of Care: Facilitating Recovery in Mental Health Services Settings</i>	Direct care staff, Senior & middle managers	Curriculum, Training	Public sector MH provider agencies	
<i>Developing Trauma-Informed Organizations: A Tool Kit</i>	Policymakers, Program directors	Tool Kit, Training	Corrections, Domestic violence agencies, SA treatment & MH provider agencies	Women; Co-occurring SA & MH disorders
<i>National Executive Training Institute for the Reduction of Seclusion and Restraint: Creating Violence Free and Coercion Free Mental Health Treatment Settings</i>	Senior & middle managers	Curriculum/Manual, Training, Video	Child, youth, adult, & forensic MH facilities	Reduction of seclusion & restraint
<i>Risking Connection: A Training Curriculum for Working with Survivors of Childhood Abuse</i>	Direct care staff, management, and clinicians in all settings	Curriculum/Manual, Training, slides, Train-the-trainer, TA	Child-serving, Child residential, Domestic Violence, Crime victims, Corrections, SA treatment programs	Customizable focus for each setting
<i>Risking Connection in Faith Communities: A Training Curriculum for Faith Leaders Supporting Trauma Survivors</i>	Faith leaders, MH providers	Curriculum/Manual, Training	Faith-based settings	Faith communities
<i>The Sanctuary Model</i>	Organizational leaders	Consultation, Curriculum/Manual, Implementation guide, TA, Training	Acute care inpatient for adults & children; Child residential; Community-based programs; Juvenile Corrections; SA programs for women, children & adolescents	
<i>Women and Addiction: A Gender-Responsive Approach</i>	Clinicians, Counselors, Program directors, State service systems	Manual, DVD, CEU test, Consultation, DVD, Manual, Training	Public and private SA treatment, mental health services, criminal justice settings	Women, SA, MH

Key: MH – Mental Health; SA – Substance Abuse; TA – Technical Assistance

Creating Cultures of Trauma-Informed Care

Description: The Creating Cultures of Trauma-Informed Care (CCTIC) model engages the system or organization in a *culture change*, emphasizing core values

of safety, trustworthiness, choice, collaboration, and empowerment in every facet of program activities, physical settings, and relationships. Implementing cultural shifts of this scope requires the full participation of administrators; supervisory, direct

service, and support staff: and consumers. CCTIC begins with individualized consultation to ensure adequate system-wide support and to tailor the change process to the specific organization(s). Agencies then designate a workgroup, with staff and consumer representatives, to coordinate the change process. The workgroup, along with others from the organization, then attend a formal training in trauma-informed care, with interactive exercises designed to stimulate ideas and priorities for systemic change. From a menu of educational modules, including one focused on staff support and care, the workgroup chooses those most relevant for their particular programs. Follow-along consultation addresses plans for, and obstacles to, implementing trauma-informed changes.

Creating Cultures of Trauma-Informed Care, developed over the last ten years by Community Connections, draws substantially on *Using Trauma Theory to Design Service Systems*, a small (103 pp.) book edited by Maxine Harris, Ph.D., and Roger Fallot, Ph.D. (2001). Used by state service systems and provider organizations, this work presents a step-by-step model for state mental health, substance abuse, and other public human service systems, public and private 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 and other violence.

The authors and their colleagues have developed materials to accompany the book: 1) a “Trauma-Informed Services Self-assessment and Planning Protocol;” 2) a “Trauma-Informed Self-assessment Checklist;” and 3) a “Trauma-Informed Services Implementation Form.” The *protocol* provides a structured model for programs to review and set priorities for change in three services-level domains (informal and formal service procedures; formal service policies; and trauma screening, assessment, and service planning) and in three administrative-level domains (administrative support for trauma-informed change; trauma training and education; and human resources practices). The *checklist* is used by programs as part of their initial review and then as a tool for

monitoring their progress toward more trauma-informed service settings. The *implementation form* guides the specific changes each program establishes as its priorities. Throughout the review and planning process, the guiding principles of a trauma-informed service system—safety, trustworthiness, choice, collaboration, and empowerment—are highlighted.

Status of Research: Several states have participated in this approach to trauma-informed systems change, with most efforts to date focusing on smaller regions or pilot projects within a larger state system. Two formal qualitative evaluations have been conducted. One pilot project, in a mental health agency in Maine, 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 of this program 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.

The second evaluation (Marra, J.V., Fallot, R., & Frisman, L.K. (2007) described the implementation process in one region of the Connecticut state mental health and substance abuse system and the responses from administrators, service providers, and consumers. This evaluation also reported largely positive responses from all stakeholder groups. Increased awareness of trauma, enhanced consumer

choice, and greater safety and hospitality in the physical environment were especially noteworthy findings. A more formal evaluation, using both consumer and staff fidelity ratings, is currently being planned for another set of agencies in Connecticut.

Contact Information: To obtain the book, contact Kate Boucek, M.S.W
202-608-4784
kboucek@ccdc1.org
Or order it 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
202-608-4735
rwolfson@ccdc1.org

Creating Trauma Informed Systems of Care: Facilitating Recovery in Mental Health Service Settings

Description: This curriculum training toolkit is for use in state mental health agencies and other public sector service provider agencies. It is designed to improve staffs' knowledge and understanding about the prevalence, experience, and impact of trauma on individuals served in public settings, including state institutions. The contents of each module are organized for use by agency in-house trainers, educators, and managers to assist in disseminating this information to staff members. While the curriculum contains a pre and post-test to assist in determining knowledge transfer, the most important outcomes will be measured in behavioral change. The experiential component embedded in most modules will seek to ensure that participants successfully transfer learning to their work settings. Agencies will be encouraged to identify outcome measures that can be tracked toward the goal of implementing a system of care that is trauma-informed and recovery-based.

The curriculum is designed for senior managers, middle managers, and direct care staff members in public service settings. Agencies/service providers include: behavioral health, criminal justice, homeless

services, developmental disabilities, public health, and peer support. Curriculum modules can be tailored to the needs of the specific audience.

The full day curriculum contains seven modules. These modules are:

- Module 1: Setting the Stage
 - Module 2: Trauma: An Introduction
 - Module 3: Understanding the Biopsychosocial Impact of Trauma
 - Module 4: Trauma Informed Care
 - Module 5: Leadership
 - Module 6: Trauma Tools I
 - Module 7: Trauma Tools II
 - Module 8: Experiences of Trauma/Current Assumptions about Seclusion and Restraint
 - Module 9: Identifying and Managing Risk Factors
- Appendices include Exercises, Pre and Post Test, and Trauma Template Plan.

Each Module Contains:

1. Power Point Slides – with “Instructor Notes” to serve as a training guide, improving understanding of the exercises, usefulness of the slide content, and consistency of the presentations in training.
2. Objectives
3. References
4. Briefly Annotated Bibliography of well chosen resources for further readings
5. Handouts – with Transfer of Learning Exercises for note taking and commitment to change

First person examples are used throughout the curriculum modules to convey the experiences of consumers with histories of trauma who have been recipients of services in state operated facilities and agencies.

A two-hour training is designed for direct care staff who work in hospital settings and need information on trauma informed care, but may have little time to attend all day trainings. The training provides the workers with an understanding of the effects of

trauma on the lives of those they serve. This training may be delivered at orientation, staff development trainings, and in continuing education classes.

Status of Research: No research to date

Contact Information:

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703-739-9333 or 301- 634-1785
NCTIC@nasmhpd.org
[http:// mentalhealth.samhsa.gov/nctic/](http://mentalhealth.samhsa.gov/nctic/)

**Developing Trauma-Informed Organizations:
A Tool Kit**

Description of Model: 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. To date, it has been used as the basis for planning changes within substance abuse treatment provider agencies, mental health provider agencies, domestic violence agencies and correctional programs. 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.

Contact Information: To obtain the Tool Kit, materials, and training information, contact:

Marissa Daley
617-661-3991
marissadaley@healthrecovery.org
www.healthrecovery.org

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

Description: This is a trauma-informed approach to preventing violence and reducing seclusion and restraint (S/R) practices in mental health settings, practices often experienced as retraumatizing by service users. In developing this model, the National Association of State Mental Health Program Directors (NASMHPD) 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, and the principles of continuous quality improvement (CQI). Using this information, substantiated in other literature reviews completed by objective and unrelated colleagues, NASMHPD developed the first comprehensive curriculum to successfully reduce the use of seclusion and restraint in mental health facilities.

The 17-module, two or two and one-half day NASMHPD training curriculum is designed to assist child, youth, adult, and forensic 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. This 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. This curriculum is manualized in English only and is also available on compact discs that video-taped a training in 2005.

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%. An ongoing three year, 36+ site program evaluation is ongoing through 2007.

Contact Information: 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 703-739-9333 extension 140 kevin.huckshorn@nasmhpd.org www.nasmhpd.org/ntac

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

Description: Risking Connection® is a theoretically sophisticated, accessible treatment and response framework guided by a manual. Its helps providers develop optimally helpful responses to trauma survivors through a comprehensive contextual foundation for trauma informed services. The focus of the program on the impact of the work on the helping professional, and from teaching providers to understand and use their own reactions productively, supports decreased levels of stress and burnout for providers.

Risking Connection® for Working with Survivors of Childhood Abuse is used in many states as workforce development for all levels of staff and providers of care to persons who have survived trauma and in diverse settings and fields including corrections, substance abuse, child residential and developmental disabilities. This includes non-degreed direct care workers as well as workers with advanced degrees, and front line staff. Please note that Risking Connection® is a core model which has contextual adaptations for different audiences (see “Additional Contextual Adaptations”).

Modules in the version for use for those providing clinical services—and time frames—may be used flexibly and selectively. 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: Putting It All Together.

This five module, 20-hour curriculum from Sidran Institute is guided by a manual and offers assessment, self-reflection, group discussion, and clinical practice exercises, making it interactive and experiential. The manual also contains client and provider worksheets. Modules used and time frame are flexible.

Risking Connection® was developed by the Sidran Institute. Karen W. Saakvitne, Ph.D. and Laurie Anne Pearlman and their colleagues at the Trauma Research, Education, and Training Institute, Inc. (TREATI) wrote the text with input from an editorial board consisting of other helping professionals and trauma survivors with extensive experience in state mental health systems, clinical treatments of traumatic stress conditions, curriculum design, and the law.

Additional contexted adaptations. In collaboration with the International Conference of War Veteran Ministers, Risking Connection® has been adapted for use by leaders of faith communities who wish to acknowledge the presence of and better relate to trauma survivors in their congregations (see entry for Risking Connection® in Faith Communities). Other contextual adaptations in progress focus on domestic violence settings, military families, and providers of primary health care.

Status of Research: Unpublished one-year post training survey of Risking Connection® users in New York and Massachusetts completed in August 2002 reported high levels of satisfaction with the increase in ability to help trauma survivors in a variety of treatment settings. Over 90% of respondents gave Risking Connection® training credit for “improving my effectiveness as a treatment provider”, “empowered me to help clients address symptoms and work toward more effective methods of

coping”, and “boosting my enthusiasm and levels of hope regarding working with trauma survivors.”

Evaluation 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 has been completed. Evaluation was highly positive for Risking Connection’s role in contextualizing the childhood trauma antecedents to drug use, unsafe sex, and other risk-taking behavior which may lead to HIV.

Evaluation has been designed and funded 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. Training of residential staff is in progress.

Research has been designed, submitted, and funded by National Institutes of Health (NIH) in partnership with Georgetown Center for Trauma and the Community, Georgetown University Medical School, for use of Risking Connection® in an urban primary care setting.

Contact Information: To learn more, or to schedule a training event, contact:
Esther Giller at Sidran Institute
410-825-8888, ext. 207
esther.giller@sidran.org
www.sidran.org

Risking Connection® in Faith Communities: A Training Curriculum for Faith Leaders Supporting Trauma Survivors

Description: Studies show that people who are regularly involved in faith communities generally approach their clergy person first when terrible things happen in their lives. In collaboration with the International Conference of War Veteran Ministers and a multifaith board of clergy, pastoral counselors and survivor/congregants, Sidran Institute developed a contextual version of the Risking Connection® model for use in faith-based settings across the Abrahamic traditions (the Jewish, Islamic, and Christian communities). While the core elements are the same, emphasis is placed on issues related to the

spiritual effects of trauma and concerns about world view, identity, and making meaning—without engaging doctrine or dogma in mixed training groups.

This curriculum is offered primarily as a 20-hour, three-day program focusing on five modules, however other formats are possible. Understanding trauma, growth promoting relationships, and identifying and managing vicarious traumatization are the foundational modules, with additional modules focusing on the spiritual connection and trauma, and healing communities.

Faith leaders and mental health providers are taught how to collaborate with each other to provide a congruent healing experience for the congregant/client. Specifics about when and how to refer are included, without addressing the specifics of the canonical law of any tradition.

Status of Research: Sidran Institute was selected as one of five sites nationally to develop a 3-year pilot project, Collaborative Response to Crime Victims in Urban Areas, funded by a grant from Department of Justice, Office of Victims of Crime, and the Maryland Crime Victim’s Resource Center.

The objective was to build collaboration between faith based providers and traditional victim services providers (which, taking a public health approach, Sidran expanded to include mental health, substance abuse, and social services agencies). This project used Risking Connection®: A Training Curriculum for Working with Survivors of Childhood Abuse with multi-disciplinary groups of secular service providers and Risking Connection® in Faith Communities with clergy, parish nurses and congregational leaders as the core training and operational philosophy.

The federally funded project using Risking Connection® as its basis was thoroughly evaluated by an independent evaluator from the University of South Carolina. Evaluator’s reported: “In-depth evaluations for the Risking Connection® trainings were overwhelmingly positive for multiple sessions.”

“Sidran’s Risking Connection® trainings were used to help faith-based and secular providers gain understanding of the effects of crime on victims, the role that spirituality can play in their healing, and how providers can make more successful cross-referrals to address victims’ needs

holistically. An important component of the training is the philosophy that all persons working in the community are providers, and that faith leaders provide a spiritual service that complements the more traditional human services of secular providers. The trainings helped providers from diverse backgrounds establish a common language, shared vision, and mutual trust to further future work together.

“It was evident in the trainings that people started with separate languages and then began to rely on their overlapping languages. People made an effort to be inclusive in listening and speaking. They were engaging each other in their differences.”

—Community organizer

This series of trainings included those specifically for faith-based providers, for secular providers, combined faith-secular trainings, and even trainings co-sponsored by the Baltimore Departments of Health and Social Services for selected social-service staff.”

Contact Information: To learn more, or to schedule a training event, contact:
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The Sanctuary Model ®

Description: The Sanctuary Model ®, developed by Sandra Bloom, M.D. and her colleagues is a trauma-informed, evidence-supported template for system change based on the active creation and maintenance of a nonviolent, democratic, productive community in which staff are empowered as key decision-makers to influence their own lives and the welfare of their constituents. Although the model is based on trauma theory we have found its tenets have application in working with children, adults, and families across a wide diagnostic spectrum.

The Sanctuary Model enables organizations to: work more effectively and therapeutically with fragile and traumatized clients; improve outcomes; reduce restraints; build cross-functional teams, improve staff morale; increase employee retention; reduce violence, increase

staff accountability, and create a truly collaborative and healing environment. The Sanctuary Model is not an intervention but a full system approach focused on helping injured clients recover from the damaging effects of interpersonal trauma. Because it is a full system approach, effective implementation of the Sanctuary Model requires extensive leadership involvement in the process of change as well as staff and client involvement at every level of the process.

The aims of the Sanctuary Model are to guide an organization in the development of a culture with seven dominant characteristics all of which serve goals related to trauma resolution:

- Culture of Nonviolence – helping to build safety skills and a commitment to higher goals
- Culture of Emotional Intelligence – helping to teach affect management skills
- Culture of Inquiry & Social Learning – helping to build cognitive skills
- Culture of Shared Governance – helping to create civic skills of self-control, self-discipline, and administration of healthy authority
- Culture of Open Communication – helping to overcome barriers to healthy communication, reduce acting-out, enhance self-protective and self-correcting skills, teach healthy boundaries
- Culture of Social Responsibility – helping to rebuild social connection skills, establish healthy attachment relationships
- Culture of Growth and Change – helping to restore hope, meaning, purpose

In the Sanctuary Model, the impact of creating a trauma-informed culture should be observable and measurable. The outcomes we should expect to see include:

- Less violence including physical, verbal, emotional forms of violence
- Systemic understanding of complex biopsychosocial and developmental impact of trauma and abuse with implications for response
- Less victim-blaming; less punitive and judgmental responses

- Clearer more consistent boundaries, higher expectations, linked rights and responsibilities
- Earlier identification of and confrontation with perpetrator behavior
- Better ability to articulate goals, create strategies for change, justify need for holistic approach
- Understanding of reenactment behavior and resistance to change
- More democratic environment at all levels

The initial training institute is followed by three years of on-going consultation and technical assistance provided remotely and on-site by the Sanctuary Leadership Development Institute Faculty. Participation in the Sanctuary Leadership Development Institute qualifies an organization to join the Sanctuary Network and participate in an on-going certification program. Sanctuary is a registered trademark and the right to use the Sanctuary name is contingent on engagement in this training program and an agreement to participate in an on-going, peer-review certification process.

As of May of 2007, twenty programs from around the country are a part of the Sanctuary Network and include residential programs for children; juvenile justice facilities; acute care adult inpatient; community-based programs for children and families; substance abuse programs for women, children, and adolescents and acute care psychiatric programs for children. Two states have provided funding for participating programs through the Oklahoma Office of Mental Health and the New York State Office of Children and Family Services.

Materials: The Sanctuary Implementation Guide and Sanctuary Staff Training Manuals and materials are available only through participation in the Sanctuary Leadership Development Institute. The group curriculum written by Bloom, Foderaro, and Ryan titled, S.E.L.F: A Trauma-Informed Psychoeducational Group Curriculum is available for purchase at www.sanctuaryweb.com. Many other articles about the Sanctuary Model are available at this site as well.

Since the Sanctuary Model is an organizational approach, there really are no limits in terms of ages, genders, or specific client groups. Programs from

Ecuador and Mexico are participating in the Sanctuary Network so we have some minimal non-English-speaking adaptability.

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).

Salem Hospital, Salem, Oregon.

This hospital is a 400-bed community general hospital serving a catchment area of approximately 350,000 people. 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 had been virtually eliminated by October of 2002. Use of locked seclusion decreased from 150 episodes in 1999 to one episode for 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 was no increase in the use of psychotropic medications; in fact, there was an overall decrease in the use of emergent and “forced” medication injections.

There was no change in patient selection. Emergency departments, police, jails, and crisis centers all referred patients regularly. Many patients had co-occurring substance abuse disorders along with symptoms of a major mental illness. Throughout this period, patient satisfaction scores improved. There were significantly decreased staff and patient injuries, decreased time off due to work-related injuries, increased staff retention, and very little staff turnover once the model was fully implemented. There was an overall slight decrease in staff numbers due to more efficient use of time. Physician recruitment and retention was extremely successful due to the model.

West Chester Campus, Jewish Board of Family and Children’s Services, Hawthorne, NY

Evaluation Methods: Dr. Jeanne Rivard was the primary investigator of the NIMH grant that funded this study. 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.

Therapeutic Community Outcomes: The short form of the Community Oriented Programs Environment Scale (COPEs; Moos, 1996) was used to assess the extent to which units were operating as therapeutic communities along selected dimensions. Trends in the frequency of critical incidents were then measured by analyzing data from the agency’s management information system. We found 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 ($p = .001$). We are still analyzing data measuring trends over time in the

frequency of critical incidents that occurred in the residential treatment units.

Youth Outcomes: The following instruments were used to assess youth outcomes that were hypothesized to be responsive to the Sanctuary Model: Child Behavior Checklist (Achenbach, 1991), the Trauma Symptom Checklist for Children (Briere, 1996), the Rosenberg Self Esteem Scale (Rosenberg, 1979), the Nowicki-Strickland Locus of Control Scale (Nowicki & Strickland, 1973), the peer form of the Inventory of Parent and Peer Attachment (Armsden & Greenberg, 1987), the Youth Coping Index (McCubbin, Thompson, & McCubbin, 1996) and the Social Problem Solving Questionnaire (Sewell, Paikoff, & McKay, 1996). Although baseline data were collected for 165 youth, substantial attrition occurred due to youth being discharged through usual program operations. By study end, 87 youth yielded three waves of data (i.e., baseline, three months, and six months). No significant differences were found comparing baseline and three-month measures. On repeated analyses ($N = 87$) comparing baseline and six-month outcomes, however, we found 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 ($p = .15$).

SLDI Evaluation Research

To participate in the Sanctuary Leadership Development Institute, every organization must be willing to perform repeated evaluations over the three-year period and beyond. The data being collected is part of a three-year study developed to assess the impact of the Sanctuary Model on the organizational cultures of participating agencies/facilities. The data component of the Sanctuary process is comprised of four assessment tools, three of which were developed by the Division of Policy, Planning and Research at Andrus Children’s Center. They are an environmental assessment, an implementation survey, and a demographic assessment. The fourth assessment, the Community Oriented Programs Environment Scale, is used to assess the organization’s ability to function as a therapeutic community.

What has emerged from experience with various therapeutic and social service 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 children, adults, and families have sustained.

Contact Information: To obtain further information on the manual, the institute, and training and consultation services, contact:

Sandra L. Bloom, M.D; CommunityWorks
215-248-5357,

S13132020@msn.com

www.sanctuaryweb.com

For information on the Sanctuary Leadership Development Institute, contact:

Sarah Yanosy, LCSW; Andrus Children's Center
914-965-3700 ext. 1117

syanosy@jdam.org

www.andruschildren.org

Women and Addiction: A Gender-Responsive Approach

Description: 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, *Women and Addiction: A Gender-Responsive Approach* (2007) is a manual and DVD that provides an overview of the essentials for creating trauma-informed, woman-centered services. It includes a theoretical foundation and guiding principles, the current research on gender differences, a discussion of what counselors need to know and do in order to be effective, and a description of important program elements. The complete package is part of Hazelden's Clinical Innovators Series and includes a self-test for continuing education units (CEU's).

The manual presents the Women's Integrated Treatment (WIT) model which is a comprehensive approach based on theory, research, and years of clinical experience. It integrates theories of addiction, women's psychological development, and trauma. It offers program directors, counselors, clinicians, and other helping professionals a basic understanding of current knowledge, treatment philosophies, and

principles that can serve as a framework for creating services for women and increasing women's opportunities for sobriety and ongoing recovery. The principles are applicable in a variety of settings and are suitable for individual and group therapy.

In this manual, "woman-centered" and "gender-responsive" refer to the creation of an environment – through site selection, staff selection, program development, program content and materials – that reflects an understanding of the realities of women's and girls' lives and that addresses and responds to their challenges and strengths.

Included in the manual are the following topics:

- Current research on the differences between women and men;
- Relational-cultural theory;
- Trauma theory;
- Elements of woman-centered treatment;
- Using trauma theory in women's treatment; and
- Importance of the therapeutic environment.

Status of Research: One completed study of the "Women's Integrated Treatment" (WIT) model using Helping Women Recover (HWR) and Beyond Trauma (BT), in a residential program for women with their children, demonstrated a decrease in depression (using Beck's Depression Inventory) and trauma symptoms (using the Trauma Symptom Checklist – 40 scale). There was a significant decrease in both depression and trauma symptoms at the completion of HWR ($p < .05$). There was further improvement ($p < .05$) when the women participated in the BT groups that followed HWR. The Women's Integrated Treatment (WIT) model is currently being further evaluated in several rigorous experimental studies funded by the National Institute on Drug Abuse. The preliminary findings show significant improvement among the women randomized to WIT compared to treatment as usual.

Covington, S. (2008). Women and addiction: A trauma-informed approach. *Journal of Psychoactive Drugs*, SARC Supplement 5, November 2008.

Contact Information: To obtain the *Women and Addiction: A Gender-Responsive Approach* materials (manual, DVD, CEU test), and for additional information on training, consultation, and research:
Stephanie S. Covington, Ph.D., L.C.S.W.
858-454-8528

sscird@aol.com

www.stephaniecovington.com

www.centerforgenderandjustice.org

Trauma-Informed Service Models for Adults

Guide to Individual Trauma-Informed Service Models for Adults				
Name of Model	Intended Audience	Type of Services	Approach	Special Focus
Domestic Violence Group Intervention	Women	Leader's Manual, Training	Group sessions	Domestic Violence
Economic Success in Recovery	Women	Curriculum (English & Spanish)	Group sessions	SA, MH
Trauma Informed Addictions Group Intervention	Women, Men	Leader's Manual, Training	Single-sex & Co-ed Group sessions	SA, MH
Trauma Issues Associated with HIV Infection: A Group Intervention	Women	Leader's Manual, Training	Group sessions	HIV Infection

Key: MH – Mental Health; SA – Substance Abuse

Domestic Violence Group Intervention

Description: 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.

Contact Information: To obtain a leader’s manual (Domestic Violence: A 10 Session Group Treatment Intervention) and more information contact:
Kate Boucek, M.S.W.
202-608-4784
kboucek@ccdc1.org
www.ccdc1.org

Economic Success in Recovery

Description: 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. Economic Success in Recovery: An educational group

currículo for women in recovery (English) and Exito Con Mi Dinero y Mi Recuperacion: Un curriculum 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.’ Four published papers present findings showing race/ethnic differences in clinical profiles and services needs and that women in the intervention stay in treatment longer and at follow-up have lower sexual

HIV risk behaviors, and lower rates of drug use and mental health and trauma symptoms than those in the comparison condition. (Amaro, Gampbel, Larson, Lopez, Richardson, Savage, & Wagner, 2005; Amaro, Larson, Zhang, Acevedo, & Matsumoto, 2007; Amaro, Chernoff, Brown, Arévalo, & Gatz, 2007; Amaro, Dai, Arévalo, Acevedo, Matsumoto and Nieves, 2007).

Amaro, H., Gampbel, J., Larson, M.J., Lopez, L., Richardson, R., Savage, A., & Wagner, D. (2005). Racial/Ethnic Differences in Social Vulnerability among Women with Co-occurring Mental Health and Substance Abuse Disorders: Implications for Treatment Services. *Journal of Community Psychology*, 33(4), 495-511.

Amaro, H., Larson, M. J., Zhang, A., Acevedo, D., Dai, J., & Matsumoto, A. (2007). Effects of trauma intervention on HIV sexual risk behaviors among women with co-occurring disorders in substance abuse treatment. *Journal of Community Psychology*, 35(7), 895-908.

Amaro, H., Chernoff, M., Brown, V., Arévalo, S., & Gatz, M. (2007). Does integrated trauma-informed substance abuse treatment increase treatment retention? *Journal of Community Psychology*, 35(7), 845-862.

Amaro, H., Dai, J., Arévalo, S., Acevedo, A., Matsumoto, A., & Nieves, R. (2007). Effects of integrated trauma treatment on outcomes in a racially/ethnically diverse sample of women in urban community-based substance abuse treatment. *Journal of Urban Health*, 84(4), 508-522.

Amaro, H, and Nieves, RL. (2004). Economic Success in Recovery: An educational group curriculum for women in recovery. Boston Consortium of Services for Families in Recovery, Public Health Commission, Boston, MA.

Contact Information: To obtain curriculum and additional information, contact:

Dr. Hortensia Amaro
h.amaro@neu.edu

or

Rita Nieves, R.N., M.P.H.
Rita.Nieves@bphc.org

Trauma Informed Addictions Group Intervention

Description: 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.

Contact Information: To obtain the leader's manual, materials, and more information contact:
Kate Boucek, M.S.W.
202-608-4784
kboucek@ccdc1.org
www.ccdc1.org

Trauma Issues Associated with HIV Infection: A Group Intervention

Description: 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.

Contact Information: To obtain the manual, *Trauma Issues Associated with HIV Infection: An 11-Session Group Treatment Intervention*, and more information contact:
Kate Boucek, M.S.W.
202-608-4784
kboucek@ccdc1.org
www.ccdc1.org

Trauma-Specific Service Models for Adults

Guide to Trauma-Specific Service Models for Adults				
Name of Model	Intended Audience	Type of Services	Intended Setting	Approach
<i>Addictions and Trauma Recovery Integration Model (ATRIUM)</i>	Women, Men, SA, Self-injury, SMI	Manual/Curriculum (English & Spanish), TA, Training	SA & MH treatment settings	Single-sex group sessions; Individual sessions
<i>The Associative Skills Model: Taking Charge of Change; The Trouble with Feelings; and Boundaries, Precious Boundaries</i>	Direct service providers, Highly degreed professionals, Women & Men consumers	Manual/Curriculum, DVD, Training	Corporate environments, Faith communities, Communities of persons with life changing diseases and persons with disabilities	
<i>Beyond Trauma: A Healing Journey for Women</i>	Women, SA, Group facilitators	Curriculum, Consultation, DVD/video, Facilitator manual, Participant workbook, Training	Corrections, Outpatient, Residential settings	Group sessions
<i>Cognitive-Behavioral Treatment for PTSD Among People with Severe Mental Illness</i>	Women, Men, SMI	Manual	Public-sector MH clinics	Group & individual sessions
<i>Eye Movement Desensitization and Reprocessing (EMDR)</i>	Certified MH professionals	Book, Manual, Training	MH agencies	
<i>Growing Beyond Survival: A Self Help Toolkit for Managing Traumatic Stress</i>	Women, Men	Workbook w/ tools, Training	MH, Corrections, DV	Group sessions; individual sessions, Self-help
<i>Helping Women Recover (HWR): A Program for Treating Addiction</i>	Women, SA, MH	Manual, Book (in progress)	Outpatient, inpatient & residential SA treatment programs, Corrections, Domestic violence shelters, MH clinics	Group or individual sessions
<i>Individual Cognitive-Behavioral Treatment for PTSD in People with Severe Mental Illness</i>	Women, Men, SMI	Manual, Book (in progress)		Individual sessions
<i>Integrated Substance Abuse, Mental Health and Trauma Treatment with women: A case study workbook for staff training</i>	Women	Curriculum	MH & SA Treatment	
<i>Managing Traumatic Stress Through Art: Drawing from the Center</i>	Women, Men	Workbook w/tools, Training	Any setting	Group or individual sessions
<i>Prolonged Exposure (PE) Therapy</i>	Women, Men	Training, PE Therapist guide	Community MH outpatient clinics, Inpatient units, Private Practice, Rape counseling centers, Veterans' centers	Individual sessions
<i>The PTSD Psychoeducation Program for People with Severe Mental Illness</i>	Women, Men, SMI	Video		Group or individual sessions
<i>Restoring Hope and Trust: An Illustrated Guide to Mastering Trauma</i>	Women, Men	Educational Curriculum	Any setting	Group sessions

Guide to Trauma-Specific Service Models for Adults

Name of Model	Intended Audience	Type of Services	Intended Setting	Approach
<i>Seeking Safety</i>	Women, Men, adolescent, any clinician; broad range of clients	Manual (English, Spanish, French, German, Swedish), Video training series, card deck, poster; onsite training/consultation, research. Website: www.seekingsafety.org	Any clinical setting (e.g., outpatient, inpatient, residential, homeless, VA/military, criminal justice, domestic violence, private practice, MH, SA, SMI)	Group or individual sessions
<i>Spirituality and Recovery Curriculum</i>	Women, SA	Manual/Curriculum, Training, Consultation		Groups sessions
<i>Spirituality in Trauma Recovery Group</i>	Women, Men	Manual, Training	Outpatient, inpatient and residential settings	Group sessions
<i>Symptom-Specific Group Therapy (SSGT) for Complex Post Traumatic Stress Disorder (CPTSD)</i>	Women, Men, SMI	Manuals available at www.Lulu.com		Single-sex group sessions
<i>Trauma Affect Regulation: Guide for Education and Treatment (TARGET©©)</i>	Women, Men, Family members	Manuals, Training, QA, Fidelity	MH & SA settings, Corrections, Health Care	Group or individual sessions
<i>Trauma, Addictions, Mental health And Recovery (TAMAR) Trauma Treatment Group Model</i>	Women, Men	Manual, TA, Training	Communities, Corrections, State psychiatric hospitals	Group sessions
<i>Trauma Recovery and Empowerment Model (TREM)</i>	Women, MH, SA	Consultation, Manual, Self-help workbook, Training, Video, Website: www.ccdc1.org	Residential & non-residential SA & MH programs, Corrections, Homelessness, and Domestic Violence programs	Group sessions
<i>Trauma Recovery and Empowerment Profile (TREP) and Menu of Strategies for Improving a Woman's Trauma Recovery and Empowerment Profile</i>	Clinicians, Women & Men consumers	Manual/Instrument, Training	Residential & non-residential SA & MH programs, Corrections, Homelessness, and Domestic Violence programs	Individual sessions
<i>The Trauma Recovery Group: Group Cognitive-Behavioral Treatment for PTSD in People with Severe Mental Illness</i>	Women, Men, SMI	Manual (in progress)		Group sessions
<i>Trauma Resiliency Model (TRM)</i>	Direct service providers, Community advocates, Supervisory staff, First responders	TRM training trauma presentations, Curriculum, Tx.model for adults & children	Provider settings, conferences, field-work during disasters	Individual or group sessions
<i>Trauma Safety Drop-In Group: A Clinical Model of Group Treatment for Survivors of Trauma</i>	Women, Men	Drop-in Group, Manual		Group sessions
<i>TRIAD Women's Group Model</i>	Women, SA, MH	Manual, Consultation, Training	Corrections, Outpatient & residential community MH centers, SA treatment facilities	Group sessions
<i>A Woman's Path to Recovery (Based on A Woman's</i>	Female adult &	Book, Training, Lectures, Demonstrations,	In-patient, Outpatient,	Group sessions, Clinician Led, Self-

Guide to Trauma-Specific Service Models for Adults

Name of Model	Intended Audience	Type of Services	Intended Setting	Approach
<i>Addiction Workbook</i>)	adolescents, SA	Experiential exercises	Clinical settings, Self-help	help

Key: MH – Mental Health; SMI – Severe Mental Illness; SA – Substance Abuse; PE – Prolonged Exposure; TA – Technical Assistance

Addictions and Trauma Recovery Integration Model (ATRIUM)

Description: 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.

Contact Information: To obtain the manual, and for information on training and technical assistance (in English and Spanish), contact:

Dusty Miller
 413-584-8404, 413 203 1432 (h&w) or
 (413) 313 6317 (c)
dustymi@aol.com
www.dustymiller.org

The Associative Skills Model: Taking Charge of Change; The Trouble with Feelings; and Boundaries, Precious Boundaries

Description: This three-module model, which can be taught on a flexible time and content-specific basis, teaches a basic trauma informed cognitive framework with accompanying skills. The premise is that the developmental disruptions of childhood trauma often prevent the development of a coherent frame of reference for three major areas impacted by trauma: the ability to cope with change in constructive ways; to identify, respond to and modulate affect, and the ability to identify, explore, set and change basic boundaries. Each module can be presented in a four-hour or one day format. An overview of all three, without skill development, is available as a one day program.

Audiences for this model range from direct services workers to highly degreed professionals as well as survivors of trauma. Greatest effect is achieved when providers as well as survivors both employ the elements of the model.

Delivery is a combination of lecture, experiential activity, and as appropriate role play. Adult learning principles and practices are integral in the delivery of this model, which is guided by module-specific manuals. Contexted versions for specific settings are available as customizations. Adaptations have been presented in the corporate environment, in faith communities, to persons with life changing diseases and in the community of persons with disabilities, and a video/DVD lecture only version has been available.

Taking Charge of Change addresses the issue of coping with and making change as fundamental to recovery from traumatic experiences. It teaches a set of constructs that, like algorithms, create a common framework for developing self-regulation that leads to increased self-determination and more effective coping skills. This module is a prerequisite to the modules on affect and boundaries.

Objectives for this module are:

- Identifying the feelings of change
- Differentiating between reactions and responses to the feelings of change

- Recognizing why people often focus on failure over success when faced with change
- Using the awareness of the benefits of failure and success to redirect the self
- Converting self-discipline, often abusive, to “disciplining” the self in the service of change

The Trouble with Feelings builds on the change module in response to the role of feelings in change. Often survivors of childhood trauma have exceptionally limited vocabularies for affect, and without a construct for how feelings develop, names for different feelings, and even placement of feelings along a continuum, management and modulation of affect is even more difficult.

This module in the Associative Skills series supports increased effectiveness of the therapeutic work required around affect regulation through addressing these objectives:

- How children develop their knowledge and experience of affect (at a general level)
- Describing situations in which affect becomes problematic and why
- Defining the concept of a continuum and its role in affects
- Recognizing the three basic feelings of pleasure, fear, and anger
- Identifying and placing gradations of these three feelings on a continuum
- Determining healthy expressions of each
- Practicing modulation skills

Boundaries, Precious Boundaries is the final module in the Associative Skills Series, and like the module on feelings, seeks to remediate knowledge and experience often simply missing for those who experience childhood trauma. By focusing on how boundaries are developed, types of boundaries people have, how those boundaries are identified and expressed, how to change boundaries (and what to expect when this occurs), trauma survivors and skilled helpers have a common knowledge set from which to operate.

This series was developed by professional educator and trauma survivor Elizabeth Power, M.Ed., whose work in self-determination and recovery includes

materials for persons with dissociative disorders, adapting to disabilities, and coping with change. Her work along the spectrum of association and dissociation has been used in multiple contexts from the corporate to the clinical since the 1990s.

Status of research: None conducted. Program reviews, and user comments, are highly positive.

Contact Information: To learn more or schedule this training event, contact Esther Giller, Sidran Institute 410-825-8888 extension 207 esther.giller@sidran.org.

Beyond Trauma: A Healing Journey for Women

Description: 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 or DVD's (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 description) 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. There is also a completed study funded by the California Endowment. The site for this study was a residential substance-abuse program for women and children. Pre- and post-tests were used with 50 women to evaluate the following domains: relapse, mental health symptoms related to trauma (anxiety, depression, PTSD), and family functioning (parenting skills and reunification). Results show a decrease in depression, as well as a decrease in other trauma-related symptoms.

Trauma-informed Services for Women in Treatment (completed) (5/1/04- 10/30/06)

Funded by the California Endowment.

Contact for data:

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and

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Gender-Responsive Treatment for Women in Prison (ongoing)

Two year experimental pilot study funded by NIH IR21DA 18699-01A1 (August 20, 2005-June 30, 2007). A random assignment of women in a prison TC to treatment as usual or enhanced gender-responsive treatment. Treatment being enhanced by *Beyond Trauma* as well as *Helping Women Recover* and other materials developed by Dr. Covington.

Contact person: Nena Messina, Ph.D. at UCLA at nmessina@ucla.edu

Enhancing Substance Abuse Treatment and HIV Prevention for Women Offenders (ongoing)

Funded by NIDA 1R01DA22149-01. (September 1, 2006 – August 31, 2009). This 3-year study is examining Mental Health Systems, Inc. (MHS) Readiness and Capacity for Practice Improvement as it incorporates women-focused treatment into four MHS program sites currently serving female drug court participants. An experimental component will determine the effectiveness of a women-focused (WF) treatment program based on HWR, BT and other Covington materials compared to standard mixed-gender (MG) outpatient treatment to promote positive behaviors among 150 women offenders (e.g., HIV risk reduction and substance abuse, and increased psychological functioning). Contact person: Nena Messina, Ph.D. at UCLA at nmessina@ucla.edu

Contact Information: To obtain the *Beyond Trauma* program curriculum (facilitator's manual, participant's workbook, instructional videos or DVD's) and for additional information on training, consultation, and research, contact

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

Description: 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 8

individual therapy sessions. Group work takes place in 14 (90-minute) 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 was funded by a three-year NIMH treatment development grant. Data show that staff at community mental health centers are reluctant to engage in trauma-focused therapy themselves, but agree that people with SMI have high rates of trauma, need PTSD treatments, and that cognitive-behavioral interventions are likely to be efficacious if delivered with sensitivity and skill (Frueh et al., 2006). In an open trial design evaluation of the treatment program, adults (n = 20) with PTSD and either schizophrenia or schizoaffective disorder were treated via an 11-week cognitive-behavioral intervention for PTSD (Frueh et al., 2008). Results

offer preliminary hope for effective treatment of PTSD among adults with schizophrenia or schizoaffective disorder, especially among treatment completers (n = 13). Data showed significant PTSD symptom improvement, maintained at 3-month follow-up. Further, 12 of 13 completers no longer met criteria for PTSD or were considered treatment responders. Clinical outcomes for other targeted domains (e.g., anger, general mental health) also improved and were maintained at 3-month follow-up. Participants evidenced high treatment satisfaction, with no adverse events. Significant improvements were not noted on depression, general anxiety, or physical health status.

Contact Information: For information about the model and obtaining a draft manual and materials, contact:

B. Christopher Frueh, Ph.D.

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Eye Movement Desensitization and Reprocessing (EMDR)

Description: EMDR is a scientifically validated integrative psychotherapy for the treatment of PTSD and other trauma-related conditions. Developed by Francine Shapiro in 1989 (www.emdr.com), it is a phase-oriented approach using a protocol with a standardized set of procedural steps, grounded in a theoretical foundation known as the Adaptive Information Processing model (AIP). The model assumes that unprocessed experiences are the basis of much psychopathology and there is a natural ability of the brain, under appropriate conditions, to resolve disturbing emotional material that fuels current symptoms. Standardized procedures which include bilateral stimulation (eye movements, taps or tones) facilitate entry into an accelerated learning state in which traumatic experiences can be processed effectively.

The eight phases and specific protocols used to address the client's presenting complaints are described in detail in the book *Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols, and Procedures* (Shapiro 2001) and training is available in many US locations throughout the year. The model

includes a careful clinical history to identify client strengths and vulnerabilities and to identify the experiences to begin to process. The client is educated about the symptom picture and given tools for stabilization and preparation for the work. Processing the trauma includes a focus on the attendant negative beliefs, emotion and physical sensations and closely monitors the client's subjective level of discomfort throughout the procedures. In contrast to exposure therapies, the client is allowed to move at his/her own pace through the associative chain to work through the traumatic experiences. The closing parts of the session focus on returning the client to equilibrium, and verifying plans in the event of distress in between sessions. The EMDR protocols include the targeting of past events that contribute to the pathology, triggers that elicit disturbance (including triggers to substance use), and positive templates for self-image and behavior.

With respect to substance abuse, there is a specific EMDR protocol targeting urges and a comprehensive EMDR protocol that also includes procedures for increased stabilization and processing the underlying trauma that plays a key role in drug use. Some case reports have indicated that processing the underlying trauma with EMDR also results in increased stabilization. An innovative pilot study in the Thurston County Drug Court Program in Olympia, Washington utilized Seeking Safety as a structured preparation phase for safety and stabilization prior to individual treatment with EMDR. Outcomes showed significant improvement on all four post-treatment assessments for those who completed the ITTP, including reduction and/or elimination of trauma symptoms, decreased dissociation, decreased depression and increased self-esteem. One of the most important findings for future investigation was that participants who completed the entire ITTP graduated 75% of the time, while those that dropped out had significantly lower Drug Court Program completion and graduation rates (25%). Program completion and graduation is the variable most consistently associated with low post-program recidivism (Drug Courts: The Second Decade; 2006). The ITTP is intended to be a replicable, structured, phased trauma treatment intervention for trauma and substance abuse.

Status of Research: EMDR is listed as an empirically validated and effective treatment in numerous practice

guidelines *including* those of the American Psychiatric Association (2004), and the Department of Veterans Affairs/Department of Defense (2003). There are at least 18 randomized clinical trials that have been conducted on EMDR with a wide range of trauma populations and comparison conditions. EMDR has been demonstrated to be superior to a wide range of therapies, and equivalently effective to trauma focused CBT, without the need for sustained arousal, detailed description of the event, prolonged focus on the trauma, or the 40-100 hours of homework needed in CBT treatments. EMDR has also been found superior to antidepressants. For a full list of studies and outcomes see www.emdrhap.org.

Contact Information: For EMDR clinical training and supervision offered internationally, contact EMDR Institute at: www.emdr.com
For the EMDR Chemical Dependency Treatment Manual, and for low cost trainings provided for U.S. mental health agencies and individuals clinicians working in agencies, contact the EMDR Humanitarian Assistance Programs at: www.emdrhap.org.

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

Description: This approach teaches skills that empower survivors to take control of and de-escalate their most distressing trauma-related symptoms. The model was originally designed for therapist-run symptom management therapy groups.

This workbook version, developed by Sidran Institute, 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 to find relief from trauma-related symptoms (including poor concentration, sleep disturbances, panic attacks,

nightmares, flashbacks, and other physical responses). It also examines the relationship between trauma and self-harming behaviors, difficulties with sexuality, and substance abuse.

Status of Research: No research to date.

Contact Information: To obtain this resource, for training on using this resource and for additional information, contact: Sidran Institute 410-825-8888 x 207, esther.giller@sidran.org www.sidran.org/gbs

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

Description: 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.

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 has been evaluated at several sites. One completed research study funded by the California Endowment was conducted at a residential substance-abuse program for women and children. Pre- and post-tests were used with 50 women to evaluate the following domains: relapse, mental health symptoms related to trauma (anxiety, depression, PTSD), and family functioning (parenting skills and reunification). This study evaluated both *Helping Women Recover* and *Beyond Trauma*. The results indicated a decrease in depression (using Beck's Depression Inventory) and other trauma-related symptoms (using the Trauma Symptom Checklist – 40 scale), as well as less relapse. There was a significant decrease in both depression and trauma symptoms at the completion of HWR ($p \leq .05$). There was further improvement ($p \leq .05$) when the women participated in the BT groups that followed HWR. In addition, empirical validation for HWR is being tested via two experimental studies funded by the National Institute on Drug Abuse (NIDA). Preliminary evidence from the first study shows significant improvement during parole among during parole among previously incarcerated women who were randomized to a women's integrated prison treatment program using *Helping Women Recover* and *Beyond Trauma* sequentially, as compared to women who were randomized to a standard prison therapeutic community. Women who participated in the Women's Integrated Treatment (WIT) program were significantly more likely to be participating in voluntary aftercare treatment services (25% vs. 4%) and significantly less likely to be incarcerated at the time of the 6-month follow-up interview (29% vs. 48%) compared to women who participated in the standard treatment. Another randomized study among women participating in drug court treatment settings is currently underway and results should be available in 2009. All of these studies also qualitatively assessed treatment staff and client perceptions of the elements of the program. Focus group results indicate strong support and high

satisfaction for the curricula mentioned above from residential treatment, drug court, and prison participants and staff.

In addition, there is approximately 10 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.

Trauma-informed Services for Women in Treatment (completed) (5/1/04- 10/30/06)
Funded by the California Endowment.

Contact for data:

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Cynthia Burke at SANDAG at cbu@sandag.org

Gender-Responsive Treatment for Women in Prison (completed)

Two year experimental pilot study funded by NIH IR21DA 18699-01A1 (August 20, 2005-June 30, 2007). A random assignment of women in a prison TC to treatment as usual or enhanced gender-responsive treatment. Treatment is being enhanced by using *Helping Women Recover* as well as *Beyond Trauma* and other materials developed by Dr. Covington. Contact person: Nena Messina, Ph.D. at UCLA at nmessina@ucla.edu

Enhancing Substance Abuse Treatment and HIV Prevention for Women Offenders (ongoing) Funded by NIDA 1R01DA22149-01. (September 1, 2006 – August 31, 2009). This 3-year study is examining Mental Health Systems, Inc. (MHS) Readiness and Capacity for Practice Improvement as it incorporates women-focused treatment into four MHS program sites currently serving female drug court participants. An experimental component will determine the effectiveness of a women-focused (WF) treatment program based on HWR, BT and other Covington materials compared to standard mixed-gender (MG) outpatient treatment to promote positive behaviors among 150 women offenders (e.g., HIV risk reduction and substance abuse, and increased psychological

functioning). Contact person: Nena Messina, Ph.D. at UCLA at nmessina@ucla.edu

Covington, S. (2008). Women and addiction: A trauma-informed approach. *Journal of Psychoactive Drugs*, SARC Supplement 5, November 2008.

Covington, S., Burke, C., Keaton, S., Norcott, C. (2008). Evaluation of a trauma-informed and gender-responsive intervention for women in drug treatment. *Journal of Psychoactive Drugs*, Substance Abuse Research Consortium Supplement 5, November 2008.

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

To extend and deepen the trauma work introduced in HWR, *Beyond Trauma: A Healing Journey for Women* (see description) can be used with [HWR](#).

Contact Information: To obtain the HWR facilitator's manual and a *Woman's Journal* and for additional information on training, consultation, and research, contact:

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Individual Cognitive-Behavioral Treatment for PTSD in People with Severe Mental Illness

Description: Developed by Kim Mueser, Ph.D. and Stanley Rosenberg, Ph.D. at the Dartmouth Psychiatric Research Center and the Dartmouth Trauma Intervention Research Center. This treatment program is a manualized 12-16 week individual intervention for men or women with persistent mental illness and PTSD. The program incorporates the following components: orientation to the program, developing a crisis plan, breathing retraining, psychoeducation about PTSD and related effects of trauma, cognitive restructuring, and termination. The program does not utilize exposure therapy approaches for PTSD. The preponderance of the program is

focused on teaching cognitive restructuring as a skill for managing negative feelings, and for identifying and correcting trauma-related beliefs that contribute to and maintain PTSD symptoms.

Status of Research: Two pilot studies of the CBT for PTSD program have been completed which demonstrated the feasibility of the intervention with both Caucasian and minority clients with severe mental illness, high rates of retention in treatment, and significant reductions in PTSD symptoms, depression, and other psychiatric symptoms from pre- to post-treatment, with gains maintained at a 3-month follow-up (Hamblen et al., 2004; Lu et al., in press; Mueser et al., 2004; Rosenberg et al., 2004). In addition, one randomized controlled trial of the program has been completed, in which the CBT for PTSD program was compared with treatment as usual in 108 individuals with severe mental illness (primary diagnoses of major depression, bipolar disorder, schizoaffective disorder, or schizophrenia) and PTSD living in rural northern New England (Mueser et al., 2008). Results showed high rates of retention in the CBT for PTSD program, and significantly greater improvements for clients who received CBT compared to TAU in PTSD symptoms, depression, other psychiatric symptoms, knowledge about PTSD, trauma-related beliefs about the world, and working alliance with the case manager (who was different than the therapist who provided the treatment). A replication study is currently underway in an urban setting.

Additional applications of this treatment model have been made for several other special populations, with pilot work completed or controlled trials under way for persons with PTSD in addiction treatment settings, adolescents, disaster/terrorism survivors, and person's receiving treatment in primary care settings.

The manual for this intervention has been turned into a book by Mueser, Rosenberg, and Rosenberg for American Psychological Association Press that includes descriptions of applying the treatment model to a range of special populations (see below).

Hamblen, J., Jankowski, M. K., Rosenberg, S. D., & Mueser, K. T. (2004). Cognitive-behavioral treatment for PTSD in people with severe mental illness: Three case studies. *American Journal of Psychiatric Rehabilitation*, 7, 147-170.

Lu, W., Fite, R., Kim, E., Hyer, L., Yanos, P. T., Mueser, K. T., & Rosenberg, S. D. (in press). Cognitive-behavioral treatment of PTSD in severe mental illness: Pilot study replication in an ethnically diverse population. *American Journal of Psychiatric Rehabilitation*.

Mueser, K. T., Bolton, E. E., Carty, P. C., Bradley, M. J., Ahlgren, K. F., DiStaso, D. R., Gilbride, A., & Liddel, C. (2007). The trauma recovery group: A cognitive-behavioral program for PTSD in persons with severe mental illness. *Community Mental Health Journal*, 43, 281-304.

Mueser, K. T., Rosenberg, S. D., Jankowski, M. K., Hamblen, J., & Descamps, M. (2004). A cognitive-behavioral treatment program for posttraumatic stress disorder in severe mental illness. *American Journal of Psychiatric Rehabilitation*, 7, 107-146.

Mueser, K. T., Rosenberg, S. D., & Rosenberg, H. J. (in press). *Treatment of Posttraumatic Stress Disorder in Special Populations: A Cognitive Restructuring Program*. Washington, DC: American Psychological Association.

Mueser, K. T., Rosenberg, S. R., Xie, H., Jankowski, M. K., Bolton, E. E., Lu, W., Hamblen, J. L., Rosenberg, H., McHugo, G. J., & Wolfe, R. (2008). A randomized controlled trial of cognitive-behavioral treatment of posttraumatic stress disorder in severe mental illness. *Journal of Consulting and Clinical Psychology*, 76, 259-271.

Rosenberg, S. D., Mueser, K. T., Jankowski, M. K., Salyers, M. P., & Acker, K. (2004). Cognitive-behavioral treatment of posttraumatic stress disorder in severe mental illness: Results of a pilot study. *American Journal of Psychiatric Rehabilitation*, 7, 171-186.

Contact Information: Information about the program can be obtained from either:

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Integrated Substance Abuse, Mental Health and Trauma Treatment with women: A case study workbook for staff training

Description: This staff training manual is a product of research-based treatment enhancement activities developed and conducted by the *Boston Consortium of Services for Families in Recovery* (BCSFR), Boston Public Health Commission and Institute on Urban Health Research at Northeastern University. The BCSFR was funded by the *Women, Co-occurring Disorders and Violence Study* (WCDVS); WCDVS was sponsored by the Substance Abuse and Mental Health Services Administration. This manual is the product of one of the strategies utilized by the BCSFR, to assist staff in delivering substance abuse treatment that integrates services for mental health and trauma issues. The BCSFR formed an *Interdisciplinary Resource Team* (IRT) designed to promote ongoing development and enhancement of skills among service providers treating women with co-occurring substance abuse, mental health disorders, and a history of trauma. At IRT meetings, members had the opportunity share case-presentations specifically chosen to assist substance abuse treatment providers in identifying challenges they face while offering integrated services to women with substance abuse problems. Through discussion of case presentations, the interdisciplinary team was able to identify strategies and solutions to assist counselors in their daily work with clients. The IRT also provided networking opportunities and developed mechanisms through which providers were able to improve and increase communication and collaboration across centers providing substance abuse and mental health services. Members of the IRT included clinical directors, clinical coordinators, counselors, case managers, child-care assistants, and mental health service providers from five licensed substance abuse treatment programs located in Boston. In addition, clinicians from affiliated mental health agencies also participated in the IRT as part of the service integration strategy. During a three-year period, these providers met once a month for two hours over a structured working lunch to discuss challenges faced in serving a largely poor, African American and Latina clientele. Each case presents learning objectives; key clinical, cultural and contextual issues; discussion questions that assist staff in considering key issues in treatment; and relevant background readings and references.

Status of Research: The *Integrated Substance Abuse, Mental Health and Trauma Treatment with women: A case study workbook for staff-training*, was one of the mechanisms developed by the BCSFR to help providers deliver integrated treatment as part of a

package of interventions 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.' Four published papers present findings showing a) race/ethnic differences in clinical profiles and services needs and b) that women in the intervention stay in treatment longer and at follow-up, have lower sexual HIV risk behaviors, and lower rates of drug use and mental health and trauma symptoms than those in the comparison condition (Amaro, Chernoff, Brown, Arévalo, & Gatz, 2007; Amaro, Dai, Arévalo, Acevedo, Matsumoto and Nieves, R., 2007; Amaro, Gampbel, Larson, Lopez, Richardson, Savage, & Wagner, 2005; Amaro, Larson, Zhang, Acevedo, & Matsumoto, 2007).

Amaro, H., Chernoff, M., Brown, V., Arévalo, S., & Gatz, M. (2007). Does integrated trauma-informed substance abuse treatment increase treatment retention? *Journal of Community Psychology*, 35(7), 845-862.

Amaro, H., Dai, J., Arévalo, S., Acevedo, A., Matsumoto, A., & Nieves, R. (2007). Effects of integrated trauma treatment on outcomes in a racially/ethnically diverse sample of women in urban community-based substance abuse treatment. *Journal of Urban Health*, 84(4), 508-522.

Amaro, H., Gampbel, J., Larson, M. J., Lopez, L., Richardson, R., Savage, A., & Wagner, D., 2005. Racial/Ethnic Differences in Social Vulnerability among Women with Co-occurring Mental Health and Substance Abuse Disorders: Implications for Treatment Services. *Journal of Community Psychology*, 33(4), 495-511.

Amaro, H., Larson, M. J., Zhang, A., Acevedo, D., Dai, J., & Matsumoto, A. (2007). Effects of trauma intervention on HIV sexual risk behaviors among

women with co-occurring disorders in substance abuse treatment. *Journal of Community Psychology*, 35(7), 895-908.

Amaro, H., Melendez, M.P., Melnick, S., and Nieves, R.L. (2005). *Integrated Substance Abuse, Mental Health and Trauma Treatment with Women: A case study workbook for staff training*. Boston Consortium of Services for Families in Recover, Boston Public Health Commission, Boston, MA.

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Managing Traumatic Stress through Art: Drawing from the Center

Description: Under the auspices of Sidran Institute, three art therapists, Barry M. Cohen, Mary-Michola Barnes, and Anita B. Rankin, have collaborated to produce this workbook style manual and model. Designed for trauma survivors to use in individual therapy, in groups, or independently, *Managing Traumatic Stress through Art* introduces inventive ways to understand, manage, and transform the aftereffects of trauma. It consists of 26 carefully structured step-by-step art projects, augmented by tear out images, and writing experiences.

The model's first section, Developing Basic Tools for Managing Traumatic Stress, is devoted to art projects for establishing safety and containing strong feelings and impulses. The second section, Acknowledging and Regulating Your Emotions, helps the trauma survivor to make sense of overwhelming emotional experiences. The final section, Being and Functioning in the World, focuses on self and relational development, leading into the future.

Managing Traumatic Stress through Art will inspire survivors to explore the aftermath of traumatic stress as it affects self-image, relationships with others, and functioning in the world. The projects encourage creative growth and help to establish a sense of personal safety, while exploring and honoring feelings of anger, fear, shame, and sadness. The art experiences are broad enough to be of value to survivors of a wide variety of

traumatic experiences, ranging from childhood abuse to accidents to disabling mental illness.

Status of Research: No research to date.

Contact Information: To obtain this resource, contact: Sidran Institute 410-825-8888 www.sidran.org/store; for training in using this resource and for additional information, , 410-825-8888 x 207, esther.giller@sidran.org

Prolonged Exposure (PE) Therapy

Description: Prolonged Exposure (PE) therapy is a cognitive-behavioral treatment program for individuals suffering from posttraumatic stress disorder (PTSD). This treatment was developed by Edna B. Foa, Ph.D., Professor of Psychology at the University of Pennsylvania and the founder and director of the Center for the Treatment and Study of Anxiety. The program consists of a course of individual therapy designed to help clients process traumatic events and thus reduce trauma-induced psychological disturbances. The standard treatment program consists of 9 to 12, 90-minute sessions. However, the treatment course can be shortened or lengthened depending on the needs of the client and the rate of progress, but usually range from 7 to 15 sessions. PE includes three main components:

- Psychoeducation about common reactions to trauma and the cause of chronic post-trauma difficulties
- Imaginal exposure: repeatedly revisiting the traumatic memory in imagination and recounting it in detail as well as discussing the thoughts and feelings that emerged from the recounting experience
- In-vivo exposure: gradually approaching situations, places, people, and objects that are feared and avoided despite being safe because of their association with the trauma memory

PE is designed for adults aged 18 and older who have experienced either single or multiple/continuous traumas and currently suffer from significant PTSD symptoms. PE substantially reduces PTSD and related symptoms in female victims of rape, aggravated assault, and childhood sexual abuse, and in men and

women whose PTSD symptoms are related to combat, traffic and industrial accidents, and violent crime. Most extensively used with adults, PE has also been successfully used with children, primarily with those whose symptoms were related to sexual abuse or assault. PE is also useful with children whose PTSD is related to accidents, disasters, and terrorist attacks. A developmentally sensitive version of PE, called Prolonged Exposure for Adolescents (PE-A), has obtained promising results in pilot studies and is currently being investigated in two randomized controlled trials. PE-A is described in the next section.

PE can be used in a variety of clinical settings, including community mental health outpatient clinics, veterans' centers, rape counseling centers, private practice offices, and inpatient units. Treatment is individual and is conducted by therapists trained to use the *PE Therapist Guide* (Foa, Hembree, & Rothbaum, 2007), which specifies the agenda and treatment procedures for each session.

Training: PE is a form of CBT and is implemented by trained therapists (e.g., social workers, counselors, psychologists, psychiatrists). Thus training in PE is essential to its successful implementation. Several levels of training are available, ranging from a half-day workshop to familiarize the therapist with PE to a 4-day in-depth workshop. In a 2-day basic workshop, the three PE procedures are demonstrated on videotapes and therapists practice the procedures using role-playing. In addition to this basic training, the comprehensive 4-day workshop includes in-depth examination and discussion of typical and atypical treatment responses and how to recognize and manage challenges presented by complex clients. Therapists are shown techniques for promoting effective emotional engagement during imaginal and in-vivo exposures as well as how to overcome difficulties with homework assignments.

Status of Research: To date, nine large randomized controlled trials investigating the comparative efficacy of PE have been published and more are underway. Clients in these studies were predominantly African American and white. On average, over 70% of clients no longer have the diagnosis of PTSD after a 9- to 12-session course of PE therapy (i.e., they have a highly significant reduction in trauma-related symptoms,

including distressing thoughts, feelings, and flashbacks; avoidance of thoughts and other reminders of the traumatic event; and hyperarousal symptoms). Improved daily functioning, including substantial reduction in depression, general anxiety, and anger have been observed in clients treated with PE. Treatment gains are maintained for at least 1 year after treatment ends. PE has also been beneficial for those suffering from co-occurring PTSD and alcohol or substance abuse when combined with substance abuse treatment. The PE therapist guide is in English and has been translated into Hebrew, Spanish, Japanese, and Chinese translations are underway.

In 2001, PE received an *Exemplary Substance Abuse Program Award* from SAMHSA, U.S. Department of Health and Human Services, and was designated a Model Program. PE also received an *Exemplary Service and Support to Victims and Witnesses of Crime Award* from the Philadelphia Coalition for Victim Advocacy

Foa, EB, Hembree, EA, Rothbaum, BO. (2007). *Prolonged Exposure for PTSD: Emotional Processing of Traumatic Experiences*. New York: Oxford University Press

Rothbaum, BO, Foa, EB, Hembree, EA. (2007). *Reclaiming Your Life From A Traumatic Experience Workbook*. New York: Oxford University Press

Contact Information: For program, training, and research information, contact Dr. Edna Foa or Dr. Elizabeth Hembree: Center for the Treatment and Study of Anxiety
Phone: 215-746-3327
Website: ctsa@mail.med.upenn.edu

The PTSD Psychoeducation Program for People with Severe Mental Illness

Description: Developed by Stanley Rosenberg, Ph.D. Kim Mueser, Ph.D., and their colleagues at the Dartmouth Psychiatric Research Center and the Dartmouth Trauma Intervention Research Center. This program for clients with severe mental illness and PTSD can be implemented on an individual- or group-basis. The goal of the program is to provide basic information about PTSD and its treatment, but is not intended as a direct treatment for PTSD symptoms. The program is conducted in 3 sessions and includes a

video about trauma and PTSD, which is used to provide basic information and to stimulate discussion between the client(s) and clinician.

Status of Research: Two non-controlled pilot studies of the CBT for PTSD program have been completed. The first study included 70 inpatients with severe mental illness and PTSD at New Hampshire Hospital. Results showed that participants reported high levels of satisfaction with the program and improvements from before the program to after the program in knowledge about PTSD (Pratt et al., 2005). A second study evaluated the program delivered in two group cohorts to 13 female outpatients in Indianapolis with severe mental illness and PTSD (M. Salyers, unpublished data). Similar improvements in knowledge about PTSD from before to after treatment were reported, as well as qualitative feedback indicating participants' satisfaction with the group.

Pratt, S. I., Rosenberg, S. D., Mueser, K. T., Brancato, J., Salyers, M. P., Jankowski, M. K., & Descamps, M. (2005). Evaluation of a PTSD psychoeducational program for psychiatric inpatients. *Journal of Mental Health, 14*, 121-127.

Contact Information: Information about this program can be obtained from Stanley Rosenberg Stanley.d.Rosenberg@dartmouth.edu

Restoring Hope and Trust: An Illustrated Guide to Mastering Trauma

Description: A ten-session model for conducting psychoeducational groups on trauma developed at the Menninger Clinic for use in treatment with a wide range of clients and their loved ones. This short, educational curriculum captures the material from Jon Allen's *Coping with Trauma: A Guide to Self-Understanding* that is most important in understanding and learning to master the impact of trauma. The authors, Lisa Lewis and Kay Kelley, in addition to Jon Allen, have found this shorter course to be helpful to people struggling with trauma.

It targets three audiences: people struggling to contain and master the spillover of past trauma into their current lives; those who love them and want to have a better idea of how to be helpful; and professionals

who would like to conduct psychoeducational trauma groups in their home communities.

The theme of the model is simple: past trauma often does not remain in the past but all too often spills over into the present in the form of intrusive re-experiences of trauma, associated neuro-physiological changes, adverse effects on current identity and world view, and depressive mood changes. This can lead traumatized individuals to develop and rely on a range of stopgap coping mechanisms, such as alcohol use, illegal drugs, or self-injurious behaviors. The perceived short-term benefits of these coping measures disappear and unintended negative effects, such as long-term drug abuse, often result. Reenactments of past trauma in current interpersonal relationships can lead to compassion fatigue in loved ones. Individuals using this ten-session group model can learn to attain greater mastery over trauma symptoms and a sense of well being.

Mindfulness exercises help to center students of this model before beginning the work. Self-study questions at the end of each section help the user make the lessons of each chapter more personally relevant.

Status of Research: In ongoing use at the Menninger Clinic, Houston, TX.

Contact Information: To obtain this resource and for additional information, contact: Sidran Institute 410-825-8888

www.sidran.org/store
orders@sidran.org

Seeking Safety

Description: Developed by Lisa M. Najavits, Ph.D., at Harvard Medical/McLean Hospital, *Seeking Safety* is a manualized model that offers coping skills to help clients attain greater safety in their lives. It is present focused and designed to be inspiring and hopeful. It is highly flexible and can be used for group or individual format; women, men, and adolescents; all levels of care (e.g., outpatient, inpatient, residential); all types of trauma and substances; and any clinician. There are 25 treatment topics, each representing a safe coping skill relevant to both PTSD and SUD. All topics are independent, and thus can be done in any order, with

as few or many sessions as there is time for (it is not required to do all 25 topics). The model has been successfully implemented with a variety of populations including incarcerated, homeless, adolescents, veterans, substance abuse, mental health, and diverse ethnicity. Seeking Safety is used broadly with clients who need improved coping skills; they do not have to meet criteria for PTSD and substance abuse as the skills can be generalized. 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).

The treatment manual, *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse*, (Najavits, 2002) includes clinician guidelines and client handouts. It offers up to 25 topics to address cognitive, behavioral, interpersonal, and case management domains. Each topic represents a safe coping skill relevant to trauma and substance abuse: 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.

Implementation of the model is enhanced by various materials including a website with extensive downloadable materials (www.seekingsafety.org), the published manual in English, Spanish, French, German, and Swedish; a poster and card deck of the Safe Coping Skills in the model; five hours of video-based training; and numerous national on-site trainings. Information on all of these is available from www.seekingsafety.org.

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. Thus far, it is the only model for PTSD and substance use disorder that meets standard criteria as an effective treatment (Chambless & Hollon, 1998;

Najavits et al., in press). The evidence base of 15 published studies represents a broad range of investigators and populations and includes seven pilot studies, four randomized controlled trials (RCTs), two multisite controlled trials, one controlled nonrandomized trial (a site from one of the multisite trials), and one dissemination study. The studies had samples of clients who were severe and chronic in both trauma/PTSD and substance abuse, and who represent broad diversity in ethnicity and range of settings (e.g., criminal justice, VA, adolescent treatment, homeless, public sector); see the Web site www.seekingsafety.org, section Outcomes. The model has consistently shown positive outcomes on trauma symptoms and substance abuse as well as other domains (e.g., suicidality, HIV risk, social functioning, problem solving, sense of meaning); has consistently outperformed treatment-as-usual; has shown comparable results to the gold-standard treatment, relapse prevention; and has shown consistent high satisfaction by both clients and clinicians. Seeking Safety is listed as a “strongly recommended” treatment in the Veterans Affairs Uniformed Services Package for Mental Health (Department of Veterans Affairs, 2008), pg. 17. It is also on the National Registry (www.nrepp.samhsa.gov), although the evidence base and ratings there are highly outdated at this point. For summaries of the research literature on the model, see Najavits, Ryngala et al. (in press) and Najavits (in press). All of the published research articles on the model can be freely downloaded from www.seekingsafety.org (section Outcomes).

Najavits, LM (in press). An implementation guide to *Seeking Safety*. In D. Springer, A. Rubin (Eds.), *Substance Abuse Treatment for Youths and Adults from Clinician's Guide to Evidence-Based Practice Series*. Hoboken, NJ: John Wiley.

Najavits, L. M., Ryngala, D., Back, S. E., Bolton, E., Mueser, K. T., & Brady, K. T. (in press). Treatment for PTSD and comorbid disorders: A review of the literature. In E. B. Foa, T. M. Keane, M. J. Friedman & J. Cohen (Eds.), *Effective treatments for ptsd: Practice guidelines from the international society for traumatic stress studies* (2nd ed.). New York: Guilford.

Contact Information: The manual (Najavits, 2002b) can be ordered from any bookseller, or from the website www.seekingsafety.org (section Order); the

implementation materials (translations, videos, card deck, posters) can be obtained from the same section of the website. Information on upcoming trainings, and how to schedule training or consultation is on the website (section Training). Research is on the website in the section Outcomes.

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Spirituality and Recovery Curriculum

Description: 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, available in both English and Spanish, was developed by the Boston Consortium of Services for Families in Recovery, Boston Public Health Commission, the Institute on Urban Health Research, Northeastern University (Amaro, Mangual & Nieves, 2004).

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.’

Four published papers present findings showing race/ethnic differences in clinical profiles and services needs and that women in the intervention stay in treatment longer and at follow-up have lower sexual HIV risk behaviors, and lower rates of drug use and mental health and trauma symptoms than those in the comparison condition (Amaro, Gampbel, Larson,

Lopez, Richardson, Savage, & Wagner, 2005; Amaro, Larson, Zhang, Acevedo, & Matsumoto, 2007; Amaro, Chernoff, Brown, Arévalo, & Gatz, 2007; Amaro, Dai, Arévalo, Acevedo, Matsumoto and Nieves, 2007).

Amaro, H., Gampbel, J., Larson, M.J., Lopez, L., Richardson, R., Savage, A., & Wagner, D. (2005). Racial/Ethnic Differences in Social Vulnerability among Women with Co-occurring Mental Health and Substance Abuse Disorders: Implications for Treatment Services. *Journal of Community Psychology*, 33(4), 495-511.

Amaro, H., Larson, M. J., Zhang, A., Acevedo, D., Dai, J., & Matsumoto, A. (2007). Effects of trauma intervention on HIV sexual risk behaviors among women with co-occurring disorders in substance abuse treatment. *Journal of Community Psychology*, 35(7), 895-908.

Amaro, H., Chernoff, M., Brown, V., Arévalo, S., & Gatz, M. (2007). Does integrated trauma-informed substance abuse treatment increase treatment retention? *Journal of Community Psychology*, 35(7), 845-862.

Amaro, H., Dai, J Arévalo, S., Acevedo, A., Matsumoto, A., & Nieves, R. (2007). Effects of integrated trauma treatment on outcomes in a racially/ethnically diverse sample of women in urban community-based substance abuse treatment. *Journal of Urban Health*, 84(4), 508-522.

Amaro, H, Mangual, S, and Nieves, RL. (2004). *Spirituality in Recovery: An educational group curriculum for women in recovery*. Boston Consortium of Services for Families in Recovery, Public Health Commission, Boston, MA.

Contact Information: For more information or copies of these materials, please contact

Dr. Hortensia Amaro

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or

Rita Nieves, R.N., M.P.H.,

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Spirituality in Trauma Recovery Group

Description: This manualized group intervention was developed as part of the D.C. Trauma

Collaboration Study at Community Connections, one of the Women, Co-Occurring Disorders, and Violence Study sites. Its 11 sessions address spiritual and religious resources for empowerment and recovery from the impact of 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: This group's effectiveness was recently examined in a randomized wait-list control design, as part of a doctoral dissertation at Washington University in St. Louis (Bowland, 2008). Among older women survivors of interpersonal trauma, group participants showed significantly greater reductions in mental health symptoms (depression, PTSD, and anxiety); in physical health symptoms; and in spiritual distress than did participants in the control condition.

Contact Information: To obtain a manual and for training and consultation information, visit

www.ccdc1.org or contact

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www.ccdc1.org

Symptom-Specific Group Therapy (SSGT) for Complex Post Traumatic Stress Disorder (CPTSD)

Description: Symptom-Specific Group Therapy (SSGT) for individuals with Complex Post Traumatic Stress Disorder (CPTSD) is a manualized, group-based program, developed by Anne-Marie Shelley PhD, Kristina Muenzenmaier MD and colleagues, to address the symptoms of CPTSD often observed in individuals with serious mental illness (SMI) (Muenzenmaier et al, 2005). The clinical goal of the program is to educate people about symptoms of CPTSD and to teach coping skills to deal with these distressing symptoms, using psycho-education, skills training (both cognitive and behavioral) and social support. There are separate groups for males and for females and both have been manualized (Shelley, 2006). SSGT for CPTSD is a component of BPC's

Trauma Program, directed by Kristina Muenzenmaier MD.

The SSGT for CPTSD program and manual consists of 12 modules presented over 12 weekly sessions. Each module is aimed specifically at one of the symptoms of CPTSD, such as nightmares, flashbacks, dissociation, avoidance, addiction, numbing, hyperarousal, impulsivity, aggression, self-injury and poor self-esteem. Each module also teaches a coping skill or 'tool' for the management of the targeted CPTSD symptom. The analogy of a toolbox is used, with each group providing a new skill, or 'tool' to add to the toolbox. These tools include behavioral coping skills (for example grounding, behavior scripts, positive distractions), cognitive strategies (re-scripting nightmares, self-soothing, positive coping statements, safe places imagery), social support (communication skills and assertiveness training) and medication management.

Each of the 12 modules is subdivided into the following sections:

1. Introduction to topic (and brief revision of previous session)
2. Stickers to illustrate the module's Topic and corresponding Tool
3. Relating and sharing personal experiences.
4. Psychoeducation, with written handouts for patients
5. Skills training (or 'tool') for symptom management
6. Practice exercises and/or homework

The SSGT for CPTSD Project (Muenzenmaier et al, 2007) is part of a larger program, conceived and developed at Bronx Psychiatric Center (BPC) over the past 10 years: The SSGT for SMI (Serious Mental Illness) Project (Battaglia et al, 2007). SSGT for SMI is a group-based treatment program, created for the management of those syndromes, or symptom clusters, that are routinely observed in Serious Mental Illnesses (SMIs). SSGT consists of eight treatment groups, each of which has been manualized. These are:

1. Positive Symptoms (such as delusions, hallucinations and paranoia)

2. Negative Symptoms (for isolation, amotivation, lack of involvement)
3. Activation (for affective dysregulation, anger and aggression)
4. Dysphoric Mood (for depression, anxiety, panic and irritability)
5. Autistic Preoccupation (for attentional problems, exaggerated internal focus, turning inward).
6. Trauma Symptoms for Women (as described above) and
7. Trauma Symptoms for Men
8. Substance Abuse

We are currently also developing the SSGT Peer Empowerment Project. This project gives patients who have graduated from one or more SSGT groups the opportunity of receiving training to become assistant group leaders and co-leaders. Another new direction we are exploring is combining SSGT for CPTSD with art or music therapy, for individuals who prefer more non-verbal modalities.

Status of Research: A pilot study (Shelley et al, 2001) examining the efficacy of the first 5 groups, which correspond to the 5 factors of schizophrenia as identified by the Positive and Negative Syndrome Scale (PANSS) (Kay, Opler & Fiszbein, 1992), found that participants showed a 22% decrease in symptom severity over 6 months.

Preliminary pilot data for the male and female CPTSD groups, showed that participants who received SSGT in the Trauma Symptoms for Men or the Trauma Symptoms for Women Groups, in addition to standard medication and routine care, showed a decrease in symptom severity as indexed by the Post-Traumatic Symptom Checklist (PCL), Abbreviated Dissociative Experiences Scale (DES-A), Abbreviated Psychoticism Scale (PS-A) and an increase in the Knowledge, Use and Helpfulness of Positive Coping Skills (KUH-PCS).

THE SSGT for SMI Project (2007) (Vol. I-VIII) Battaglia et al. Library of Congress, Washington D.C.

THE SSGT for CPTSD Project (2007) Muenzenmaier et al. Library of Congress, Washington D.C.

Muenzenmaier, Castille, Shelley, Jamison, Battaglia & Opler (2005) Comorbid posttraumatic stress disorder and schizophrenia. *Psychiatric Annals*, 35 (1), 51-56.

Shelley A.M. (2004) Symptom-Specific Group Treatment (SSGT) Program for Serious Mental Illness Manual (Volume I-VI). Library of Congress, Washington D.C.

Shelley, Battaglia, Lucey, Ellis & Opler (2001) Symptom-Specific Group Therapy for Inpatients with Schizophrenia. *The Einstein Quarterly Journal of Biology and Medicine*, 18, 21-28.

Shelley, Muenzenmaier, Spei, Margolis, Battaglia & Opler (submitted) Symptom-Specific Group Therapy for Inpatients with Complex Post Traumatic Stress Disorder: A Preliminary Report

The Manuals 'Complex PTSD (Trauma) Group for Women' (Shelley 2006) and 'Complex PTSD (Trauma) Group for Men' (Shelley 2006) are both available from Lulu.com.

Contact Information: For further information please contact: A.M. Shelley PhD , shelleybpc@aol.com, brpgams@omh.state.ny.us
J. Battaglia, brcdjbb@omh.state.ny.us
K. Muenzenmaier, brmdkmm@omh.state.ny.us

Trauma Affect Regulation: Guide for Education and Treatment (TARGET©)

Description: TARGET© was developed by Julian Ford, Ph.D., as an educational and therapeutic approach for the prevention and treatment of complex Posttraumatic Stress Disorder (PTSD). TARGET© provides a practical skill set that can be used by trauma survivors and family members to de-escalate and regulate extreme emotion states, to manage intrusive trauma memories in daily life, and to restore the capacity for information processing and autobiographical memory. TARGET© teaches a sequence of seven (7) skills described as the FREEDOM steps. The focus in TARGET© is on shifting the way a person processes information and emotions so that s/he is able to live life and make

sense of memories without being trapped in an alarm state.

TARGET© explains post-traumatic symptoms as the product of an ingrained, but reversible, biological change in the brain's alarm and information processing systems and the body's stress response systems. Using graphics and simple language, TARGET© describes the stress response system as an "alarm" in the brain that is triggered by trauma or extreme stress. When the brain becomes stuck in "alarm" mode a person cannot access the brain's capacities for clear thinking, and therefore reacts to all types of current stressors as survival threats. This causes serious difficulties in their relationships and daily life activities that can be addressed by using the FREEDOM skill set.

Essential Components: TARGET© is designed to address the primary personal issues that are related to trauma, such as PTSD symptoms, rage, traumatic grief, survivor guilt, shame, interpersonal rejection, and existential/spiritual alienation. The seven (7) core skills in TARGET© are taught through repeated coaching and guided practice and are described by the acronym, FREEDOM.

Applications: TARGET© originally was designed for and has been field tested in public sector and private nonprofit community mental health and addiction treatment settings with adults and adolescents. Although the information provided is complex, the language used in participant materials and in leader guides is down-to-earth rather than technical or academic terminology. The pacing of materials within and across sessions is designed to sustain participant interest without taxing clients' sometimes impaired information processing abilities. TARGET© has been adapted for several other trauma-affected populations:

- Survivors, rescue workers, and families affected by September 11, 2001
- Advocacy for women who have experienced domestic violence and their children
- Incarcerated men and women in prison or when newly re-entering the
- community

- Girls and boys in the juvenile justice system in secure and community programs
- Girls and boys in mental health and addictions treatment programs and schools
- Women with young children who are at risk for criminal justice involvement

TARGET© is manualized for adults and adolescents and can be offered in individual or group counseling or psychoeducation sessions conducted by clinicians, case managers, rehabilitation specialists, or teachers for 10 to 12 sessions. TARGET© has been adapted for interventions that are not specifically focused on trauma recovery, such as anger management, anxiety/stress management, pain management, interpersonal skills, screening and orientation for new clients or residents, and general support groups.

Status of Research: A randomized effectiveness study was conducted comparing 9-session TARGET© groups versus trauma-informed substance abuse groups (TSU) in three adult substance abuse treatment programs (Frisman, L. K., Ford, J. D., Lin, H., Mallon, S., & Chang, R. (in press). Outcomes of trauma treatment using the TARGET© model. *Journal of Groups in Addiction and Recovery*). TARGET© was superior to TSU in maintaining sobriety.

A three-year randomized clinical trial study funded by the Department of Justice of TARGET© delivered as a 12-session individual therapy for PTSD was conducted with 147 low-income urban mothers. Findings are under review for publication and were presented at the Annual Conventions of the American Psychological Association and the International Society for Traumatic Stress Studies in 2007. TARGET© was superior to a comparison social problem solving therapy (Present Centered Therapy; PCT) on improved emotion regulation and posttraumatic beliefs at posttest and follow-up, and led to additional improvements in dissociation and affectively-modulated coping and relational involvement.

A three-year randomized clinical trial study funded by the Office of Juvenile Justice and Delinquency Programs of TARGET© delivered as a 12-session individual therapy for PTSD compared to a relational therapy (Enhanced Treatment as Usual, ETAU) with 61 girls involved in delinquency was completed in Fall 2008. TARGET© was associated with greater improvement than ETAU on PTSD symptoms and

remission from PTSD (77% versus 53%) at the conclusion of therapy.

A two-year field trial funded by the Office of Juvenile Justice and Delinquency Programs of TARGET© delivered as a group and milieu intervention in every Juvenile Detention Center in Connecticut will be completed in Fall 2008. Juvenile Justice data and admission/discharge questionnaire data are being collected in this quasi-experimental study of the impact of the sequential introduction of TARGET© into mixed-gender and gender-specific (girls only) detention centers.

Endorsements: TARGET© was designated as the first promising practice model for traumatized youths in the juvenile justice system by the National Child Traumatic Stress Network (www.nctsn.org) and is endorsed by the California Evidence-Based Clearinghouse for Child Welfare (www.cachildwelfareclearinghouse.org), the RAND Corporation Gulf States Policy Institute (www.rand.org), and NREPP: SAMHSA's National Registry of Evidence-based Programs and Practices (www.nrepp.samhsa.gov).

TARGET© is copyrighted by the University of Connecticut and is distributed exclusively by Advanced Trauma Solutions, Inc. through intensive training, consultation, and quality assurance programs.

Contact Information: For information, training, and materials, contact Judith Ford
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www.ptsdfreedom.org

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

Description: 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 15-week, 15-module trauma-specific group intervention combining psycho-educational approaches with expressive therapies. It is designed for women and men with histories of trauma. 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. Men and 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%.

Contact Information: To obtain the manual and for information on training and technical assistance, Marian Bland, LCSW-C
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Trauma Recovery and Empowerment Model (TREM)

Description: 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 and Maxine Harris (see below).

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. Results of the quasi-experimental WCDVS study conducted in D.C. and Baltimore showed advantages for TREM over services as usual in both PTSD and mental health symptoms and drug and alcohol abuse (Fallot, McHugo, & Harris, 2005). At the Denver site (Toussaint, VanDeMark, Bornemann, & Graeber, 2007), results indicated that TREM participants, in comparison to those receiving usual services, had better outcomes on both mental health symptoms in general and trauma-related symptoms in particular (e.g., sense of personal safety, feelings of dissociation, coping with trauma). 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 (Love and Life: 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.

Fallot, R.D., McHugo, G.J., & Harris, M. (2005). DC Trauma Collaboration Study: Background and Preliminary Report. Unpublished manuscript, Community Connections.

Toussaint, D., VanDeMark, N., Bornemann, A., & Graeber, C. (2007). Modifications to the Trauma Recovery and Empowerment Model (TREM) for substance-abusing women with histories of violence: Outcomes and lessons learned at a Colorado substance abuse treatment center. *Journal of Community Psychology* 35(7), 879-894.

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.

Contact Information: To obtain the manual or the instructional video contact;
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For information on training and consultation, contact Rebecca Wolfson Berley, M.S.W.
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To obtain the Copeland workbook and 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

Description: Developed by Maxine Harris, Ph.D., and colleagues at Community Connections., this skills rating scale and its accompanying menu of skill building strategies may be used as clinical tools for clinicians and survivors to evaluate trauma recovery 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: For women Trauma Recovery and Empowerment Model (TREM) group participants in the District of Columbia Trauma Collaboration Study, clinician ratings on the TREP were significantly correlated with many of the participants' self-reported outcomes. Though the study was not designed to test mediation formally, these findings suggest that the development of trauma recovery skills may be part of the pathway to positive symptom reduction outcomes (Fallot, McHugo, and Harris, 2005).

Contact Information: To obtain copies of TREP and the Menu of Strategies, contact:
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The Trauma Recovery Group: Group Cognitive-Behavioral Treatment for PTSD in People with Severe Mental Illness

Description: Developed by Kim Mueser, Ph.D. at the Dartmouth Psychiatric Research Center and the Dartmouth Trauma Intervention Research Center, and Patricia Carty, M.S., C.C.B.T. and colleagues at the Mental Health Center of Greater Manchester, Manchester, NH, based on the individual CBT for PTSD model developed by Mueser and Rosenberg (described above). This program is a 21-week standardized group intervention for women and men with severe mental illness and PTSD. Group size ranges between 6 and 8 clients. The components of the program include: orientation, breathing retraining, psychoeducation about PTSD and related effects of trauma, cognitive restructuring, teaching coping skills for managing persistent PTSD symptoms, and developing a personal recovery plan. Women and men are included in groups, which are co-facilitated by male and female co-leaders. The program has been in

place for seven years at the Mental Health Center of Greater Manchester.

Status of Research: One non-controlled pilot study of the CBT for PTSD program has been completed, which included 80 clients who participated in the first 11 groups. This study showed high rates of retention in treatment, and significant reductions in PTSD symptoms, depression, and post-traumatic cognitions from pre- to post-treatment, with gains maintained at a 3-month follow-up (Mueser et al., 2007).

The manual for this program is currently being developed. Thus far, groups have been based on a detailed outline, supplemented by the manual for the individual CBT for PTSD program developed by Mueser and Rosenberg (above).

Mueser, K. T., Bolton, E. E., Carty, P. C., Bradley, M. J., Ahlgren, K. F., DiStaso, D. R., Gilbride, A., & Liddel, C. (2007). The trauma recovery group: A cognitive-behavioral program for PTSD in persons with severe mental illness. Community Mental Health Journal. Published ahead of print: DOI: 10.1007/s10597-006-9075-2.

Contact Information: Further information can be obtained from:

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Trauma Resiliency Model (TRM)

Description: The Trauma Resource Institute (TRI) is a non-profit trauma training center that provides training nationally and internationally in the Trauma Resiliency Model™ (TRM) and the Veterans Resiliency Model™ (VRM). The training, developed by TRI's Co-founders, Elaine Miller-Karas, MSW and Laurie Leitch, PhD, is based on current neuroscience findings about the way that untreated trauma affects the nervous system. Focusing as it does on the *biology* of trauma rather than the *psychology* of trauma TRM and VRM training is appropriate with populations that are not insight-oriented and in communally-oriented cultures. Thoughts and feelings are incorporated in TRM and VRM but are secondary to the sensory tracking that re-regulates the nervous system. VRM training includes orientation to “Battlemind injury”

and TRI's “Balancemind™” and has been piloted with OEF/OIF and Vietnam veterans.

TRM and VRM training is practical and skills-based and provides trainees with knowledge about the ways trauma affects the nervous system as well as 6 core skills for returning the nervous system to balance. There is an extensive experiential component in trainings that are 2-3 days long. Post-training case consultation is also encouraged in order to deepen the use of skills and address questions specific to various work settings.

The training is offered in several versions from 4 hours to three days. Both TRM and VRM have individual treatment as well as group formats and both have a Level 1 training (basic) and a Level 2 training (advanced).

1. Key Concepts of TRM/VRM:

- Traumatic symptoms are conceptualized as the result of “too much, that happens too fast,” resulting in nervous system dysregulation when the mind-body system cannot “digest” the experience.
- The patterns that cause physiological suffering as well as psychological suffering are entrenched in the nervous system;
 - Symptoms can include attentional disorders, pain syndromes, irritability and rage, cold sweats, Gastrointestinal problems, exhaustion, difficulty concentrating, distractibility, troubled sleep, flashbacks & nightmares, self-blame & guilt, grief, loss of confidence.
 - Symptoms may also include mood disorders such as depression and anxiety, and PTSD.
 - Efforts to self-medicate can cause substance abuse and chemical dependency.
- Symptoms are often the result of the body's natural (and automatic) defensive responses of fight and flight which were blocked during the traumatic event and freeze which is the automatic response when escape or fight has not been possible.
- The traumatic response can lead to a process that is self-perpetuating even in the absence of on-going external stressors or threat.

2. Trauma Resiliency Model and Veterans Resiliency Model are skills-based intervention programs for adults and children (TRM) which are:

- Designed to foster re-balancing of the nervous system;
- Designed to be delivered as a skill-based intervention program;
- Taught by Trauma resource Institute (TRI) to clinicians in two 3-day modules (TRM Levels 1 & 2) and a 1-day group training for clinicians who have taken TRM 1 & 2. Case consultation ideally follows each level of training in order to anchor the skills. TRI also provides training in Veterans Resiliency Model (VRM) Levels 1 & 2 and VRM-G for group work;
- Focused on the biological basis of trauma rather than the psychological basis of trauma;
 - Based upon the latest developments in neuroscience regarding the impact of trauma on the Autonomic Nervous System;
 - Incorporates the skills of Somatic Experiencing, information from Sensory Integration, and Gendlin's "Felt Sense;"
 - Used also as a self-care and team-care model for clinicians to reduce secondary traumatization and burn-out;
 - Designed to teach the skills which can help re-regulate the nervous system and promote resiliency.

3. TRM & VRM Treatment:

- Uses observation and tracking of neurobiological patterns;
- Gradually helps attention to be brought to internal body sensations, both those that are pleasant or neutral and those that are more difficult to tolerate;
- Uses sensory tracking to interrupt the disorganization in the nervous system;

- Promotes a sense of self-mastery over intense body states by using TRM & VRM skills for self-regulation and balance.
- Offers supplementary materials including workbooks, and skills cards to make use of TRM and VRM skills easy, accessible, and on-going which promotes independence.

Settings:

TRM has been used cross-culturally and in diverse settings with different languages and using translators, in countries and settings impacted by genocide, war, and natural disasters, with local community groups, first responders, in prison, in mental health service settings serving adults and children suffering from both recent trauma and past trauma. TRM is effective with both developmental and shock trauma in children and adolescents. TRM has been taught to teachers for use in stabilizing children after disasters as well as for the teachers' own self-care.

VRM has been used in the Veterans Administration with post-deployment veterans from the OEF/OIF and Vietnam wars. TRI developed the concept of "Balancemind™" as an antidote to "Battlemind injury" and teaches stabilization and affect-management skills to help sustain Balancemind.

Status of Research: Has been demonstrated to be effective in low dosage treatment (1-2 sessions). Several effectiveness studies are currently underway, and an outcome study has been published in *Traumatology*, September 2007, and one is due to be published in January 2009 in *Social Work*.

Contact information:

Website: www.traumaresourceinstitute.com

Contact with questions about training: Elaine Miller-Karas, Elainemk27@mac.com

Contact with questions about research: Laurie Leitch L.leitch@comcast.net

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

Description: 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

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

TRIAD Women's Group Model

Description: 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.

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

A Woman's Path to Recovery (Based on A Woman's Addiction Workbook)

Description: A Woman's Path to Recovery is a clinician-led program for women with substance use disorders. The model uses chapters from A Woman's Addiction Workbook (Najavits, 2002) as the basis for sessions conducted by clinicians. However, the workbook can also be used on its own without clinician involvement. The workbook is divided into two main sections: exploration and healing. The exploration section helps women look at their lives in relation to gender and addiction issues. It provides background on the relationship between gender and addiction; gender differences in addiction and recovery processes; historical barriers to treatment faced by women; and subgroups of women at risk for addiction. It then encourages women to identify their life themes in five

key areas relevant to women and addiction: body and sexuality, stress, relationships, trauma and violence, and thrill-seeking. They can also evaluate addiction and co-occurring mental disorders. The healing section of the book guides women through methods of recovery. It is organized into four domains--relationships, beliefs, actions, and feelings--and includes a series of exercises for each domain. The book conveys a supportive tone for the journey of healing and provides specific recovery resources. Overall, the model addresses social and emotional problems unique to women. Difficult areas in a woman's life are explored through the psychology that underlies female addictive behavior. The model also explicitly addresses behavioral addictions, such as addiction to sex, shopping, and eating. When conducted in clinician-led format, the session length and program duration can be modified, depending on the setting or client needs. A Woman's Addiction Workbook (Najavits, 2002) costs \$22 and is available through national and online bookstores or via www.seekingsafety.org (section "Order"). Clinician training is optional; it includes lectures, demonstrations, and experiential exercises, and can be arranged through the developer. Training costs vary depending on the length of training and other factors.

Population(s) the model is designed for and used with: adult and adolescent females; all cultures. The model also specifically addresses subgroups of females who are at heightened risk for addictions.

Status of Research: One published study is available on the model (Najavits, Rosier, Nolan & Freeman, 2007). This study appears to be the first outcome study of a gender-focused, manual-based substance-abuse recovery model for women. Participants were opioid-dependent women in a methadone maintenance treatment program who received 12 sessions of A Woman's Path to Recovery in group format over two months. Assessment was conducted before and after the intervention using psychometrically valid scales and urinalysis. The only professionally-led treatment participants received during the study were the 12 sessions of this treatment, plus two required one-hour individual sessions as part of the methadone maintenance treatment protocol. The study treatment was 12 group sessions over 8 weeks. Clients completed readings and exercises from the workbook on a time-limited

schedule of 12 sessions. The groups were co-led by a male and female counselor. Participants' average age was 35 years; most were unmarried and unemployed. All participants reported 30 days of drug problems in the prior month. Lifetime drug use indicated an average of 11 years for heroin, 12 years for cannabis, and 7 years for cocaine. All had at least two current DSM-IV substance use disorder diagnoses. Results indicated statistically significant improvements in drug use (verified by urinalysis), impulsive-addictive behavior, global improvement, and knowledge of the treatment concepts. Clients had a high attendance rate (87% of available sessions), and strong treatment satisfaction. Comments from participants at the exit interview included: "There are a lot of issues that affect women differently than men. . . I felt more comfortable talking about issues men just would not understand"; "If I didn't have that book, I would have been back out there [using drugs] in a heartbeat."

Najavits, L. M., Rosier, M., Nolan, A. L., & Freeman, M. C. (2007). A new gender-based model for women's recovery from substance abuse: Results of a pilot outcome study. *American Journal of Drug and Alcohol Abuse*, 33(1), 5-11.

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Manualized Adaptations of Trauma-Specific Service Models for Adults

Guide to Manualized Adaptations of Trauma-Specific Service Models for Adults				
Name of Model	Intended Audience	Type of Services	Approach	Special Focus
<i>Cultural and Linguistic Adaptation and Expansion of Trauma Recovery and Empowerment Model: Spanish</i>	Latina Women	Manual, Training	Group sessions	HIV prevention
<i>An Introduction to Trauma Issues for Women on Inpatient or Short-Stay Units</i>	Women	Manual/Curriculum, Training	Group sessions	SA, MH
<i>Men's Trauma Recovery and Empowerment Model (M-TREM): A Clinician's Guide to Working with Male Trauma Survivors in Groups</i>	Clinicians working with Male trauma survivors	Manual, Training	Group sessions	SA, MH

Key: MH – Mental Health; SA – Substance Abuse

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

Description: 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 culturally adapted and translated to Spanish to make it more appropriate and accessible to Latina women. The title of this cultural adaptation and Spanish language translation is:

Saber Es Poder: Modelo de Trauma y Recuperación para Mujeres Latinas, (Harris, M., Wallis, F., & Amaro, H, 2006).

This cultural adaptation of TREM was conducted and evaluated over a six year period and includes adaptations in content, language and approach to address deep cultural structures rather than surface structures. Multiple issues addressed by the TREM manualized group treatment are contextualized within the Latino immigration, minority and cultural experiences, The adaptation also expanded the original TREM 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.’

Four published papers present findings showing race/ethnic differences in clinical profiles and services needs and that women in the intervention stay in treatment longer and at follow-up have lower sexual HIV risk behaviors, and lower rates of drug use and mental health and trauma symptoms than those in the comparison condition (Amaro, Gampbel, Larson, Lopez, Richardson, Savage, & Wagner, 2005; Amaro, Larson, Zhang, Acevedo, & Matsumoto, 2007; Amaro, Chernoff, Brown, Arévalo, & Gatz, 2007; Amaro, Dai, Arévalo, Acevedo, Matsumoto and Nieves, 2007).

Amaro, H., Gampbel, J., Larson, M.J., Lopez, L., Richardson, R., Savage, A., & Wagner, D. (2005). Racial/Ethnic Differences in Social Vulnerability among Women with Co-occurring Mental Health and Substance Abuse Disorders: Implications for Treatment Services. *Journal of Community Psychology*, 33(4), 495-511.

Amaro, H., Larson, M. J., Zhang, A., Acevedo, D., Dai, J., & Matsumoto, A. (2007). Effects of trauma intervention on HIV sexual risk behaviors among women with co-occurring disorders in substance abuse treatment. *Journal of Community Psychology*, 35(7), 895-908.

Amaro, H., Chernoff, M., Brown, V., Arévalo, S., & Gatz, M. (2007). Does integrated trauma-informed substance abuse treatment increase treatment retention? *Journal of Community Psychology*, 35(7), 845-862.

Amaro, H., Dai, J., Arevalo, S., Acevedo, A., Matsumoto, A., & Nieves, R. (2007). Effects of integrated trauma treatment on outcomes in a racially/ethnically diverse sample of women in urban community-based substance abuse treatment. *Journal of Urban Health*, 84(4), 508-522.

Harris, M., Wallis, F and Amaro, H. (2006). *Saber es Poder: Modelo de Trauma y Recuperacion para Mujeres Latinas*. (A Spanish translation and cultural adaptation of Maxine Harris' Trauma Recovery and Empowerment manual). Boston Consortium of Services for Families in Recovery, Public Health Commission, Boston, MA.

Contact Information: To obtain a manual and for more information, contact
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An Introduction to Trauma Issues for Women on Inpatient or Short-Stay Units

Description: 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.

Contact Information: To obtain a manual and for additional information visit www.ccdc1.org or contact
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Men's Trauma Recovery and Empowerment Model (M-TREM): A Clinician's Guide to Working with Male Trauma Survivors in Groups

Description: 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 shown promising results, based on the feedback of group leaders and participants. In an initial group of six participants, for example, 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. M-TREM is currently being examined in an NIMH-funded study designed, first, to revise and refine the treatment manual and, second, to conduct a small, randomized controlled trial of the group's effectiveness in reducing PTSD and other symptoms.

Contact Information: To obtain the manual, visit www.ccdc1.org or contact Kate Boucek, M.S.W.
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For information on training, call Rebecca Wolfson Berley, M.S.W., Director of Trauma Training
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Models for Developing Trauma-Informed Service Systems and Organizations: Children

Guide to Developing Trauma-Informed Service Systems and Organizations for Children				
Name of Model	Intended Audience	Type of Services	Intended Setting	Approach
<i>Child Adult Relationship Enhancement (CARE)</i>	Adults who interact with Children (preschool - adolescence)	Curriculum Guide, Training	Various settings	Group or Individual sessions
<i>Child Development Community Policing Program (CD-CP)</i>	Police; MH, Domestic Violence Advocacy, Child Protection, and Juvenile Justice professionals	Training, Books, Manual, DVD, Website: www.nccev.org	Various settings	
<i>Preventing Child Abuse Within Youth Serving Organizations: Getting Started on Policies and Procedures</i>	Adults who interact with Children (preschool - adolescence)	Manual	Various settings	
<i>Stewards of Children: Adults Protecting Children from Abuse</i>	Adults	Training, DVD, Workbook, Website: www.darknesstolight.org	Various settings	Instructor-led or Online format
<i>Trauma Informed Organizational Self Assessment</i>	Program Staff and Administrators	Self-Assessment instrument, Website: www.familyhomelessness.org		
<i>Trauma Systems Therapy (TST)</i>	Agencies and Organizations	Manual, Book, Training	Agencies and Organizations	

Key: MH – Mental Health; PSB – Problematic Sexual Behavior

Child Adult Relationship Enhancement (CARE)

Description: Child Adult Relationship Enhancement (CARE) is a trauma-informed, field-initiated modification of specific Parent-Child Interaction Therapy (PCIT) skills for general usage by adults who work with traumatized children. This promising intervention approach is based on PCIT, but it is a separate intervention that began developing collaboratively in 2004 by the Trauma Treatment Training Center (TTTC) and Cincinnati Children’s Hospital Medical Center with therapists and service providers in a variety of settings whom the TTTC had trained in PCIT. In response to feedback from the children and families they served, these therapists modified the standard PCIT model to serve special circumstances and culturally diverse clients. Using the

TTTC’s structured conference call and listserv platforms, these community providers then shared their successful adaptations of core PCIT components so that they could be incorporated into the developing CARE model. Thus, CARE reflects a collaborative co-creation between the TTTC and a range of agencies (i.e., battered women shelters, foster care agencies, residential care facilities, medical care settings, homeless shelters). As a result, CARE can be generalized to a wide variety of settings and implemented at different levels of intensity.

CARE utilizes the 3 P skills (Praise, Paraphrase and Point-out-Behavior) based on PCIT’s PRIDE skills: Praise, Reflect, Imitate, Describe and Enthusiasm, to connect with children, a set of techniques for giving children effective positive commands to increase

compliance, and selective ignoring techniques to redirect problematic behaviors. CARE also contains a trauma education component to contextualize the use of these skills with the kinds of behaviors and problems exhibited by many traumatized children. The basics of the CARE skills can be taught in about 3-6 hours in groups or individually. A CARE Curriculum Guide for Trainers is available to clinicians who have completed PCIT training.

CARE training is applicable for adults who interact with children from preschool through adolescence in a large range of settings. These settings include but are not limited to: 1) foster parents; 2) foster care caseworkers and child protection workers; 3) battered women shelter staff; 4) homeless shelter staff; 5) child victim advocates; 6) residential treatment center staff; 7) day care providers and Head Start teachers; 8) medical care providers; 9) partial hospitalization staff; 10) social service case aides; 11) home visitation providers; 12) international adoptions staff; 13) medical students; and 14) receptionists/other administrative staff who come in contact with children. The TTTC has had direct or indirect experience working with service providers in all of these populations/settings and has used this accumulated experience to shape the CARE Curriculum Guide.

Status of Research: CARE is supported by pragmatic evidence of its effectiveness with concepts derived from the evidence-based PCIT, but further evaluation is warranted.

Contact Information: Trauma Treatment Training Center, Cincinnati, OH
www.OhioCanDo4Kids.org
CARE trainers: Erica Pearl, PsyD, Barbara Boat, PhD, & Erna Olafson, PhD, PsyD

For questions about how to obtain CARE training:
Lacey Thieken, Mayerson Center for Safe & Healthy Children
Phone: 513.636.0042
Fax: 513.636.0204
Email: Lacey.Thieken@cchmc.org

Child Development Community Policing Program (CD-CP)

Description: The CD-CP Program is a collaborative partnership between police, mental health, domestic violence advocacy, child protection, and juvenile justice professionals. The program's mission is to decrease the negative psychological consequences of violence exposure on children and families. The CD-CP Program was developed in New Haven, Connecticut in 1991 by the Yale Child Study Center and the New Haven Department of Police Service. The program model includes the following components:

- Cross training for police, mental health clinicians and others in principles of child development and psychological response to trauma and principles and practice of community policing;
- Acute response service, which places trained clinicians and officers on-call 24/7 to provide immediate direct assessment and intervention for children and families exposed to or involved in violence or other potentially traumatic incidents;
- Weekly interdisciplinary program conference to develop, review and track case-specific intervention plans for children and families referred to the acute response service;
- Domestic Violence-Home Visit Intervention (DV-HVI) provides outreach home visits and follow-up advocacy by teams of patrol officers and domestic violence advocates to children and families affected by intimate partner violence;
- Trauma Clinic that provides services for acute response and treatment for children and families. This serves as a secondary prevention model for post-traumatic stress and long term treatment for the effects of traumatic stress. The Child and Family Traumatic Stress Intervention (CFTSI) has been developed and implemented with children and families within days or weeks of traumatic events to decrease post traumatic impact.

The following is a sample of available materials regarding the program:

- Marans, S., Adnopoz, J., Berkman, M., Esserman, D., MacDonald, D., Nagler, S., et al. (1995). The

police-mental health partnership: A community-based response to urban violence. New Haven: Yale University Press.

- Marans, S. Berkman, M. (2005). Police-mental health collaboration on behalf of children exposed to violence: The Child-Development Community Policing program model. In, *Handbook of Community-Based Clinical Practice*, Lightburn, A. & Sessions, P. (Eds.). Oxford University Press (USA).
 - CD-CP Program Manual
 - CD-CP Acute Response Protocol
 - Domestic Violence Home Visit Intervention (DV-HVI) Manual
 - One on One: Connecting Cops and Kids: DVD and Training Manual
 - Child and Family Traumatic Stress Intervention Manual
 - Guidelines for Parents and Professionals on Trauma and Catastrophic Events

Status of Research:

- An intensive CD-CP program evaluation in New Haven, CT and Charlotte, NC that examines changes in law enforcement practice and child and family functioning is underway.
- A 12 month longitudinal study comparing 50 women who received DV-HVI home visits with 50 others who received standard police services only found that, at baseline, intervention subjects felt safer and more positively toward the police than comparison subjects. At 6 month and 12 month follow-up interviews, intervention subjects were more likely to call the police for new domestic violence incidents than control subjects, but the new calls to the police were more likely to be for less serious, non-violent incidents. Intervention subjects were also more likely to be engaged in court based advocacy/legal services for themselves and mental health services for their children.
- A randomized evaluation of the Child and Family Traumatic Stress Intervention (CF-TSI) is currently in progress in the city of New Haven. Two hundred and fifty children who have experienced a traumatic event (e.g. motor vehicle accidents,

sexual abuse, domestic, community violence, etc) will be recruited within 4 weeks of the incident and randomly assigned to the CF-TSI or a treatment as usual comparison group. Parents and children will be interviewed at baseline, post-intervention and 3 months later to determine the effectiveness of the CF-TSI in reducing child symptoms and increasing parent-child communication and feelings of social support. To date 42 families have completed baseline interviews and been randomized and 15 families have completed 3 month follow-up.

Contact Information: For further information on Program Research contact: Dr. Carla Stover, Ph.D. carla.stover@yale.edu.

For more information about the program contact National Center for Children Exposed to Violence: Steven R. Marans, Ph.D., Director, and Professor of Child Psychiatry and Psychiatry
Phone: (203) 785-3377
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or Visit our Website:
www.ncccev.org

Preventing Child Abuse Within Youth Serving Organizations: Getting Started on Policies and Procedures

Description: In the first section, you will find six key components of child sexual abuse prevention for organizations. These components were identified by the Centers for Disease Control and Prevention (CDC) in conjunction with experts. The experts included advocates, child sexual abuse researchers, professionals who provide prevention resources for organizations, and representatives of youth-serving organizations that have child sexual abuse prevention programs.

1. Screening and selecting employees and volunteers
2. Guidelines on interactions between individuals
3. Monitoring behavior

4. Ensuring safe environments
5. Responding to inappropriate behavior, breaches in policy, and allegations and
6. suspicions of child sexual abuse
7. Training about child sexual abuse prevention.

Each component is described in detail, including the prevention goals, critical strategies, and additional strategies that could be considered depending on the context and resources of individual organizations.

The sections that follow offer suggestions for addressing challenges to developing and implementing a strategy to prevent child sexual abuse and provide tools to help organizations move forward. A list of publications and organizations that can provide helpful information is provided in Appendix B.

This report is designed for representatives of youth-serving organizations who are interested in adopting strategies to prevent child sexual abuse. Whether these strategies are developed within the context of an overall risk management plan or are addressed separately, organizations need to examine how they can protect youth from sexual abuse.

Status of research: No research to date

Contact Information: For information or questions about content -- Renee Wright, CDC
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Stewards of Children: Adults Protecting Children from Abuse

Description: Darkness to Light's *Stewards of Children* Prevention Program is a revolutionary sexual abuse prevention training program that educates adults to how to prevent, recognize, and react responsibly to child sexual abuse. The program addresses the trauma of child sexual abuse in a sensitive and empowering way, increasing the understanding of its impact on health, mental health and well being. Procedures to reduce the risk of re-victimization are also presented.

The 2.5 hour training program is based on Darkness to Light's "*7 Steps to Protecting Our Children*" as the core curriculum and interweaves the stories of adults with lived experiences of child sexual abuse with the advice of experts in the areas of prevention, intervention and law enforcement to emphasize and teach the 7 steps. The presentation of the survivor stories and outcomes are based on hope, self-determination and empowerment. Hearing the lived experiences of childhood sexual abuse trauma survivors often enables other survivors to come forward and consider treatment for the first time, although the focus is to teach adults the skills to protect children. The training is presented using a 1.25 hour training DVD/video and interactive workbook in a format that teaches specific tools and encourages discussion and participation in the development of a personal prevention plan. The curriculum also includes interactive discussions that can be customized for various audiences, organizations and settings.

The *Stewards of Children* program is designed for any adult who has responsibility for a child's safety, targeting parents, staff and volunteers of organizations, clubs, corporations and agencies that serve children and youth. The focus of the curriculum is primary prevention, accomplished by teaching adults how to prevent child sexual abuse from occurring the first time. For example, adults learn about the prevalence and consequences of sexual abuse and are encouraged to monitor situations where one-on-one contact between adults and children might occur, to screen adults who work with children, and to initiate conversation about healthy sexuality, appropriate physical contact and child sexual abuse prevention. The curriculum also addresses secondary prevention by teaching adults to identify when abuse has occurred, how to respond appropriately, as well as, the prevention of re-victimization. Prevention education occurs within the context of asking participants to think about the children for whom they are responsible and how they may be vulnerable to child sexual abuse, thus providing both the motivation and the empowerment to act.

The philosophy of the Stewards of Children curriculum is to change attitudes about child sexual abuse through the principles of choice, consciousness, personal power, and relentless compassion and to motivate individuals to act courageously and assertively toward child sexual abuse prevention. The

Stewards of Children curriculum is being used in numerous youth serving agencies, organizations and settings including child advocacy centers, family advocacy programs on military bases, prevention programs, faith-based, sports and recreational clubs and organizations, youth camps, educational settings (primary, secondary and higher education), foster care, treatment foster care, residential settings, early childhood education, child welfare, juvenile justice, as well as numerous other agency, non profit and intervention programs.

Steward of Children is made available through two formats, instructor led and online. In the instructor led format, a *Darkness to Light* trained facilitator is taught to lead group discussion that reinforces the learning objectives and addresses thoughts and feelings stimulated by the DVD and workbook. Facilitators have ongoing contact with *Darkness to Light* that includes updates in their training and support for initiatives in their communities including funding strategies and evaluation tools. They also have opportunities to learn about the development of child protection policies and practices for organizations. This resource enhances primary prevention in that facilitators not only train individuals in child sexual abuse prevention, but also equip organizations to create a culture where prevention efforts are supported.

The web-based version of *Stewards of Children* is available through the Darkness to Light website, www.darknesstolight.org. A web-based version of the interactive workbook is downloaded and participants are able to work at their own individual pace.

Additional assets are the structure and standardization of the Stewards of Children program. The curriculum incorporates basic principles of adult learning that includes delivery in visual, auditory and written modes to support different learning styles. The facilitated discussion of the instructor led format affords active participation in learning with the idea that personal engagement will lead to action. The workbook is written at an 8th grade reading level, making it broadly accessible to adults of all educational levels. The standardized training for facilitators ensures that facts about child sexual abuse are delivered accurately and prevention strategies are enacted in a climate that supports their effectiveness.

Status of Research: In an evaluation of the *Stewards of Children* program, nine organizations and nearly 500 individuals participated in a comparison of pre- and post-training evaluating the effectiveness of the *Stewards of Children* curriculum and the efficiency of the training format. Results showed a 38% improvement in both child sexual abuse knowledge and attitudes, changes that were maintained over two months. Participants also reported significant increases in preventive behaviors after training. Participants were more likely to:

- Discuss issues of sexual abuse with a child or another adult
- Pay attention to potential signs of sexual abuse
- Drop in unexpectedly to ensure that a child is safe in the care of another adult

The core curriculum, “7 Steps” of the *Stewards of Children* program has also undergone evaluation. In 2004, researchers with the College of Charleston completed a web-based study and found a significant increase in knowledge of child sexual abuse prevention after exposure to the “7 Steps” information. This finding suggests that the “7 Steps” effectively reached individuals with varying degrees of knowledge regarding child sexual abuse, and then brought all groups to the same performance level.

The efficacy of the “7 Steps” web-based versus print version was also evaluated in 2005. The study used two separate Solomon 4 Group Research Designs to test the effectiveness of the web-based and the print version of the prevention materials. In addition to comparing the efficacy of each version against a control group, the research design afforded comparison of the web-based and print versions of the prevention information. The results established that regardless of presentation format, exposure to 7 Steps has a significant impact on knowledge and attitudes about sexual abuse and its prevention. This finding has particular interest for the web-based Stewards of Children program.

Contact Information: To obtain additional information: Pat Patrick, LISW
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www.darknesstolight.org

Trauma Informed Organizational Self Assessment

Description: Developed by the National Center on Family Homelessness (NCFH), the Trauma-Informed Organizational Self-Assessment was designed to provide programs with concrete guidelines for how to modify their practices and policies to ensure that they are responding appropriately to the needs of clients who have experienced traumatic stress. The Self-Assessment is divided into five categories that should be closely examined when creating a trauma-informed program. These categories include: Supporting Staff Development, Creating a Safe and Supportive Environment, Assessing and Planning Services, Involving Consumers, and Adapting Policies. Specific practices have been identified within each of these categories that are necessary to the creation of a trauma-informed program. The Trauma-Informed Organizational Self-Assessment is designed to help programs evaluate their practices, identify strengths and challenges, and based on their findings, develop a strategic plan for increasing their capacity to provide trauma-informed services.

The Trauma-Informed Organizational Self-Assessment is accompanied by a User's Guide that has been created to assist programs in utilizing the Self-Assessment. The User's Guide contains information about the relationship between trauma and homelessness; the nature of trauma-informed care; the content, development and implementation of the items in the Self-Assessment; and a detailed description of the five domains and examples of how to provide trauma-informed care within each domain. The User's Guide is designed to be used in conjunction with the Self-Assessment. Together, the Trauma-Informed Organizational Self-Assessment and User's Guide constitute the Trauma-Informed Organizational Toolkit.

The Trauma-Informed Organizational Self-Assessment was developed by the National Center on Family Homelessness with the help of experts in the fields of homelessness and trauma, consumers, and Boston area homeless service providers. During the second year in the development of the Self-Assessment, NCFH further refined the tool by, 1) piloting the Self-Assessment in nine Massachusetts area shelters; 2) adding a response scale; 3) revising

the items and format; 4) evaluating the process and using the piloting experience to clarify the items and shorten the Self-Assessment; and 5) creating a User's Guide that corresponds to the newly refined Self-Assessment and more fully describes the implementation process. During the third year in the development of the Trauma-Informed Organizational Self-Assessment, NCFH piloted the Self-Assessment in three national programs serving families experiencing homelessness. NCFH used this piloting to make final revisions to the Self-Assessment format, response scales, and items. Based on this national piloting, NCFH was able to identify concrete strategies and practices that programs can incorporate to begin to create trauma-informed organizational change.

Status of Research: The initial development of the Trauma-Informed Organizational Self-Assessment involved the creation of Self-Assessment items by experts in the fields of homelessness and trauma, along with refinement of the tool based on feedback gathered from focus groups with shelter providers.

In year two of its development, 87 staff members in nine Massachusetts area shelters used the tool to examine their systems and evaluate the extent to which they incorporated trauma-informed practices into their programs. Shelter staff members completed the Self-Assessment twice in order for NCFH to analyze the reliability of the measure. After completing the Self-Assessment tool, five area shelters agreed to form multi-disciplinary trauma workgroups to work to mobilize systemic changes. NCFH facilitated this process, and assessed training needs. After 4 months of consultation with NCFH, using the Self-Assessment as a guide for creating change, sites completed the Self-Assessment and differences between pre and post-test responses were analyzed.

In year three of its development, three national programs serving families experiencing homelessness used the Self-Assessment to examine their daily practices and policies and evaluate their strengths and challenges to providing trauma-informed care. NCFH facilitated this process, providing initial trauma education and training and 7-8 months follow-up consultation after the initial assessment. Program administrators and staff members used the Trauma-Informed Organizational Self-Assessment to guide their strategic planning towards becoming more

trauma-informed.. At the end of the project year, programs were able to identify concrete changes in their daily practice as well as attitudinal and cultural shifts within the broader organization.

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Trauma Systems Therapy (TST)

Description: Trauma Systems Therapy (TST) was developed to help agencies and organizations effectively work with traumatized children and their families. This treatment model aims to assist agencies and organizations develop specific and integrated treatment plans for these children and families through the integration of 4 service elements considered critical for providing effective care. These service elements are 1) skill-based psychotherapy, 2) home and community based preventative care, 3) psychopharmacology, and 4) advocacy. TST specifies how these services should be integrated and operationalizes the activities that should occur within each respective service element. TST also includes recommendations on organizational process related to supporting and integrating these 4 service elements. This model is meant to be adapted by organizations based on the services they are already providing and receiving reimbursement for via third party payment. The TST organizational process facilitates an organizations ability to leverage existing programs and resources and forming partnerships with other organizations that may already be providing 'missing' service elements. The aim of this process is an organizations ability to support a well trained and functioning TST team that includes the aforementioned 4 service elements of TST. This team may include members from different organizations based on how services are organized and reimbursed in a given county or state. This team is trained to develop and implement integrated treatment plans for traumatized children and families with fidelity to the TST model.

TST includes a formalized and specific assessment and treatment planning process. All children with traumatic stress are believed to have problems that relate to 2 main factors 1) the inability to regulate

emotional and behavioral states when confronted with a stressor (that usually consciously or unconsciously reminds the child of the traumatic event or events), 2) the inability of the child's social environment and system of care to sufficiently help him or her regulate these emotional states. The assessment, treatment planning, and treatment implementation process has a high degree of focus on these two main factors. TST also assumes that, to be effective, trauma-oriented services must be family-focused, strength-based, and well-integrated with systems of care. Services must also be specific, integrated with, operationalized and delivered close to the source of the problem (e.g. home, school, neighborhood, etc.).

TST is fully manualized and was published in book form in 2006 (Saxe, Ellis, & Kaplow, 2006).

Status of Research: TST has been fully developed, manualized and can be delivered with fidelity. The results of an open trial of 110 families comprising a cohort of children from inner city Boston and another from rural New York state have been published (Saxe, Ellis, Fogler, Hansen, & Sorkin, 2005). These families were enrolled in TST and assessed 3 months later. These children were largely multiply traumatized and managing significant environmental stressors such as poverty, risk of homelessness, and parental mental illness and substance abuse. While almost 60% of families needed more intensive home and community-based care at the beginning of treatment, only 39% of families needed this level of treatment after 3 months. A recent, not yet published follow up study shows that at 15-months after enrollment in treatment these gains persist and even improve. Unpublished data from a pilot randomized controlled study of TST vs. treatment as usual in an inner city sample of traumatized children show that three months following enrollment in treatment 90% of families receiving TST were still in treatment whereas only 10% of the treatment as usual families were still in treatment. This finding suggests that TST is very effective at engagement, and highlights the importance of 1) family engagement and 2) integration of care within the existing services system.

TST is currently being adapted for this age group.

Saxe, G., Ellis, B. H., & Kaplow, J. (2006). *Collaborative Care of Traumatized Children and Teens: The Trauma*

Systems Therapy Approach. New York, NY: Guilford Press.

Saxe, G. N., Ellis, B. H., Fogler, J., Hansen, S., & Sorkin, B. (2005). Comprehensive care for traumatized children: An open trial examines Trauma Systems Therapy. *Psychiatric Annals*, 35(5), 443-447.

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Trauma-Specific Models for Parenting

Guide to Trauma-Specific Models for Parenting				
Name of Model	Intended Audience	Type of Services	Intended Setting	Approach
<i>Impact of Early Trauma on Parenting Roles</i>	Women actively parenting young children.	Manual, Website: www.cdc1.org	MH, SA	Group sessions
<i>Nurturing Program for Families in Substance Abuse Treatment and Recovery, 2nd edition</i>	Parents, women, and children in recovery	Curriculum, Manual, Training, Consultation	Inpatient, Outpatient, and Community-based service agencies	Group sessions
<i>Parenting at a Distance</i>	Women involved in Partial Parenting	Manual, Website: www.cdc1.org	MH, SA	Group sessions
<i>Pathways to Family Reunification and Recovery (Caminos Para la Reunificacion y la Recuperacion): An Educational Group Curriculum for Women in Recovery</i>	Women	Manual/Curriculum (English & Spanish)		Group sessions
<i>Strengthening Multi-Ethnic Families and Communities: A Violence Prevention Parent Training Program</i>	Parents of children (ages 3-18)	Curriculum, Training, Website: www.parentingacrosscultures.com	Various settings	

Impact of Early Trauma on Parenting Roles

Description: 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.

Contact Information: To obtain the manual *Non-Traditional Parenting Interventions*, which contains this group intervention, contact: Kate Boucek, M.S.W., 202-608-4784 or kboucek@ccdc1.org

For information on training or consultation, call Rebecca Wolfson Berley, M.S.W., Director of Trauma Training 202-608-4735 or rvolfson@ccdc1.org
Or visit website at: www.cdc1.org

Nurturing Program for Families in Substance Abuse Treatment and Recovery, 2nd edition

Description: This is a parenting curriculum offered in groups for women and children in recovery from substance use disorders, 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 by the Institute for Health and Recovery, this 2nd edition of the original Nurturing Program curriculum builds upon lessons learned through the Women Embracing Life and Living (WELL) Project - one of nine SAMHSA Women, Co-Occurring Disorder and Violence Study sites. Adaptations include additional information about the needs of families affected by mental illness and trauma, in addition to substance use disorders. IHR's original Nurturing Program was recognized by the Center for Substance Abuse Prevention as a model program for best practices in strengthening families.

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. The curriculum consists of 17, 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.

The curriculum is intended to enhance coping strategies through concept presentations, practice sessions, role-plays, and activities. Each session covers a different topic including hope; growth and trust; families and substance use; feelings; self-esteem; family communication; confrontation and problem solving; body talk; what babies teach us; managing stress; setting boundaries; schedules and routines; safety and protecting children; guiding behavior; knowing our values; love and loss; and having fun.

Groups of 8 - 12 participants are implemented in a variety of settings including inpatient, outpatient, and community-based service agencies. Participants may join at any time throughout the series.

Status of Research: A demonstration project measured the impact of implementing the original Nurturing Program in two urban residential treatment programs in Massachusetts for pregnant and parenting chemically-dependent women. Women in both programs made dramatic improvements in self-esteem and experienced significant gains in parenting knowledge and attitudes. Participants were also overwhelmingly positive about the impact of the parenting training on their lives. A number of other studies have been done around the country that have shown positive outcomes from using the Nurturing Program, including in California, Rhode Island, Florida, and Massachusetts. In addition, the original Nurturing Program is listed on the California Evidence-Based Clearinghouse for Child Welfare, an on-line connection that provides up-to-date information on evidence-based child welfare practices.

Contact Information: To obtain the manual Nurturing Program for Families in Substance Abuse Treatment and Recovery, to obtain published articles about the original curriculum, or for information on training and consultation, contact

Marissa Daley
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www.healthrecovery.org

Parenting at a Distance

Description: 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. The group also addresses concerns related to the loss of custody or death of children.

Status of Research: No research to date.

Contact Information: To obtain the manual *Non-Traditional Parenting Interventions*, which contains this group intervention, contact:
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kboucek@ccdc1.org
www.ccdc1.org

For information on training or consultation, contact
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Director of Trauma Training
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Pathways to Family Reunification and Recovery (Caminos Para la Reunificación y la Recuperación): An educational group curriculum for women in recovery

Description: 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 (Amaro & Nieves, 2004). 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.’

Four published papers present findings showing race/ethnic differences in clinical profiles and services needs and that women in the intervention stay in treatment longer and at follow-up have lower sexual HIV risk behaviors, and lower rates of drug use and mental health and trauma symptoms than those in the comparison condition (Amaro, Gampbel, Larson, Lopez, Richardson, Savage, & Wagner, 2005; Amaro, Larson, Zhang, Acevedo, & Matsumoto, 2007; Amaro, Chernoff, Brown, Arévalo, & Gatz, 2007; Amaro, Dai, Arévalo, Acevedo, Matsumoto and Nieves, 2007).

Amaro, H and Nieves, RL. (2004). *Pathways to Family Reunification and Recovery: An educational group curriculum for women in recovery*. Boston Consortium of Services for Families in Recovery, Public Health Commission, Boston, MA.

Amaro, H., Gampbel, J., Larson, M.J., Lopez, L., Richardson, R., Savage, A., & Wagner, D. (2005). Racial/Ethnic Differences in Social Vulnerability among Women with Co-occurring Mental Health and Substance Abuse Disorders: Implications for Treatment Services. *Journal of Community Psychology*, 33(4), 495-511.

Amaro, H., Larson, M. J., Zhang, A., Acevedo, D., Dai, J., & Matsumoto, A. (2007). Effects of trauma intervention on HIV sexual risk behaviors among women with co-occurring disorders in substance abuse treatment. *Journal of Community Psychology*, 35(7), 895-908.

Amaro, H., Chernoff, M., Brown, V., Arévalo, S., & Gatz, M. (2007). Does integrated trauma-informed substance abuse treatment increase treatment retention? *Journal of Community Psychology*, 35(7), 845-862.

Amaro, H., Dai, J., Arevalo, S., Acevedo, A., Matsumoto, A., & Nieves, R. (2007). Effects of integrated trauma treatment on outcomes in a racially/ethnically diverse sample of women in urban community-based substance abuse treatment. *Journal of Urban Health*, 84(4), 508-522.

Contact Information: To obtain the curriculum and for further information, contact Dr. Hortensia Amaro h.amaro@neu.edu

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

Description: This program was developed by Marilyn Steele, Ph.D. (Child Clinical Psychologist) in collaboration with Marilyn Marigna (community focus); Jerry Tello (cultural focus), and Ronald Johnson (youth focus), and is a prevention-intervention parent training program for parents with children between 3 and 18 years that addresses violence against the self (drugs/alcohol, depression/suicide), violence in the family (child abuse, domestic violence), and violence against the community (juvenile delinquency, crime, gangs). The curriculum is structured into an Orientation and 12 weekly 3-hour sessions, provides for two community speaker sessions, and integrates anger management and developmental information in five component areas: Cultural/Spiritual Focus; Rites of Passage; Positive Discipline; Enhancing Relationships, and Community Involvement. This strength-based program emphasizes the importance of spiritual / cultural / family values, and utilizes a “facilitative-discussion” format to enhance parent competence, parent/child interactions, child competence, parent relationships and community involvement. All facilitators must attend a Five-Day Training Workshop.

The program has been used successfully in the US, England, Australia and Ireland with high-risk and hard-to-reach groups, including teen parents, foster parents, court-ordered parents (child abuse, substance abuse, domestic violence), parents of troubled youth, parents of teens, grandparents, fathers, parents of children with developmental challenges, gay parents, single parents, parents in prison, parents with refugee status, and parents who do not read/write or speak English. It has also been used in the wider community in schools (all levels), churches, and with parents whose children are 0-5 years. Parent materials have been translated into Arabic, Bengali, Bosnian-Serbo Croatian, Chinese, Farsi, African-Based French, Hmong, Korean, Laotian, Russian, Samoan, Somali, Spanish, Turkish, Urdu, and Vietnamese. By the end of 2007, the number of translations will increase with the additions of Gujerati, Polish, Punjai, Simplified Chinese, Dinka, and Hazaragi.

Status of Research: The program contains a built-in 32-item Parent Pre/Post Evaluation Process. The results of over 3,000 parent pre/post questionnaires were analyzed and documented in *The Monograph: Parenting Styles and Program Impact, Consulting and Clinical Services, 2002*. The program significantly enhanced parent competence in managing child behavior, expression and management of emotions, and access/utilization of community resources, as well as their perception of their children's self-esteem, self-discipline, and problem-solving skills. Parents reported that the program also enhanced family bonding, community bonding, and pride in cultural heritage. Although analyses revealed interaction effects for individual groups, the program significantly impacted parent attitudes and behaviors, regardless of sex, marital status, ethnic background, level of education, risk factors or child age group.

The *Strengthening Families and Communities Program* was selected by 30% (2000) and 50% (2001) of the communities receiving funding under SAMHSA's Strengthening Families Initiative. In a report dated *January 2004: Content Analysis of Family Strengthening Final Reports (Cohort I)*, F. Belgrave, D. Brome, Gears, Inc., consultation by Center for Substance Abuse Prevention & McFarland and Associates, SAMHSA concluded that the *Strengthening Multi-Ethnic Families and Communities*

Program, as compared to other parent training programs, was particularly suited to meeting community high-risk issues, the program was implemented with good fidelity, and grantees made fewer cultural and structural modifications, reporting that the curriculum was already well suited to meeting the needs of their families.

The curriculum's ability to significantly impact six protective factors for 71 women in a home for recovering single mothers is documented in an article published in *The Source, Volume 12, No.2; National Abandoned Infants Assistance Resource Center*. A research article entitled "Empowering High-Risk Families of Children with Disabilities," *Research on Social Work Practice, Vol. 15, No.6, November 2005, 501-515; M. Farber, Lt. Joseph P. Kennedy Institute, Washington DC*, concluded that the curriculum was able to meet the needs of high-risk African American families rearing children with development delays, and that all outcomes evidenced statistically significant and practically meaningful positive trends. A recent evaluation (July 2007) of 82 parent classes in the United Kingdom (2004-2005) concluded that the Program had a positive impact on the participants and the children, and to some extent the wider family/community. Three-fourths (75%) of the participants were of minority ethnic origin, reporting a total of 89 different ethnicities, and almost half (46%) had a first language other than English. Evaluations are currently being conducted for the projects in Australia and Ireland.

Program Materials are only available to individuals/organizations that have trained facilitators to implement the program.

Contact Information: For more information contact Dr. Marilyn Steele, Ph.D.
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Trauma-Specific Service Models for Children and Family/Parents/Caregivers

Guide to Trauma-Specific Service Models for Children and Family/Parents/Caregivers				
Name of Model	Intended Audience	Type of Services	Intended Setting	Approach
<i>Alternatives for Families – A Cognitive-Behavioral Therapy (AF-CBT), formerly known as, Abuse-Focused Cognitive Behavioral Therapy for Child Physical Abuse</i>	Children/Adolescents (5-16), and their Caregivers/Families	Book, Manual and Workbook, Training, Consultation, Community partner orientation, Websites: www.nctsn.org ; www.partnershipsforfamilies.org	Outpatient, In-home, and Inpatient settings	Individual, Parent-Child and Family sessions
<i>Attachment, Self-Regulation and Competency (ARC): A Comprehensive Framework for Intervention with Complexly Traumatized Youth</i>	Children, Adolescents, and their Caregivers and Families	Manual, Website: www.traumacenter.org	Various settings	Menu-based approach
<i>Child-Parent Psychotherapy (CPP)</i>	Children (ages 0-6) and their Parents	Manual, Training, Consultation	Various settings	
<i>Combined Parent Child Cognitive-Behavioral Approach for Children and Families At-Risk for Child Physical Abuse (CPC-CBT)</i>	Children (ages 3-18) and their Caregivers			Group, Individual & Family sessions
<i>International Family Adult and Child Enhancement Services (IFACES)</i>	Refugee Children and Adolescents	Case management services	Various settings	
<i>Parent-Child Interaction Therapy (PCIT)</i>	Children (ages 2-7) and their Parents	PCIT manual, Coding manual, Workbooks, Website: www.PCIT.org	Various settings	
<i>Safety, Mentoring, Advocacy, Recovery, and Treatment (SMART)</i>	Sexually abused children under the age of 11 exhibiting problematic sexual behavior (PSB)	Manual, Workbook, Training, Consultation	Various Settings	Individual, Family and Group sessions
<i>Trauma Focused Cognitive Behavioral Therapy (TF-CBT) for Children and Their Parents, Cognitive Behavioral Therapy for Childhood Traumatic Grief (CBT-CTG), Combined TF-CBT and Sertraline for Children</i>	Children and Youth (ages 3-18) and their Parents	Manual (English, Dutch & German, in process of translating into Mandarin, Korean, & Japanese), Book, Training, Child and parent workbooks, Website: www.musc.edu/tfcbt	Outpatient, Residential, Home, Foster Home, and School settings	Individual, Family or Group sessions
<i>Trauma Systems Therapy</i>	Agencies and Organizations	Manual	Agencies and Organizations	

Key: MH – Mental Health; SA – Substance Abuse

Alternatives for Families - A Cognitive-Behavioral Therapy (AF-CBT) **[formerly, Abuse-Focused Cognitive Behavioral Therapy]**

Description: AF-CBT was developed by David J. Kolko, Ph.D., and updated, in collaboration with Amy D. Herschell, Ph.D., Barbara L. Baumann, Ph.D., and Meghan Shaver, M.S.W., to help children, parents and other caregivers involved in child physical abuse or exposed to related circumstances involving physical force (e.g., excessive physical discipline or punishment, hostile interactions, chronic family conflict or coercion). Alternatives for Families - A Cognitive-Behavioral Therapy (AF-CBT), formerly known as Abuse-Focused Cognitive Behavioral Therapy, has been renamed to more clearly reflect its focus on skills training in prosocial intrapersonal and interpersonal skills with both children and their caregivers or families. These skills provide families with specific alternatives to the use of physical force, coercion, and related maladaptive interaction patterns. This name change has also been made because the term “abuse” applies to a minority of the families who are referred for AF-CBT and, even if applicable, may create treatment engagement obstacles by accentuating client defensiveness and self-perceptions of being stigmatized.

With its integration of interventions for caregivers and their children, AF-CBT seeks to reduce caregiver and family risk factors for physically abusive and coercive behavior and to ameliorate the consequences of these experiences for children, at both the individual and family-context levels. Children who have been exposed to physical abuse or coercion may experience significant psychiatric, behavioral, and adjustment problems, many of which may persist through adolescence and young adulthood, and they are at risk for re-abuse. Appropriate candidates for AF-CBT include caregivers who rely upon the use of physical force with their children, children and adolescents who exhibit externalizing behavior problems (e.g., aggressive behavior) and limited social competence, and families whose interactions appear hostile, coercive, and volatile.

AF-CBT incorporates several behavioral and cognitive-behavioral methods that have been described and examined for use with physically

abusive or at-risk families by several investigators over the past few decades. The approach draws from some complementary conceptual models, including behavioral and learning theory, cognitive therapy, family-systems therapy, and developmental victimology. AF-CBT emphasizes training in both intrapersonal and interpersonal skills designed to enhance self-control, promote positive family relations, and reduce violent behavior. The primary techniques or treatment modules include the processing of abusive and coercive incidents, clarification, affect regulation, cognitive restructuring, effective behavior management, social skills training, and training in problem-solving and communication skills. Common treatment goals include reducing a caregiver’s level of anger and use of force, promoting non-aggressive (alternative) discipline strategies, minimizing views or attributions that support physical violence, enhancing coping skills, and encouraging prosocial parent-child interactions. With its integration of both individual and joint sessions, AF-CBT is suitable for application by trained practitioners in individual, parent-child, or family sessions across diverse outpatient, home/foster home, and inpatient settings. The treatment manual (session guide), workbook (worksheets, handouts), training examples (role-plays), and program monitoring forms (outcome measures) are integrated in a structured approach designed to enhance accessibility to practitioners and supervisors.

Status of Research: Over the past three decades, many of the key procedures incorporated in AF-CBT have been found effective by other investigators in improving child, parent, and/or family functioning, and reducing abuse risk or re-abuse among diverse populations of parents, children, and families. In a clinical trial that examined both clinical and child welfare outcomes through 1-year follow-up, the two main interventions that have now been integrated in AF-CBT (i.e., individual child and parent CBT, family therapy) were evaluated separately and compared to a condition representing usual care (i.e., cases receiving routine services in other community agencies). Weekly ratings of parents’ use of physical discipline and force, and their level of anger problems, during treatment decreased for the two AF-CBT interventions, but the decline was significantly faster for individual CBT than for family therapy (Kolko, 1996a). Compared to routine community services, the

individual CBT and family therapy interventions were associated with significantly greater improvements in child (e.g., less child-to-parent aggression, fewer child externalizing behaviors), caregiver (e.g., decreased child abuse potential, improvement in individual treatment targets reflecting abusive behavior, less psychological distress), and family clinical outcomes (e.g., less conflict and more cohesion), which were generally maintained at one-year follow-up (Kolko, 1996b). Official records revealed short-term abuse recidivism rates of 5% and 6% for the individual CBT and family therapy conditions, respectively, and 30% for those receiving routine services. Both CBT and family therapy had high rates of treatment fidelity, session attendance, and consumer satisfaction.

Much of the material on AF-CBT is found in the book "Assessing and Treating Child Physical Abuse in Children and their Families: A Cognitive-Behavioral Approach" (Kolko, D. J., & Swenson, C. C.), which is available from Sage Publications at www.Sagepub.com or www.amazon.com. Practitioner materials include a manual (session guide), accompanying workbook (handouts/worksheets), implementation guide, and orientation and community partner brochures. The materials are being used on a local, national, and international basis with clients from diverse ethnic, racial, and socioeconomic backgrounds. AF-CBT is currently being examined in a federally-funded randomized treatment effectiveness trial being conducted across several types of community agencies, services, and programs that will evaluate outcomes related to practitioner implementation and child welfare/family health status (NIMH Grant 074737) and a mentored scientist award (NIMH Grant 074716) that will refine and evaluate innovative methods to implement and sustain AF-CBT in community practice. Information about this study and its use of AF-CBT is available from: www.partnershipsforfamilies.org.

Contact Information: General information about AF-CBT is available from the National Child Traumatic Stress Network (www.nctsn.org).

Information about training in AF-CBT and additional resources for disseminating or implementing the model are available from: David J. Kolko, Ph.D., kolkodj@upmc.edu

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Attachment, Self-Regulation, and Competency (ARC): A Comprehensive Framework for Intervention with Complexly Traumatized Youth

Description: ARC is a framework for intervention with youth and families who have experienced multiple and/or prolonged traumatic stress. ARC identifies three core domains that are frequently impacted among traumatized youth, and which are relevant to future resiliency. ARC provides a theoretical framework, core principles of intervention, and a guiding structure for providers working with these children and their caregivers.

Within the three core domains (attachment, self-regulation, and competency), ten building blocks of trauma-informed treatment and service are identified. ARC is a menu-based approach. For each building block or guiding principle, the ARC manual provides key concepts and guiding theoretical structure, educational information for providers and caregivers, specific tools for clinicians, and developmental considerations.

The ten building blocks include the following:

<u>Attachment</u>	<u>Self-Regulation</u>	<u>Competency</u>
Caregiver Affect Management	Affect Identification	Developmental Tasks
Attunement	Affect Modulation	Executive Functions
Consistent Response	Affect Expression	Self Development
Routine and Rituals		

The intervention is detailed in a manual by Kinniburgh and Blaustein (2005) and available at www.traumacenter.org.

ARC was designed to be an adaptable treatment framework in order to allow for individualized treatment approaches that are based on a comprehensive assessment of developmental strengths

and deficits within a given familial and cultural context. This approach allows for implementation and application across the multitude of service settings in which these youth present. To date, ARC has been used with a range of populations (including pre-/post-adoptive, internationally adopted, urban high-risk, Native Alaskan, juvenile justice-involved, child-welfare involved, and war refugee youth), in a range of settings (including outpatient, community mental health, residential treatment, secure facility, domestic violence shelter, and hospital settings), and age groups (ap. age 5 through late adolescent, and their caregiving systems).

Status of Research: ARC is in the pilot stages of evaluation. Formal evaluation (pre-/post-assessment/program evaluation) is being done at all sites currently using ARC. Experimental research has not yet been done, but comparison data is being collected at one site (treatment-as-usual comparison group); this data has not yet been analyzed.

Preliminary data from a pilot study with adoptive children treated in an outpatient setting indicates that ARC leads to reduction in child posttraumatic stress symptoms, anxiety, and depression, as well as increased adaptive and social skills. Caregivers report reduced distress and view their children's behaviors as less dysfunctional.

Kinniburgh & Blaustein (2005)

Contact Information: To obtain materials and acquire additional information, contact:

Kristine M. Kinniburgh, LICSW

Margaret E. Blaustein, Ph.D.

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Main Trauma Center Page: www.traumacenter.org

ARC Information Page:

<http://www.traumacenter.org/research/ascot.php>

Child-Parent Psychotherapy (CPP)

Description: CPP is an evidence-based treatment for children aged 0-6 who have experienced a range of traumatic stressors, including chronic exposure to family and community violence. The model incorporates a focus

on trauma experienced by the parent, the child, or both. It examines how the trauma and the parents' relational history affect the parent-child relationship and the child's developmental trajectory. A central guiding goal is to support and strengthen the parent-child relationship as a vehicle for establishing and protecting the child's mental health. Treatment also focuses on contextual factors that may affect the parent-child relationship (e.g. culture and socioeconomic and immigration related stressors). Targets of the intervention include parents' and children's maladaptive representations of themselves and each other and interactions and behaviors that interfere with the child's mental health. Over the course of treatment, parent and child are guided to create a joint narrative of the traumatic event, identify and address traumatic triggers that generate dysregulated behaviors and reinforce mutual traumatic expectations, and place the traumatic experience in perspective. The treatment is detailed in the published manual by Alicia F. Lieberman, Ph.D. and Patricia Van Horn, J.D., Ph.D. titled *Don't hit my mommy: A manual for Child-parent Psychotherapy with young witnesses of family violence*. Information regarding conducting CPP with children who have experienced the traumatic loss of a loved one is provided in *Losing a parent to death in the early years: Guidelines for the treatment of traumatic bereavement in infancy and early childhood*. Another book by Lieberman and Van Horn, *Psychotherapy with infants and young children: Repairing the effects of stress and trauma on early attachment*, presents the theoretical rationale for intervention with young children and their caregivers when their relationships are challenged by life circumstances ranging from brief perturbations to post-trauma responses.

As noted above, CPP was designed for children aged 0-6 and their caregivers. The model was originally developed as a home visiting model but can and has been implemented in clinic and school settings as well as in a variety of other settings, such as playgrounds and hospitals. The basic theoretical principals have been found effective with diverse groups. The model has been used with a wide range of ethnic minority groups including Spanish and English speaking Latinos (Mexican, Central, and South Americans), African Americans, and Asians (predominantly Chinese). Additional information about the use of CPP with culturally diverse families can be found at http://www.nctsn.org/nctsn_assets/pdfs/promising_practices/ CPP_Culture%207-13-07.pdf.

Status of Research: Five randomized controlled trials (RCT's) detailed in 7 published studies support the efficacy of CPP with infants, toddlers, and preschoolers. Three of these trials were conducted with trauma-exposed children. These studies support the use of CPP with young children with documented histories of maltreatment and exposure to domestic violence. They also suggest that CPP is efficacious for parents and children who have experienced multiple, chronic traumas. In these studies, CPP was found to be efficacious in terms of reducing child and caregiver general symptoms and PTSD symptoms, strengthening the child-parent attachment relationship, and improving children's representations of themselves, their parents, and their relationships. One study involving a 6-month longitudinal follow-up shows that improvements in child and caregiver symptoms continue after the end of treatment.

Of note, of the five CPP RCT's, four were conducted with predominantly ethnic minorities. CPP is often conducted with Spanish speaking immigrants. One RCT involving 100 Spanish speaking Latina immigrant mothers whose children were anxiously attached found positive treatment effects even in this multiply stressed population.

Contact Information: For information on CPP and training and consultation in this model, contact Chandra Ghosh Ippen, Ph.D., Child Trauma Research Project
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Combined Parent-Child Cognitive Behavioral Therapy: Empowering Families At-Risk for Physical Abuse to Develop Healthy Outlooks and Positive Environments

Description: Combined Parent-Child Cognitive-Behavioral Treatment (CBT), which was developed by Treatment Services Director Melissa K. Runyon, PhD, in collaboration with Esther Deblinger, PhD, at the Institute, is an evidence-based treatment model that aims to empower parents to effectively parent their children in a non-coercive manner, improve parent-child relationships, assist children in healing from their abusive experiences, and enhance the safety of family members. This model helps to reduce the risk of the

recurrence of child physical abuse in children and families at-risk for child physical abuse. The model incorporates elements from TF-CBT model for sexually abused children, which was co-developed by the Institute's Clinical Director Esther Deblinger, PhD, and other CBT models targeting families in which physical abuse and domestic violence occurs.

The program offers both group and individual therapy to children, ages three to 18, and their caregivers. The group therapy program is time-limited and consists of 16-two hour sessions which involve meeting with both parents and children separately and together. The individual therapy program consists of 90 minute sessions which involve meeting separately with both the parent and child, as well as family meetings. The length of therapy may exceed 16 sessions if necessary.

The treatment consists of three components:

1. Child Intervention
2. Parent Intervention
3. Parent-Child Intervention

Parent and child interventions are conducted concurrently for the first hour of each session, while the end of the session involves integrated joint parent-child therapy. Over the course of group sessions, more time is devoted to the joint parent-child sessions during which families receive individual attention from a consistent coach.

Some of the topics covered in the structured therapy sessions include:

- Providing parents with information concerning emotional and behavioral effects on children of severe corporal punishment and child physical abuse
- Providing education about realistic expectations for children's behavior based on developmental level
- Empowering parents to be effective by working collaboratively with them to develop adaptive coping skills, non-violent conflict resolution skills and a variety of child behavior management skills
- Teaching children a variety of positive coping skills (i.e., identification and expression of feelings,

cognitive coping, assertiveness and anger management)

- Enhancing safety and communication in the family by developing a safety plan and discussing and processing past abusive interactions

Status of Research: For information, contact Melissa K. Runyon, Ph.D.

Contact Information: Melissa K. Runyon, Ph.D., Associate Professor of Psychiatry
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International Family Adult and Child Enhancement Services (IFACES): A Comprehensive Service Model for Refugee Children

Description: Established in 1999, International Family, Adult and Child Enhancement Services (FACES), a community-based mental health program of the Heartland Alliance for Human Needs & Human Rights, provides comprehensive services to children, adolescents, and their families from a variety of countries. The program provides culturally informed multidisciplinary services in both the office and community settings when indicated. The outreach-oriented services model has evolved as a result of staff efforts to create a program that can be culturally sensitive and creative around overcoming obstacles to providing services for refugees from a variety of different cultural and linguistic backgrounds. Like ACT and mental health work with people who are homeless, the FACES team provides case management services, tending to basic survival needs and adjustment challenges, often prior to beginning more traditional mental health services. Case management activities build trust between the program participant and staff and allow for assessment and engagement into mental health services at the same time.

The team is not only multidisciplinary, but also multi ethnic. Ethnic mental health workers have themselves come to the U.S. as refugees, and are a critical link to the refugee communities, able to conduct outreach, and work in partnership with clinical staff as both interpreters and cultural brokers. The ethnic mental health workers during the time of the study were Congolese, Kosovar, Togolese, Algerian, Bosnian, and Ethiopian, and spoke the following languages: Albanian, Amharic, Arabic, Berber, Bosnian,

French, Kurdish, Lingala, Oromo, Swahili, and Tigrinya. In addition to English, clinical staff also spoke Spanish, Russian, and Ukrainian. As a result, in all, FACES staff spoke 15 different languages among them during the time of the study. Although not every ethnicity and language is covered by the team, a concern with culture is at the forefront of the work. If a child being served speaks a language not represented within the team, a trained health care interpreter provided by the agency's Cross Cultural Interpreting Service serves in a similar capacity as the FACES ethnic mental health worker.

FACES services are provided to program participants at locations that are most comfortable and convenient for them, including at home, in the community, or at school. This helps to reduce the stigma associated with seeking services at a mental health clinic, and allows staff to observe and intervene in children's natural settings. Consultation with other providers, such as teachers, and advocacy with other service systems is also seen as an important component of the mental health service.

Status of Research: For information contact Dr. Liautaud (below)

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To obtain the manual *Nurturing Families Affected by Substance Abuse, Mental Illness and Trauma*, to obtain copies of published articles about the original curriculum, or for information on training and consultation, contact

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Parent-Child Interaction Therapy (PCIT)

Description: Parent Child Interaction Therapy (PCIT) is an evidence-based intervention developed by Sheila Eyberg, PhD, for oppositional and disruptive children aged 2-7 and their parents. It has been modified as a promising practice for the treatment of children aged 2-12 with trauma and/or maltreatment

histories and their parents. PCIT addresses the common behavior challenges and/or relationship difficulties often seen in children who have had complex trauma histories. PCIT stabilizes family relationships and sets the stage, when necessary, for subsequent trauma-focused treatment.

PCIT offers effective parenting skills transmitted by the therapist, using live coaching, while parents or caregivers interact with children during two sequential treatment components of several weeks each: a relationship enhancement component followed by a positive discipline component. PCIT is a criteria-based therapy, so that parents progress to the next treatment stage when they demonstrate mastery of key skills during weekly 5-minute coded interactions. PCIT is typically completed in 12-20 sessions.

The goals of PCIT treatment are:

- An improvement of the parent-child or caregiver-child relationship;
- An increase in children's prosocial behaviors and a decrease in child behavior problems;
- An increase in positive parenting skills and a decrease in negative disciplinary behaviors by parents;
- A decrease in parental stress.

Dr. Eyberg's evidence-based, session by session PCIT manual, coding manual and workbooks are available at PCIT.org, the University of Florida's PCIT website. Current protocols and checklists for the modifications suitable to treat older children (7-12) or traumatized children and their caregivers are made available during trainings conducted by the Trauma Treatment Training Center at Cincinnati Children's Hospital or the Indian Country Child Trauma Center at the University of Oklahoma. Additional PowerPoint and research materials are available at www.PCIT.org; www.OhioCanDo4Kids.org, www.OKPCIT.org, and www.pcit.tv.

Modifications: PCIT's relationship enhancement component (Child-Directed Interaction or CDI) remains unchanged from its evidence-based original, but there have been necessary modifications to the discipline component (Parent-Directed Interaction or PDI) for older children with a primary referral of family violence.

The original PCIT for disruptive children aged 2-7 includes physical prompts for children who noncomply during PDI (e.g., physically moving the child to a timeout area.). When Chaffin et al. (2004) adapted PCIT for physically abusive parents with children aged 7-12, they replaced the required or prompted compliance for preschool children with graduated consequences for noncompliance in school-aged children. Centers who train foster parents or parents have also replaced the hands-on timeout room backup used in the original PCIT with loss of privileges as timeout backup when developmentally appropriate. This modification brings the intervention into compliance with SAMHSA's guidelines limiting the use of isolation and restraint with children. There is evidence from research on similar parenting programs that loss of privileges as a backup for timeout is effective (Barkley, 1997; Forgatch, Bullock, & Patterson, 2004).

Cincinnati's Trauma Treatment Training Center teaches loss of privilege rather than timeout room isolation as backup for a child's timeout chair noncompliance. Preliminary outcome data on this modification as used by community providers trained by the Cincinnati team demonstrates its effectiveness as a promising practice, with results showing significant improvement on several measures regarding problem behavior, trauma symptoms, dissociative characteristics, and stress levels of caregivers.

PCIT is grounded theoretically in developmental, social learning, family systems, and attachment theory. PCIT's strongest evidence base is for oppositional defiant children aged 2-7 and their parents, but there is a growing body of evidence for its application to older children when physical abuse is the presenting concern (up to age 12) and families with trauma and maltreatment histories. It is effective with single parents, cognitively limited parents, court-ordered parents, two-parent families, and foster parents. Cultural adaptations have been effective with Latino/Hispanic families, African American Families, and Native American families. PCIT has been disseminated internationally (e.g., Hong Kong, Norway, The Netherlands) and has been translated into different languages (e.g., Spanish and Mandarin).

PCIT has been adapted for:

- Head Start classrooms;
- Group treatment;
- Home rather than office based sessions;
- Domestic violence shelters; and
- Residential treatment centers.

Status of Research: PCIT is supported by more than 20 years of research and practice (Herschell, Calzada, Eyberg, & McNeil, 2002), and there are over 100 published research articles and book chapters, and doctoral dissertations including several randomized controlled studies showing its effectiveness. Hood & Eyberg (2003) examined the long-term maintenance of changes following PCIT for young children with Oppositional Defiant Disorder (ODD) and associated behavior disorders. Results indicated that the significant changes that mothers reported in their children's behavior at the end of treatment were maintained at long-term follow-up three to six years after treatment.

PCIT has been shown to significantly improve outcomes for high-risk families (Ware, Fortson, & McNeil, 2003; Timmer, Urquiza, Zebell & McGrath, 2005; Urquiza & McNeil, 2006). In a randomized controlled study by Chaffin, et al. (2004), 19 percent of parents assigned to PCIT had a re-report for physical abuse at a median of 850 days after treatment termination compared with 49 percent of parents assigned to the standard community parenting group.

Adaptations for PCIT have been and continue to be studied for various populations in several PCIT laboratories and training sites. McCabe et al. (2005) have developed the GANA program [for Mexican American families in PCIT](#), and Choate, Pincus, Eyberg, & Barlow (2005) [have adapted PCIT for children with Separation Anxiety Disorder](#). In a recent CDC-funded project, PCIT has been effective in children with Fetal Alcohol Spectrum Disorders and other prenatal substance exposure (Gurwitch, Mulvihill, Chaffin, et al., in preparation)

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Contact Information: For information on PCIT training: Dr. Sheila Eyberg of the University of Florida

(www.PCIT.org) and the University of California Davis CAARE Center (www.pcit.tv).

University of Oklahoma Health Sciences Center (<http://devbehavpeds.ouhsc.edu/pcit.asp>) Trauma Treatment Training Center-Cincinnati Children's Hospital (www.OhioCanDo4Kids.org). For information on PCIT research labs: Go to <http://pcit.org>

For information on PCIT dissemination studies: contact University of Oklahoma Health Sciences Center and University of Washington – Seattle Harborview.

Safety, Mentoring, Advocacy, Recovery, and Treatment (SMART)

Description: The Safety, Mentoring, Advocacy, Recovery, and Treatment (SMART) Model developed by a team of clinicians at the Kennedy Krieger Institute Family Center is a structured, phase-based, abuse-focused, treatment approach to address the emotional and behavioral needs of young children with a history of sexual abuse exhibiting problematic sexual behavior (PSB). A major premise of the model is that the PSB stems from emotional responses to the prior child sexual abuse causing the child to form cognitive distortions about themselves, others, and the world around them. A unique feature of the model is the formation of parallel narratives of the child's experiences as a victim and as one who victimizes others. Children are supported to examine their roles and perceptions associated with each of these experiences. Clinicians guide children and their families through this process and provide the context for comparison leading to the integration of these experiences into a single narrative.

The SMART Model consists of three clinically essential phases: Safety and Stabilization, Triggers/Integration, and Re-Socialization. Each phase of treatment incorporates established practices proven to be effective in trauma treatment, such as CBT and psycho-education that reinforce safety/stability concerns, affect and behavioral regulation, as well as strategies for developing new coping patterns that no longer involve harm to self or others through trauma-informed interventions. A

primary concern at all times is the provision of safety, both physical and emotional.

The SMART model utilizes individual, family, and group therapy simultaneously. Used independently, these therapeutic approaches are frequently insufficient to eliminate PSB; however, the synergy created by concurrent use of these approaches yields an integrated comprehensive treatment model that promotes recovery and the acquisition of appropriate adaptive skills. To date, the average length of stay for model completion is 12 months. Length of stay may vary based on the individualized needs of the family and the child's ability to master concepts and build skills.

Status of Research: An analysis of the data collected during the piloting of the model (N=62) supports the effectiveness of the SMART model in reducing and/or eliminating PSB exhibited by young children with a history of sexual abuse. Children treated with the SMART model made behavioral and emotional improvements in functioning across multiple areas up to one year following treatment. Mean total functional impairment from the beginning to the end of treatment was reduced in half. Future research using a comparison group and randomized design is planned.

Contact Information: For more information on the model and on training and consultation services, contact lead developer, Betsy Offermann, LCSW-C
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Trauma Focused Cognitive Behavioral Therapy (TF-CBT) for Children and Parents; Cognitive Behavioral Therapy for Childhood Traumatic Grief (CBT-CTG); Combined TF-CBT and Sertraline for Children

Description: TF-CBT and its adaptations were developed by Judith A. Cohen, M.D., Anthony P. Mannarino, Ph.D, and Esther Deblinger, 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. TF-CBT was developed by integrating cognitive and behavioral interventions with developmental, psychobiological, humanistic and psychodynamic principles in order to

restore and enhance children's interpersonal trust, empowerment and resilience. Whenever possible this model also includes parents or other caretakers in treatment in order to focus on strengthening familial support and relationships. TF-CBT can be provided to children 3 to 18 years old and their parents by trained mental health professionals in individual, family, or group sessions in outpatient, residential, home or foster home or school settings. TF-CBT targets symptoms of posttraumatic stress disorder (PTSD) such as intrusive thoughts of the traumatic event; avoidance of reminders of the trauma; emotional numbing; excessive physical arousal/activity; irritability; trouble sleeping or concentrating, as well as depressive, anxiety and behavioral symptoms which often co-occur with PTSD. 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. **The childhood traumatic grief (CTG) adaptation of the model, CBT-CTG**, was developed by adding grief-focused components to TF-CBT. CBT-CTG has been used with diverse populations including uniformed service families, survivors of domestic homicides, disaster survivors and victims of war. The **TF-CBT + Sertraline model** was designed and evaluated because many traumatized children receive selective serotonin reuptake inhibitors (SSRI) and/or other medications in usual care despite few studies to evaluate whether this approach is helpful.

Status of Research: TF-CBT is recognized as a Model Program by SAMHSA. Compared to traumatized children receiving other forms of active therapy such as child-centered therapy, 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. The **CBT-CTG** model has been tested in two open studies and one small randomized trial; children with CTG symptoms experienced significant improvement in CTG and PTSD symptoms while parents experienced significant improvement in their own PTSD symptoms and functioning. In contrast, in a pilot randomized trial the **TF-CBT + Sertraline** model did not appear to be more effective than TF-CBT + placebo in reducing children's PTSD or other symptoms.

The TF-CBT and CBT-CTG treatment models are described in the book “Treating Trauma and Traumatic Grief in Children and Adolescents” which is available from www.guilford.com or www.amazon.com. The manual has been translated into Dutch and German. TF-CBT and CBT-CTG are being implemented internationally, particularly in Zambia where assessment instruments and the manual are being adapted to be culturally appropriate. Other international implementation projects are occurring in Germany, Holland, Israel, Norway and Pakistan. Many resources for implementing TF-CBT are available in Spanish and can be obtained at www.musc.edu/tfcbt. Free online training in the TF-CBT model is available to licensed mental health professionals at www.musc.edu/tfcbt; 10 free CE credits are provided to course completers. Limited opportunities to participate in TF-CBT Learning Collaboratives are available through the National Child Traumatic Stress Network (www.nctsn.org).

An additional study specifically for children living in foster care was completed by Northwestern University. This study showed that TF-CBT was superior to Systems of Care treatment as usual for preventing placement disruption, running away and for improving emotional and behavioral problems as well as trauma symptoms in foster children who had experienced diverse types of trauma.

Contact Information: For information on training in the TF-CBT model and implementation resources see www.musc.edu/tfcbt or at www.pittsburghchildtrauma.org.

For information about participating in a TF-CBT Learning Collaborative, contact

Jan Markiewicz

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For more information visit:

www.modelprograms.samhsa.gov or contact:

Judith Cohen

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Trauma Systems Therapy

Description: Trauma Systems Therapy (TST) was developed to help agencies and organizations effectively work with traumatized children and their families. One of the aims of this treatment model is to facilitate the development of trauma informed service

systems. Details of TST within the services system are provided in section *Trauma-Informed Models for Service Systems and Organizations: Children* of this manual.

TST contains 4 operationalized and integrated service elements considered critical for providing effective traumatic stress care. These service elements are 1) skill-based psychotherapy, 2) home and community based preventative care, 3) psychopharmacology, and 4) advocacy.

TST conceptualizes child and adolescent traumatic stress as the interface of two conceptual axes: 1) the degree of emotional and behavioral dysregulation when a child is triggered by overt and subtle reminders of a trauma and 2) the capacity of the child’s social-ecological environment to protect the child from these reminders, or help the child to regulate emotions in the face of such reminders.

The treatment is phase-based, and recommends different treatment modules depending on the degree of emotional dysregulation and the stability of the social environment. Treatment proceeds in stages depending on the child’s degree of emotional/behavioral regulation and environmental stability (see Table 1). Children experiencing greater dysregulation of emotions and more unstable environments are assessed to be in a more acute stage, and receive correspondingly more intensive interventions. Recommended treatment modules for the most acute problems include modules that focus specifically on aspects of the social environment that are believed to be impacting the child’s symptomatology. Children move from one module to the next based on improvements in the stability of the social environment and/or emotional regulation. As children transition to a more stable environment, and demonstrate better emotional regulation skills, the focus of the intervention plan shifts and may include more office or clinic-based work to help the child develop coping skills or cognitively process the trauma.

TST was developed to service trauma-exposed children ages 6-19. It is particularly useful for children who are contending with complex problems associated with poverty and/or ongoing exposure to stressors. It has been used in urban and rural areas, and adapted for use with young children (ages 3-6)*, substance-

using traumatized adolescents, refugee children, medically-traumatized children. It has been implemented in schools, mental health outpatient clinics, through social service departments, in residential care facilities, in medical hospitals (for medically-traumatized youth), and in foster care settings

Status of Research: TST has been fully developed, manualized and can be delivered with fidelity. results of an open trial of 110 families comprising a cohort of children from inner city Boston and another from rural New York state have been published (Saxe, Ellis, Fogler, Hansen, & Sorkin, 2005). These families were enrolled in TST and assessed 3 months later. These children were largely multiply traumatized and managing significant environmental stressors such as poverty, risk of homelessness, and parental mental illness and substance abuse. While almost 60% of families needed more intensive home and community-based care at the beginning of treatment, only 39% of families needed this level of treatment after 3 months. A recent, not yet published follow up study shows that at 15-months after enrollment in treatment these gains persist and even improve. Unpublished data from a pilot randomized controlled study of TST vs. treatment as usual in an inner city sample of traumatized children show that three months following enrollment in treatment 90% of families receiving TST were still in treatment whereas only 10% of the treatment as usual families were still in treatment. This finding suggests that TST is very effective at engagement, and highlights the importance of 1) family engagement and 2) integration of care within the existing services system.

This model is currently being adapted for this age group.

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Trauma-Specific Service Models for Children

Guide to Trauma-Specific Service Models for Children				
Name of Model	Intended Audience	Type of Services	Intended Setting	Approach
<i>Assessment-Based Treatment for Traumatized Children: A Trauma Assessment Pathway Model (TAP)</i>	Clinicians treating Children (ages 2-18)	Training, Manual, Website: www.taptraining.net	Treatment centers	Individual and Family Sessions
<i>Cognitive Behavioral Therapy for Childhood Traumatic Grief (CBT-CTG)</i>	Children and Youth (ages 3-18) and their Parents	Manual (English, Dutch & German), Book, Training, Website: www.musc.edu/tfcbt	Outpatient, Residential, Home, Foster Home, and School settings	Individual, Family or Group sessions
<i>Complex Trauma Cognitive Behavioral Therapy</i>	Children & Adolescents with or without Caregivers, SA, MH	Website: http://stjohns.edu/academics/centers/psychology/partners/partners.stj	Inpatient psychiatric facilities	Individual sessions
<i>Culturally Modified Trauma-Focused Treatment (CM-TFT)</i>	Latino Children (ages 4-18)	Manual (under revision), PowerPoint, Website: www.musc.edu/ncvc		
<i>Group Intervention for Children of Mothers with Co-occurring Mental Health and Substance Abuse Disorders and Histories of Interpersonal Violence</i>	Children (ages 5-7 and ages 8-10)	Manual, Training, Consultation		Group sessions
<i>Integrative Treatment of Complex Trauma (ITCT) for Children and Adolescents</i>	Children, Adolescents (ages 3-21), and their Families	Manual, Training, Consultation, Websites: www.memorialcare.com/miller/services/abuse.cfm , www.johnbriere.com , www.nctsn.org/nctsn_assets/pdfs/promising_practices	School and Clinic settings	Individual, Family & Group sessions
<i>Life Skills/Life Story</i>	Adolescent Girls (ages 12-22)		Residential, School, and Clinic settings	Group or Individual sessions with therapist
<i>Love and Life: 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</i>	Adolescent Girls (ages 12-18)	Manual, Book, Training	MH, Schools	Group sessions
<i>Prolonged Exposure Therapy for Adolescents with Post Traumatic Stress (PE-A)</i>	Adolescents (ages 13-17)	Manual (English & Hebrew)		
<i>Real Life Heroes (RLH)</i>	Children (ages 6-14 with adaptations for adolescents and preschool children) and primary	Workbook, Practitioner Manual, Research & Practice Textbook, Consultation, Fidelity Instruments; Web Access Links:	Child and Family Services: Home-based, Foster or Kinship Family Care, Residential	Individual and Child – Caring Adult Sessions; Guidelines For

Guide to Trauma-Specific Service Models for Children				
	caregivers; especially designed for children and families with complex traumatic stress	http://www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM_ID=226 ; http://www.nctsn.org/nctsn_assets/pdfs/promising_practices/RLH_General.pdf	Treatment, Mental Health Clinics	Assessment, Service Planning
<i>Sanctuary Model for Children in Residential Settings</i>	Children	Training, Consultation, Website: www.sanctuaryweb.com	Residential, Acute Care, Out-patient, Juvenile Justice, and Substance Abuse settings	
<i>Seeking Safety</i>	Adolescents, SA, MH	Manual, (English, Spanish, French, German, Swedish), video training series; card deck, poster; onsite training/consultation; research Website: www.seekingsafety.com	Any clinical setting (e.g., outpatient, inpatient, residential, homeless, criminal justice, domestic violence, private practice, MH, SA)	Individual or groups sessions
<i>Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)</i>	Adolescents	Leader Manual, Participant Handouts & Worksheets, Training, Consultation	Various settings	Group sessions
<i>Trauma Affect Regulation: Guide for Education and Treatment (TARGET©)</i>	Adolescents (age 10-21)	Manuals, Training, QA, Fidelity	MH & SA settings, Juvenile Justice,, Schools	Group or individual sessions
<i>Trauma and Grief Component Therapy (TGCT)</i>	Older Children & Adolescents (ages 10-18)	Manual, Workbook	School, community MH, or other service settings	Group or Individual sessions
<i>TRIAD Girls Group Treatment Model</i>	Adolescent Girls, SA	Manual, Worksheets		Group sessions
<i>Voices: A Program of Self-Discovery and Empowerment for Girls</i>	Adolescent Girls and Young Women (ages 12-18), SA, MH	Facilitator's Manual, Girl's workbook, Curriculum, Training, Consultation, TA, Websites: www.stephaniecovington.com ; www.centerforgenderandjustice.com	Outpatient & residential SA treatment, MH clinics, schools, juvenile justice	Group or Individual sessions

Key: MH – Mental Health; SA – Substance Abuse

Assessment-Based Treatment for Traumatized Children: A Trauma Assessment Pathway Model (TAP)

Description: *The Assessment-Based Treatment for Traumatized Children: A Trauma Assessment Pathway Model (TAP)* is a treatment model developed by the Chadwick Center for Children & Families at Rady Children's Hospital in San Diego. The TAP model incorporates assessment, triage, and essential components of trauma treatment into clinical

pathways designed to treat children from 2-18 years of age who have experienced one or more traumatic events or situations. This model is meant to be adaptable and flexible in order to meet the cultural and language needs of the child and his or her family. The goals of TAP include: (1) providing treatment center staff with the knowledge and skills to incorporate standardized assessments into the intake and ongoing treatment process; (2) providing a treatment model that is directed by the uniqueness of the child and his or her family; (3) providing guidelines for clinicians to

make decisions regarding trauma treatment strategies based upon the child's unique presentation. TAP is divided into two parts. Part I of the model describes the assessment process how to develop a Unique Client Picture, how to triage, and when to make referrals. Part II focuses on trauma treatment and includes an explanation of evidence-supported interventions found in the literature that are organized into a "Trauma Wheel" and used to create a "Treatment Pathway."

As stated previously, the TAP model has three components. The first component is Assessment, which includes clinical interview, behavioral observations, and standardized assessment measures that help clinicians organize and understand the client's symptom presentation, history, cultural and family influences. This process leads to the creation of the Unique Client Picture, and guides the clinician as they hypothesize about the bases for the client's problems and identify treatment needs. Triage is the second component of TAP and is the process in which children are referred to the most appropriate and available evidenced-based treatment (i.e. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Abuse-Focused Cognitive Behavioral Therapy (AF-CBT), or Parent Child Interaction Therapy (PCIT)) and/or other additional services (i.e. medication evaluation, Kids in Court programs, mentor programs, etc.) based on the needs of the child and his/her family. Decision trees are available to help the clinician to make appropriate triage decisions based on assessment and the Unique Client Picture. The third component is Treatment. This component of the model is defined through the Trauma Wheel and the Treatment Pathway. These identify and structure the use of essential elements of trauma treatment for children based upon the most current research evidence. Treatment through the TAP model is used when a child does not fit specific criteria for existing evidence-based treatment models or needs additional treatment after receiving treatment through a referred treatment model. Treatment through the TAP model is also used when the most appropriate evidenced-based treatment is not available (i.e. no training or appropriate setting).

The Trauma Wheel includes Relationship Building, Child Development, Cultural Influences,

Psychoeducation and Skill Building, Maladaptive Cognitions, Affect Regulation, and Trauma Integration. The first three features of the wheel, relationship building, child development, and cultural influences, are considered ongoing influences and considerations. These aspects of the wheel influence how a clinician will proceed with therapy and will influence decisions about types of interventions used during the course of treatment. The other features of the Trauma Wheel are considered essential components of trauma treatment for children and are also included in the Treatment Pathway. The Treatment Pathway helps the clinician decide where to begin in treatment based on the Unique Client Picture. During the course of treatment, the clinician spends time on each component of the Trauma Wheel, but the length of time and order of intervention depends on the Unique Client Picture. Decisions concerning order of interventions and any changes in treatment are influenced by ongoing assessment, including follow-up standardized assessments, behavioral observations, and clinical interview. Treatment tasks are provided with the intent that specific interventions used to address the treatment tasks are selected based on the needs of the individual client and his/her Unique Client Picture.

Status of Research: Although the TAP model is still in the early stages of research, we have been testing the TAP model within the Chadwick Center and with some of our partner National Child Traumatic Stress Network (NCTSN) sites. Initial efforts focused on the utility of assessment measures in the treatment process. Results of this pilot test are reported in an unpublished article by Hazen and colleagues (2006). Thirty-five Chadwick Center clinicians participated in a survey regarding the utility of assessment measures in the treatment process. On average, clinicians felt that assessment measures were only moderately useful for identifying client problems, developing treatment goals, and initial treatment plans, as well as monitoring progress in treatment. Most clinicians indicated a need for further training on administration and clinical use of assessments. Based on the results of this study, the TAP Model was created to fulfill this need by providing pathways for making assessment decisions and instruction on integrating assessments into treatment planning, triage, and tracking treatment progress. Guidelines for integrating assessment

information to form the Unique Client Picture were also included in the model, along with decision and triage trees intended to help clinicians make referral, triage, and treatment decisions for their clients.

The Chadwick Center is currently in the process of testing the TAP model at four independent sites across the country. Clinicians trained thus far ($N = 47$) report they are able to confidently make sense of information obtained through assessment, interview, and observation, and create clinical hypotheses and the Unique Client Picture using the revised TAP Model. They feel confident in their ability to provide assessment results to clients and monitor change throughout the course of treatment. In addition to the reported studies, several studies are either currently underway or are in the stages of development. These studies involve an independent study on the implementation of the TAP model at the four NCTSN sites trained, a case study and a treatment outcome study examining triage and treatment decisions made by therapists using the TAP model and symptom changes as a result of treatment through the TAP model at the Chadwick Center.

Hazen, A., Taylor, N., Landsverk, J., Ryan, B.E., Garland, A., Wilson, C. (2006). *Clinician Perspectives on the Use of Standardized Assessments in Mental Health Services for Maltreated Children*. Unpublished Manuscript.

Taylor, N., Gilbert, A., Mann, G., & Ryan, B.E. (2005). *Assessment-based treatment for traumatized children: A trauma assessment pathway*. San Diego, CA: Chadwick Center for Children & Families.

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For further information see:

www.chadwickcenter.org or www.taptraining.net

Cognitive Behavioral Therapy for Childhood Traumatic Grief (CBT-CTG)

Please refer to *Trauma Focused Cognitive Behavioral Therapy (TF-CBT) for Children and Parents* in the section titled *Trauma-Specific Service Models for Children and Family/Parents/Caregivers*, on page 70 of this report.

Complex Trauma Cognitive Behavioral Therapy

Description: Complex Trauma Cognitive Behavioral Therapy (CT-CBT) was developed by David J. Kolko, Ph.D., Judith A. Cohen, M.D., Anthony P. Mannarino, Ph.D, Esther Deblinger, Ph.D., and Elissa J. Brown, Ph.D. to address the severe, varied trauma-related psychopathology among children and adolescents served in inpatient psychiatric facilities. Psychopathological syndromes experienced by the inpatient youth include: oppositional defiant disorder, conduct disorder, substance-related disorders, posttraumatic stress disorder and other anxiety disorders, bipolar depression, and major depressive disorder. Thus, CT-CBT is a combination of two empirically-supported trauma-specific interventions designed to reduce: (1) behavior problems and social-cognitive deficits (Abuse-Focused Cognitive Behavioral Therapy) and (2) internalizing symptoms and trauma-specific fears (Trauma-Focused Cognitive Behavioral Therapy).

Abuse-Focused Cognitive Behavioral Therapy (AF-CBT) was developed by David J. Kolko, Ph.D. to help physically-abused youth and their caregivers. AF-CBT specifically aims to reduce children's aggression and oppositional behavior and families' use of interpersonal violence. AF-CBT incorporates conceptual principles and therapeutic procedures from several areas (e.g., learning, behavioral therapy, family-systems theory, cognitive therapy, developmental victimology). Treatment emphasizes instruction in specific intrapersonal (e.g., cognitive, affective) and interpersonal (e.g., behavioral) skills designed to promote the expression of prosocial behavior and discourage the use of coercive/aggressive behavior at both the individual and family levels. CT-CBT includes the following AF-CBT components: affection regulation skills, psychoeducation about interpersonal violence and cognitive behavioral therapy, relaxation training, social problem solving, and anger management. TF-CBT was developed by Judith A. Cohen, M.D., Anthony P. Mannarino, Ph.D, and Esther Deblinger, Ph.D. to help youth and their caregivers overcome the negative effects of child sexual abuse. TF-CBT targets symptoms of posttraumatic stress disorder, anxiety, depression, and self-injurious behavior, such as substance abuse. CT-CBT emphasizes the following TF-CBT components: cognitive restructuring and

developing a trauma narrative. Cognitive restructuring helps children systematically identify and challenge negative or distorted thoughts that may be precursors of emotional problems. The trauma narrative is designed to habituate children to cues of the trauma (e.g., smells, sights, sounds) without the feared consequences, such that emotional distress and avoidance decrease. The trauma narrative also helps children contextualize the trauma. During the narrative sessions, children and their therapist will identify previously unreported emotions and cognitions associated with the trauma. These will be addressed systematically using the aforementioned coping skills, especially cognitive restructuring.

After completion of AF- and TF-CBT components, youth complete a “tool box reminder.” The tool box reminder is a creative representation of the skills they have learned in therapy. It not only allows the youth to teach the skills to others (resulting in having a better understanding of them), but provides relapse prevention against future trauma-related mental health problems.

Although both AF-CBT and TF-CBT were designed as child-caregiver programs, the inpatient youth have little contact with their caregivers. As a result, CT-CBT was designed for the children and adolescents, with the ability to include caregivers should they choose to participate.

CT-CBT was developed for children and adolescents, age 10-to-17-years old, of diverse racial, ethnic, and socioeconomic backgrounds, and complex trauma histories. The intervention is conducted at inpatient psychiatric facilities in individual sessions, the length of which vary from 20 to 45 minutes, depending on the abilities of the patient.

Status of Research: CT-CBT is currently being evaluated by Dr. Brown in a randomized clinical trial comparing CT-CBT to treatment-as-usual with 10-17-year-old youth in an inpatient psychiatric facility in New York City.

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Culturally Modified Trauma-Focused Treatment (CM-TFT)

Description: CM-TFT was developed for use with Latino children and is based on Trauma-Focused Cognitive Behavior Therapy (Cohen, Mannarino, & Deblinger, 2006) for use with Latino trauma victims. The treatment development has been based on the research literature and over 10 years of clinical work with this population. CM-TFT is a tailored approach to providing treatment that attempts to increase engagement by increasing the cultural relevance of the intervention. Potential cultural factors are assessed and addressed, including spirituality, familismo, gender roles, beliefs about sex, views of mental health and mental health treatment, racism/discrimination, exploitation, and barriers to accessing treatment (e.g., transportation, poverty). In collaboration with several National Child Traumatic Stress Networks across the country, the intervention has been further developed to address the needs of Hispanic children from various countries of origin, regions of the United States, and levels of acculturation. CM-TFT was developed by Michael de Arellano, Ph.D. and Carla Danielson, Ph.D. The CM-TFT manual is presently under revision, and a PowerPoint is also available.

The population the model is designed for and used with ranges in age from 4 to 18, and includes Latino/Hispanic males and females, with a broad range of acculturation levels from recently immigrated to multi-generation in the U.S. The majority of children are of Mexican descent, in addition to children from other Latin American countries.

Status of Research: Several focus groups were conducted with Latino parents, therapists working with Latino families, and other mental health professionals with expertise in Latino populations to further develop the intervention and treatment manual. Currently, individual case studies have been conducted, and a multi-site pilot feasibility trial is currently underway with diverse group of Latino families, in terms of nationality, socioeconomic status,

level of acculturation, and geographic location in the United States.

Contact information: For readers to obtain materials and acquire additional information:

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

Description: 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, video clips, 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 Children's Study indicate that children who participated in this intervention sustained positive improvement on an overall measure of resiliency as well as on measures of interpersonal relationships, self-identity, and safety knowledge 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. (Noether et al., 2007).

Contact Information: 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, and for information on training and consultation, visit www.nationaltraumaconsortium.

Integrative Treatment of Complex Trauma (ITCT) for Children and Adolescents

Description: ITCT is a comprehensive, assessment driven, components-based model integrating theoretical and clinical approaches for the treatment of complex trauma in children and adolescents. The ITCT model was developed through the collaborative efforts of Cheryl Lanktree, Ph.D. at Miller Children's Abuse and Intervention Center (MCAVIC) and John Briere, Ph.D. at the Psychological Trauma Program at University of Southern California, Keck School of Medicine. This is a relationally based model incorporating tenets of complex trauma theory (Cook, Spinazzola, Ford, Lanktree, et al., 2005; Herman, 1992), and aspects of attachment theory (Bowlby, 1988), cognitive behavioral theories, and the Self Trauma Model (Briere, 2002). ITCT is designed to address the multiple domains of functioning impacted by exposure to severe, multiple, and/or prolonged traumatic experiences of an interpersonal nature. Results of regular, standardized assessment of functioning assist clinicians in identifying significant problem areas and provide information about improvement or exacerbation in problem areas (e.g., attachment insecurity, affect dysregulation, hyperarousal) specific to individual clients. Consideration of titrated exposure and the "therapeutic window" (Briere, 1996, 2002) guides the pace of treatment and use of ITCT treatment components (e.g., relationship processing, emotion identification, relaxation training). Treatment is provided through multiple modalities, including individual, collateral, and family sessions, in addition to group therapy for sexual abuse victims, those suffering from traumatic grief, students exposed to community violence, and caregivers requiring therapy or parenting education.

ITCT was originally developed for use in school and clinic settings with culturally diverse clients, ages 3 to 21, and their families. Specific cultural groups for which ITCT has been used include ethnic minorities (African American, Latino American, Asian American, and Pacific Islander Americans), low socioeconomic status, gender-specific child and adolescent groups, and immigrants from Mexico, Central America, Pacific Islands, and Southeast Asia. ITCT has also been adapted for use in urban schools in economically impoverished areas, including alternative (e.g., storefront) school settings. Traumatic experiences addressed by ITCT include child abuse and neglect, exposure to domestic violence, community violence, traumatic losses, parental substance abuse, and severe medical trauma. This model has been used with English- and Spanish- speaking clients. ITCT groups have been designed for adolescent girls' who have experienced sexual abuse, children and adolescents experiencing traumatic loss and grief, and for non-offending female caregivers.

Status of Research: Preliminary outcome studies demonstrate significant and clinically meaningful improvement in trauma-related symptoms, such as posttraumatic symptoms, depression, anxiety, dissociation, and sexual concerns. Additional studies examining outcomes for clinic based and school-based clients are currently underway. A two-site study (Lanktree, Gilbert, Briere, Taylor, Chen, Maida, & Saltzman, in press) examined the trauma specific measures used with ITCT, specifically the Trauma Symptom Checklist for Children (TSCC; Briere, 1996) and the Trauma Symptom Checklist for Young Children (TSCYC; Briere, 2005), and indicated evidence of convergent and discriminant validity for these measures.

Separate manuals outlining ITCT treatment protocols for children (8 – 12), adolescents (13 – 21), and group treatment of sexually abused adolescent girls will be available in 2008.

Contact Information: To obtain information and materials on ITCT and training/consultation in this model, contact
MCAVIC-USC Child and Adolescent Trauma Program

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or

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Co-director

562 933-0590,

Or visit our web pages at

http://www.memorialcare.com/miller/services/abuse_cfm, www.johnbriere.com.

http://www.nctsn.org/nctsn_assets/pdfs/promising_practices.

Life Skills/Life Story

Description: Life Skills/Life Story was specifically developed to meet the needs of adolescent girls who have experienced childhood abuse and other traumas such as domestic violence and community violence. The program is comprised of two modules. The first module focuses on developing positive goals, the skills to meet this goals and sense of self-efficacy. Skills development focuses on those that are typically compromised from exposure to chronic trauma and interpersonal violence. These include developing emotional awareness and modulation, appropriate assertiveness skills, and flexibility and range in ways of relating to others, depending on the relationship and the context. Topics include sexual activity, group pressure and gangs/cliques, independence from and disappointment in parents and other caretakers, the importance of social support and how to request it. The skills component has been successfully implemented in a group format in residential and school settings but can be implemented in one-on-one setting with a therapist. This component of the treatment has been implemented in periods as short as three months and as long as one year. The second module is a titrated discussion and analysis of the traumatic events that have occurred. This has been implemented through written narrative, poetry, and collage. The treatment has been developed by the Institute for Trauma and Resilience directed by Marylene Cloitre at the Child Study Center in New York City. It has been successfully implemented in a residential school setting, in inner city public schools and in clinic settings. The program has served primarily minority girls, with ages 12 through 22.

Status of Research: Research has been completed indicating that the treatment as compared to those not participating in the program (either waitlist or treatment as usual) significantly reduces symptoms of post traumatic stress and depression and enhances interpersonal skills, sense of social connection and teacher reported improvement in school functioning.

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Love and Life: 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

Description: 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, and revised a third time in summer 2005. 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 experiential exercise and a "Dear Alicia" problem-solving activity. 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.

Status of Research: In the spring of 2004 through the spring of 2005, the SAMHSA-funded Youth Violence Prevention Program, Project Hope in Washington, D.C., offered a total of 16 Love and Life: G-TREM groups in 11 different public schools, co-led by clinicians from Community Connections and DC's Department of Mental Health's School Based Mental Health Program. Evaluation of this project found positive responses to the groups among both participants and leaders. In qualitative interviews, over 90% of participants reported overall satisfaction with the group, and over 90% said they would recommend it to friends. They also reported specific beneficial effects of group participation: increases in such skill areas as improvement in handling anger and in self-confidence and self-esteem, as well as increased knowledge about sex and their bodies. Girls rated strongest potential group benefits in the key outcome domains of perceived general safety, self-esteem and the ability to assert oneself. Similarly, feedback from group leaders indicated that girls' skills in these areas had increased, identifying areas of relationships with others, girls' ability to deal with stressful events, and self-esteem as the domains most positively affected by the group. All of the 14 group leaders said they would recommend the group to colleagues and other agencies.

Contact Information: To obtain the manual, the book, and additional information, Kate Boucek, M.S.W.
202-608-4784
kboucek@ccdc1.org
www.ccdc1.org

or

For a report of G-TREM pilot data, please contact Rebecca Wolfson Berley, M.S.W., Director of Trauma Training
202-608-4735
rwolfson@ccdc1.org

Prolonged Exposure Therapy for Adolescents with Post Traumatic Stress (PE-A)

Description: This program is based on Prolonged Exposure Therapy (PE), a method of treatment developed by Edna Foa and colleagues at the University of Pennsylvania. Prolonged Exposure targets the

symptoms of Posttraumatic Stress Disorder as well as associated symptoms of depression that may develop as a result of trauma. PE-A reduces symptoms by helping clients emotionally process their traumatic experiences. This is accomplished by systematically confronting safe but anxiety producing situations, places or thoughts that have developed in the wake of the trauma. Prolonged and repeated confrontation of anxiety helps trauma survivors overcome their excessive fear and anxiety by providing corrective information related to the survivors beliefs about self, others and the world, and by helping the survivor to habituate to the discomfort associated with memories of the trauma and activities that evoke the memory of the trauma.

The adult PE program has been modified for use with adolescents by increasing family involvement, increasing attention to the social and developmental challenges faced by adolescents, and building in developmentally appropriate exercises that can be selected by the therapist, in response to the needs of the individual patient. Treatment is provided in weekly 60 to 90 minute sessions over approximately 14 weeks. Treatment is composed of four distinct phases:

- Pretreatment Preparation, which includes a motivational building exercise to improve attendance and treatment adherence, and a case management exercise to address potential barriers to therapy.
- Psychoeducation, which provides education about common reactions to trauma, breathing retraining (i.e., teaching the client how to breath in a calming way), and education about the rationale for the treatment.
- Exposure and Processing, which includes both in-vivo exposure to situations that produce anxiety by evoking memories or thoughts of the trauma, and imaginal exposure to the story of the trauma itself.
- Relapse Prevention, which includes a review of the treatment and anticipation of future challenges.

The treatment is designed for male and female adolescents aged 13-17 but has been implemented with younger children. The pilot data were collected in a Philadelphia urban rape crisis center specializing in the treatment of adults and children who have been sexually assaulted, and in a hospital based clinic in Israel where patients experienced a variety of traumatic events including sexual assault and abuse, motor vehicle

accidents, and terror attacks. Clients were predominantly African American and White in the American sample, and White in the Israeli sample. The manual is in English and has been translated into Hebrew.

Status of Research: Though two randomized, controlled treatment outcome studies of PE-A are currently underway, neither has been completed. Pilot data collected in the U.S. and Israel are quite promising. In an open trial of PE-A, PTSD symptoms among 45 adolescent clients were significantly reduced from pre- to post-treatment and 71% percent of the patients achieved remission by the end of treatment. The within subject effect size of 2.13 found for these 45 patients who received PE is similar to published results of adult assault survivors following treatment with prolonged exposure.

Contact Information: To obtain materials or to acquire additional information about PE-A, contact Dr. Edna Foa or Dr. Elizabeth Hembree at Center for the Treatment and Study of Anxiety
Phone: 215-746-3327
Website: ctsa@mail.med.upenn.edu

Real Life Heroes (RLH)

Description: *Real Life Heroes* utilizes an activity-based workbook to help children with traumatic stress to build the skills and interpersonal resources needed to re-integrate painful memories and to foster healing after experiences of abuse, neglect, family violence, severe illness, losses, deaths, or abandonment. The model includes a developmental, attachment centered curriculum that uses the metaphor of heroes to rekindle hope, en-courage and empower caring adults to help children overcome traumas, and enhance family and cultural strengths. The curriculum integrates nonverbal and verbal modalities and helps children and caring adults move step-by-step from trauma narratives to life stories highlighting mastery and moving through traumatic events to safety, helping others, and strengthening nurturing relationships.

Real Life Heroes was developed by Richard Kagan, Ph.D. to engage hard-to-reach children and families in child and family service programs, children who often demonstrate the impact of multiple traumas and challenge caregivers, educators, and practitioners with symptoms of complex

trauma including affect dysregulation, dissociation, memory fragmentation, and poor executive functioning. The workbook utilizes creative arts (drawing, rhythm, music, and movement) as well as life story work to help practitioners implement core components of effective treatment for complex trauma (Cook, Spinazzola, Ford, Lanktree, et al., 2005). The model also helps practitioners to rebuild (or build) positive, enduring relationships between hurt (and often hurting) children and adults committed to guiding children into adulthood. Components include: (1.) Rebuilding Attachments (Safety, Commitment, & Attunement); (2.) Personal Power (Affect regulation, Mindfulness—Centering, Storytelling—Meaning making, Re-integration & Empowerment with Family and Cultural Heritage); and (3.) Traumatic Stress Reduction (Cognitive Behavior Therapy, Graduated Exposure—Desensitization, & Working through the ‘Tough Times’ to Safety, Strength, & Security).

Real Life Heroes can be utilized as a comprehensive framework for trauma and attachment-centered therapy or as a component of other comprehensive treatment programs for traumatic stress to facilitate engagement, attachment, desensitization and life story work. The *Practitioner’s Manual* provides detailed guidelines for therapists and can be used as a chapter by chapter reference including: Objectives, Overview, Step-by-step (key points and sequence), Pitfalls (problems that can undermine therapy), Troubleshooting (challenges and solutions), and Checkpoints (essential elements). Combining the *Practitioner’s Manual*, *Life Storybook*, and accompanying text, *Rebuilding Attachments with Traumatized Children* provides practitioners with step by step, practical tools for implementation along with a theoretical and research-based understanding of principles for interventions and recommended adaptations for specific populations. The *Manual* also includes tools to assist with assessment, service planning, engagement, getting unstuck, and fidelity.

Real Life Heroes was especially designed for children in child and family service programs who frequently lack safe, nurturing homes and secure relationships with caring and committed adults but can also be used to help children with more secure attachments. The model was designed to help therapists strengthen caring adults, and when necessary, to search for caring adults and engage them to rebuild attachments and provide long term guidance, nurture, and safe homes for

troubled children. The workbook and session by session guidelines help therapists and family members to recover and enhance family and cultural strengths and to promote skill building, attachments, and trauma processing. The model can be used by child welfare programs as a prescriptive methodology to address primary goals including preventing placements, reuniting families, or finding alternate permanent homes for children who cannot return to biological parents.

Real Life Heroes is listed in SAMHSA’s National Registry of Evidence-based Programs and Practices http://www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM_ID=226 and as an Evidence-supported and Promising Practice by the National Child Traumatic Stress Network (http://www.nctsnet.org/nctsn_assets/pdfs/promising_practices/RLH_General.pdf).

Status of Research: Therapists have consistently reported positive results during ten years of case studies with children with Complex PTSD involved in home-based or clinic-based family counseling and with children who have been living in foster families and residential treatment centers due to dangerous behaviors and often repeated experiences of physical or sexual abuse, and neglect. A pilot research study (Kagan, Douglas, Hornik & Kratz, 2008) was conducted to evaluate the effectiveness of this model with 41 children and adolescents at Parsons Child and Family Center, a community practice site of the National Child Traumatic Stress Network. Data from the Parsons study were utilized to assess changes from enrollment and at four, eight, and 12 months of treatment. Children were involved in high-risk, home-based counseling, foster family care, residential treatment and an out-patient mental health clinic. At study enrollment, clinicians completed the UCLA PTSD Checklist (Pynoos, Rodriguez, Steinberg, Stuber & Frederick, 1998) and 25% of the sample were found to have experienced 1-2 traumatic events; 47.5% had experienced 3-4 traumatic events; and 27.3% had experienced 5-6 traumatic events.

At four months, children (N = 36) demonstrated reductions ($p < .05$) in:

- trauma symptoms on child self-reports evaluated with the Trauma Symptom Checklist for Children, TSCC (Briere, 1996).

- problem behaviors reported by primary caretakers on the Conners Behavior Rating Scale--Parent-Long Version (Conners, 1997).

At the end of the 12 month study period (N = 25), results included:

- reduced trauma symptoms reported by the adult caregiver on the PROPS (Greenwald, 1999a, 1999b) in relation to the number of *Real Life Heroes* chapters completed ($p < .001$).
- Increased security/attachment over time reported by the child ($p < .05$) on the Security Scale (Kerns, Klepac & Cole, 1996).

Results supported the efficacy of applying components of trauma and attachment-centered therapies in child and family services. The pilot study did not include a control group; however, results supported the model's effectiveness to reduce symptoms of traumatic stress, reduce behavioral problems, and increase children's security with primary caregivers. The sample population and practitioners were representative of child and family services and included children and families who had experienced physical and sexual abuse, severe neglect, and children who lacked a safe, non-offending parent and a secure home. The 'doing with' activities appeared to enhance children's perception that they were not alone and could count on support from important people in their lives. Working with therapists and safe adults on opening up and recovering memories of children being nurtured, valued, and doing good things appeared to foster the strengths needed for children and parents or guardians to reduce traumatic stress reactions. Therapists reported that the model helped them to engage children who had experienced multiple traumas including neglect, abandonment, physical and sexual abuse, domestic violence, losses, and separations, placements away from families of origin and that the curriculum helped therapists persevere with application of cognitive behavioral therapy and desensitization components over time.

For additional information, please see Kagan, R., Douglas, A., Hornik, J., & Kratz, S. (2008). *Real Life Heroes* Pilot Study: Evaluation of a Treatment Model for Children with Traumatic Stress. *Journal of Child and Adolescent Trauma*, 1:5-22.

Contact Information: For additional information on the *Real Life Heroes* model, please see summaries and reviews by the National Registry of Evidence-based Programs and Practices (http://www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM_ID=226) and the National Child Traumatic Stress Network (http://www.nctsn.org/nctsn_assets/pdfs/promising_practices/RLH_General.pdf).

For additional information about the *Real Life Heroes* Pilot Study or use of *Real Life Heroes* at Parsons Child and Family Center, please contact: Richard Kagan, Ph.D. Director of Psychological Services, Parsons Child and Family Center, 60 Academy Rd., Albany, NY 12208; e mail: kaganr@parsonscenter.org; (518) 4262600 ext. 2725.

For additional information regarding training and consultation, please contact: Richard Kagan, Ph.D., One Pinnacle Place, Suite 200, Albany, NY 12203; e mail: rmkagan@nycap.rr.com.

To obtain *Real Life Heroes: A Life Storybook for Children (2nd edition)*, the *Real Life Heroes Practitioner Manual*, or the accompanying text, *Rebuilding Attachments with Traumatized Children*, please contact: Haworth Press (Taylor & Francis Group) www.haworthpress.com; (800 Haworth) or book stores including: amazon.com or bn.com.

Sanctuary Model for Children in Residential Settings

Description: 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.

As of 2007, The Sanctuary Model® is being adapted for use in over twenty acute care, residential, out-patient, juvenile justice and substance abuse settings for children in various parts of the United States and Mexico.

Status of Research: Two evaluation projects are now underway. Eighteen of the current organizations in the Sanctuary Leadership Development Institute are participating in a three-year evaluation to determine whether or not the training and consultation brings about significant changes in key determinants of safe environments, including reductions in restraints, staff injuries, staff turnover. A parallel project is being conducted on seven of the agencies – five residential treatment settings and two juvenile justice programs – that have been funded through New York State Office of Family and Children’s Services. This evaluation is being independently conducted by Stonybrook University.

An earlier research project was conducted on the implementation of the Sanctuary Model, funded by NIMH grant MH62896. The study showed support for the implementation of the model. 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. Her findings were that 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, R.H. (1996). *Community oriented program scale: Sampler set manual, test booklets, and scoring key (3rd Ed)*. Redwood City, CA: Mindgarden; Moos, R.H. (1997). *Evaluating treatment environments: The quality of psychiatric and substance abuse programs*. New

Brunswick, NJ: Transaction Publishers.] 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.

The research project was published in four articles: Rivard, J.C., McCorkle, D., Duncan, M.E., Pasquale, L.E., Bloom, S. L., Abramovitz, R. (2004). *Implementing a Trauma Recovery Framework for Youths in Residential Treatment*. Child and Adolescent Social Work Journal, 21(5): 529-550; Rivard, J. C. (2004). *Initial findings of an evaluation of a trauma recovery framework in residential treatment*. Residential Group Quarterly 5(1): 3-5; Rivard, J.C., Bloom, S. L., Abramovitz, R., Pasquale, L.E., Duncan, M., McCorkle, D., Gelman, A. (2003). *Assessing the Implementation and Effects of a Trauma-focused Intervention for Youths in Residential Treatment* Psychiatric Quarterly 74(2): 137-154; Rivard, J.C., Bloom, S. L., McCorkle, D. and Abramovitz, R. (2005) Preliminary results of a study examining the implementation and effects of trauma recovery framework for youths in residential treatment. *Therapeutic Community: The International Journal for Therapeutic and Supportive Organizations* 26(1): 83-96

Contact Information: An extensive collection of articles and information is available at www.sanctuaryweb.com. For additional information on the model and on training and consultation services via the Sanctuary Leadership Development Institute, contact: Sarah Yanosy, Andrus Children's Center 914-965-3700 x1117 syanosy@jdam.org, www.andruschildren.org

Seeking Safety

Description: Developed by Lisa M. Najavits, Ph.D., at Harvard Medical/McLean Hospital, *Seeking Safety* is a manualized model that offers coping skills to help clients attain greater safety in their lives. It is present focused and designed to be inspiring and hopeful. It is highly flexible and can be used for group or individual format; all levels of care (e.g., outpatient, inpatient, residential); all types of trauma and substances; and any clinician. There are 25 treatment topics, each representing a safe coping skill relevant to both PTSD and SUD. All topics are independent, and thus can be done in any order, with as few or many sessions as there is time for (it is not required to do all 25 topics). Seeking Safety is used broadly with clients who need improved coping skills; they do not have to meet criteria for PTSD and substance abuse as the skills can be generalized. 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). Used widely with adults, it has been implemented with adolescents (both boys and girls), and a published randomized controlled trial is available on adolescent girls; an outcome study on young African-American men court-ordered into treatment is currently in preparation.

The treatment manual, *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse*, (Najavits, 2002) includes clinician guidelines and client handouts. It offers up to 25 topics to address cognitive, behavioral, interpersonal, and case management domains. Each topic represents a safe coping skill relevant to trauma and substance abuse: 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.

Implementation of the model is enhanced by various materials including a website with extensive downloadable materials (www.seekingsafety.org), the published manual in English, Spanish, French, German, and Swedish; a poster and card deck of the Safe Coping Skills in the model; five hours of video-based training; and numerous national on-site trainings. Information on all of these is available from www.seekingsafety.org.

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 (Najavits et al., 2006). In a randomized controlled trial with 33 adolescent girls comparing Seeking Safety plus treatment-as-usual versus treatment-as-usual alone, 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 model has also been studied with older adolescents and young adults by Hamilton (2006), as part of a substance abuse residential treatment program. Participants were 76 African-American males aged 18 to 25, all referred by drug courts. During the six-month residential program, all clients completed all of the assigned modules of Seeking Safety. Results at end of treatment indicated significant decreases in substance use; 7 of 10 subscales of the Trauma Symptom Inventory; all 5 subscales of the Cognitive Distortions Scale; the anxiety subscale of the SCL-90; and the rate of unprotected sex. Both studies used the existing treatment manual for Seeking Safety without substantial modification, indicating that, at least based on initial evidence, the model appears to be relevant and acceptable to adolescents.

Contact Information: The manual (Najavits, 2002b) can be ordered from any bookseller, or from the website www.seekingsafety.org (section Order); the implementation materials (translations, videos, card deck, posters) can be obtained from the same section of the website. Information on upcoming trainings, and how to schedule training or consultation is on the website (section Training). Research, including those on adolescents, is on the website in the section Outcomes.

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Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)

Description: SPARCS is a group intervention that was specifically designed to address the needs of chronically traumatized adolescents who may still be living with ongoing stress and may be experiencing problems in several areas of functioning. These areas include difficulties with affect regulation and impulsivity, self-perception, relationships, somatization, dissociation, numbing and avoidance, and struggles with their own purpose and meaning in life as well as worldviews that make it difficult for them to see a future for themselves. Overall goals of the program are to help teens cope more effectively in the moment, enhance self-efficacy, connect with others and establish supportive relationships, cultivate awareness, and create meaning. Group members learn and practice each of the core SPARCS skills throughout the intervention and frequently report use of these skills outside of group. Core components of this intervention include Mindfulness practice, Relationship building/communication skills, Distress Tolerance, and Problem-solving and Meaning Making. Treatment also includes psychoeducation regarding stress, trauma, and triggers.

This intervention is strength-based and is appropriate for traumatized adolescents with or without current/lifetime PTSD. It is based on the assumption that the adolescents' symptoms (behavioral, interpersonal, and affective) represent their best efforts at coping with extreme stress. The treatment facilitates therapists' ability to help group members identify and build upon their

strengths. SPARCS is a present-focused intervention, and is not an exposure based model. Although there is no direct exposure component or construction of a trauma narrative, traumas are discussed in the context of how they relate to adolescents' current behavior and to their understanding of their problems and difficulties in the here and now. Group members routinely discuss and process their personal experiences throughout the group.

Groups are one hour in length and have been provided in a variety of settings including outpatient clinics, schools, group homes, boarding schools, residential treatment centers and facilities, and foster care programs. Sessions can be divided into two segments and conducted twice a week to accommodate class periods in a school setting. It is recommended that SPARCS be implemented in settings where adolescents can remain in treatment long enough to complete the intervention. SPARCS is predominantly cognitive-behavioral and draws upon Dialectical Behavior Therapy (Miller, Rathus, & Linehan, 2006), Trauma Affect Regulation: Guide for Education and Therapy for Adolescents and Pre-Adolescents (TARGET©-A: Ford, 2007), and Trauma and Grief Component Therapy (TGCT: Layne, Saltzman, Pynoos, et. al., 2000).

To date SPARCS has been conducted with ethnically diverse groups, including African American, Latino, Native American, LGBTQ, and refugee/immigrant populations, as well as adolescents in gangs and in rural settings. SPARCS has also been implemented with adolescents in foster care and in shelters with runaway/homeless youth. Some SPARCS handouts are available in Spanish and have been used with Spanish speaking youth and their caregivers.

Status of Research: Pilot data indicate significant improvement in overall functioning over the course of treatment (as measured by the Youth Outcome Questionnaire SR-2.0) for adolescents receiving SPARCS, with significant changes noted more specifically on subscales measuring conduct problems, inattention/hyperactivity, and interpersonal relationships. There was also a significant decline in PTSD symptoms, with improvements noted in the overall severity of posttraumatic stress symptoms, as well as in scores assessing symptoms related to re-experiencing, avoidance, hyper-arousal (Criterion B, C, and D respectively). Encouraging results were also

found in an Evidence Based Practices Pilot Program conducted by the Illinois Department of Children and Family Services in conjunction with The Mental Health Services and Policy Program at Northwestern University, with improvements noted on several of the subscales of the YOQ, including somatic complaints and anxious/depressive symptomatology. The pilot also compared SPARCS to treatment as usual using the Child and Adolescent Needs and Strengths (CANS) instrument. Results indicated that SPARCS was associated with significant improvements in Risk Behaviors as compared to the treatment as usual group. Furthermore, adolescents receiving SPARCS were half as likely to run away, and one-fourth less likely to experience placement interruptions (i.e., arrests, hospitalizations, runaways, etc.).

Contact Information: To obtain a manual and for information on training and consultation, contact: Mandy Habib, Psy.D. Division of Trauma Psychiatry 516-562-3276 mhabib@nshs.edu.

Trauma Affect Regulation: Guide for Education and Treatment (TARGET©)

Description: This model is adapted for use with adolescents. TARGET© was developed by Julian Ford, Ph.D., as an educational and therapeutic approach for the prevention and treatment of complex Posttraumatic Stress Disorder (PTSD). TARGET© provides a practical skill set that can be used by trauma survivors and family members to de-escalate and regulate extreme emotion states, to manage intrusive trauma memories in daily life, and to restore the capacity for information processing and autobiographical memory. TARGET© teaches a sequence of seven (7) skills described as the FREEDOM steps. The focus in TARGET© is on shifting the way a person processes information and emotions so that s/he is able to live life and make sense of memories without being trapped in an alarm state.

TARGET© explains post-traumatic symptoms as the product of an ingrained, but reversible, biological change in the brain's alarm and information processing systems and the body's stress response systems. Using graphics and simple language, TARGET© describes the stress response system as an "alarm" in the brain that is triggered by trauma or

extreme stress. When the brain becomes stuck in "alarm" mode a person cannot access the brain's capacities for clear thinking, and therefore reacts to all types of current stressors as survival threats. This causes serious difficulties in their relationships and daily life activities that can be addressed by using the FREEDOM skill set.

Essential Components: TARGET© is designed to address the primary personal issues that are related to trauma, such as PTSD symptoms, rage, traumatic grief, survivor guilt, shame, interpersonal rejection, and existential/spiritual alienation. The seven (7) core skills in TARGET© are taught through repeated coaching and guided practice and are described by the acronym, FREEDOM.

Applications: TARGET© originally was designed for and has been field tested in public sector and private nonprofit community mental health and addiction treatment settings with adults and adolescents. Although the information provided is complex, the language used in participant materials and in leader guides is down-to-earth rather than technical or academic terminology. The pacing of materials within and across sessions is designed to sustain participant interest without taxing clients' sometimes impaired information processing abilities. TARGET© has been adapted for several other trauma-affected populations:

- Survivors, rescue workers, and families affected by September 11, 2001
- Advocacy for women who have experienced domestic violence and their children
- Incarcerated men and women in prison or when newly re-entering the community
- Girls and boys in the juvenile justice system in secure and community programs
- Girls and boys in mental health and addictions treatment programs and schools
- Women with young children who are at risk for criminal justice involvement

TARGET© is manualized for adults and adolescents and can be offered in individual or group counseling or psychoeducation sessions conducted by clinicians,

case managers, rehabilitation specialists, or teachers for 10 to 12 sessions. TARGET© has been adapted for interventions that are not specifically focused on trauma recovery, such as anger management, anxiety/stress management, pain management, interpersonal skills, screening and orientation for new clients or residents, and general support groups.

Status of Research: A randomized effectiveness study was conducted comparing 9-session TARGET© groups versus trauma-informed substance abuse groups (TSU) in three adult substance abuse treatment programs (Frisman, L. K., Ford, J. D., Lin, H., Mallon, S., & Chang, R. (in press). Outcomes of trauma treatment using the TARGET© model. *Journal of Groups in Addiction and Recovery*). TARGET© was superior to TSU in maintaining sobriety.

A three-year randomized clinical trial study funded by the Department of Justice of TARGET© delivered as a 12-session individual therapy for PTSD was conducted with 147 low-income urban mothers. Findings are under review for publication and were presented at the Annual Conventions of the American Psychological Associations and the International Society for Traumatic Stress Studies in 2007. TARGET© was superior to a comparison social problem solving therapy (Present Centered Therapy; PCT) on improved emotion regulation and posttraumatic beliefs at posttest and follow-up, and led to additional improvements in dissociation and affectively-modulated coping and relational involvement.

A three-year randomized clinical trial study funded by the Office of Juvenile Justice and Delinquency Programs of TARGET© delivered as a 12-session individual therapy for PTSD compared to a relational therapy (Enhanced Treatment as Usual, ETAU) with 61 girls involved in delinquency was completed in Fall 2008. TARGET© was associated with greater improvement than ETAU on PTSD symptoms and remission from PTSD (77% versus 53%) at the conclusion of therapy.

A two-year field trial funded by the Office of Juvenile Justice and Delinquency Programs of TARGET© delivered as a group and milieu intervention in every Juvenile Detention Center in Connecticut will be completed in Fall 2008. Juvenile Justice data and admission/discharge questionnaire data are being collected in this quasi-experimental study of the impact of

the sequential introduction of TARGET© into mixed-gender and gender-specific (girls only) detention centers.

Endorsements: TARGET© was designated as the first promising practice model for traumatized youths in the juvenile justice system by the National Child Traumatic Stress Network (www.nctsn.org) and is endorsed by the California Evidence-Based Clearinghouse for Child Welfare (www.cachildwelfareclearinghouse.org), the RAND Corporation Gulf States Policy Institute (www.rand.org), and NREPP: SAMHSA's National Registry of Evidence-based Programs and Practices (www.nrepp.samhsa.gov).

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Contact Information: For information, training, and materials, contact Judith Ford
860-751-9072
Judy@advancedtrauma.com
www.ptsdfreedom.org

Trauma and Grief Component Therapy (TGCT)

Description: Developed by Christopher M. Layne, Ph.D., William R. Saltzman, Ph.D., and Robert S. Pynoos, M.D., M.P.H., Trauma and Grief Component Therapy (TGCT) is a manualized treatment for trauma-exposed or traumatically bereaved older children and adolescents that may be implemented in school, community mental health, or other service settings. The program has been implemented with a wide range of trauma-exposed and traumatically bereaved older child and adolescent populations, in both the United States and international settings. These populations include youth impacted by community violence, traumatic bereavement, natural and man-made disasters, war/ethnic cleansing, domestic violence, witnessing interpersonal violence, medical trauma, serious accidents, physical assaults, gang violence, and terrorist events. Individual session length is an average of 50 minutes. (Sessions can be shortened in length to accommodate school class periods. Alternatively, individual sessions can be expanded up to 90 minutes in length, as needed and if time allows.) Depending on the number and types of

treatment modules that are implemented, the total number of sessions ranges from 10 to 24. The program is applicable to either individual or group-based treatment modalities and guidelines are provided for adapting the program in a culturally and ecologically sensitive manner. TGCT is specifically designed to identify and effectively treat youths whose distress and dysfunction fall within the moderately to severely distressed range. It is thus intended to address the needs of both moderately exposed and severely exposed youths.

TGCT is a multi-component (modularized) treatment manual and accompanying workbook with detailed instructions for conducting individual or group sessions. The intervention is assessment-driven, with specific treatment modules being selected for implementation based on clients' problems, needs, and strengths. The intervention contains a variety of components. These include (a) initial assessment, case conceptualization, and treatment planning; (b) psychoeducation, (c) emotional regulation skills, (d) addressing youths' and families' traumatic stress experiences and reactions, (e) promoting adaptive coping (e.g., social support, problem-solving, contending with trauma and loss reminders), (f) addressing maladaptive beliefs relating to trauma and loss, (g) promoting adaptive developmental progression, (h) addressing grief and loss, (i) maintaining adaptive routines, (j) relapse prevention, and (k) ongoing monitoring, surveillance, and evaluation of treatment response. Family/parent sessions are offered at key points in treatment. Assessment tools are available to measure all major targeted therapeutic outcomes.

The program has been implemented and evaluated with a broad variety of school age to high school groups (ages 10 – 18), including war-exposed Bosnian adolescents (comprised of ethnic Muslim, Croatian, and Serbian youths); multi-racial, multi-ethnic middle and high school students exposed to community violence and school shootings in Pasadena, Long Beach, and Santee, Southern California; and among adolescents exposed to the September 11th 2001 terrorist attacks in New York City. Preliminary versions of the intervention were implemented with children exposed to community violence in an impoverished urban community in Inglewood,

California; with socioeconomically disadvantaged youths exposed to gang-related violence in San Fernando, California; and with youths exposed to a massive earthquake in Armenia. It has been translated into Bosnian and has been implemented in school, clinic and community outpatient settings.

Status of Research: A multi-site randomized controlled treatment outcome study of the effectiveness of a trauma/grief-focused group treatment for war-exposed adolescents in 10 Bosnian secondary schools was conducted in 2000 – 2001. Students were randomly assigned to either a 17-session manualized trauma/grief-focused group treatment (Trauma and Grief Component Therapy) (n = 71) conducted by trained school psychologists and pedagogues, or a control group (n = 73) who received a school milieu intervention conducted by the same school psychologists and pedagogues. Students were assessed at pre-treatment (beginning of school year), post-treatment (end of school year), and at 4-month follow-up on self-report measures of PTSD symptoms (UCLA Reaction Index; range 0-68), depression symptoms (Depression Self-Rating Scale; range 0-72), traumatic grief (UCLA Grief Scale, Traumatic Grief Subscale; range 0-24), and existential grief (UCLA Grief Scale, Existential Grief Subscale; range 0-24).

Results: Reliable reductions in PTSD symptoms (58% at post-treatment; 81% at selected follow-up) found in the treatment group compare favorably to rates reported in randomized controlled efficacy trials. Rates of reliable reductions in depression (23% at post-treatment, 61% at follow-up) and traumatic grief (40% at post-treatment) found in the treatment group are comparable or superior to rates found in community treatment settings. Substantial, but lower, rates of change in the comparison group were found for PTSD symptoms (33% at post-treatment; 21% at follow-up) and depression symptoms (13% at post-treatment; 52% at follow-up). Odds ratios of the likelihood of reliable symptom reduction were higher in the treatment group compared to the control group (up to 15.19 for PTSD at follow-up) for all outcomes. The treatment group had minimal to modest percentages of reliably worsened cases (0% to 9%), whereas the control group had modest to substantial percentages (3% to 17%), at post-treatment and follow-up.

Contact Information: To obtain a manual and for information on training and consultation, contact Christopher Layne, Ph.D., UCLA - National Center for Child Traumatic Stress (310) 235-2633, extension 223. cmlayne@mednet.ucla.edu

TRIAD Girls Group Treatment model

Description: 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 is in process.

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

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

Description: 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. *Voices* is an adaptation of *Helping Women Recover* for girls. 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 aggression. 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 (self, connecting with others, healthy living, and the journey ahead), with a total of 18 90-minute sessions. There are over 90 exercises included in the facilitator's guide. 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). A pilot study was conducted in CT and NYC using the gender-responsive girls' curriculum, *Voices: A Program of Self-Discovery and Empowerment*. This study (funded by CSAT) focused on fidelity and gathered initial data for a larger NIDA grant proposal. One proposal submitted to the National Child Health and Development Institute is a multi-site project with court-ordered girls in a randomized study that compares outcomes from *Voices* to current practices. Outcome measures will assess for 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). Both standardized tools for measurement and other developed instruments will be used. Another proposal is pending with the Donaghue Foundation. Pages 85, 86.

Contact Information: For additional information on research, contact: Jo Hawke, Ph.D.
hawke@PSYCHIATRY.UCHC.EDU

To obtain the *Voices* curriculum materials and for additional information on training, consultation, and research, contact
Stephanie S. Covington, Ph.D., L.C.S.W.,
858-454-8528
sscird@aol.com
www.stephaniecovington.com
www.centerforgenderandjustice.org.

Trauma-Specific Peer Support and Self Help Models

Guide to Trauma-Specific Peer Support and Self Help Models				
Name of Model	Intended Audience	Type of Services	Intended Setting	Approach
<i>The Essence of Being Real: Relational Peer Support for Men and Women</i>	Women, Men	Manual, training: Website: www.sidran.org		Group peer-to-peer sessions
<i>Growing Beyond Survival: A Self Help Toolkit for Managing Traumatic Stress</i>	Women, Men	Workbook w/ tools, Training	MH, Corrections, DV	Group sessions; individual sessions, Self-help
<i>Healing the Trauma of Abuse: A Women's Workbook</i>	Women	Workbook, Website: www.mentalhealthrecovery.com		Self-help or for use with a therapist or supportive friend
<i>Journey of Self-Discovery: A Study Guide for Trauma Survivors</i>	Women, SA, MH	Manual/Curriculum		Psycho-educational training program
<i>Restoring Hope and Trust: An Illustrated Guide to Mastering Trauma</i>	Women, Men, adolescent, any clinician; broad range of clients	Curriculum	Various Settings	Group or individual sessions, and self-help
<i>The Way of the Journal: A Journal Therapy Workbook for Healing</i>	Women, Men, adolescent, any clinician; broad range of clients	Curriculum	Various Settings	Group or individual sessions, and self-help
<i>Well Recovery Groups</i>	Women, SA, MH	Manual, Website: www.healthrecovery.com		Group sessions
<i>A Woman's Addiction Workbook</i>	Women, SA	Self-help book, Website: www.seekingsafety.org		Self-help or for use with a clinician
<i>Women's Leadership Training Institute: An Educational Group Curriculum for Women in Recovery.</i> Instituto de Entrenamiento para Mujeres Lideres en Recuperacion: Un curriculo educativo y grupal para mujeres en recuperacion	Women, SA, MH	Manual/ Curriculum, Training		Peer-led training program
<i>A Woman's Way through the Twelve Steps</i>	Women, SA, MH	Facilitator's guide, participant's workbook, DVD, book, consultation, training, TA	Outpatient, inpatient and residential substance abuse treatment, MH clinics, DV shelters, criminal justice settings	Group process, peer-led
<i>Your Surviving Spirit: A Spiritual Workbook for Coping with Trauma</i>	Women, Men	Workbook, Training, TA (English & Spanish), Website: www.dustymiller.org		Self-help

Key: MH – Mental Health; SA – Substance Abuse; TA – Technical Assistance

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

Description: Developed by Sidran Institute in partnership with the consumer advocates of the TAMAR Project, the Maryland Women, Co-occurring Disorders and Violence Study Site, this is a manualized approach to creating, facilitating, and maintaining a peer support program for people who have experienced traumatic events. It has also been successfully used by service providers who work with trauma survivors, for peer to peer support among helpers. 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. The program stands on its own, but uses many of the concepts and the RICH® relationships guidelines drawn from Risking Connection®, making it an ideal companion piece for systems using RC. The manual was written by Jennifer Wilkerson, M.S. who was on staff at Sidran at the time.

Status of Research: No research to date.

This resource can be downloaded for free from the Sidran website (www.sidran.org), but Sidran would like to know where it is being used, and by whom.

Contact Information: For additional information, training on using this resource, or to discuss bulk purchases, contact: Esther Giller, Sidran Institute 410-825-8888 x 207, or to purchase printed bound copies of the manual, e-mail orders@sidran.org.

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

Description: This approach teaches skills that empower survivors to take control of and de-escalate their most distressing trauma-related symptoms. The model was originally designed for therapist-run symptom management therapy groups.

This workbook version, developed by Sidran Institute, 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 to find relief from trauma-related symptoms (including poor concentration, sleep disturbances, panic attacks, nightmares, flashbacks, and other physical responses). It also examines the relationship between trauma and self-harming behaviors, difficulties with sexuality, and substance abuse.

Status of Research: No research to date.

Contact Information: To obtain this resource, for training on using this resource and for additional information, contact: Sidran Institute 410-825-8888 x 207, esther.giller@sidran.org www.sidran.org/gbs

Healing the Trauma of Abuse: A Women's Workbook

Description: 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.

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

Journey of Self-Discovery: A Study Guide for Trauma Survivors

Description: A manualized program updated in June 2007, created by New Partnerships for Women, a

collaborative consumer/provider/advocate project in Wisconsin. The manual focuses on understanding the scope of trauma in women's lives, the effects of trauma, symptom self management, meeting basic needs, and self-advocacy. This four part psycho-educational training program, jointly taught by consumers and providers, is available for women who have experienced mental health and/or substance abuse problems and who have histories of trauma.

Status of Research: No research to date.

Contact Information: To obtain the curriculum and for additional information, contact: Dianne Greenley 608-267-0214 dianneg@drwi.org, or visit this website: <http://www.theannainstitute.org/SGTS.html>

Restoring Hope and Trust: An Illustrated Guide to Mastering Trauma

Description: A ten-session model for conducting psychoeducational groups on trauma developed at the Menninger Clinic for use in treatment with a wide range of clients and their loved ones. This short, educational curriculum captures the material from Jon Allen's *Coping with Trauma: A Guide to Self-Understanding* that is most important in understanding and learning to master the impact of trauma. The authors, Lisa Lewis and Kay Kelley, in addition to Jon Allen, have found this shorter course to be helpful to people struggling with trauma.

It targets three audiences: people struggling to contain and master the spillover of past trauma into their current lives; those who love them and want to have a better idea of how to be helpful; and professionals who would like to conduct psychoeducational trauma groups in their home communities.

The theme of the model is simple: past trauma often does not remain in the past but all too often spills over into the present in the form of intrusive re-experiences of trauma, associated neuro-physiological changes, adverse effects on current identity and world view, and depressive mood changes. This can lead traumatized individuals to develop and rely on a range of stopgap coping mechanisms, such as alcohol use, illegal drugs, or self-injurious behaviors. The perceived short-term

benefits of these coping measures disappear and unintended negative effects, such as long-term drug abuse, often result. Reenactments of past trauma in current interpersonal relationships can lead to compassion fatigue in loved ones. Individuals using this ten-session group model can learn to attain greater mastery over trauma symptoms and a sense of well being.

Mindfulness exercises help to center students of this model before beginning the work. Self-study questions at the end of each section help the user make the lessons of each chapter more personally relevant.

Status of Research: In ongoing use at the Menninger Clinic, Houston, TX.

Contact Information: To obtain this resource and for additional information, contact: Sidran Institute 410-825-8888 www.sidran.org/store orders@sidran.org.

The Way of the Journal: A Journal Therapy Workbook for Healing

Description: Originally the result of author Kathleen Adams's work with sexual trauma survivors, THE WAY OF THE JOURNAL has proved itself to be a theoretical and developmental model useful for recovery from all types of traumatic stress. It is also especially effective for individuals who have had a difficult time getting started with a therapeutic writing program and for therapists who wish to offer a clinically sound approach to journal writing. It offers a practical, pragmatic, and theoretically grounded way to use journal therapy techniques and interventions for healing of body, psyche, and soul.

The second edition of the model (1998), published by Sidran Institute, offers new theoretical ideas on the Journal Ladder, a developmental approach to journal therapy, and thumbnail sketches of journal interventions that are not specifically practiced within the workbook. There is a section on working with dreams in the journal. The vital tools of structure, pacing, and containment continue to dominate the theoretical ground

When appropriately used, free writing (unboundaried, unstructured, open-ended, nondirected) can be a highly effective technique that offers clarity, insight, and intuitive connection. But it's not the technique of choice for either end of the post-traumatic stress continuum. In the hyperarousal part of the PTSD cycle, free writing feels uncontrolled and oceanic; in the numbing part of the cycle, it feels flat and empty.

The Way of the Journal's ten-step ladder starts with the most highly structured, highly contained, highly paced journal technique (sentence stems) and gradually build in fluidity and openness. The continuum *ends* with free writing, which is where most people begin.

With the foundation of structure, pacing, and containment in place, journalers can learn to match their mood, issue, or desired outcome with a journal intervention that will enhance the likelihood of success. The ten techniques are: sentence stems; the 5-minute writing sprint; the structured writing exercise; clustering; alphaPoems; characters sketches; dialogue; springboards; poetry; and finally free writing. With practice journalers learn to approach their most difficult or painful issues with the journal interventions that are most likely to succeed. The workbook teaches vital tools for creating a positive journal relationship, including balance, permission, and choice-making

Status of Research: Used extensively at the Center for Journal Therapy, Wheatridge, CO

Contact Information: To obtain this resource and for additional information, contact: Sidran Institute 410-825-8888
www.sidran.org/store
orders@sidran.org

Well Recovery Groups

Description: 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.

Contact Information: 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, contact: Marissa Daley
617-661-3991
marissadaley@healthrecovery.org
www.healthrecovery.org

A Woman's Addiction Workbook

Description: 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 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. This model can also be conducted by clinicians (see the published outcome study described below for details).

Status of Research: A published outcome study (Najavits, Rosier, Nolan, Freeman, 2007) 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 professional counselors 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.

Contact Information: To obtain the workbook, the published outcome study, and additional information, contact: Lisa M. Najavits, Ph.D.

617-731-1501 (phone)

617-701-1295 (fax).

info@seekingsafety.org, or go to:

www.seekingsafety.org

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

Description: 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 (Amaro, Nieves, & Saunders, 2004).

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.' Four published papers present findings showing race/ethnic differences in clinical profiles and services needs and

that women in the intervention stay in treatment longer and at follow-up have lower sexual HIV risk behaviors, and lower rates of drug use and mental health and trauma symptoms than those in the comparison condition (Amaro, Gampbel, Larson, Lopez, Richardson, Savage, & Wagner, 2005; Amaro, Larson, Zhang, Acevedo, & Matsumoto, 2007; Amaro, Chernoff, Brown, Arévalo, & Gatz, 2007; Amaro, Dai, Arévalo, Acevedo, Matsumoto and Nieves, 2007).

Amaro, H., Gampbel, J., Larson, M.J., Lopez, L., Richardson, R., Savage, A., & Wagner, D. (2005). Racial/Ethnic Differences in Social Vulnerability among Women with Co-occurring Mental Health and Substance Abuse Disorders: Implications for Treatment Services. *Journal of Community Psychology*, 33(4), 495-511.

Amaro, H, Nieves, RL, and Saunders, L. (2004). *Women's Leadership Training Institute: An educational group curriculum for women in recovery*. Boston Consortium of Services for Families in Recovery, Public Health Commission, Boston, MA.

Amaro, H., Larson, M. J., Zhang, A., Acevedo, D., Dai, J., & Matsumoto, A. (2007). Effects of trauma intervention on HIV sexual risk behaviors among women with co-occurring disorders in substance abuse treatment. *Journal of Community Psychology*, 35(7), 895-908.

Amaro, H., Chernoff, M., Brown, V., Arévalo, S., & Gatz, M. (2007). Does integrated trauma-informed substance abuse treatment increase treatment retention? *Journal of Community Psychology*, 35(7), 845-862.

Amaro, H., Dai, J., Arevalo, S., Acevedo, A., Matsumoto, A., & Nieves, R. (2007). Effects of integrated trauma treatment on outcomes in a racially/ethnically diverse sample of women in urban community-based substance abuse treatment. *Journal of Urban Health*, 84(4), 508-522.

Contact Information: To obtain a manual, contact: Dr. Hortensia Amaro

h.amaro@neu.edu

or

Rita Nieves, R.N., M.P.H.,

Rita_Nieves@bphc.org

A Woman's Way through the Twelve Steps

Description: The *A Woman's Way through the Twelve Steps* program was 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, to address the unique needs of women in recovery. Traditionally, the self-help program and materials of Alcoholics Anonymous (and other Twelve Step groups) have focused on men's recovery. Many women find the male-based language and the lack of female examples difficult to identify with. In addition, many substance-abusing women have experienced trauma and do not find help for this in Twelve Step recovery (it's often not even mentioned). These materials are specifically designed to include trauma and other pertinent issues in women's lives. The A Woman's Way (AWW) program materials consist of the following:

A Woman's Way through the Twelve Steps (book) A diverse group of recovering women were interviewed about their experience of using the Steps and what the Steps meant to them. Trauma and its relationship to addiction recovery is an often repeated theme.

A Woman's Way through the Twelve Steps (workbook) Each chapter focuses on a Step. There are exercises to assist the women in understanding the underlying themes in each Step. While the Steps were designed for addiction recovery they are also tools for living life.

A Woman's Way through the Twelve Steps (facilitator guide) This manual consists of thirteen 90 minute group sessions that can be peer-led. Each session focuses on one of the Steps and has focus questions, interactive exercises, self-soothing techniques, and the

sharing of gratitude. While the focus is on recovery from addiction, the theme of trauma is interwoven throughout. There is also a section on how to adapt this for use with teen-age girls.

The accompanying DVD can be used by the peers to assist in self-training and can also be used with the women participants. There are scenes of women interacting in a facilitated group and sharing their experiences with the various exercises.

Status of Research: No research to date.

Contact Information: To obtain the *A Woman's Way* curriculum materials and for additional information on training and consultation, contact Stephanie S. Covington, Ph.D., L.C.S.W., 858-454-8528
sscird@aol.com
www.stephaniecovington.com
www.centerforgenderandjustice.org

Your Surviving Spirit: A Spiritual Workbook for Coping With Trauma

Description: 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.

Contact Information: To obtain the manual, and for information on training and technical assistance (in English and Spanish) and to obtain copies of the manual, contact: Dusty Miller
413-584-8404
413 203 1432 (h&w)
(413) 313 6317 (c)
dustymi@aol.com
www.dustymiller.org

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 lifespan, including sexual abuse, physical abuse, severe neglect, loss, abandonment, threat, and/or the witnessing of violence. Although not as prevalent in the lives of most clients, trauma may also be caused by overwhelming experiences such as natural disasters, terrorism, and combat.

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 and supported in 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 staff, a unit or office within the department, and/or ongoing, high-visibility leadership on the part of the lead system administrator. This person or group should develop a written plan with trauma-related goals, objectives and timelines, approved and activated by administration, and should meet regularly with system administrator.
- 2. State trauma policy or position paper.** A written statewide policy or position statement should be adopted and endorsed by administrative leadership, and disseminated to all parts of the service system, stakeholder groups, and other collaborating systems. 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* (www.nasmhpd.org) serves as a model of such a position paper.
- 3. Workforce recruitment, hiring, and retention.** The system should prioritize recruitment, hiring, and retention of staff with educational backgrounds, training in and/or lived experience of trauma. These staff or “trauma champions” provide needed expertise and an infrastructure to promote trauma-informed policies, training and staff development, and trauma-based treatment and support practices throughout the service system. They advocate for consideration of trauma in all aspects of the system. There should be outreach to sources of prospective trauma-educated/informed employees (e.g. universities, professional organizations, peer-led and peer support programs, consumer advocacy groups; other training sites). Professional organizations and universities should be approached to set standards and to offer curriculums preparing students to work with trauma survivors. Incentives, bonuses, and promotions for staff and supervisors should take into account their role in trauma-related activities. Support should be provided for direct care staff to address impacts on staff of trauma work. There should be a written policy and regularly monitored plan for building and supporting workforce trauma-competency in all aspects of the service system. Policies and procedures should ensure safety from sexual offenders in all recruitment, screening and hiring practices of both employees and volunteers, and guidelines should be established to prevent and respond to reported incidents of such abuse.
- 4. Workforce orientation, training, support, job competencies and 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, including administration, should receive orientation and basic education about the prevalence and traumatic impacts of sexual and physical abuse and other overwhelming adverse experiences in the lives of service recipients. In order to ensure safety and reduction of harm, training should cover dynamics of retraumatization and how practice can mimic original sexual and physical abuse experiences, trigger trauma responses, and cause further harm to the person. All employees must also be educated about the impacts of culture, race, ethnicity, gender, age, sexual orientation, disability, and socio-economic status on individuals' experiences of trauma.

Direct service staff and clinical staff should be educated in a trauma-informed understanding of unusual or difficult behaviors, in the maintenance of personal and professional boundaries, in trauma dynamics and avoidance of iatrogenic retraumatization, in the relationships between trauma, mental health symptoms and other problems and life difficulties, and in vicarious traumatization and self-care. They should learn application of trauma-informed issues and approaches in their specific content areas, and trauma-specific techniques such as grounding and teaching trauma recovery skills to clients.

Staff whose clinical work includes assessment and treatment should be required and supported to implement evidence-based and promising practices for the treatment of trauma, and to attend ongoing advanced trauma trainings. Whenever possible, trainings should be multi-system, inclusive of staff in mental health and substance abuse, health care, educational, criminal justice, social services systems and agencies, and promoting systems integration and coordination. *(Goals 3.1, 3.2, 4.2, 4.3, 4.4, 5.3, 5.4: President's New Freedom Commission on Mental Health Final Report)*

- 5. Consumer/Trauma Survivor/Recovering person involvement and trauma-informed rights.** The voice and participation of consumers

who have lived experiences of trauma should be actively involved in all aspects of systems planning, oversight, and evaluation. Trauma-informed individualized plans of care should be developed in collaboration with every adult and child and child's family or caregivers receiving mental health system services. Consumers with trauma histories should be significantly involved in staff orientation, training and curriculum development 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 rights to maximum choice, collaboration and empowerment) and to the ways in which these rights may be systematically violated. *(Goals 2.1, 2.2, 2.3, 2.4, 2.5: President's New Freedom Commission on Mental Health Final Report)*

Administrative Policies/Guidelines Regarding Services

- 6. Financing criteria and mechanisms to support the development of a trauma-informed service system and implementation of evidence-based and promising 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 promising 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. *(Goal 3: President's New Freedom Commission on Mental Health Final Report)*

7. Clinical practice guidelines for working with children and adults with trauma histories.

Findings from studies, including SAMHSA’s Women, Co-Occurring Disorders, and Violence study and more recently studies involving traumatized children, increasingly provide evidence that trauma treatment is effective. Numerous 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, respect cultural diversity, and be experienced as empowering by consumer/survivors.

8. Policies, procedures, rules, regulations and standards to support access to trauma treatment, to develop trauma-informed service systems and to avoid retraumatization.

Policies and regulations that guide system-wide practices are central to ensuring that trauma-informed and trauma-specific services are adopted consistently. Trauma-informed policies and procedures are crucial to reducing or eliminating potentially harmful practices such as seclusion and restraint, involuntary medication, etc. Therefore, they must be carefully reviewed, revised, monitored and enforced to take into account the needs of trauma survivors. Licensing, regulations, certification, and contracting mechanisms should all reflect a consistent focus on trauma. Policies and regulations addressing confidentiality, involuntary hospitalization and coercive practices, consumer preferences and choice, privacy, human resources, rights and grievances for employees are also key. 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. *(Goal 3: President’s New Freedom Commission on Mental Health Final Report)*

9. Needs assessment, evaluation, and research to explore prevalence and impacts of trauma; assess trauma survivor satisfaction, service

utilization and needs; and to monitor and make adjustments in trauma-informed and trauma-specific service approaches. Data on trauma prevalence, trauma impacts, effectiveness of trauma services and consumer satisfaction can provide rationale for support/funding of such services and the training necessary for their implementation. Such data should be regularly collected and used as part of ongoing quality improvement and planning processes. Evaluation and research activities should be carried out through internal staffing or through liaison with external evaluators and researchers, to determine the effectiveness of systems-change to a trauma-informed system, and to identify outcomes of trauma-related services. These findings are incorporated into ongoing services modifications and planning. *(Goals 5.1, 5.4: President’s New Freedom Commission on Mental Health Final Report)*

Trauma Services

10. Universal 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. At a minimum, questions should include histories of physical and sexual abuse, domestic violence, and witnessed violence. Individuals 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.

11. 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 and trauma play 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 trauma-informed

system recognizes that trauma results in multiple vulnerabilities and affects many aspects of a survivor's life over the lifespan, and therefore coordinates and integrates trauma-related activities and trainings with other systems of care serving trauma survivors. A basic understanding of trauma and trauma dynamics, including that caused by childhood or adult sexual and/or physical abuse shown to be prevalent in the histories of mental health consumers, 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 allows services to be delivered in a way that will avoid retraumatization and facilitate consumer participation in treatment. A trauma-informed service system is knowledgeable and competent to recognize and respond effectively to adults and children traumatically impacted by any of a range of overwhelming adverse experiences, both interpersonal in nature and caused by natural events and disasters. *(Trauma-informed service systems increase capacity to address Goals 2, 3, 4 and 5 in the President's New Freedom Commission on Mental Health Final Report)*

- 12. Trauma-specific services, including evidence-based and promising 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, including adults, and children and their families. As part of national research initiatives including the SAMHSA *Women, Co-Occurring Disorders, and Violence* study and SAMHSA's National Child Traumatic Stress Network, numerous evidence-based and promising practice trauma treatment models applicable in public sector service systems, have been manualized and proven to effective in reducing symptoms. Many of these best practice models have been identified in the SAMHSA publication "Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services". Selected 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 studies such as the WCDVS, trauma treatment programs should provide integrated trauma, mental health and substance abuse services and counseling designed to address all three issues simultaneously. *(Goals 2.1; 3; 4.3; 5.2; 6.1 President's New Freedom Commission on Mental Health Final Report)*

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