

"What happened to you?"

**Addressing Trauma with
Community Mental Health
Populations:
A Toolkit for Providers**

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This manual is dedicated to Bruce, Charles, and Rondi

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Foreword

Both the title of this manual, and the picture that is found on the front cover, are worthy of explanation. In many sectors of the behavioral healthcare world, and for many years, the prevailing question faced by the trauma-surviving consumers in our care has typically been some version of, “What is wrong with you?” Even when asked in a compassionate manner, such a question inadvertently focuses on what for many are the manifestations of under-identified and under-treated traumatic experiences – addictive disorders, personality disorders, and other forms of mental or emotional illness. One of the most significant paradigm shifts involved in embracing a trauma-informed system of care is the greater amount of attention paid to asking, and hearing the answer to, a different question, namely, **“What happened to you?”**

The symbol of the feather encased in a solid, dark block is intended to reflect this important co-existence of the vulnerable, traumatized individual that so frequently exists behind often thick and multiple layers of maladaptive attempts to cope with the soul-shattering impact of experiences that have been significantly traumatic – physically, sexually and/or emotionally. The move to trauma-informed and trauma-specific service systems must ideally include the ability of our behavioral healthcare workers to rightly look at presenting problems and symptoms, but also to look further and to consider whether such presenting concerns may be the sequelae of traumatic experiences. Effective treatment rests upon accurate diagnosis, and the better we become at trauma-informed diagnosis and treatment, the better our consumers’ service outcomes will be.

The completion of this project would not have been possible without the contributions of many individuals, too many to name and thank here. Of special note are two particular groups that deserve to be singled out – our conference training planning committee (*Yarrow Halstead, Anne Rogers, Jan Baltzell, Carol Hartford, Karma Mohring and Brenda Scotton*), and our clinical trauma champions (*Flo Hepola, Nathan Rahn, Mike Ferriter, Carol Ludwig, Linda Bacigalupi, Wendy Svatora, and Sarah Starkey*). Tremendous time and effort was also contributed by our volunteer videographer, Steve Towery. In various and unique ways, the commitment of each of these named individuals to the cause of developing and implementing trauma-informed and trauma-specific services at Community Support and Treatment Services (CSTS) has been hugely significant, and much appreciated! None of these efforts would have been possible without administrative support from the very top, and for that, our Executive Director, Donna Sabourin, also deserves much credit and thanks.

Thanks are also extended to the State of Michigan’s Department of Community Health for approving the block grant resources that were used in advancing this initiative, and for allowing the extensions needed to bring this project to full completion. Thanks also to the Washtenaw Community Health Organization for serving as the fiduciary for this grant-supported effort.

On the pages that follow is the story of one community mental health agency’s efforts to move in the direction of trauma-informed and trauma-specific service delivery. It is hoped that the trial-and-error learning and the progress described within this manual can be helpful in guiding

additional efforts to move forward with this crucial element of behavioral healthcare within the State of Michigan's public community mental health system. For Washtenaw County CSTS, it is a journey that is far from complete. Just as progress to this point has built upon the previous efforts of many concerned stakeholders, the way forward will also need to be additionally informed by the efforts of others. For the benefit of service recipients, service providers, and the greater communities in which we live, consider joining in the advancement of this important frontier of behavioral healthcare!

~ Steve Wiland

I. Overview

Over the past two decades, there has been growing evidence concerning the prevalence and impact of trauma in the lives of people who come into contact with various human service systems, including Michigan's Community Mental Health provider network. Increasing awareness of the pervasiveness and damaging impact of trauma has led to the inescapable conclusion that if behavioral healthcare providers are to be as effective as possible, their services must address this area of recovery need. As so well articulated by Roger FalLOT, Maxine Harris, and others, trauma-informed and trauma-specific service approaches are indicated for all of the following reasons.

Trauma is widespread. National community-based surveys find that between 55 and 90% of us have experienced at least one traumatic event over the course of a lifetime – and individuals report that, on average, they have experienced nearly five traumatic events! The experience of trauma is simply not the rare exception we once considered it to be (*FalLOT & Harris, 2009*). It is the expectation, rather than the exception, among a majority of the populations referred to Community Mental Health service providers.

As noted by Lisa Najavits (*2002c*) and others, the dual diagnosis of PTSD and substance abuse is surprisingly common, with PTSD rates among all recipients of substance abuse treatment found to be between 12%-34%. For female recipients, PTSD rates have been found to be between 30%-59%, with rates of lifetime trauma even more common (*Kessler et al, 1995; Langeland & Hartgers, 1998; Najavits et al, 1997; Stewart, 1996; Stewart et al, 1999, Triffleman, 1998*).

The impact of trauma is broad and touches multiple life domains. Trauma exposure increases the risk of a tremendous range of negative outcomes: mental and emotional health disorders like posttraumatic stress disorder, depression, excessive hostility, and generalized anxiety; substance use disorders and related consequences; physical health problems, including those associated with eating disorders; struggles in interpersonal relating; and self-harmful urges and behaviors, among many others. Trauma therefore touches many areas of life not always obviously or readily connected with the traumatic experience itself. This broad impact makes it particularly important to understand how the dots connect between experiences of trauma and their aftereffects (*FalLOT & Harris, 2009*).

Individuals with co-occurring PTSD and substance use disorders suffer a variety of life problems that may complicate their clinical prognosis and treatment, including other DSM-IV disorders, relational and medical problems, maltreatment of their children, custody battles, homelessness, HIV risk, and domestic violence (*Brady et al, 1998; Brady et al, 1994; Brown & Wolfe, 1994; Dansky et al, 1999; Najavits et al, 1998a*).

The impact of trauma is often deep and life-altering. Trauma can be fundamentally life-changing, especially for those individuals who have faced experiences of complex trauma in which abuse was repeated and prolonged, or when the violence was perpetrated by those in the

roles of caretakers. Physical, sexual, and emotional violence may have become a central reality around which profound neurobiological and psychosocial adaptations occur. Trauma survivors may come to see themselves as fundamentally flawed, and to perceive the world as a pervasively dangerous place. Trauma can shape a person's way of viewing and being in the world, leading to severe disempowerment and psychological damage (*Fallot & Harris, 2009*).

Treatment outcomes for individuals with co-occurring PTSD and substance use disorders are far worse than for other dually diagnosed populations, or for those with substance use disorder alone (*Ouimette et al, 1998; Ouimette et al, 1999*).

Violent trauma is often self-perpetuating. Individuals who are the victims of violence are at increased risk of becoming perpetrators of violence themselves. This intergenerational transmission of violence is predictable, and well documented. Community violence is often built around cycles of retaliation. Many of our institutions – not only criminal justice settings, but also schools, hospitals and religious institutions – are too frequently places where violent trauma is perpetuated rather than eliminated (*Fallot & Harris, 2009*).

Individuals with co-occurring PTSD and substance use disorders are vulnerable to repeated traumas (*Fullilove et al, 1993; Herman, 1992*), and to a greater extent than those with substance use disorders alone (*Dansky et al, 1998*). A downward spiral effect is common – for example, using substances can increase vulnerability to traumatic experiences, which in turn can lead to additional substance use (*Fullilove et al, 1993*).

Trauma is insidious and preys particularly on the most vulnerable among us. People who are impoverished, who are homeless, who have been diagnosed with severe mental health problems, who struggle with alcohol or drug abuse, or who have developmental disabilities – all of these groups are at increased risk of traumatic victimization (*Fallot & Harris, 2009*). And because these groups are well-represented among the populations served by Michigan's Community Mental Health provider network, it is imperative that the public behavioral healthcare system become as knowledgeable and effective as possible in addressing this critical element of recovery.

Various subpopulations have higher rates of co-occurring PTSD and substance use disorders, including combat veterans, inmates, victims of domestic violence, the homeless, and adolescents (*Bremner et al, 1996; Clark & Kirisci, 1996; Dansky et al, 1999; Davis & Wood, 1999; Jordan et al, 1996; Kilpatrick et al, 2000; Ruzek et al, 1998*).

Trauma affects the way people approach potentially helpful relationships. Not surprisingly, individuals with histories of abuse are often reluctant to engage in, or quickly drop out of, many social services. Hypervigilance and suspicion are often important and thoroughly understandable self-defense mechanisms in coping with trauma exposure (*Fallot & Harris, 2009*). But these self-protective ways of coping make it more difficult for survivors to experience the safety and trust necessary to engage in relationships with helpful others, including providers of Community Mental Health services.

Trauma has often occurred in the service context itself. Involuntary and physically coercive practices, as well as many other activities that trigger trauma-related reactions, are still too common in some of our centers of help and care (*Fallot & Harris, 2009*). Michigan’s public behavioral healthcare system must break this pattern of unintentional retraumatization in order to make comprehensive progress in addressing trauma within our priority service populations.

Growing awareness of these facts regarding trauma has led to calls for the development of both **trauma-informed** and **trauma-specific** services. Human service systems become **trauma-informed** by thoroughly incorporating, in all aspects of service delivery, an understanding of the prevalence and impact of trauma and the complex pathways to healing and recovery. Trauma-informed services are designed specifically to avoid re-traumatizing those who come seeking assistance. They seek “safety first” and commit themselves to “do no harm.” Studies such as the SAMHSA-funded Women, Co-Occurring Disorders, and Violence Study have provided evidence that trauma-informed approaches can enhance the effectiveness of mental health and substance abuse services. By contrast, **trauma-specific services** have a more focused primary task – to directly address trauma and its impact and to facilitate trauma recovery. An increasing number of promising and evidence-based practices address PTSD and other consequences of trauma, especially for people who often present with other complicating vulnerabilities (e.g., substance use, severe mental health problems, homelessness, and/or contact with the criminal justice system).

II. Getting Started

Grant funding resources

Following attendance at a statewide training on the topic of “Trauma-informed Systems of Care” by Roger Fallot, this project was proposed to the State of Michigan’s Department of Community Health (MDCH) for block-grant funding for fiscal year 2008-09. The project’s goal was as follows (excerpted from the more complete grant proposal found in **Appendix A.1: Competitive Grant Proposal Narrative**):

“The proposed project, ‘Addressing Trauma Within the Community Mental Health Population: A Toolkit for Practitioners,’ is intended to address the need for developing trauma-informed and trauma-specific services to populations served by Washtenaw County’s community mental health provider, Community Support and Treatment Services. We plan to review existing evidence-based practice models, to make indicated adjustments for efficacious use with the severely and persistently mentally ill populations we serve, and to lay the foundation for service delivery by educating and training staff at all levels and scopes of practice. Appropriate clinical supervision support will be established, group and individual treatment protocols will be designed, and gender- and trauma-specific treatment will be initiated . . .

Nationally recognized experts in the area of trauma, such as Roger Fallot and Maxine Harris, have helped to raise awareness of the need for greater trauma-informed and trauma-specific services. National community-based surveys find that between 55% and 90% of the general population have experienced at least one traumatic event in their lifetime. The prevalence percentages only increase among those populations made more vulnerable by risk factors including mental, emotional, and developmental disorders, co-occurring addictions, and poverty, all of which are risk factors with disproportionately high representation among the populations served by our public sector community mental health system . . .

The need for this proposed project has been evident locally for a number of years, most recently emphasized through CSTS’ work with consumers in treatment for co-occurring mental health and substance use disorders, over half of which report historical experiences of trauma. Additionally the work of CSTS’ Project Outreach Team (PORT) uncovered an even higher prevalence of traumatic experiences among the homeless populations they serve. Several consumers of CSTS’ ACT and PORT teams and DBT-track services have reported unresolved/under-resolved historical experiences of sexual or physical trauma, as well as the witnessing of significant violence, and have asked for assistance in addressing this as part of their co-occurring disorders treatment. Although CSTS is among the leaders in the State of Michigan in the implementation of integrated dual disorders treatment, the lack of greater trauma-informed and trauma-specific services represents a gap in the current clinical treatment continuum . . .

This project will improve the support available to numerous CSTS’ consumers in their recovery from co-occurring mental health and/or substance use disorders, as unresolved/under-resolved trauma has been found to be a significant obstacle to a more satisfying, higher-functioning and sustainable state of wellness and recovery. Trauma poses a significant relapse risk for both the

recurrence of mood-disorder and personality-disorder symptoms, as well as for relapse of addictive disorders. Effective trauma-informed and trauma-resolution services will address the shame and stigma often experienced by trauma survivors that can impede their efforts to make their recovery needs known in this realm. This project will improve access to available services that can make an important difference in consumers' lives, leading to greater independence, empowerment, and fuller participation in community life. This training project will better facilitate healing from the incredibly disempowering effects of trauma.”

Kickoff Meeting

After learning of the approval of the trauma grant proposal by MDCH, an invitation was extended across the agency to any/all individuals interested in meeting to begin to discuss how best to move ahead with addressing trauma within our service recipient populations. A two-hour meeting was convened at the local Ypsilanti Public Library on December 2nd, 2008, and 24 staff attended, in response to a cross-agency open invitation, representing all three of the agency's departments – Adult Services, Youth and Family, and Developmental Disabilities. Represented disciplines included Social Work, Psychology, Nursing, and Psychiatry, with scopes of practice ranging from case manager, therapist, and peer support specialist to supervisor, psychiatric nurse and the agency's Medical Director.

“Trauma 101” Presentation – As it was not known what level of knowledge existed among those assembled, the kickoff meeting began with a “Trauma 101” presentation that included a working definition/description of trauma, Posttraumatic Stress and Posttraumatic Stress Disorder (PTSD), along with some prevalence and gender-specific trend data, presented with the help of the set of slides duplicated below. Descriptions of PTSD diagnostic criteria were taken from the Diagnostic and Statistical Manual of Mental Disorders: Fourth Edition (APA, 1994), and are duplicated in their entirety immediately following the slides.

<p style="text-align: center;">What is Trauma?</p> <p>Trauma is the physical and emotional reaction to an event that is:</p> <ul style="list-style-type: none"> – Life threatening, or – Seriously jeopardizes the physical, emotional or spiritual well-being of that person or someone close to them, and – The person experiences intense fear, helplessness or horror. 	<p style="text-align: center;">Traumatic Events include:</p> <ul style="list-style-type: none"> • War, battles, combat (death, explosions, gunfire...) • Natural disasters (floods, tornados, fires...) • Catastrophe (harmful/fatal accidents, terrorism) • Violent attack (animal attack, assault with or without a weapon, battery and domestic violence, rape, threats of bodily harm with or without a weapon) • Abuse (physical, sexual, mental and/or verbal)
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What is Trauma?

- Trauma is an experience that overwhelms our capacity to have a sense of control over ourselves and our immediate environment, to maintain connection with others and to make meaning of our experience.



How do people react to trauma?

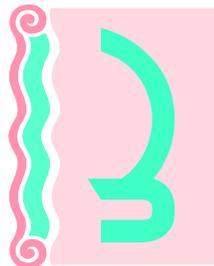
PTS: Post Traumatic Stress

- PTS is the emotional and physical reaction from the memories of a traumatic event experience, and the shattered sense of personal safety. Symptoms can include:
 - Anxiety
 - Flashbacks
 - Dissociation
- While discomforting, these reactions do not disrupt the individual's overall ability to function.



How do people react to trauma?

- **PTSD: Post Traumatic Stress Disorder** – characterized by three clusters of symptoms . . .



PTSD – Intrusive Symptoms

- **Intrusive memories and emotions** interfere with normal thought processes and social interactions.
- **Flashbacks** feature auditory and visual hallucinations and can be triggered by ordinary stimuli such as the sound of an airplane flying overhead (combat), violent scenes on TV, the smell of a certain cologne.



PTSD – Intrusive Symptoms

- **Nightmares and night terrors** also feature aspects of the traumatic event (*often literal, but can be figurative*).
- **Dissociative symptoms** include psychic numbing, depersonalization and amnesia.



Avoidant Symptoms

- Avoiding emotions
- Avoiding relationships
- Avoiding responsibility to and for others
- Avoiding situations that are reminiscent of the traumatic event.
 - *People with PTSD commonly avoid stimuli and situations that remind them of the traumatic event because they trigger symptoms.*



Hyper-arousal Symptoms

- Sleep disturbance
- Explosive outbursts
- Irritability
- Panic symptoms
- Extreme vigilance
- Exaggerated startle response



– People experiencing hyper-arousal (constant “flight or fight”) are always on the alert for danger or threat, and are easily startled.

Types of PTS/PTSD

Type I or Simple PTS/D

- The response to one or more traumatic events that are NOT linked in any way (e.g., one rape, one car accident, one sudden loss).



Type II or Complex PTS/D

- The response to a combination of specific traumatic events that ARE linked to each other in some way (e.g., father is sexually abusive, child resists and the parent kills their cat, mother finds out about the abuse and blames the child and kicks her out of the house).

Types of PTS/D



PTS/D can also be classified as:

- **Acute** – symptoms last less than 3 months.
- **Chronic** – symptoms last more than 3 months
- **Delayed** – symptoms first appear at least 6 months after the traumatic event occurred (*this is very common with individuals who were sexually abused as children*)

Risk Factors for developing PTSD

- The severity, type and duration of the traumatic event.
- Repeated exposure to stress and/or multiple traumatic events.
- Lack of adequate and competent support for the person after being exposed to a traumatic event.
- A predisposing mental health condition.



Gender differences

- For **women**, the most common events were rape, sexual molestation, physical attack, threatened with a weapon, physical abuse.
- **Women** not only experience a greater number of PTSD symptoms than men, but they also experience them more frequently and for longer durations.



Gender differences

- The traumatic events most often associated with PTSD in **men** were rape, combat exposure, childhood neglect, and childhood physical abuse.



DSM-IV Criteria for Posttraumatic Stress Disorder [309.81] (APA, 1994)

- A. The person has been exposed to a traumatic event in which both of the following were present:
- (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
 - (2) the person's response involved intense fear, helplessness, or horror.
Note: In children, this may be expressed instead by disorganized or agitated behavior
- B. The traumatic event is persistently re-experienced in one (or more) of the following ways:
- (1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. **Note:** In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
 - (2) recurrent distressing dreams of the event. **Note:** In children, there may be frightening dreams without recognizable content.
 - (3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). **Note:** In young children, trauma-specific reenactment may occur.
 - (4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
 - (5) physiological reactivity on exposure to internal or or external cues that symbolize or resemble an aspect of the traumatic event
- C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
- (1) efforts to avoid thoughts, feelings, or conversations associated with the trauma
 - (2) efforts to avoid activities, places, or people that arouse recollections of the trauma
 - (3) inability to recall an important aspect of the trauma
 - (4) markedly diminished interest or participation in significant activities
 - (5) feeling of detachment or estrangement from others
 - (6) restricted range of affect (e.g. unable to have loving feelings)
 - (7) sense of a foreshortened future (e.g. does not expect to have a career, marriage, children, or a normal life span)
- D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
- (1) difficulty falling or staying asleep
 - (2) irritability or outbursts of anger
 - (3) difficulty concentrating
 - (4) hypervigilance
 - (5) exaggerated startle response
- E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Research Study Handout – Copies of an research article from the Annals of General Psychiatry entitled, “*Psychiatric Diagnoses, Trauma, and Suicidality*” (Floen & Elklit, 2007) were also distributed, to prompt additional consideration of the associations between various psychiatric diagnoses, the incidence and sequelae of trauma, and the occurrence of self-harmful thoughts and behaviors. This study of 139 patients admitted for psychiatric hospitalization found that 91% reported at least one traumatic experience, and 69% reported multiple traumatic experiences, yet only 7% carried a diagnosis of Posttraumatic Stress Disorder (PTSD). Suicidal thoughts had been experienced by 67% of patients within the preceding month, and 31% had attempted suicide within the week prior to hospital admission. Floen and Elklit associated various psychiatric diagnoses and self-harmful thoughts and behaviors with specific traumas, and concluded that traumatized patients appear to be underdiagnosed or misdiagnosed, thereby compromising the effectiveness of their treatment.

These conclusions are resonant with the findings of this writer’s own research, which studied a representative sample of 50 Community Mental Health service recipients with co-occurring mental health and substance use diagnoses. Although there was clinical chart documentation indicating that a majority of these service recipients reported experiencing one or more significant physical or sexual traumas, none were diagnosed with Posttraumatic Stress Disorder, and none were being provided treatment that intentionally addressed the traumatic experiences and their sequelae at the time of the study (Wiland, 1999).

At the end of the kickoff meeting, interest was solicited from those in attendance for continuing to meet together in one or more work groups, to assist in identifying and accomplishing the efforts necessary to move the trauma initiative forward. Work groups were suggested in each of the following areas, and interested participants were identified with the understanding that they would be contacted shortly to convene sessions on each of the following focus areas:

- Agency-wide Trauma Conference Planning
- Trauma-informed “Front-door Services”
- Trauma-informed “Core Services”
- Trauma-specific “Therapy Services”

Agency WIKIPEDIA

To support the ongoing work of the trauma initiative, pages were established in the agency’s WIKIPEDIA, as a central clearinghouse of information that could be easily accessed by staff across the entire organization. Those WIKIPEDIA pages are duplicated below to give a sense of what was included. The functionality of the WIKIPEDIA format allowed for building in point-and-click accessible links that would take viewers to the referenced powerpoint presentations, articles, brochures, handouts and websites for further information and exploration. Each of these resources (which are available in the public domain) are available to the readers of this publication via the associated **Appendices** and/or listed references.

TRAUMA-INFORMED & TRAUMA-SPECIFIC SERVICES AT CSTS

CSTS is in the process of developing and further expanding our capacity to offer trauma-informed, and trauma-specific services to all of our consumers with this important recovery need. Much of the currently identified need has become apparent in our work with dually disordered individuals, and CSTS currently offers Women's Trauma Groups through our PORT/JPORT and ACT departments, as well as a recently launched Men's Trauma Group currently meeting at the PORT offices.

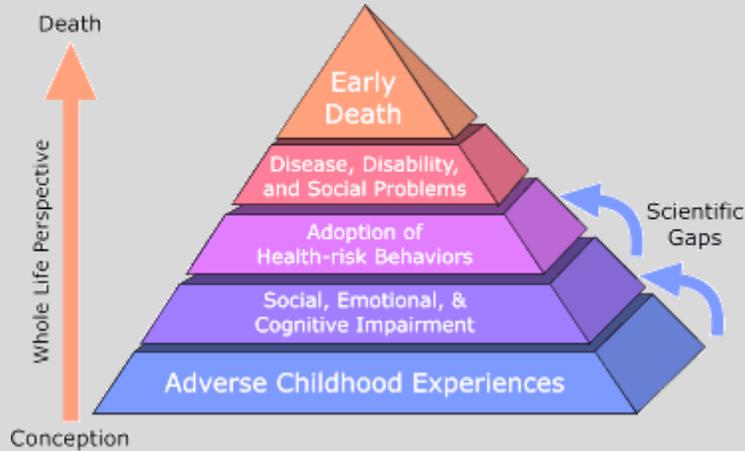
WHY DOES IT MATTER?

You may be wondering, "Why is it important to address the occurrence of trauma with our affected CSTS consumers?" There is significant evidence implicating the experience of trauma with increased prevalence of mental health and substance use disorders, with negative treatment outcomes, as well as with other negative outcomes in many life domains. Symptoms of posttraumatic stress can co-occur along with other distressing symptoms, or may mimic or mask symptoms of other mental and emotional disorders. Please take the time to review the diagnostic criteria for PTSD from the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (APA, 1994).

Individuals with trauma histories are more likely to develop co-occurring mental health and substance use disorders, and conversely, individuals with pre-existing mental health disorders, substance use disorders, or co-occurring disorders are more likely to experience subsequent traumatic life experiences. For more information on PTSD and co-occurring disorders, click on the following link to view and/or download a copy of the [Posttraumatic Stress and Co-Occurring Disorders powerpoint presentation](#) [see **Appendix A.2: Posttraumatic Stress and Co-Occurring Disorders slides**]. Additional information on the role of trauma in addictions recovery is available by navigating to the National Trauma Consortium's publication via the following link: [Enhancing Substance Abuse Recovery Through Integrated Trauma Treatment](#) (Finkelstein et al, 2004).

Reference an **article** from the April 2007 edition of the *Annals of General Psychiatry* which examines the associations between psychiatric diagnoses, trauma and suicidality in psychiatric patients, by following this link: [Psychiatric Diagnoses, Trauma and Suicidality](#) (Floen & Elklit, 2007).

Click on this link to view an article, **powerpoint presentation** and other information from the Center for Disease Control and Prevention and Kaiser Permanente study on the impact of [Adverse Childhood Experiences](#) (Felitti et al, 1998).



TRAUMA RECOVERY MODELS FOR ADULTS

Several evidence-based models have emerged as effective for addressing the recovery needs of trauma survivors. The two that have seemed to be the best fit for working with needful CSTS consumers have been the **Seeking Safety** treatment model developed by Lisa Najavits and others, and the **TREM** and **M-TREM** models developed by Maxine Harris and Roger Falot at Community Connections in Washington, DC. Both of these are described in greater detail below.

Seeking Safety

Seeking Safety is designed to be a therapy for trauma, post-traumatic stress disorder (PTSD), and substance abuse. The developer feels that this model works for individuals or with groups, with men, women or with mixed-gender groups, and can be used in a variety of settings (e.g. outpatient, inpatient, residential). The developer indicates that the key principles of Seeking Safety are safety as the overarching goal, integrated treatment, a focus on ideals to counteract the loss of ideals in both PTSD and substance abuse, knowledge of four content areas (cognitive, behavioral, interpersonal, and case management), and attention to clinician processes.

For additional information on the best-practice **Seeking Safety** treatment model developed by Lisa Najavits for treating co-occurring Posttraumatic Stress Disorder and Substance Use Disorders, navigate to SAMHSA's National Registry of Evidence-based Programs and Practices at <http://www.nrepp.samhsa.gov/find.asp>, and enter Seeking Safety in the search domain. Practical implementation information and guidance can be viewed by following this link to access an online copy of [Clinical Guidelines for Implementing the Seeking Safety model for treating PTSD and Substance Abuse](#) (Najavits, 2002b). For a taste of what the

Seeking Safety modules include, view the “Asking for Help” section of Lisa Najavits’ manual entitled **Seeking Safety: A Treatment Manual for PTSD and Substance Abuse** (Najavits, 2002c), which is also available via the Seeking Safety website at <http://www.seekingsafety.org> . Additional information (including a complete listing of the 25 involved module topics, additional resources on PTSD and substance abuse, a listing of “Safe Coping Skills,” information on Grounding Exercises, a Self-Care Assessment, a PTSD Checklist, the Trauma Symptom Checklist, the Professional Quality of Life Scale (with Compassion Satisfaction and Fatigue subscales), the Stressful Life Experiences Screening, and the Seeking Safety Adherence Scale), is also available via the Seeking Safety website. [see **Appendix A.3: Seeking Safety Model Description and Resources**]

Trauma Recovery and Empowerment Model

The Trauma Recovery and Empowerment Model is intended for trauma survivors, particularly those with exposure to physical or sexual violence. This model is gender-specific: TREM for women and M-TREM for men. This model has been implemented in mental health, substance abuse, co-occurring disorders, and criminal justice settings. The developer feels this model is appropriate for a full range of disciplines.

For additional information on the best-practice **Trauma Recovery and Empowerment Model (TREM)** developed by Maxine Harris and Roger Fallot at Community Connections, navigate to SAMHSA’s National Registry of Evidence-based Programs and Practices at <http://www.nrepp.samhsa.gov/find.asp>, and enter Trauma Recovery and Empowerment Model in the search domain. Click on the following link to view and/or download and use a copy of the [Men's Trauma Recovery and Empowerment Model \(M-TREM\) powerpoint presentation](#) [see **Appendix A.4: M-TREM slides**] that describes the TREM model adapted for working with male trauma survivors. Additional information is available by visiting the [Community Connections - Trauma Recovery and Empowerment Model website](#) at <http://www.communityconnectionsdc.org/>.

*Additional models that have been recognized as promising with certain populations include the **Addictions and Trauma Recovery Integrated Model (ATRIUM)** developed by Dusty Miller, the **Beyond Trauma** approach developed by Stephanie Covington, and the **TRIAD** model, developed by Colleen Clark and Fred Fearday. These are described in greater detail below.*

Addictions and Trauma Recovery Integration Model (ATRIUM)

ATRIUM is a 12-session recovery model designed for groups as well as for individuals and their therapists and counselors. The acronym, ATRIUM, is meant to suggest that the recovery groups are a starting point for healing and recovery. This model has been used in

local prisons, jail diversion projects, AIDS programs, and drop-in centers for survivors. ATRIUM is a model intended to bring together peer support, psycho-education, interpersonal skills training, meditation, creative expression, spirituality, and community action to support survivors in addressing and healing from trauma.

For an overview description of the ATRIUM approach, view the ATRIUM powerpoint presentation at

[see <http://womenandchildren.treatment.org/media/presentations/c-1/Miller.ppt>].

Beyond Trauma: A Healing Journey for Women

Beyond Trauma: A Healing Journey for Women is an integrated curriculum for women's services based on theory, research, and clinical experience. While the materials are designed for trauma treatment, the connection between trauma and substance abuse in women's lives is a theme throughout. The program has been developed for use in residential and outpatient treatment settings, domestic violence programs, mental health clinics, and criminal justice settings. *Beyond Trauma* has a psychoeducational 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. Additional information on the work of Stephanie Covington can be viewed at her website at <http://www.stephaniecovington.com>.

Triad

Triad is a women's trauma model, developed by and implemented at one of the research sites of the **Women, Co-occurring Disorders and Violence Study (WCDVS)**, and 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, 1992a, 1992b*). As its name implies, *Triad* is targeted for women who experience challenges around the three issues of trauma, mental health, and substance abuse and is designed to promote survival, recovery, and empowerment (*Clark & Fearday, 2003*). This cognitive-behavioral model is based, in part, on Linehan's (1993) Cognitive-Behavioral Treatment model, Evans and Sullivan's (1995) work on substance abuse and trauma, and Harris' (1998) work on trauma and serious mental illness.

(For a description of this significant study, consider reviewing the many informational resources available at the <http://www.prainc.com/wcdvs/publications> website, including the relevant data and statistical findings emerging from this research.)

Trauma recovery resources in the local Washtenaw County community include the following:

Survivors of Incest Anonymous (SIA)

Support and assistance is available in the form of the peer-led, community-based, 12-Step support group known as Survivors of Incest Anonymous (SIA). To view an **informational flier** about a local (Ann Arbor) weekly 12-Step support group meeting for survivors of incest, click on this link: [Survivors of Incest Anonymous \(SIA\) meeting flier](#). For more information on SIA, visit their website at www.siawso.org.

TRAUMA MODELS FOR CHILDREN

For a rendering of the 2004 findings of the Kauffman Best Practices Project to Help Children Heal From Child Abuse, entitled, Closing the Quality Chasm in Child Abuse Treatment: Identifying and Disseminating Best Practices visit <http://www.chadwickcenter.org/Documents/Kaufman%20Report/ChildHosp-NCTAbrochure.pdf>.

For a description of the **SAMHSA-endorsed Model Program for working with traumatized youth** and implementation guidance, click here: [How to Implement Trauma-Focused Cognitive Behavioral Therapy](#) (*Child Sexual Abuse Task Force and Research & Practice Core, National Child Traumatic Stress network, 2004*). There is also an available, excellent on-line training on this approach, approved for 10 Social Work CEUs, that can be accessed free-of-charge at <http://tfcbt.musc.edu/>.

Some excellent general principles to consider when working with children who have been traumatized are included in the [Child Physical and Sexual Abuse: Guidelines for Treatment](#) manual published by the National Crime Victims Research and Treatment Center & the Center for Sexual Assault and Traumatic Stress (*Saunders et al, 2004*).

Additional information is also available at the [National Child Traumatic Stress Network](#) website, at <http://www.nctsn.org>, which features links to [Resources for Parents and Caregivers](#), as well as [Resources for School Personnel](#).

Recognizing that the trauma treatment and recovery needs of children and adolescents are uniquely different in many respects from that of adults, a CSTS workgroup has been formed to consider how best to develop and provide services that address these needs. Follow this link to check out the developments in the **Youth and Family Trauma Work Group**.

ADDITIONAL TRAUMA INFORMATION AND RECOVERY RESOURCES

Click here to view a copy of the **SAMHSA publication** for women, [Helping Yourself Heal: A Recovering Woman's Guide to Coping With Childhood Abuse Issues](#) (CSAT, 2003).

Click here to view a copy of the **SAMHSA publication** for men, [Helping Yourself Heal: A Recovering Man's Guide to Coping With the Effects of Childhood Abuse](#) (CSAT, 2004).

Click here to view and/or download a copy of the **SAMHSA publication**, [It's My Time To Live: Journeys to Healing and Recovery](#) (Veysey et al, 2006), which emerged out of the 1998 national Women, Co-Occurring Disorders and Violence Study (WCDVS).

2008-09 TRAUMA-INFORMED AND TRAUMA-SPECIFIC SERVICES GRANT PROJECT

CSTS was approved for 2008-09 Block Grant funding to develop and implement better trauma-informed and trauma-specific services. Following an agency-wide kickoff meeting on December 2nd of 2008, the following four work groups were established to address the four following focus areas:

I. TRAUMA TRAINING CONFERENCE PLANNING

This group is focusing on the planning necessary to provide a 2009 mid-March training conference to assist in informing the efforts of CSTS and of partner organizations around the community to become more trauma-informed in their respective service areas, as well as to begin to equip clinical staff to develop and deliver effective trauma-specific individual and group therapies.

Our conference is planned for March 19th and 20th at the Ann Arbor Four Points Sheraton. For all the details, check out the [Developing and Implementing Trauma-Informed Services conference brochure](#) [see **Appendix B.1: Trauma-informed Services Conference brochure**].

Minutes of the Trauma Training Conference Planning work group are available via the **Trauma Training Conference Planning Work Group** wiki page.

II. TRAUMA-INFORMED "FRONT-DOOR SERVICES"

This group is focusing on reviewing the following service areas to determine if they are as trauma-informed and trauma-sensitive as reasonably possible:

Screening, Referral, Intake, Orientation, Initial Assessment, Psychiatric Evaluation, Personal Health Review, Reception, Waiting Room / Lobby areas, etc.

Minutes of the Trauma-informed "Front-Door Services" work group are available via the **Front-Door Services Work Group** wiki page.

III. TRAUMA-INFORMED "CORE SERVICES"

This group is focusing on reviewing the following service areas to determine if they are as trauma-informed and trauma-sensitive as reasonably possible:

Medication Review, Client Services Management, Supports Coordination, Specialty Assessments, Person-Centered Planning, Vocational Services, Residential Services, etc.

Minutes of the Trauma-informed "Core Services" work group are available via the **Core Services Work Group** wiki page.

IV. TRAUMA-SPECIFIC THERAPY SERVICES

This group is focusing on developing, implementing, and expanding trauma-specific individual and group therapies. The models and approaches that will be examined and considered in these efforts include the following:

- **Addictions & Trauma Recovery Integrated Model (ATRIUM)** – *Dusty Miller*
- **Beyond Trauma: A Healing Journey for Women** – *Stephanie Covington*
- **Seeking Safety** – *Lisa Najavits et al;*
- **Trauma Recovery and Empowerment Model (TREM & M-TREM)** – *Maxine Harris & Roger Fallot;*
- **Triad** – *Colleen Clark & Fred Fearday*

Minutes of the Trauma-specific Therapy Services work group are available via the Trauma Therapy Work Group wiki page.

Establishing these pages on the agency WIKIPEDIA allowed for every communication about the trauma initiative and its various work groups to be accompanied by a link that agency staff could easily click on and follow to learn more about the subject of trauma, the ongoing trauma initiative project, and how individuals might be able to become more actively involved.

III. Self-selected Work Groups

Follow-up communication was made to each of the staff who had participated in the kickoff meeting, as well as to those others who had indicated an interest but were unable to attend. “Champions” were directly solicited to lead each of the four work groups, and the 6 to 9 staff that had indicated interest in one or more of the identified work groups began to meet to work on each of the identified project areas, which were described in the following ways:

1. **Trauma Conference Planning** – *This group is focused on the planning necessary to provide a 2009 mid-March training conference to assist in informing the efforts of CSTS and of partner organizations around the community to become more trauma-informed in their respective service areas.*
2. **Trauma-informed “Front-door Services”** – *This group is focused on reviewing the following service areas to determine if they are as trauma-informed and trauma-sensitive as reasonably possible: Screening, Referral, Intake, Orientation, Initial Assessment, Psychiatric Evaluation, Personal Health Review, Reception, Waiting Room / Lobby areas, etc.*
3. **Trauma-informed “Core Services”** – *This group is focused on reviewing the following service areas to determine if they are as trauma-informed and trauma-sensitive as reasonably possible: Medication Review, Client Services Management (case management), Supports Coordination, Specialty Assessments, Person-Centered Planning, Vocational Services, Residential Services, etc.*
4. **Trauma-specific “Treatment Services”** – *This group is focused on developing, implementing, and expanding trauma-specific individual and group therapies. The models and approaches that will be examined and considered in these efforts include the following:*
 - a. **Addictions & Trauma Recovery Integrated Model (ATRIUM)** – *Dusty Miller;*
 - b. **Seeking Safety** – *Najavits et al;*
 - c. **Trauma Recovery and Empowerment Model (TREM & M-TREM)** – *Roger Fallot & Maxine Harris;*
 - d. **Beyond Trauma: A Healing Journey for Women** – *Stephanie Covington;*
 - e. **Triad** – *Colleen Clark & Fred Fearday.*

Identifying and soliciting interested “champions” to chair the various work groups was necessary to ensure that the work moved forward, but populating the work groups with self-selected

volunteers was also viewed as critically important. With the significant quantity and quality of work that needed to be done, assigning staff involuntarily to the involved tasks seemed a strategy much less likely to be sustainable and successful. Inviting interested staff to declare and follow-through on their interest not only allowed for sharing the workload of the project across a wider array of personnel, but the dynamic of work group members “buying in” and being motivated internally rather than externally supported a sustainable long-term effort much more effectively than would have otherwise been the case. Successful efforts were made to include Peer Support Specialists and other consumers in each of these identified work groups.

As the energy and resources of agency staff were applied to the existing work group focus areas, additional focus areas were identified that were viewed as needing to be addressed in the service of more comprehensively transforming the agency into a trauma-informed organization. This led to the formation of the additional staff-led work groups focusing on the additional areas described below:

5. **Trauma-informed Staff Support and Self-Care** – *This group is focused on examining the experience of the clinician working with traumatized clients. The goal of the group is to develop and implement simple, manageable steps to help prevent Compassion Fatigue and/or Burnout and to promote Compassion Satisfaction (a protective factor).*

6. **Youth and Family Trauma Work Group** – *This group developed when it became clear that the trauma treatment needs of children were significantly different than those of adult populations, and that there was a need to address those needs with a variety of therapeutic strategies, with the following being among those considered:*
 - a. **Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)**
 - b. **Abuse-Focused Cognitive Behavioral Therapy (AF-CBT)**
 - c. **Parent Child Interaction Therapy (PCIT)**
 - d. **Eye Movement Desensitization and Reprocessing (EMDR)**
 - e. **Theraplay**
 - f. **Dyadic Developmental Psychotherapy (DDP)**

The accomplishments of 5 of these 6 work groups will be described in the pages that immediately follow, while the work of the **(1) Trauma Conference Planning** group is addressed in *Chapter IV. Trauma-informed Services Conference*.

(a) Trauma Conference Planning Work Group

For a description of the work of the Trauma Conference Planning Work Group, please see Chapter IV. Trauma-informed Services Conference.

(b) Trauma-informed “Front-door Services” Work Group

As indicated previously, this group focused on reviewing the following service areas to support them becoming as trauma-informed and trauma-sensitive as reasonably possible:

- Screening
- Referral
- Intake
- Orientation
- Initial Assessment
- Psychiatric Evaluation
- Personal Health Review
- Reception
- Waiting Room / Lobby areas

Under the capable leadership of one of the agency’s self-selected trauma champions, this work group met monthly to begin to address related topics. Representation was sought from across the agency’s multiple different teams and sites, and individuals participated from several Adult Services teams (Continuous Support Teams, CCRT, PORT, SLECS), as well as from the Youth & Family and Developmental Disabilities departments. The 18 different participants included clinical staff, administrative staff and reception/support staff, along with consumers and peer support specialists, from a total of 5 different sites, each bringing their unique needs, perspectives and ideas to the involved discussions.

Additional perspective and ideas were gained from reviewing an excellent existing article on “A Trauma-Informed Approach to Screening and Assessment” (*Fallot & Harris, 2001*).

Accomplishments of the “Front-door Services” Work Group***Warm, welcoming, safe clinic spaces***

One of the many discussions that occurred at the Trauma conference focused on how warm, welcoming, non-threatening and consumer-friendly the physical spaces could become at service-providing sites. Numerous ideas were generated and acted upon to improve the physical environment at CSTS sites in the following ways:

A more welcoming lobby

- Anti-stigma posters, photographs, quilts, and other artwork were hung on the lobby walls, which made the spaces much more welcoming, especially for those needing to spend time waiting for appointments with Client Services Management, Nursing, or Psychiatry staff.
- Background music was provided in some lobby areas with an inexpensive combination of small speakers and of songs accessed via the internet on receptionists’ computers, with an openness to adjust musical genres to best meet visitors’ preferences. Over time, the “playlist” developed into classical music during most mornings, and soft rock/pop during most afternoons, with overwhelmingly positive feedback.
- One lobby was equipped with an attractive and soothing fountain that was donated by an employee.
- The “cheek-to-jowl” seating arrangements (compelled by chairs fastened closely to each other or to the floor) were reported as being experienced as physically uncomfortable/intrusive, and recommendations were made to seek alternative arrangements for seating that were more respectful of physical boundaries.
- Relief was sought from the sometimes overwhelming traffic flow through the main lobby by recommending that whenever possible, staff, police and ambulance personnel use the side employee entrance when needing to enter and exit the site. The potentially retraumatizing triggers of police, fire, and ambulance personnel storming through the main entrance lobby were able to be avoided, with positive consumer feedback in support of this change.
- A recommendation for having an in-lobby greeter/guide/triage person was also advanced, as a role that could perhaps be filled by a Peer Support Specialist, student intern, or by the rotating Site Person of the day.
- Another recommendation was advanced for removing the Plexiglass barrier currently separating reception staff from consumers at the service counters, as this was experienced by many clients as impersonal, unwelcoming, potentially stigmatizing, and an impediment to better communication.

More pleasant “warmer” clinic spaces

- One idea that was able to be acted on fairly immediately addressed the difficulty experienced by many consumers (and staff from other sites, as well) trying to navigate the maze-like hallways of the primary Ann Arbor Adult Services office. Trying to find

particular meeting rooms, or even the rest rooms, was often an exercise in frustration for those not well-acquainted with the layout. This was addressed by the creation and posting of numerous signs around the premises, which elicited positive feedback from visiting clients and staff alike.

- A greater number of artistic wall hangings of various types were sought and hung at major clinic sites. A number of these were comprised of consumer artwork which was solicited through various means, one of which was a consumer art show and competition after which art pieces could be purchased. Colorful self-care posters, including the “Safe Coping Skills” poster from Seeking Safety (Najavits, 2005c), were acquired and displayed in treatment group meeting rooms.
- Plans were formed and implemented to “green” the sites with indoor and outdoor plants, headed by staff with “Master Gardener” credentialing and experience.
- The avid smoker “gauntlet” that frequently encumbered the front door walkway and that was sometimes experienced as verbally obnoxious or potentially threatening was addressed through an aggressive campaign to engage clients in Nicotine Recovery services and activities, confront those persisting in ignoring posted “No Smoking” signs, and relocate committed smokers to space farther from the building entrance.
- Lastly, staff who were linked with the local Food Gatherers operation recommended that staff at each site complete the minimal training involved to be able to actively participate in becoming a site for food to be delivered and provided for clients to help enhance better nutrition and engagement efforts.

Trauma-informed interactions with clients

Better language and communication

- Clients who participated in this work group advanced other recommendations for changing some of the language found in agency literature and other written materials frequently provided to service recipients, and adding additional information to increase their usefulness. Of identified interest was more accessible information about community resources and services; contact information (e-mail addresses, phone numbers) for those who may have questions; more detailed information about the entire menu of service options and orientation to the larger system and community network and how to successfully navigate it. It was recommended that the agency WIKIPEDIA be made accessible to the general public, at least for the many informational portions that addressed some of the above areas. A recommendation was advanced for greater dissemination of recovery “success stories” for the encouragement of other consumers and staff alike.

Clinical processes and documentation

- Upon review of the targeted service delivery processes and involved documentation, it was acknowledged that some of the significant “front-door” service contacts and interactions with consumers were not as trauma-informed and trauma-sensitive as could

be the case. Many of the first contacts with newly referred clients represent uniquely important opportunities to establish safety, trustworthiness, choice, collaboration and an empowerment orientation to ongoing service participation. In addition, many of these first contacts are also important opportunities to assist consumer with identifying any known trauma history so that appropriate care can be provided.

- The language of the questions asked in first-contact Initial Assessments, Personal Health Reviews, and Psychiatric Evaluations require further review and consideration for trauma-sensitivity. This effort is ongoing at the time of this publication, with recommendations to be advanced in the Spring of 2010 when the agency's electronic health record is due to be updated.
- Generally speaking, there is a need to respectfully, sensitively and creatively determine how to routinely ask the question, "What happened to you?" as part of initial service encounters. It is also important to note that, while there may be improved language and more sensitive questions to be asked, the way in which such consumer interviewing occurs is at least as important. There are no "magic bullet" trauma-discerning questions, and just as efforts to upgrade associated clinical forms are viewed as necessary, so too will staff orientation/training play a part in trauma-informing these "front-door" service processes.

(c) Trauma-informed "Core Services" Work Group

As previously indicated, this group focused on reviewing the following service areas to support advancement toward becoming as trauma-informed and trauma-sensitive as reasonably possible:

- Medication Review
- Client Services Management (case management)
- Supports Coordination
- Specialty Screening / Assessments (OT, PT, Psychological, Substance Abuse)
- Person-Centered Planning
- Vocational Services
- Residential Services, etc.

This work group recognized the need for an instrument or tool for use in the review of the processes and documents represented by the list above. Efforts were made to utilize the *Trauma-informed Program Self-Assessment Scale* from Community Connections to get a current snapshot of trauma-informed status (or lack thereof), in order to guide efforts to improve moving forward. See **Appendix B.2: Trauma-informed Program Self-Assessment Scale** for

the complete instrument – the portions that were helpful in the work of the “Core Services” Work Group are excerpted below:

DOMAIN 3: TRAUMA SCREENING, ASSESSMENT, AND SERVICE PLANNING

“To what extent does the program have a consistent way to identify individuals who have been exposed to trauma, and to include trauma-related information in planning services with the consumer?”

Criterion	1	2	3	4	5
1. Universal Trauma Screening: Within the first month of service participation, every consumer has been asked about exposure to trauma.	No consumer has been asked about trauma exposure.	Fewer than 30% of consumers have been asked, within the first month of service participation, about trauma exposure.	30-60% of consumers have been asked about trauma exposure.	61-90% of consumers have been asked about trauma exposure.	More than 90% of consumers have been asked about trauma exposure.
2. Trauma Screening Content: The trauma screening includes questions about lifetime exposure to sexual and physical abuse.	No standardized trauma screening approach exists.	A standardized screening for trauma has been approved but not implemented.	A standardized screening approach has been implemented but does not include questions about sexual or physical abuse.	The screening includes questions about EITHER sexual OR physical abuse OR about abuse in general OR about a specific time period.	The standardized screening includes questions about lifetime exposure to both physical and sexual abuse.
3. Trauma Screening Process: The trauma screening is implemented in ways that minimize consumer stress; it reflects considerations given to timing, setting, relationship to interviewer, consumer choice about answering, and unnecessary repetition.	No discussion of the screening process has occurred.	A plan for minimizing stress in screening has been developed.	A screening plan that includes flexible responses to consumers has been implemented.	The screening process is routinely reviewed to ensure that it minimizes consumer and staff distress.	Consumers and staff report satisfaction with the screening process.

Criterion	1	2	3	4	5
4. Trauma Assessment: Unless specifically contraindicated due to consumer distress, the program conducts a more extensive assessment of trauma history and needs and preferences for trauma-specific services for those consumers who report trauma exposure.	The program has conducted no trauma assessments.	A plan for conducting trauma assessments has been developed.	An assessment plan that includes both trauma history and service needs and preferences has been implemented.	The assessment process is routinely reviewed to ensure that it minimizes consumer and staff distress.	Consumers and staff report satisfaction with the assessment process.
5. Trauma and Service Planning: The program ensures that those individuals who report the need and/or desire for trauma-specific services are referred for appropriately matched services.	No referrals for trauma-specific services are made.	A plan for referrals, including the accessibility of trauma-specific services, has been developed.	In addition to (2), fewer than 30% of those needing or requesting trauma-specific services are referred for accessible services.	In addition to (2), 30-80% of those needing or requesting trauma-specific services are referred for accessible services.	In addition to (2), more than 80% of those needing or requesting trauma-specific services are referred for accessible services.
6. Trauma-Specific Services: The program offers, or has identified other programs that offer, trauma-specific services with four “criterion” characteristics: effective, accessible, affordable and responsive to the preferences of the program’s consumers.	No trauma-specific services are offered or identified.	Offered or identified trauma-specific services have one of the four criterion characteristics.	Offered or identified trauma-specific services have two of the four criterion characteristics.	Offered or identified trauma-specific services have three of the four criterion characteristics.	Offered or identified trauma-specific services have all four of the four criterion characteristics.

Additional perspective and ideas were gained from reviewing excellent existing articles on “Envisioning a Trauma-Informed Service System: A Vital Paradigm Shift” (*Harris & Fallot, 2001a*), “Trauma-Informed Services and Case Management” (*Freeman, 2001*), “Trauma-Informed Approaches to Housing” (*Bebout, 2001*), and “Defining the Role of Consumer-Survivors” (*Prescott, 2001*).

Accomplishments of the “Core-Services” Work Group

Focusing on the portion of the *Service-level Change* section of Community Connections’ *Trauma-informed Program Self-Assessment Scale* domains that seemed pertinent (i.e., Domain 3: Trauma Screening, Assessment, and Service Planning), the work group participants took copies of the instrument to their respective sites and teams, and surveyed their colleagues in order to arrive at an accurate reckoning of the current reality. The results of these efforts made it clear that there was room for improvement along all of the involved criterion for each of these service processes and forms. Incremental progress became the recommended short-term goal, consistent with the realistic recognition that transforming the agency’s entire culture, along with all of its service processes and documentation, represents an overwhelming task, one that will need to be intentionally pursued in the months and years to come. Shorter-term recommendations included the following:

Trauma-informed service interactions with clients

Core service processes and documentation

- Upon review of the targeted service delivery processes and involved documentation, it was acknowledged that some of the significant “core services” interactions with consumers were not as trauma-informed and trauma-sensitive as could be the case. Many of these core service interactions with service recipients contribute to setting the expectation that consumers will have for how well available services will address their needs. Respectfully and matter-of-factly continuing to raise the “*What happened to you?*” question is important as trust is able to build over the longer periods of time that core services are delivered. A menu of available trauma-specific treatment services also needs to continue to be developed, and become a part of every indicated Person-centered Planning process so that consumers can know that help is available once trauma-recovery needs are identified.
- The language of the questions asked in core-service Med Reviews, case management or supports coordination contacts, Specialty Assessments, Person-centered Planning and subsequent provision of other services require further review and consideration for trauma-sensitivity, an effort that is ongoing at the time of this publication, with recommendations to be advanced in the Spring of 2010 when the agency’s electronic health record is due to be updated.
- It is again important to note that, while there may be improved language and more sensitive questions to be asked, the way in which such consumer interviewing occurs is at least as important. There are no “magic bullet” trauma-discerning questions, and just as efforts to upgrade associated service-delivery documentation are viewed as necessary, so too will staff orientation/training play a part in trauma-informing these “core services” processes.

(d) Trauma-specific “Therapy Services” Work Group

As indicated previously, this group focused on developing, implementing, and expanding trauma-specific individual and group therapies for service recipients of our agency. The models and approaches that were examined and considered in these efforts included the following:

- ***Addictions & Trauma Recovery Integrated Model (ATRIUM)***
- ***Beyond Trauma: A Healing Journey for Women***
- ***Seeking Safety***
- ***Trauma Recovery and Empowerment Model (TREM)***
- ***Triad***

Members of the work group reviewed content materials of each of these models with an eye toward goodness-of-fit for CSTS consumer needs and CSTS treatment service design. Also helpful in this review effort was the fine work accomplished by the National Trauma Consortium (*Finkelstein et al, 2004*), some of which is excerpted in the model-specific descriptions below:

Addictions and Trauma Recovery Integration Model (ATRIUM)

ATRIUM Overview – *ATRIUM* (Miller & Guidry, 2001) is based on the premise that trauma impacts body, mind, and spirit. Informed by Miller’s personal knowledge of the mental health system and addiction recovery, *ATRIUM* is designed to intervene at all three levels. *ATRIUM* is a 12-session recovery model designed for groups as well as for individuals and their therapists and counselors. The acronym, *ATRIUM*, is meant to suggest that the recovery groups are a starting point for healing and recovery. This model integrates cognitive-behavioral and relational treatment while emphasizing mental, physical, and spiritual health. Specifically, the 12-week curriculum is designed for survivors of sexual and physical abuse, those with substance abuse and other addictive behaviors, those who are actively engaged in harmful relationships, people who self-injure or who have serious psychiatric diagnoses, and those who enact violence and abuse against others. *ATRIUM* is designed to work well as a peer-led or a professionally led model and can be used for individuals working with therapists or counselors, or in group or peer support settings.

ATRIUM is a blend of psychoeducational, 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.

ATRIUM Settings – *ATRIUM* provides a holistic approach to trauma healing and is well suited for implementing within substance abuse or mental health treatment settings as well as in peer group environments. Closed groups are recommended as each session builds on the last.

Beyond Trauma: A Healing Journey for Women

Beyond Trauma: A Healing Journey for Women Overview – *Beyond Trauma: A Healing Journey for Women* was developed by Stephanie S. Covington in 2003. The curriculum includes 11 modules on the following topics: Connection between Violence, Abuse & Trauma; Power and Abuse; Reactions to Trauma; How Trauma Impacts our Lives; The Addiction-Trauma Connection; Grounding and Self-Soothing; Abuse and the Family; Mind / Body Connection; The World of Feelings; Healthy Relationships (Wheel of Love); and Endings and Beginnings. As with her *Helping Women Heal* curriculum, *Beyond Trauma* presents an integrated approach to women's treatment, based on theory, research, and clinical experience, and deepens and expands the trauma work in *Helping Women Heal*. Groups are intended to be 90 minutes in length and to include 4 to 10 women and 1 facilitator. It is recommended that the curriculum be implemented in closed groups. The curriculum utilizes a workbook that includes a summary of the material covered in each session and provides a place for women to complete exercises and record reflections.

Beyond Trauma: A Healing Journey for Women Settings – This curricula is designed as a group intervention but can also be used individually. It is appropriate for both residential and outpatient settings, and has been implemented in substance abuse, mental health, and criminal justice settings.

Seeking Safety

Seeking Safety Overview – *Seeking Safety* was developed by Dr. Lisa Najavits at Harvard Medical School/McLean Hospital under a grant funded in 1992 by the National Institute on Drug Abuse (NIDA) (*Najavits, 2002c*). Published as a treatment manual in 2002, *Seeking Safety* is a present-focused therapy designed to promote safety and recovery for individuals with PTSD and substance abuse and for individuals who have trauma histories but who do not meet the clinical criteria for PTSD. The treatment manual consists of 25 topics and includes both client handouts and clinician guidelines. A sampling of topics includes the following: safety, taking back your power, when substances control you, setting boundaries in relationships, coping with triggers, detaching from emotional pain (grounding), self-nurturing, and creating meaning. *Seeking Safety* is based on key principles of safety, interpersonal treatment, a focus on ideals, four content areas (cognitive, behavioral, interpersonal, and case management), and attention to clinician processes.

Seeking Safety Settings – *Seeking Safety* was designed to be used and has been implemented in a wide variety of settings including substance abuse treatment (outpatient, inpatient, and residential), correctional facilities, health and mental health centers, etc., as well as for group and individual formats, females and males.

Trauma Recovery and Empowerment Model (TREM)

Trauma Recovery and Empowerment Model Overview – The *Trauma Recovery and Empowerment Model (TREM)* was developed by Dr. Maxine Harris and colleagues at Community Connections in Washington, DC (Harris, 1998). A fully manualized 24-29 session group intervention for women trauma survivors with substance abuse and/or mental health problems, this model draws on cognitive-behavioral, skills training, and psychoeducational techniques to address recovery and healing from sexual, physical, and emotional abuse. *TREM* groups include 8-10 members and are facilitated by trained female co-leaders who focus on a specific recovery topic in each weekly 75-minute session.

TREM consists of three major parts. In the empowerment section, sessions help group members learn strategies for self-comfort and accurate self-monitoring as well as ways to establish safe physical and emotional boundaries. The second component of *TREM* focuses more directly on trauma experience and its impact. Topics address various forms of violence including physical, sexual, emotional, and institutional abuse. Discussions help women to explore and reframe the connection between their experiences of abuse and other current difficulties, including substance use, mental health symptoms, and interpersonal problems. In the third section, focus shifts more explicitly to skills building. These sessions include emphases on communication style, decision making, regulating overwhelming feelings, and establishing safer, more reciprocal relationships.

TREM addresses substance abuse throughout the intervention. In groups of women with substance abuse problems, the use of alcohol and other drugs and corresponding recovery skills are discussed in virtually every session.

Skills such as self-awareness, self-soothing, emotional modulation, development of safe and mutual relationships, and consistent problem solving are aimed at active substance abuse treatment and relapse prevention.

Trauma Recovery and Empowerment Model Settings – *TREM* has been implemented in a wide range of settings including residential and non-residential

substance abuse and mental health programs, correctional institutions, and welfare-to-work programs.

Triad

Triad Overview – The *Triad* women’s trauma model, developed by and implemented at one of the WCDVS sites, 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, 1992a, 1992b). As its name implies, *Triad* is targeted for women who experience challenges around the three issues of trauma, mental health, and substance abuse and is designed to promote survival, recovery, and empowerment (Clark & Fearday, 2003). This cognitive-behavioral model is based, in part, on Linehan’s (1993) Cognitive-Behavioral Treatment model, Evans and Sullivan’s (1995) work on substance abuse and trauma, and Harris’s (1998) work on trauma and serious mental illness.

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 use disorders. Additional goals are to increase abstinence for those with substance dependence and to support women in maintaining their personal safety. This 16-week group model is structured in four phases (four sessions per phase) with each weekly group lasting 2 hours. Each session includes specific goals and objectives to facilitate short-term treatment planning.

Triad Settings – *Triad* groups fit easily within outpatient or residential community mental health centers and substance abuse treatment facilities and are currently being offered in jails (with modifications). *Triad* groups are designed so that women can join at the beginning of each of the four phases for a “modified open” format.

Accomplishments of the Trauma-specific “Therapy Services” Work Group

The work of the membership of this Trauma-specific “Therapy Services” work group was largely responsible for planning and presenting the various inservice and externally provided clinical training sessions on the **Beyond Trauma**, **Seeking Safety**, and **TREM** treatment models (see *Chapter IV – Trauma-specific Trainings*). Significant elements of each of these approaches were found to be helpful for including in the trauma-specific therapy services being designed and implemented with CSTS populations, while the **ATRIUM** and **Triad** models were viewed as less of a good fit for the broader cohorts of CSTS clients needing trauma-specific programming. Additional and more specific details of the involved analysis may be found in the 6th chapter of this publication, *Chapter VI. Model Implementation and Adaptation*, the contents of which were contributed to significantly by members of this work group.

(e) Trauma-informed Staff Support and Self-Care Work Group

As mentioned earlier, this group focused on examining the experience of the clinician working with traumatized clients. One goal of the group was to develop and implement simple, manageable steps to help prevent Compassion Fatigue and/or Burnout and to promote the protective factor of Compassion Satisfaction. More broadly, the group hoped to support and advance Compassion Satisfaction across all disciplines and scopes of practice working with trauma-surviving consumers.

Additional perspective and ideas were gained from reviewing an excellent existing article on “Care of the Clinician” (*Arledge & Wolfson, 2001*).

Accomplishments of the Trauma-informed Staff Support and Self-Care Work Group

Inspired to come together as a work group following the Trauma Conference, these staff identified a meaningful instrument, the ***Compassion Satisfaction and Fatigue Self-Test*** (*Figley, 1995*) for use in assessing how colleagues involved in serving trauma-surviving clients were faring with regard to their own mental and emotional health. A copy of this instrument may be found in **Appendix C.1: Compassion Satisfaction and Fatigue Self-Test**.

Compassion Satisfaction is defined by Idaho State University’s Beth Hudnall Stamm (<http://www.isu.edu/~bhstamm>) as the pleasure one derives from being able to do one’s work well. For example, one may feel like it is a pleasure to help others through one’s job duties. One may feel positively about one’s colleagues or one’s ability to contribute to the work setting or even to the greater good of society.

Compassion Fatigue is defined by Stamm in two parts. The first includes such elements as exhaustion, frustration, anger and depression typical of burnout. The second part is Traumatic Stress, defined as work-related exposure to extremely stressful events. This may occur from primary exposure to a directly threatening experience, or from secondary exposure to the threatening experiences of others. This latter type is known as ***Secondary Traumatic Stress*** (STS), as in the example of developing traumatic stress symptoms from repeatedly hearing stories about the trauma of others (vicarious trauma). The symptoms of STS are often rapid in onset, and associated with a specific event, and can include fearful feelings, difficulty sleeping, upsetting images coming into one’s mind, and avoiding things that remind one of the traumatic event.

An additional tool that was identified as helpful for staff was the ***Self-Care Assessment Worksheet***, a self-rated, 5-point Likert-scale checklist which could be used to inventory 65 elements across the following domains: Physical Self-Care, Psychological Self-Care, Emotional

Acclaimed Storyteller

Lisa Williams is a graduate of Eastern Michigan University. His background includes theater, visual art, film and video production, gymnastics, modern and traditional dance, vocal and instrumental music, child care, food service, and newspaper reporting. He has performed for audiences in theaters, churches, schools, and on radio and TV in several states on both sides of the Mississippi River.

Comedienne

Julia Young is not the daughter of Martha Young, psychiatric nurse practitioner and attendee at this conference. She is the winner of both "Michigan's Favorite Comic" and the "American Eagle Campus Comedy Challenge" at the University of Michigan. She co-founded an improvisational comedy group at U of M, where she majors in Screen Arts and Cultures. In her spare time she distances herself emotionally from her parents.

Workshop Presenters

<p>"Take Two Apples And Call Me In The Morning The Non-Drug Prescription For Health"</p>	<p>Judy Stone, CN, MSW: Author and nutritionist Judy Stone, CN, MSW is committed to teaching people how to feel better through the food choices they make. Judy's passion is teaching people what goes on inside the body that produces illness or health depending on what goes in the mouth. In this seminar she will teach and inspire you to think differently about some common problems many people experience such as chronic pain, digestive issues and depression, along with shedding light on why the medications typically used for these problems are problematic for long-term health. You will leave with a new way to think about your health and practical ways to get yourself feeling better.</p>
<p>Drum 4 Wellness</p>	<p>Don Allen, DCF: A musician, teacher, and practitioner of esoteric healing arts, Don has long been aware of the intersection of music and health/wellness, leading to his training as a Drum Guide Facilitator. He has studied with many master musicians from around the world and teaches classes in culturally specific drum rhythms.</p>
<p>Fitness For Life</p>	<p>Julia Collins: Julia is an ACE-Certified Personal Trainer, Schwinn Indoor Cycling Coach and one of two officer & power instructors in Michigan. Julia has owned Yogi Studio-Fitness and Massage Therapy Studio since October of 2004. Cross-training is key to her personal training approach in order to avoid injury and boredom - two of the major reasons individuals give for ending an exercise routine. Julia is training for The Detroit Free Press Half Marathon (her 2nd) and views strength training, Yoga and Pilates as crucial to that training as well.</p>
<p>Crime Prevention, Self Protection</p>	<p>Off. Candace Dorsey: I have been a law enforcement officer for 24 years. My first 7 yrs. of law enforcement were with the Detroit Police Department, then 1 yr. with Sycamore Twp. Police Dept and 16 yrs. with ENU P.D. I train staff and students with options on how to respond in the event of an emergency; safety precautions; personal safety; personal awareness, and more. I've been active with several Washtenaw County Organizations over the years: <i>Washtenaw County Youth Officer Association, Crime Prevention Association, The Children's Advocacy Center, Medical Night-Out</i> to name a few.</p>

<p>Lifestyle Wellness Exhibitor</p> <p>Emergency Preparedness</p> <p>Gardening Exhibitor</p> <p>Gardening Exhibitor</p> <p>Travel Exhibitor</p> <p>Nicotine Recovery Exhibitor</p> <p>Nicotine Recovery Exhibitor</p> <p>Pet Therapy Exhibitor</p> <p>Thrifty living Exhibitor</p> <p>Thrifty living Exhibitor</p> <p>EAP Services and Resources</p> <p>Book Table Exhibitor</p> <p>Massage Therapy station #1</p> <p>Massage Therapy station #2</p> <p>Massage Therapy station #3</p> <p>Massage Therapy station #4</p>	<p>Charles Wilson</p> <p>Gary Logan</p> <p>Baine Umholtz</p> <p>Mark Roby</p> <p>Marie Haiffer</p> <p>Brandie Hagaman</p> <p>Lisa Krugman</p> <p>Michelle Grandall</p> <p>Judy Fiegel</p> <p>Kirsten Osborne</p> <p>Sally Amos</p> <p>Nicola Rooney</p> <p>Lisa</p> <p>Deborah</p> <p>Chelsea</p> <p>Renee</p>	<p>THE EXHIBITORS</p> <p>SPECIAL THANKS TO</p>																			
<h3 style="text-align: center;">Planning Committee</h3> <p>Steve Wiland, Jan Beltz, Yarrow Halstead, Brenda Scotton, Carol Hartford, Anne Rogers, Karma Mahring, Sally Amos O'Neil</p> <h3 style="text-align: center;">Event Support</h3> <p>Kate Woods, Angie Zander, Stephanie Westry, Suzanne Gondek</p> <p>● ● ●</p> <table border="0"> <tr> <td>Donna Sabourin</td> <td>CTS Director</td> </tr> <tr> <td>Patrick Barrie</td> <td>WCHO Director</td> </tr> <tr> <td>John Shands</td> <td>CTS Adult Services PA</td> </tr> <tr> <td>Trish Gates</td> <td>CTS Developmental Disabilities PA</td> </tr> <tr> <td>Dick Deighton</td> <td>CTS Youth & Family PA</td> </tr> <tr> <td>Deb Pippins</td> <td>CTS PORT/PORT PA</td> </tr> <tr> <td>Jan Vuelker</td> <td>CTS CRT PA</td> </tr> <tr> <td>Karen Wilner</td> <td>CTS Medical Director</td> </tr> <tr> <td>Tim Florence</td> <td>CTS Associate Medical Director</td> </tr> <tr> <td>Dan Healy</td> <td>WCHO Associate Medical Director</td> </tr> </table> <h3 style="text-align: center;">This Event Made Possible By:</h3> <p>Community Support and Treatment Services</p> <p><small>In Partnership With</small></p> <p>Washtenaw Community Health Organization</p> <p><small>And Partial Funding From</small></p> <p>Michigan Department of Community Health</p>			Donna Sabourin	CTS Director	Patrick Barrie	WCHO Director	John Shands	CTS Adult Services PA	Trish Gates	CTS Developmental Disabilities PA	Dick Deighton	CTS Youth & Family PA	Deb Pippins	CTS PORT/PORT PA	Jan Vuelker	CTS CRT PA	Karen Wilner	CTS Medical Director	Tim Florence	CTS Associate Medical Director	Dan Healy
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(f) Youth and Family Trauma Work Group

As previously indicated, this group developed when it became clear that the trauma-specific treatment needs of children were significantly different than those of adult populations, in support of addressing those needs with a variety of therapeutic strategies. Although the overwhelmingly primary focus of the phase of CSTS' trauma initiative addressed by this grant project concerned adult, seriously mentally ill populations, a commitment was also extended to further the efforts already being made to advance trauma-informed and trauma-specific services within the agency's Youth and Family department. The following models were among those found in the professional literature identified as best practices for trauma-specific treatment to children and their families (*Hensler et al, 2004*):

- **Trauma-Focused Cognitive Behavioral Therapy (TF-CBT);**
- **Abuse-Focused Cognitive Behavioral Therapy (AF-CBT);**
- **Parent Child Interaction Therapy (PCIT).**

A comprehensive review of numerous additional treatment protocols was accomplished and published in 2003, entitled **Child Physical Abuse and Sexual Abuse Guidelines for Treatment**. This work was subsequently revised and republished a year later as **Child Physical and Sexual Abuse: Guidelines for Treatment** (*Saunders et al, 2004*). Over 20 different approaches were reviewed and graded according to a 6-level treatment protocol classification system (1=*well-supported, efficacious*; 2=*supported and probably efficacious*; 3=*supported and acceptable*; 4=*promising and acceptable*; 5=*innovative or novel*; 6=*concerning*), within both "Child Focused Interventions" and "Family, Parent-Child and Parent-Focused Interventions" categories. It is recommended that readers take advantage of this worthwhile resource, which is available at no cost and may be downloaded from the site indicated here (http://academicdepartments.musc.edu/ncvc/resources_prof/OVC_guidelines04-26-04.pdf), as well as in the **References and Resources** section of this manual. The reviewed interventions and their associated ratings are excerpted below, rank-ordered within respective categories from highest to lowest scores:

Child Focused Interventions:

- [1] – **Trauma-focused Cognitive-Behavioral Therapy (TF-CBT);**
- [3] – **Individual Child and Parent Physical Abuse-focused Cognitive-Behavioral Treatment (AF-CBT);**
- [3] – **Cognitive-behavioral and Dynamic Play Therapy for Children with Sexual Behavior Problems and Their Caregivers;**
- [3] – **Cognitive Processing Therapy (CPT);**
- [3] – **Eye Movement Desensitization and Reprocessing (EMDR);**
- [3] – **Resilient Peer Training Intervention;**
- [3] – **Therapeutic Child Development Program;**

- [3] – *Trauma-focused Integrative-Eclectic Therapy (IET)*;
- [4] – *Trauma-focused Play Therapy*.

Family, Parent-Child and Parent-Focused Interventions:

- [3] – *Parent-Child Interaction Therapy (PCIT)*;
- [3] – *Behavioral Parent Training Interventions for Conduct-Disordered Children*
- [3] – *Family Focused, Child Centered Treatment Interventions in Child Maltreatment*;
- [3] – *Multisystemic Therapy (MST) for Maltreated Children and their Families*;
- [3] – *Parent-Child Education Program for Physically Abused Parents*;
- [3] – *Physical Abuse-informed Family Therapy*;
- [4] – *Attachment-Trauma Therapy*;
- [4] – *Family Resolution Therapy (FRT)*;
- [4] – *Integrative Developmental Model for Treatment of Dissociative Symptomatology*;
- [4] – *Intensive Family Preservation Services*;
- [4] – *Parents United (Child Sexual Abuse Treatment Program)*;
- [4] – *Parents Anonymous*;
- [6] – *Attachment Therapy*.

As models among those most highly scored and well regarded in available professional literature (*Hensler et al, 2004; Saunders et al, 2004*), the following three were offered as a starting point for work group consideration:

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

Described as a psychotherapeutic intervention designed to help children, youth, and their parents overcome the negative effects of traumatic life events, including the following:

- child sexual or physical abuse;
- traumatic loss of a loved one;
- domestic, school, or community violence; or
- exposure to disasters, terrorist attacks, or war trauma.

TF-CBT was developed by integrating cognitive and behavioral interventions with traditional child abuse therapies that focus on enhancement of interpersonal trust and empowerment. The program can be provided to children 3 to 18 years of age and their parents by trained mental health professionals in individual, family, and group sessions in outpatient settings. It targets symptoms of posttraumatic stress disorder (PTSD), which often co-occurs with depression and behavior problems. 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 following treatment manuals or protocol descriptions are available to support development and implementation of therapy service delivery – **Treatment for Sexually Abused Children and Their Non-Offending Parents: A Cognitive-Behavioral Approach** (Deblinger & Heflin, 1996), and **A Treatment Model for Sexually Abused Preschoolers** (Cohen & Mannarino, 1993).

TF-CBT was elevated by SAMHSA from “model program” status to “evidence-based practice” status in late 2008, following a review of available, replicated research, including the following:

- *A multisite, randomized controlled trial for children with sexual abuse-related PTSD symptoms* (Cohen et al, 2004a);
- *A treatment outcome study for sexually abused preschool children: Initial findings* (Cohen & Mannarino, 1996);
- *Treating childhood traumatic grief: A pilot study* (Cohen et al, 2004b);
- *Treating sexually abused children: 1 year follow-up of a randomized controlled trial* (Cohen et al, 2005);
- *A pilot randomized controlled trial of combined trauma-focused CBT and sertraline for childhood PTSD symptoms* (Cohen et al, 2007b);
- *Sexually abused children suffering posttraumatic stress symptoms: Initial treatment outcome findings* (Deblinger et al, 1996);
- *Comparative efficacies of supportive and cognitive behavioral group therapies for young children who have been sexually abused and their nonoffending mothers* (Deblinger et al, 2001);
- *Impact of CBT for traumatized children and adolescents affected by the World Trade Center disaster. Manuscript submitted for publication* (Hoagwood et al, 2008);
- *Treating sexually abused children with post-traumatic stress symptoms: A randomized clinical trial* (King et al, 2000).

Abuse-Focused Cognitive Behavioral Therapy (AF-CBT)

Described by Saunders et al (2004) as a cognitive-behavioral intervention for children and physically abusive parents that targets beliefs and attributions about abuse and violence, and teaches skills to enhance emotional control and reduce violent behavior.

Cognitive-behavioral treatments based on the application of social learning principles, with their emphasis upon reciprocal influences between parents and children, are designed to alter the expression of appropriate or prosocial and inappropriate or deviant behavior. Interventions based on the social-situational model have emphasized instruction and training in new skills in various domains that relate to cognitive, affective, and behavioral development. In working with

physically abusive families, such techniques have been directed toward enhancing non-violent discipline, anger control or stress management, and contingency management (Kolko, 1996).

The following treatment manuals or protocol descriptions are available to support development and implementation of therapy service delivery – **Assessing and Treating Physically Abused Children and Their Families: A Cognitive-behavioral Approach** (Kolko & Swenson, 2002), and Swenson & Kolko's (2000) chapter in **The Treatment of Child Abuse**, entitled, **Long-term Management of the Developmental Consequences of Child Physical Abuse**.

Treatment outcome study references include the following:

- *Individual cognitive behavioral therapy and family therapy for physically abused children and their offending parents: A comparison of clinical outcomes* (Kolko, 1996).

Parent Child Interaction Therapy (PCIT)

Described by Saunders et al (2004) as a behavioral and interpersonal dyadic intervention for children (ages 2-8 years) and their parents or caregivers that is focused on decreasing externalized child behavior problems (e.g., defiance, aggression), increasing positive parent behaviors, and improving the quality of the parent-child relationship.

There are many underlying factors that contribute to the development of physically abusive families. Foremost among these factors is the nature of the parent-child relationship. Abusive parents are characterized by high rates of negative interaction, low rates of positive interaction, and limited and ineffective parental disciplining strategies (Kolko, 1995). At the same time, physically abused children have been reported to be aggressive, defiant, noncompliant, and resistant to parental direction (Kolko, 1995). These patterns of interaction result in a negative and coercive parent-child relationship that may escalate to the point of severe corporal punishment and physical abuse (Urquiza & McNeil, 1996). This pattern eventually can become a relatively stable form of resolving parent-child conflicts that also generates ongoing risk for child maltreatment. While it is likely that there are many different types of physically abusive parent-child relationships, this particular cycle may explain a substantial portion of physical abuse situations, especially those that evolve from routine daily interactions around compliance and discipline. Parent-Child Interaction Training (PCIT) was developed by Sheila Eyberg to address families with negative interactional patterns where the children are oppositional and defiant and has been shown to be effective with these high-risk families (Eyberg, 1988). It is an intervention that is especially appropriate for use in physical abusive situations because it targets the specific deficits often found within physically abusive parent-child dyads that can lead to maltreatment. The approach incorporates both the parent and the child (and other involved family members) in the intervention process. It provides an in vivo opportunity to alter the pattern of interactions within abusive relationships, and it serves as a mechanism to directly decrease negative affect and control - while promoting greater positive affect and discipline strategies. The interventions combine elements of family systems, learning theory and

traditional play therapy. The emphasis is on restructuring parent-child patterns, not modifying behaviors (*Hembree-Kigin & McNeil, 1995*). The therapist takes an extremely active and directive role in the process. The intervention consists of an initial set of approximately six sessions devoted to enhancing positive interactions, and then another six that focus on improving disciplinary practices. Progress is tracked and once parents achieve competence in one area they shift the treatment focus.

The following treatment manuals or protocol descriptions are available to support development and implementation of therapy service delivery – **Parent-Child Interaction Therapy** (*Hembree-Kigin & McNeil, 1995*), **Parent-Child Interaction Therapy: An Intensive Dyadic Intervention for Physically Abusive Families** (*Urquiza & McNeil, 1996*), and the treatment manual (*Urquiza et al, 1999b*) and corresponding videotape series entitled, **Parent-Child Interaction Therapy: Application to High-Risk and Maltreating Families** (*Urquiza et al, 1999b*).

Treatment outcome study references include the following:

- *Importance of therapist use of social reinforcement with parents as a model for parent-child relationships: An example with Parent-Child Interaction Therapy* (Borrego et al, 1998);
- *Parent-Child Interaction Therapy with a Family at High-Risk for Physical Abuse* (Borrego et al, 1999);
- *Parent-child interaction therapy: Integration of traditional and behavioral concerns* (Eyberg, 1988);
- *Parent-child interaction training: Effects on family functioning* (Eyberg & Robinson, 1982);

Agency WIKIPEDIA pages were created to capture and communicate some of the known information and resources supportive of the focus of this work group, replicated below:

TRAUMA MODELS FOR CHILDREN

For a rendering of the 2004 findings of the Kauffman Best Practices Project to Help Children Heal From Child Abuse, click here: [Closing the Quality Chasm in Child Abuse Treatment: Identifying and Disseminating Best Practices](#) (*Hensler et al, 2004*)

To view information on **Trauma-Focused Cognitive Behavioral Therapy**, a SAMHSA-endorsed evidence-based practice for working with traumatized youth, visit [Trauma-Focused Behavioral Therapy: Addressing the Mental Health of Sexually Abused Children](#) (*Cohen et al, 2007a*), or learn more about TF-CBT on SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP) at <http://nrepp.samhsa.gov>.

There is an available, excellent on-line training on this approach, good for 10 Social Work CEUs, that can be accessed free-of-charge at <http://tfcbt.musc.edu>.

A worthwhile manual entitled, **How to Implement Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)** is also available from The National Child Traumatic Stress

Network (NCTSN) website at http://www.nctsn.org/nctsn_assets/pdfs/TF-CBT_Implementation_Manual.pdf. The following additional materials are also available at the NCTSN website:

- **Resources for Professionals**
(http://www.nctsn.org/nccts/nav.do?pid=ctr_aud_prof),
- **Resources for Parents and Caregivers**
(http://www.nctsn.org/nccts/nav.do?pid=ctr_aud_prnt), and
- **Resources for School Personnel**
(http://www.nctsn.org/nccts/nav.do?pid=ctr_aud_schl) are also available at the NCTSN website.

Some excellent general principles to consider when working with children who have been traumatized are included in the [Child Physical and Sexual Abuse: Guidelines for Treatment](#) manual published by the National Crime Victims Research and Treatment Center & the Center for Sexual Assault and Traumatic Stress (*Saunders et al, 2004*).

For a more local resource for information, perspective and materials, check out The Southwest Michigan Children's Trauma Assessment Center at <http://www.wmich.edu/hhs/unifiedclinics/ctac/index.htm>.

Recognizing that the trauma treatment and recovery needs of children and adolescents are uniquely different in some respects from that of adults, a CSTS workgroup has been formed to consider how best to develop and provide services that address these needs. Follow this link to check out the developments in the **Youth and Family Trauma Work Group**.

Accomplishments of the Youth and Family Trauma Work Group

There was found to be a considerable amount of already existing trauma therapy experience and expertise among the Youth and Family staff, which was a great resource in the service of the group's considerations. Nine clinicians began to meet regularly as part of the Youth and Family Trauma Work Group to consider how best to expand service delivery in trauma-informed and trauma-specific directions. The consensus view was that the goodness-of-fit of one or another trauma treatment models was inextricably linked to a number of variables that differed from child to child. Elements such as the child's age, the severity and type of their trauma experiences, the developmental milestones that either had or had not yet been mastered, and the nature of the home environment all had significant impact on whether a treatment approach would be effective or not.

The work group also reviewed and contributed their content knowledge and experience to an initial review of clinician-identified trauma treatment approaches, as follows, which included suggestions for exploring more recently developed approaches:

Trauma-focused Cognitive Behavioral Therapy (TF-CBT) – Per the application experiences of Youth and Family clinicians, this SAMHSA-endorsed evidence-based practice was described as having efficacy for youth old enough to be functionally verbal with more straightforward trauma experiences, and less helpful with younger clients, particularly those with a history of multiple/more complicated traumatic experiences. This was thought to be the case because TF-CBT is so dependent upon narrative and organized thought processes, which may not be the primarily available avenue of engagement for all traumatized children.

Eye Movement Desensitization and Reprocessing (EMDR) – EMDR is an approach that utilized bilateral brain stimulation to integrate formerly un-integrated elements that can result from traumatic experiences. It was noted that this intervention can be used with children across a wide age span, but also that initial and refresher training is expensive, in spite of some certified trainers being local. (See <http://www.emdr.com> for more information).

Theraplay – Theraplay is an approach that utilizes playful techniques to foster healthy attachment, and to deal with potential behavioral and developmental problems. It can be combined with other interventions to enhance healing/recovery for trauma survivors. (See <http://www.theraplay.org> for more information).

Dyadic Developmental Psychotherapy (DDP) – DDP is designed for the treatment of children with complex trauma and attachment problems. It is a modality that is suited to address long-term trauma such as child abuse and neglect, rather than single-incident trauma like a car accident. It addresses issues such as the child's damaged sense of self-worth/shame that often results from ongoing abuse and neglect. (For more information, see <http://www.dyadicdevelopmentalpsychotherapy.org>).

Neurosequential Model of Therapeutics – This approach was described as a neurobiologically informed intervention that addresses the stress-regulating capacities of the brain as a foundational element for subsequent healing. As such, this could be a complimentary intervention along with other approaches. Bruce Perry and Rick Goskill are among the developers, and the approach is still being researched. (For more information, see <http://www.childtrauma.org/ctaServices/nmt.asp>).

Biodynamic Craniosacral Therapy – The emphasis in Biodynamic Craniosacral Therapy is to help resolve the trapped forces that underlie and govern patterns of disease and fragmentation in both body and mind. This involves the practitioner 'listening through the hands' to the body's subtle rhythms and any patterns of inertia or congestion. Through the development of subtle palpatory skills the practitioner can read the story of the body, identify places where issues are

held and then follow the natural priorities for healing as directed by the patient's own physiology. (See <http://www.craniosacraltherapy.org> for more information).

Although this work group was formed comparatively later in the grant year (4th Quarter), it was able to achieve some meaningful progress, as well as making the commitment to continue to meet on a monthly basis for as long as the group was productive. Initial achievements included adjusting the intake / orientation / initial assessment processes to be more trauma-sensitive, and engaging in regular triage among trauma-experienced clinicians to inform the assignment of incoming clients so that more effective matching could occur with a therapist having expertise in a trauma treatment approach that seemed a likely best fit.

Because of the comparatively recent development of this work group, it is still in the process of advancing the agency's Youth and Family department toward greater trauma-informed and trauma-specific services and practices, with the promise of additional service development and implementation still to come.

IV. Trauma-informed Services Conference

Following the pattern of successful prior initiatives, the trauma initiative sought to raise the awareness of a large percentage of agency staff (as well as additional staff from partner agencies around the community) by offering an all-day Trauma Conference on the topic of trauma-informed services. As there had already been some discussions with Roger Fallot and others from the Community Connections group in Washington DC (<http://www.communityconnectionsdc.org/>), and since their model of addressing trauma (TREM/M-TREM) was one of the approaches being explored by the current initiative, it was subsequently arranged for Roger, and Lori Beyer, to be the primary presenters at our Spring conference entitled, “Developing and Implementing Trauma-Informed Services” (*please see **Appendix B.1: Trauma-informed Services Conference brochure** to view a copy*). In order to make the training conference as accessible as possible to agency and community partner staff, the entire cost was covered, and a duplicate one-day program was offered on each of two successive days to allow for the flexibility of staff scheduling necessary for some organizations to be able to meaningfully participate. Social Work, Certified Addictions Counselor, and Nursing CEUs were also provided as an incentive for attendance. Invitations were strategically extended to target staff from multiple organizations on the local service provider panel who served many of the same consumers served by CSTS. These organizations included residential service providers, vocational service providers, homeless shelters and crisis services providers, physical healthcare clinics, hospital Emergency Department staff, consumer advocacy groups, and other outpatient mental health providers. Between both days, a total of 242 different staff participated, with 20 different provider agencies represented.

Trauma Conference Planning Work Group

As may be accurately surmised, a successful undertaking of such magnitude required a significant amount of planning and coordination. As indicated in the prior chapter, these efforts were the focus of the Trauma Training Conference Planning Work Group, which met weekly for over 3 months to plan how to best support an optimally effective conference experience for participants.

It is well recognized that moving toward a trauma-informed system of care involves shifting and changing the culture of behavioral healthcare provision at a systems level. This was the perspective taken by the conference planning group, which guided both the coordination efforts with the lead presenters from Community Connections, as well as the local efforts of planning and presenting the conference event.

Despite the temptation to focus the trauma conference on trauma-specific clinical skill-building in order to get trauma-specific treatment up and running ASAP, a different tack was taken. It was decided instead to first address some of the foundational cultural and organizational

elements that would need to be appropriately aligned in order for successful trauma services to be well developed and sustainably maintained. In this regard, the fivefold “core principles” framework provided by Community Connections, along with their conference presentations on “Creating Cultures of Trauma-Informed Care,” and “Staff Support in Human Service Settings: An Essential Element of Trauma-Informed Programs” were right on target.

Core Principles of a Trauma-Informed System of Care

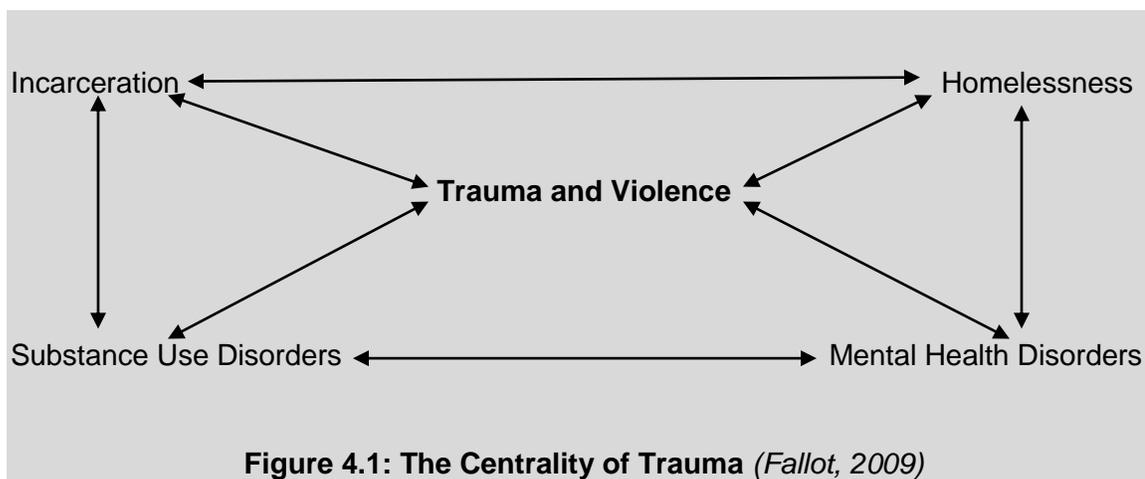
The “Developing and Implementing Trauma-Informed Services” conference focused on the 5 core principles of a trauma-informed system of care, also featured in Community Connections’ Trauma-informed Program Self-Assessment Scale (*see Appendix B.2: Trauma-informed Program Self-Assessment Scale*), and their Services Implementation Plan. This fivefold framework endorsed for trauma-informed service provision includes the following elements:

- **Safety** – addresses both physical and emotional safety, and endeavors to support those elements in all aspects of service activities and settings;
- **Trustworthiness** – seeks to optimize trustworthiness through clarity of communication, consistency of practice, and appropriate interpersonal boundaries;
- **Choice** – attempts to maximize the control and choices of service recipients in how services are provided;
- **Collaboration** – supports the sharing of power and coordination/cooperation between staff and service recipients;
- **Empowerment** – places a premium on the growth of service recipients in building skills and confidence;

Creating Cultures of Trauma-Informed Care

As aptly noted in Roger Falloot’s morning conference presentation, the position taken by Community Connections and others is that in order for services to be comprehensively and sustainably trauma-informed, change must occur at the cultural level (*Harris & Falloot, 2001a, 2001b*). The profile of the importance of addressing trauma in behavioral healthcare services has experienced a steady rise over the past several years. The Substance Abuse and Mental Health Services Administration’s most recently revised matrix of priorities and concerns, published in 2006, included addressing trauma and violence as one of its top ten cross-cutting principles (*Cline, 2007*). Substantiated both by an increasing amount of research evidence, as well as by the practice experiences of behavioral healthcare workers in the fields of mental health and substance use disorder treatment, the prevalence of trauma among our service

recipients is widespread and significant, and demands to be dealt with at a comprehensive, systems level. As Roger's conference presentation so convincingly made the case, trauma is truly central to a host of other social problems, as evidenced by the high prevalence found in homeless and incarcerated populations, as well as among those with substance-use and/or mental health disorders (see **Figure 4.1: The Centrality of Trauma** below).



Both service-level and systems-level changes typically need to occur in order for a behavioral healthcare organization to move in the direction of becoming more trauma-informed. Community Connections' "Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol" (Fallot & Harris, 2009) provides one excellent, detailed approach that has proven to be quite useful in our local efforts at CSTS. The involved framework asks specific questions designed to promote thoughtful consideration of both service-level changes and systems-level changes, across each of the following pertinent domains:

- **Service-level Change**
 - Program Procedures and Settings
 - Formal Service Policies
 - Trauma Screening, Assessment, Service Planning and Trauma-Specific Services
- **Systems-level Change**
 - Administrative Support for Program-Wide Trauma-Informed Services
 - Staff Trauma Training and Education
 - Human Resources Practices

Although the follow-through with utilizing this framework in the months subsequent to the conference comprised the more time- and labor-intensive implementation work, the initial exposure at the trauma conference was helpful for educating staff to the “big picture,” and for gaining buy-in for the work ahead.

Following Roger’s presentation, conference participants were asked to group themselves according to employer, and to engaged in a break-out session exercise that challenged them to review their organization’s culture. Participants were asked to assess the current reality of how the 5 core principles of trauma-informed service delivery were being manifested at their places of work. The break-out groups were also encouraged to brainstorm ideas for improvement that could help to inform their employers’ efforts to move forward toward a more trauma-informed system of care. Some of the results were reported out for the benefit of the larger conference audience, and all were strongly encouraged to take these documents back to their respective organizations, as valuable input for action-planning next steps. The worksheets utilized for this break-out exercise may be found in **Appendix B.3: Developing and Implementing Trauma-informed Services: Breakout Session # 1 – “How do we get there?”**.

Staff Support in Human Service Settings: An Essential Element of Trauma-informed Programs

Another focus receiving significant attention at the conference was the important component of ensuring that service-providing staff were well-supported as they went about working with trauma-surviving clients and the intensive needs they often present with. Lori Beyer’s afternoon conference presentation identified and discussed the two major pertinent (and related) elements – cultivating an organizational culture consistent with trauma-informed values for staff as well as consumers at the macro level, and managing the risk of staff experiencing secondary traumatization/compassion fatigue at the micro level.

Non-traumatizing workplace – Roger Fallot’s initial conference presentation on “Creating Cultures of Trauma-informed Care” emphasized that organizations providing trauma treatment services need to always operate with the 5 core principles in mind in order to avoid traumatizing the clients they serve. Lori Beyer’s afternoon presentation made the expanded point that for an organization to be truly trauma-informed, it needs to avoid being traumatizing to its employees as well. The core principles that had already been discussed as important for informing service delivery to trauma-surviving clients were revisited as also important for applying to the work environment for staff. Do staff feel reasonably safe in the workplace? Do staff adequately trust their colleagues, and their employer, both at the immediate supervisory level and at the administrative level? Do staff experience a healthy amount of choice and the opportunity to collaborate in job-impacting decisions? Are staff empowered to advance in the skills and competencies needed within their scope of practice? Differences between healthy and toxic workplaces were reviewed, drawing from the work of Kahn & Langlieb (2003), and Grawitch et al (2006) (see **Figure 4.2: Healthy vs Toxic Workplace Cultures** below), and the attributes of

a psychologically health worksite culture were identified as including employee involvement, work/life balance, growth and development opportunities for staff, health and safety, and recognition of staff accomplishment (APA, 2009). Organizations can actively cultivate and support these attributes of a healthy workplace culture at a macro level to support genuinely trauma-informed practice for staff, so they are best-positioned to work effectively with the clients they serve at the micro level.

Toxic Workplace Culture	Healthy Workplace Culture
Staff don't help each other	Staff know what is expected of them
Human needs are ignored	Staff have the resources to do their jobs
Staff feel alienated and dehumanized	Staff have daily opportunity to do what they do best
Alternative approaches/new ideas are discouraged	Professional development is encouraged
Cliques are common	Personal development is supported
Top-down rigidity is the rule	Praise is regularly offered

Figure 4.2: Healthy vs Toxic Workplace Cultures

Managing the burnout risk – Working with individuals having intensive needs, as is the case with many trauma survivors, puts staff at high risk for secondary/vicarious traumatization and/or compassion fatigue, which can lead to varying degrees of burnout, or other mental/emotional problems for practitioners. Following the conference lunch, Lori Beyer delivered a thought-provoking conference presentation on “Staff Support in Human Services Settings.” At the micro level, individual staff can be supported to take steps to optimally manage this risk in numerous ways, including the following, some of which will be additionally addressed in the coming chapters:

- Pertinent education / training
- Supportive supervision / consultation / debriefing with trusted others
- Appropriate use of breaks and vacation time off to pace oneself
- A strengths orientation to self and clients

- Regular use of stress management / self-soothing / coping skills
- Practicing acceptance
- Cultivating and maintaining regular communication loops / support networks
- Knowing one's limits, and asking for help when indicated
- Utilizing spiritual resources that are personally meaningful

Particularly for those clinicians considering direct treatment service work with trauma-surviving clients, an honest self-assessment is in order prior to simply diving in. Trauma treatment work is not a great fit for every practitioner, and it is important to carefully consider goodness-of-fit ahead of time, so as to not put oneself or one's clients at risk. The review items found in **Appendix D.1: Checklist for Trauma Treatment Practitioners** may be a helpful tool to use in this type of consideration.

Interestingly, the recommendations for staff listed above sound quite similar to much of what behavioral healthcare professionals regularly encourage their clients to embrace for the betterment of their emotional and mental health. Practicing what we preach will go a long way toward maintaining a healthy level of personal well-being that will allow us to be more available to our trauma-surviving clients as both positive role models and effective providers of services.

Following Lori's presentation, conference participants were asked to group themselves according to scope of practice, and to engage in a break-out session exercise that challenged them to review the practice of their own professional discipline. Participants were asked to assess the current reality of how the 5 core principles of trauma-informed service delivery were being manifested in their own work. The break-out groups were also encouraged to brainstorm ideas for improvement that could help to inform their own efforts to move forward toward more trauma-informed service delivery in their respective function within their employing organization. Some of the results were reported out for the benefit of the larger conference audience, and all were strongly encouraged to take these documents back to their respective places of work, as valuable input for guiding their own individual next steps. The worksheets utilized for this break-out exercise may be found in **Appendix B.4: Developing and Implementing Trauma-informed Services: Breakout Session # 2 – "Trauma-informed Skill Development"**.

V. Treatment Model Consideration and Adaptation

Consideration Criteria

In order to be able to provide the most effective trauma treatment services for our client populations, a determination of “goodness of fit” needed to occur with regard to the models that were being considered. Among the desired criteria for a CMH-effective treatment model were the following elements, which were taken into consideration by members of the Trauma-specific Work Group:

- **Affordability and availability of materials** – New funding for Community Mental Health service expansion was not currently available, and given the ramifications of the current economy, would not be for the foreseeable future. With this as the current reality, affordability of content materials for use in implementing the treatment model was considered important. What materials were needed, and how much did they cost? Were they easy to locate and acquire?
- **Training burden** – Given the lack of new funding to support trauma treatment service expansion, the affordability of start-up and ongoing training was also considered an important element. What were the start-up and refresher training costs? Was the provision of services with the treatment model able to be mastered by existing staff with the normal range of existing education and experience levels found in a typical CMH organization?
- **Research evidence base and applicability** – Had the model been studied with service-recipient populations similar to those served by CMH providers in the State of Michigan? Did it show validity in resulting in positive outcomes, and reliability in replicated trials with populations in different areas?
- **Destabilization risk to clients** – Did the model sufficiently take into account the risk posed to the mental health and/or substance abuse recovery status of the service recipient? Were the retraumatization risks well-managed for activating or exacerbating relapses of mental illness and/or addictive symptoms?
- **Sustainability factors** – Was the model able to be implemented in such a way that services could be maintained over the long term? What elements were important to attend to, and at what cost, in order to project a high level of sustainability?

A helpful starting point for these considerations was provided by the work done by Finkelstein, VandeMark, Fallot, Brown, Cadiz, and Heckman, leading to their 2004 publication entitled, “Enhancing Substance Abuse Recovery Through Integrated Trauma Treatment.” Although the current trauma initiative was broader in scope in its attempt to encompass CMH populations with severe mental illnesses and/or substance use disorders, the comparison done by Finkelstein et al highlighted some of the important elements for consideration, as well as some of the differences between the various models it reviewed. Their cross-comparison chart is

duplicated below (see **Table 4.1: Salient Aspects of Integrated Trauma Treatment Models** below).

	ATRIUM	Helping Women Recover	Seeking Safety	TREM	TRIAD
Overview and Theoretical Approach	Addresses mind, body <i>and</i> spirit; based on cognitive-behavioral and relational theories	Integrated curriculum addressing trauma & addiction; based on relational & CBT theory & integrating expressive arts	Present-focused therapy promoting safety and recovery; integrates cognitive-behavioral theory with interpersonal and case management domains	Addresses areas of empowerment, impact of trauma events, and skill-building; utilizes CBT, psycho-ed, and skills-training approaches	Promotes survival, recovery, and empowerment using a cognitive-behavioral approach
Service Duration & Intensity	12 weeks (60–90 min.)	17 sessions (90 min.)	25 sessions (50–90 min.)	24–29 sessions (75 min.)	16 sessions (120 min.)
Open vs Closed Sessions	Closed Groups	Closed groups recommended	Open or closed groups	Closed groups after 4 th session	Modified closed groups (open, start of each phase)
Adaptations	Has been used on a limited basis in co-ed groups	Curricula for adolescent girls and criminal justice settings are available.	Manual makes suggestions for tailoring the program to a variety of lengths of stay and settings.	Versions available for use with men, adolescent girls, and for Spanish language and culture	Has been modified for use in jails
Training & Facilitator Qualifications	Peer or professionally facilitated; initial training and TA recommended and available in English and Spanish.	Detailed facilitator manual intended to supplant formal training. Facilitators must be women and if they are abuse survivors must have had treatment.	No specific facilitator qualifications but recommended that facilitator seek support; manual includes chapter to prepare facilitator. Additional training not required.	One or two gender-specific co-leaders must be trained. Training offered by program developers usually designed for 2 trainers and up to 40 participants.	Professionals or para-professionals with experience in mental health or substance abuse & knowledgeable about group process; training and on-going supervision strongly recommended.
Manual Cost	\$25; \$22.25 at Amazon.com	Facilitator guide and woman's journal \$180; journal alone \$23	\$36	\$25 from developers; \$32.75 in book stores	None
Contact	Dusty Miller dustymi@valinet.com	Stephanie Covington sscird@aol.com	Lisa Najavits info@seekingsafety.org	Rebecca Wolfson Berley rwolfson@ccdc.org	Colleen Clark cclark@fmhi.usf.edu

Table 4.1: Salient Aspects of Integrated Trauma Treatment Models
From Finkelstein et al (2004). Enhancing Substance Abuse Recovery Through Integrated Trauma Treatment. p.9.

Model-specific Considerations

Consideration # 1: Affordability and availability of materials

In the resource-limited environment that is our current public community mental health system, and especially in light of Michigan's current economic conditions, the affordability variable carries significant weight in the decision-making equation for implementing trauma-specific treatment services. The core content manuals/texts for each of the following 5 trauma-treatment models were found to be readily available, with the price differences as indicated below – none of the costs were found to be exorbitant, especially when weighed against the cost savings from expected reductions in expensive crisis care episodes as trauma-surviving clients have access to more effective treatment.

Addictions and Trauma Recovery Integration Model (ATRIUM)

- “Addictions and Trauma Recovery: Healing the Body, Mind, and Spirit” text – [cost = \$25.00] (*Miller & Guidry, 2001*);
- Available via <http://www.amazon.com>;

Beyond Trauma

- “Facilitator’s Guide” manual – [cost = \$89.95] (*Covington, 2003a*);
- Participant Workbook – [cost = \$7.95 each] (*Covington, 2003b*);
- Available via <http://www.stephaniecovington.com>, or via <http://www.hazelden.com>;

Seeking Safety

- “Seeking Safety” manual – [cost = \$42.00] (*Najavits, 2002c*);
- Available via <http://www.seekingsafety.org>, or via <http://www.amazon.com>;

Trauma Recovery & Empowerment Model (TREM)

- “Trauma Recovery & Empowerment: A Clinician’s Guide to Working with Women” text – [cost = \$25.00] (*Harris et al, 1998*);
- “Healing the Trauma of Abuse: A Woman’s Workbook” – [cost = \$15.00 each] (*Copeland & Harris, 2000*);
- Men’s Trauma Recovery and Empowerment Model (M-TREM) manual – [cost = \$25.00] (*Fallot et al, 2001*);
- Available via <http://www.communityconnectionsdc.org>;

Triad

- Existing manual available by direct request from the University of South Florida via Colleen Clark at cclark@fmhi.usf.edu, (813) 974-9022 – [cost=\$0] (Clark & Fearday, 2003);
- Group facilitator's manual is not currently available in bookstores or via Amazon.com or elsewhere on the internet.

Consideration # 2: Training burden

As anyone who has ever implemented a new clinical treatment service knows, the cost of content materials often pales in comparison to the cost of start-up and refresher training. In the current resource-limited environment, the feasibility of training also carries significant weight – including the involved costs of actual training (trainer, space, etc.), AND opportunity costs of displaced work while staff are busy being trained. For most of these 5 trauma-treatment models, training was recommended, but not considered mandatory to begin service provision, especially in the case of the manualized interventions, the manuals for which were designed to intentionally contain sufficient practitioner guidance for starting services. The functional mastery level required by each of the 5 models was not found to exceed the skills and competencies of a typical Master's-level mental health professional CMH employee (although self-selection, motivation, and commitment to working with trauma-surviving populations is viewed as important, as will be expanded upon in a later chapter.).

ATRIUM

- Training by approved trainer is recommended, though not considered mandatory. Information on formal training cost and availability could not be found per multiple internet searches, and unsuccessful attempts to contact the developer;

Beyond Trauma

- No training required in order to start providing treatment group, as facilitator manual is intended to provide necessary guidance;
- If desired, the additional resource of 2 Facilitator DVDs (129 minutes) and 1 Client Video (45 minutes) is also available – [cost = \$366] (Covington, 2003c & 2003d);

Seeking Safety

- No training required in order to start providing group treatment, as facilitator manual is intended to provide necessary guidance;
- If desired, the additional resource of 4 training DVDs (4-½ hours) is also available – [cost = \$250] (*Najavits, 2005a, 2005b, 2005d & 2005e*);

TREM

- Training offered by developers, who recommend an initial 2-day on-site training with follow-up telephone or on-site consultation – [cost >= \$4,000];
- If desired, the additional resource of “Trauma Recovery & Empowerment: A Clinician’s Guide to Working with Women in Groups” set of DVDs is also available – [cost = \$750] (*Harris, 1999a, 1999b, 1999c, 1999d*);

Triad

- Training potentially available – contact developer Colleen Clark (cclark@fmhi.usf.edu, 813-974-9022) at the University of South Florida to further explore training availability and cost.

Consideration # 3: Research evidence base, and applicability

Of the 5 models in question, 2 had a significant research evidence base (Seeking Safety and TREM), while the others were limited in this regard, at least at the time of this publication. The other 3 were considered potentially promising practices, but lacked a broader research base and/or research evidence of replication with populations more similar to the profiles of trauma-surviving individuals with severe mental illness (both substance-abusing and not) served by CMH providers in the State of Michigan. Of the 5 trauma-treatment models, only 2 were either designed for use with, or had been successfully studied in application with, male trauma survivors – M-TREM, and Seeking Safety.

ATRIUM

- No research evidence base could be readily located;
- Developed by and for female survivors of trauma;

Beyond Trauma

- No significant research evidence base could be located (see <http://www.stephaniecovington.com> for existing citations);
- Exclusively designed for females – does not address male survivors of trauma;

Seeking Safety

- A significant research base exists, excerpted below. More details may be reviewed on SAMHSA's National Registry of Evidence-based Programs and Practices website (<http://www.nrepp.samhsa.gov>):
 - *Dissemination and feasibility of a cognitive-behavioral treatment for substance use disorders and posttraumatic stress disorder in the Veteran's Administration* (Cook et al, 2006);
 - *Promising treatments for women with comorbid PTSD and substance use disorders* (Hien et al, 2004);
 - *Description of and preliminary data from a women's dual diagnosis community mental health program* (Holdcraft et al, 2002);
 - *Twelve-month outcomes of trauma-informed interventions for women with co-occurring disorders* (Morissey et al, 2005);
 - *Seeking Safety therapy for adolescent girls with PTSD and substance use disorder* (Najavits et al, 2006);
 - *Seeking Safety plus exposure therapy: An outcome study on dual diagnosis men* (Najavits et al, 2005);
 - *"Seeking Safety": Outcome of a new cognitive-behavioral psychotherapy for women with posttraumatic stress disorder and substance dependence* (Najavits et al, 1998b);
 - *Group therapy to treat substance use and traumatic symptoms in female veterans* (Weller, 2005);
 - *A cognitive-behavioral treatment for incarcerated women with substance abuse disorder and posttraumatic stress disorder: Findings from a pilot study* (Zlotnick et al, 2003).
- **Seeking Safety** has been tested with dually diagnosed women, men, and adolescent girls. Samples have included clients in outpatient and residential settings, low-income urban women, incarcerated women, and veterans (both men and women). The treatment manual is available in both English and Spanish;
- As of November 2006, **Seeking Safety** had been replicated in nine published studies, and applied to both women and men;

TREM

- A significant research base exists, excerpted below. More details may be reviewed on SAMHSA's National Registry of Evidence-based Programs and Practices website (<http://www.nrepp.samhsa.gov>);

- Outcomes for women with co-occurring disorders and trauma: Program-level effects (Cocozza et al, 2005);
 - Twelve-month outcomes of trauma-informed interventions for women with co-occurring disorders (Morissey et al, 2005);
 - 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 (Toussaint et al, 2007).
- **TREM** was initially developed and implemented in Washington, DC, with a predominantly African-American population. Caucasian and Latina women have participated successfully in TREM. A culture-specific adaptation for Latina women has been developed and published in a separate manual;
 - As of December 2006, this intervention or an adaptation of this intervention had been evaluated in three published studies, and applied to both women and men, with the adapted men's model developed and published in a separate manual;

Triad

- No replicated research evidence base could be readily located. Inconclusive (noncomparative) pilot study data indicated positive outcomes of increased adaptive coping skills, and decreased avoidance behaviors and mental health symptoms as measured by Derogatis' Brief Symptom Inventory, in a sample of 128 participants (Veysey & Clark, 2004, pp. 48-49).

Consideration # 4: Destabilization risk to clients

Consistent with what many consider to be the first law of the healthcare professional, namely, to do no harm, the 5 trauma-treatment models were reviewed for how well they appeared to manage the risks for relapse – of mental health symptom exacerbation and/or substance use reactivation. Put quite simply, trauma treatment should not be re-traumatizing, and all 5 models were found to place a premium on the safety of the trauma-surviving client. However, not all of the models equally addressed the unique or enhanced risks found in working with populations having severe mental illness.

ATRIUM

- Designed for use with trauma survivors who may also be engaging in substance abuse and other addictive behaviors, and addresses relapse risk;

- Designed for use with trauma survivors who may also have serious psychiatric diagnoses;
- Addresses establishing internal and external safety as a first-order priority (*Miller, 2001, pp.47-48*);

Beyond Trauma

- Designed for use with only female trauma survivors who may also be engaging in substance abuse and other addictive behaviors, and addresses relapse risk;
- Not primarily designed for trauma survivors with serious mental illness, though portions are adaptable;
- Addresses establishing safety as a “Stage One” priority (*Covington, 2003a, p.23*), and does not include any form of exposure therapy;

Seeking Safety

- Designed for use with male or female trauma survivors who may also be engaging in substance abuse and other addictive behaviors, and addresses relapse risk;
- Not primarily designed for trauma survivors with serious mental illness, though readily adaptable;
- Addresses safety as the “foremost guiding principle” of treatment (*Najavits, 2002c, pp.5-7,94*), and does not include any form of explicit uncovering, revisiting or exposure therapy;

TREM

- Designed for use with male or female trauma survivors (featuring gender-specific group work) who may also be engaging in substance abuse and other addictive behaviors, and addresses relapse risk;
- Not explicitly designed for trauma survivors with serious mental illness, though development of the model occurred in a setting that serves SMI clientele, and both general principles and specific issues involved with serving clients with serious mental illness are addressed (*Harris et al., 1998, pp.227-233*);
- Addresses safety as an important foundational element, and does not include any form of explicit uncovering, revisiting or exposure therapy;

Triad

- Designed for use only with female trauma survivors who may also be engaging in substance abuse and other addictive behaviors, and addresses relapse risk;

- Addresses the needs of female trauma survivors with both substance abuse and mental health problems, particularly good-fitting with personality-disordered individuals (*Clark & Fearday, 2003, pp.2-3*).
- Appropriately addresses safety, with a strong focus on skill-building, and does not include any form of explicit uncovering, revisiting or exposure techniques.

Consideration # 5: Sustainability factors

None of the models require certification in order to implement and to begin to provide treatment services to clients. All of the models recommend appropriate debriefing and regular clinical supervision to support the health and clinical skill level of practitioners involved as therapists and/or group facilitators. Ongoing consultation is offered and/or recommended by the developers of **ATRIUM**, **Beyond Trauma**, **Seeking Safety**, **TREM**, and **TRIAD**, but not mandated. As CSTS' trauma services development and implementation proceeded, it became clear that clinical supervision support and refresher training expertise would be able to be appropriately cultivated within the agency, utilizing the experience of trauma champion clinicians actively involved in delivering trauma-treatment services.

Especially given the strong cognitive-behavioral component of the majority of these models, no major elements of any of them appeared inconsistent or incompatible with existing treatment in the typical CMH array of clinical services. (This assumes, of course, that existing clinical services are provided in a client-centered, collaborative manner, and consistent with the aims of safety, trustworthiness and empowerment!) High compatibility was found to exist with core elements of existing clinical practice approaches (*Dialectical Behavior Therapy, Motivational Interviewing, Integrated Dual Disorders Treatment*), and philosophical orientations to care (*Person-centered Planning, Self-determination, Recovery*), such that "cross-over benefit" likely exists that would support the training, practice and clinical supervision of one or more of these trauma-specific treatment models.

The findings of the involved considerations for evaluating goodness-of-fit with adult Community Mental Health service-recipient populations are summarized in **Table 4.2; Evaluating CMH Applicability Criteria** below:

	ATRIUM	Beyond Trauma	Seeking Safety	TREM	Triad
Core content material affordability and availability	Core text costs \$25	Facilitator manual costs \$90; group participant workbook costs \$8 each	Manual costs \$42 (includes handouts for group participants)	Core content manuals cost \$25 each (TREM, & M-TREM); women's workbooks cost \$15 each	Core content manual is free of charge

Training Burden	Developer-approved training is recommended, but not required; no additional training materials available	Developer-approved training is recommended, but not required; additional training materials (video) available	Developer-approved training is recommended, but not required; additional training materials (video) available	Developer-approved training is recommended, but not required; additional training materials (video) available	Developer-approved training is recommended, but not required; no additional training materials available
Research evidence base and applicability	0 published, replicated studies found; specific client profile focus (female, co-occurring addiction and mental illness)	0 published, replicated studies found; specific client profile focus (female, substance-involved or not)	9 published, replicated studies; targets client profiles including both males and females, substance-involved or not, as well as veterans, & adolescent girls	3 published, replicated studies; easily applicable to client profiles including both males and females, substance-involved or not	1 noncomparative pilot study published; targets specific client profile (female, co-occurring addiction and mental illness)
Destabilization risk to clients	Addresses substance relapse risk, SMI mental health symptom exacerbation	Addresses substance relapse risk; adaptable for SMI mental health symptom exacerbation	Addresses substance relapse risk, adaptable for SMI mental health symptom exacerbation	Addresses substance relapse risk, SMI mental health symptom exacerbation	Addresses substance relapse risk, SMI mental health symptom exacerbation; particularly good-fitting with personality-disordered clients
Sustainability factors	In addition to group session time, recommends debriefing, clinical supervision, staff support; refresher training and peer supervision may be developed in-house	In addition to group session time, recommends debriefing, clinical supervision, staff support; refresher training and peer supervision may be developed in-house	In addition to group session time, recommends debriefing, clinical supervision, staff support; refresher training and peer supervision may be developed in-house	In addition to group session time, recommends debriefing, clinical supervision, staff support; refresher training and peer supervision may be developed in-house	In addition to group session time, recommends debriefing, clinical supervision, staff support; refresher training and peer supervision may be developed in-house

Table 4.2: Evaluating CMH Applicability Criteria

Models of choice, and adaptations

Several of the models being considered (*ATRIUM*, *Triad*) explicitly targeted trauma survivors also problematically involved with substance use. Others (*Beyond Trauma*, *Seeking Safety*, *TREM*) were less explicit in their co-occurring addictions focus, such that they appeared to lend themselves more easily to utilization with trauma-surviving clients who were not also problematically substance-involved.

Several of the models specifically addressed serious co-occurring mental illness, at least to some degree (*ATRIUM*, *Seeking Safety*, *TREM* and *Triad*). Only two (*Seeking Safety*, and *TREM*) had been adapted for use and applied with male trauma-survivors.

Two of the models (*Seeking Safety*, and *TREM*) had a robust research evidence base, including utilization with populations closely approximating those served by CMH organizations, and replication with varying client groups.

Based upon all of the considerations reviewed above, the previewed models selected as the likely best fits for implementation with CMH populations were *Seeking Safety* and *TREM*. Elements of *Beyond Trauma* were also viewed as adaptable for use with some CMH client women's groups, particularly with women not problematically substance-involved. *Triad*'s high level of compatibility with the Dialectical Behavior Therapy model already implemented by many CMH organizations enhanced its apparent usefulness in working with personality-disordered trauma survivors with co-occurring addiction recovery needs. The lack of a greater research evidence base for *ATRIUM* and *Triad*, and the greater applicability of *Seeking Safety*, *TREM* and *Beyond Trauma* to CMH populations not problematically involved with substances also figured strongly into the considerations.

After significant exploration and consideration, the final recommendation and decision was to move forward with implementation efforts using the *Seeking Safety* and *TREM/M-TREM* models, with components of *Beyond Trauma* and *Triad* appearing to be useful in a supplementary manner.

Indicated model adaptations

Engagement – it is likely that due to the severe levels of disempowerment experienced by many CMH populations, additional encouragement and engagement efforts may be necessary when seeking referrals to form a group. It may take comparatively longer to establish trust and rapport with participants who have faced a lifetime of stigma and marginalization, and facilitators need to be prepared to be tested.

Pace – particularly with manualized treatments, the expectation often is to follow the session pacing as outlined in the manual. In working with trauma-surviving CMH populations with varying levels of cognitive functioning, explicit permission needs to be given to group facilitators to adapt the pace to fit the needs of the assembled group members. Flexibility is key!

Handouts – the language of various handouts may or may not be a good fit for the literacy level of one or more assembled group members. It is important to be sensitive to the possibility of needing to change handout language to fewer or simpler words, and/or creatively use clip art or other images to communicate concepts to participants.

Presentation style – similarly, greater use of artistic and experiential exercises, and less direct didactic presentation may be indicated for increased effectiveness of learning for clients with varying degrees of literacy and/or cognitive processing ability.

Structure – at times, additional structure may need to become part of a group’s operation, in order for it to be experienced by participants as optimally safe and effective. A well-conceived, repeatedly articulated format that group members have agreed upon (and ideally even helped to shape) will make it easier to manage boundary issues and/or disruptive behaviors that may occur in conjunction with various symptoms of participants’ mental/emotional disorders.

Co-facilitatorship – the involved management of group dynamics, and potential need to manage any behavior or symptom exacerbation that may occur, make it critical to have at least 2 facilitators for each group. Depending on the size of the group, a third co-facilitator may even be in order. Staffing at this level can be aided by the inclusion of student interns, peer support specialists, or inexperienced other staff desiring to observe and gain the skills and experience to equip them for increasingly more active facilitator duties in the future.

Problem-solving obstacles – many CMH consumers do not own a personal vehicle, and many with young children lack the financial resources to hire childcare to allow for regular weekly group participation. Intentionally identifying and problem-solving transportation and other potential obstacles up-front is important for retention purposes and associated better outcomes.

“No-fault” policy – many CMH consumers may be persuaded to try a trauma group for the very first time, only to learn that it is not a good fit or that the timing is not right for where they are on their uniquely individualized recovery journey. A “no-fault” policy should be adopted and practiced such that there is no shaming or blaming or perceived failure for needing to exit group prematurely, with an open invitation to return when the fit or timing may be better. Ideally, other better-fitting supportive resources can be put in place in such situations.

Diagnostic specificity – there are two sides to the decision to try to have groups be diagnostically specific. On the one hand, participants with like conditions (e.g., thought disorder, mood disorder, personality disorder) may have an initially better connection and greater mutual understanding than diagnostically mixed groups. On the other hand, waiting for a sufficiently large enough number of like-diagnosed referrals can be an obstacle to service launch, and the benefits of providing mixed groups include the cultivation of a greater amount of compassion and understanding for those group members exposed to the challenges encountered by their otherwise-diagnosed comrades.

VI. Trauma-specific Training

Of all the models reviewed by the Trauma-specific Therapy Services work group, the following three were regarded as having the best potential goodness-of-fit for working with community mental health populations:

- **Beyond Trauma** (*Stephanie Covington*)
 - Elements appeared helpful for adapted use with women’s trauma groups, particularly with those clients without co-occurring addictive disorders;
- **Seeking Safety** (*Lisa Najavits et al*)
 - Of significant interest for use with trauma groups being launched as part of the agency’s co-occurring disorders treatment service array;
- **Trauma Recovery and Empowerment Model (TREM), and Trauma Recovery and Empowerment Model for Men (M-TREM)** (*Maxine Harris & Roger Fallot et al*)
 - Of particular interest for exploring for use in developing and launching men’s trauma groups.

Elements of each of these three approaches had been studied and partially utilized by a few of the agency’s clinical staff already identified as trauma champions, some of whom were participants in the Trauma-specific Treatment Services work group. These individuals were approached with the request to help with designing and presenting inservice trainings to other clinical staff across the agency. It was hoped that the general level of awareness and interest would continue to be raised through these inservicing efforts, and that interested staff could be engaged in a collaborative process of thinking and planning how to best develop and implement trauma-specific treatment into the agency’s clinical service array. Participants in each of the inservice trainings were expressly invited to join one of the ongoing work groups, and/or to consider how trauma-specific services could be developed and implemented within their respective departments, sites, and teams.

“Beyond Trauma” Inservice

A 3-hour presentation was planned and presented to the 25 agency staff who gathered to learn about the “Beyond Trauma: A Healing Journey for Women” approach to trauma treatment established by Stephanie S. Covington, Ph.D. (see **Figure 6.1: Beyond Trauma Inservice Flier** below).

The Covington materials that had been ordered from Hazelden included Facilitator’s Guides, Client Workbooks, Facilitator DVDs (45 min.) and Client DVDs (45 min), with content utilized

from each as part of the inservice presentation (*Covington, 2003c & 2003d*). Additional information was also gained from Stephanie's website, at <http://www.stephaniecovington.com>.

Introduction to Stephanie Covington's "Beyond Trauma" program Friday, January 30 th , 2009	
Presenters: Steve Wiland LMSW/CAC-R, Flo Hepola LMSW/CAAC, and Linda Bacigalupi, M.S./L.L.P.	
I.	9:00-9:30 Introduction/overview of the "Trauma-Informed and Trauma-Specific Services" Grant Project <ul style="list-style-type: none"> A. Why did we apply for the grant? B. What does the grant entail? C. What does the grant mean for CSTS consumers and staff?
II.	9:30-10:15 Introduction/overview of the Covington model <ul style="list-style-type: none"> A. 11 modules (hand-out) B. The impact of trauma (hand-out) C. Signs and symptoms of trauma (hand-out)
	10:15-10:30 **Break**
III.	10:30-10:45 Facilitator Training Video Excerpts and Discussion
IV.	10:45-11:30 Client Video and Discussion
V.	11:30-12:00 Q & A
VI.	12:00-1:00 Follow-up Discussion over Lunch (provided)

Figure 6.1: Beyond Trauma Inservice Flier
(see also **Appendix C.1**)

Handouts were provided to participants covering the impact of trauma, the signs and symptoms that typically occur in trauma survivors, and the 11 session modules featured in Covington's "Beyond Trauma" program (see **Appendix C.2: Video Content and Program Modules**).

1. Connection between Violence, Abuse & Trauma
2. Power and Abuse
3. Reactions to Trauma
4. How Trauma Impacts our Lives
5. The Addiction-Trauma Connection
6. Grounding and Self-Soothing
7. Abuse and the Family
8. Mind / Body Connection
9. The World of Feelings

10. Healthy Relationships (Wheel of Love)
11. Endings and Beginnings

“Seeking Safety” Inservice

A 3-hour presentation was also planned and presented to the 30 staff who gathered to learn about the “Seeking Safety” approach to treating Posttraumatic Stress Disorder and Substance Abuse established by Lisa M. Najavits, Ph.D. (see **Figure 6.2: Seeking Safety Inservice Flier** below).

The Seeking Safety materials that had been acquired included Najavits’ Seeking Safety treatment manuals (*Najavits, 2002c*), copies of A Woman’s Addiction Workbook (*Najavits, 2002a*), Safe Coping card decks, and sets of 4 available videocassettes (*Najavits, 2005a, 2005b, 2005d, 2005e*) with content utilized from various of these sources to inform the inservice presentation. Additional information was also gained from the Seeking Safety website, at <http://www.seekingsafety.org>.

Introduction to “Seeking Safety,” Lisa Najavits’ Trauma Treatment Model	
Friday, February 27 th , 2009	
Facilitators: Steve Wiland LMSW/CAC-R, Wendy Svatora LMSW/CAC-M	
I.	2:00-2:35 - <i>Background context of trauma and PTSD (Najavits video)</i>
II.	2:35-3:20 - <i>“Seeking Safety” as a treatment model (Najavits video)</i>
III.	3:20-3:35 - <i>Group Discussion (All)</i>
	3:35-3:45 ** Break **
IV.	3:45-4:00 - <i>“Seeking Safety” group work at CSTS (Svatora, Wiland)</i>
V.	4:00-4:15 - <i>Overview of the “Trauma-Informed and Trauma-Specific Services” Grant Project (Wiland)</i>
VI.	4:15-4:45 - <i>“A Client’s Story” video and Group Discussion (All)</i>

Figure 6.2: Seeking Safety Inservice Flier
(see also **Appendix C.3**)

A handout was provided to participants describing implementation of the Seeking Safety model (see **Appendix A.3: Seeking Safety Model Description and Resources**), as well as an

example client handout that had been developed for use in the fledgling Seeking Safety group that was in the process of being launched within the Adult Services department of CSTS (see **Appendix C.4: Trauma Recovery and Seeking Safety – Session 1**). Some of the 25 treatment topics featured as part of the Seeking Safety approach were reviewed, with the entire list as follows:

1. Introduction to Treatment/Case Management
2. Safety
3. PTSD: Taking Back Your Power
4. Detaching from Emotional Pain (Grounding)
5. When Substances Control You
6. Asking for Help
7. Taking Good Care of Yourself
8. Compassion
9. Red and Green Flags
10. Honesty
11. Recovery Thinking
12. Integrating the Split Self
13. Commitment
14. Creating Meaning
15. Community Resources
16. Setting Boundaries in Relationships
17. Discovery
18. Getting Others to Support Your Recovery
19. Coping with Triggers
20. Respecting Your Time
21. Healthy Relationships
22. Self-Nurturing
23. Healing from Anger
24. The Life Choices Game (Review)
25. Termination

“TREM / M-TREM” Inservice

A 3-hour presentation was planned and presented to the 15 staff who gathered to learn about the “Trauma Recovery and Empowerment Model” (TREM/M-TREM) approaches established by Maxine Harris, Ph.D., and Roger Fallot, Ph.D. of Community Connections in Washington, DC (see **Figure 6.3: TREM/M-TREM Inservice Flier** below).

The TREM/M-TREM materials that had been acquired included the core clinician’s guide for the Trauma Recovery and Empowerment approach (*Harris et al, 1998*), the 5-DVD set covering Empowerment, Trauma Recovery, and Advanced Trauma Recovery Issues and Closing Rituals (*Harris, 1999a, 1999b, 1999c*), and additional manuals addressing specific issues and sub-

populations (Harris, 1999; Fallot et al, 2001; Harris et al, 2001a, 2001b; Harris, 2001; Harris & Wolfson-Berley, 2005). Content was utilized from various of these sources to develop the inservice presentation, with additional information also gained from the Community Connections website, at <http://www.communityconnectionsdc.org/web/page/657/interior.html>. One of the facilitator's of the recently launched men's trauma group utilizing the M-TREM model assisted with co-facilitating the presentation, fielding questions, and engaging the assembled clinicians in group discussion.

**Introduction to “Trauma, Recovery and Empowerment Model”
(TREM)**

Friday, July 24th, 2009

Facilitators: Steve Wiland, LMSW/CAC-R,
Mike Ferriter, LMSW, CAAC

11:00-11:10 am - *Background and Status of Trauma Grant Project*

11:10 - Noon - *Overview of the TREM Model's 33 Modules*

1. Empowerment (1-11)
2. Trauma Recovery (12-21)
3. Advanced Trauma Recovery Issues (22-30)
4. Closing Rituals (31-33)

---Lunch provided---

12:00 - 1:00 pm - *Working with SMI populations*

- General Principals
- Specific Issues
- Issues of Diagnosis

1:00-1:30 pm - *Working with Male Survivors: M-TREM's 24 Modules*

1. Male Messages, Emotions, and Relationships (1-11)
2. Trauma Recovery (12-18)
3. Recovery Skills (19-24)

1:30-2:00 pm - *Group Discussion and Next Steps*

Figure 6.3: TREM/M-TREM Inservice Flier
(see also **Appendix C.5**)

Handouts were provided to participants delineating the topics of the various sessions that comprise both the original 33-module TREM curriculum for women, and the subsequently developed 24-module M-TREM curriculum for men (see **Appendix C.6**). The topics for each are duplicated in the 2 charts below (see **Figure 6.4: TREM's 33-Module Women's Group Curriculum**, and **Figure 6.5: M-TREM's 24-Module Men's Group Curriculum**):

TREM - PART I: EMPOWERMENT	
1	Introductory Session
2	What It Means to Be a Woman
3	What Do You Know and How Do You Feel About Your Body?
4	Physical Boundaries
5	Emotional Boundaries: Setting Limits and Asking for What You Want
6	Self-Esteem
7	Developing Ways to Feel Better: Self-Soothing
8	Intimacy and Trust
9	Female Sexuality
10	Sex with a Partner
11	Transition Session from Empowerment to Trauma Recovery
TREM - PART II: TRAUMA RECOVERY	
12	Gaining an Understanding of Trauma
13	The Body Remembers What the Mind Forgets
14	What Is Physical Abuse?
15	What Is Sexual Abuse?
16	Physical Safety
17	What Is Emotional Abuse?
18	Institutional Abuse
19	Abuse and Psychological or Emotional Symptoms
20	Trauma and Addictive or Compulsive Behavior
21	Abuse and Relationships
TREM - PART III: ADVANCED TRAUMA RECOVERY ISSUES	
22	Family – Myths and Distortions
23	Family Life: Current
24	Decision Making: Trusting Your Judgment
25	Communication: Making Yourself Understood
26	Self-Destructive Behaviors
27	Blame, Acceptance, and Forgiveness
28	Feeling Out of Control
29	Relationships
30	Personal Healing
TREM - PART IV: CLOSING RITUALS	
31	Truths and Myths About Abuse
32	What It Means to Be a Woman
33	Closing Ritual

Figure 6.4: TREM's 33-Module Women's Group Curriculum

M-TREM - PART I: MALE MESSAGES, EMOTIONS, AND RELATIONSHIPS	
1	Introduction
2	Male Messages
3	Trust
4	Anger and Behavior
5	Anger and Thinking
6	Fear
7	Hurt and Loss
8	Hope
9	Shame
10	Sex
11	Intimacy
M-TREM - PART II: TRAUMA RECOVERY	
12	Gaining an Understanding of Trauma
13	What is Emotional Abuse?
14	What Is Physical Abuse?
15	What Is Sexual Abuse?
16	Abuse and Psychological or Emotional Symptoms
17	Trauma and Addictive or Compulsive Behavior
18	Abuse and Relationships
M-TREM - PART III: RECOVERY SKILLS	
19	Revenge, Acceptance and Forgiveness
20	Negotiating Family Relationships
21	Communication Skills
22	Positive Problem Solving: Overcoming Self-defeating Behaviors
23	Managing Feeling Out of Control / Self-soothing
24	Realistic Goals and Empowerment

Figure 6.5: M-TREM’s 24-Module Men’s Group Curriculum

“Seeking Safety” Training Conference

State funding that was available to advance clinical competencies in support of improving treatment services for co-occurring disorders was utilized to provide staff with additional training on the Seeking Safety model. Arrangements were made with Lisa Najavits to bring in one of her approved training associates, Kay Johnson, LICSW, for a day of CEU-approved clinical

instruction. All four regional community mental health affiliates were represented, as well as staff from the local Michigan Prisoner Reentry Initiative (MPRI), for a total of 56 participants. In addition to this cost-free training, each of the four regional affiliate CMH organizations (Washtenaw, Livingston, Monroe and Lenawee), was subsequently provided with 2 Seeking Safety manuals, and other technical assistance to support the launch of trauma treatment groups within their respective agencies.

In addition to the involved slide presentation, handouts were provided containing the following useful content information (see **Appendix A.3: Seeking Safety Model Description and Resources**, with downloadable handouts at <http://www.seekingsafety.org>).

- Definitions of PTSD, Substance Abuse, and the links between them;
- Specifics of the Seeking Safety treatment model;
- Available materials and other informational resources on PTSD, Substance Abuse, and their treatment;
- Safe Coping Skills;
- Detaching from Emotional Pain (Grounding) exercises;
- Taking Good Care of Yourself checklist;
- Creating Meaning in PTSD and Substance Abuse;
- *PTSD Checklist (Civilian Version)*;
- *Trauma Symptom Checklist 40*;
- *Professional Quality of Life Scale with Compassion Satisfaction and Compassion Fatigue subscales (Pro-QOL R-IV)*;
- *Stressful Life Experiences Screening*;

As an example of the modules found in the Seeking Safety treatment manual, material from the “Asking for Help” session (# 6 of 25) was provided as an additional handout. Lastly, the brief version of the Seeking Safety Adherence Scale was provided to training conference participants, as a guide to assist those pursuing high-fidelity implementation of this model of trauma treatment (see **Appendix A.3: Seeking Safety Model Description and Resources**, with downloadable handouts at <http://www.seekingsafety.org>).

VII. Launching Trauma-specific Services

In the process of preparing for, and launching the trauma groups currently in place within the CSTS service array, numerous elements emerged as important to attend to, both for the provision of safe and effective treatment services, as well as for ongoing sustainability. If effective and sustainable trauma-specific services were to be regarded as an entrée, the recipe for producing such would likely contain the following necessary ingredients, or critical factors, which will be individually considered in the following sections:

1. ***Administrative and program prioritization and support*** (*time, space, displaced workload costs*)
2. ***Trauma champions*** (*clinicians with sufficient desire, clinical competence and confidence*)
3. ***Appropriate screening and referral***
4. ***Joining / engagement component***
5. ***Group co-facilitation***
6. ***Debriefing***
7. ***Regular clinical supervision***
8. ***Tiering of services, and appropriate transitioning***
9. ***Individual therapy***

Critical factors

1. **Administrative/program prioritization & support** (*time, space, displaced workload costs*)

Although this is perhaps one of the more obvious elements, it cannot be overemphasized! Effective clinical services simply do not spontaneously generate themselves in a vacuum – they require the prioritization of resources in order to be successful. Involved staff need the support of immediate Supervisors and agency Administrators in order to spend the time required to participate in training, to provide and document service provision, and to participate in the ongoing debriefing and clinical supervision necessary to do the intense involved work, and to stay healthy while doing it. Additionally, the practical matters of available space for trauma group work, and appropriate staffing levels for trauma groups require appropriate attention and resourcing.

Washtenaw County CSTS had the benefit of a very supportive Executive Director, as well as the support of our local PIHP organization which served as the fiduciary for the State Block Grant that was pursued and obtained to help advance this trauma initiative. Although no new staff were added to resource the development and implementation of trauma-specific services, existing staff who stepped forward as trauma champions were supported in reworking existing caseloads and service activities in order to prioritize and accommodate trauma-specific treatment provision.

2. Trauma champions (clinicians with sufficient desire, clinical competence & confidence to do the work)

As may also be obvious, the ideal profile of a clinician providing trauma-specific services is one who is internally motivated to become involved in this type of work. It is important that staff self-select for engaging in this type of treatment service provision, rather than being involuntarily assigned. Some clinicians may already have pre-existing clinical experience and competence (and confidence), but those who do not can be provided such with appropriate levels of training and ongoing clinical supervision.

As part of the CSTS Trauma Initiative, the self-selection of trauma champions was solicited at our kickoff event (see Chapter I), as well as through other direct requests during training events, and via associated phone and e-mail communications. This cohort of existing staff was foremost among those intentionally targeted for the subsequent training episodes and participation in ongoing trauma-targeted clinical supervision.

3. Appropriate referral and screening processes

Because of the heightened risks of destabilizing the mental health and/or substance abuse recovery of our service recipients, a high degree of care must be taken when identifying, referring, and screening candidates for trauma-specific treatment services. The simple presence of a documented history of trauma in the clinical record is not by itself sufficient grounds for a referral with a high likelihood of success! Attention must be paid to such issues as the level of awareness and readiness to address trauma issues; stability of mental health and/or substance use disorder recovery; established crisis plan and network of support; sufficient robustness of distress tolerance/coping skills to be able to tolerate trauma work; and sufficient boundary strength to avoid retraumatization of self or others in the group work setting. On a referral-by-referral basis, sometimes difficult decisions must be made to include or disinclude individuals from immediate trauma group participation. For those not yet ready in any of the previously mentioned domains, individual counseling/coaching attention in the area(s) of need would become the focus, in order to work toward the goal of future group participation.

At Washtenaw County CSTS, these important decisions and processes were worked out as part of the Trauma-specific Therapy Services work group, as well as through trauma-targeted clinical supervision sessions. Different screening questions/instruments, and referral protocols are in the process of being considered for ongoing use, including those accompanying the Seeking Safety model (see **Appendix A.3: Seeking Safety Model Description and Resources**).

4. Joining / engagement component

Because of the sensitive and often difficult nature of trauma work, it can be assumed that individuals referred for trauma-specific treatment services would come to this area of their recovery with a certain degree of ambivalence. This heightens the importance of spending sufficient time and effort in one or more individual joining/engagement sessions during which basic psychoeducation about trauma can be provided, the trauma-specific treatment services can be described, and readiness for participation can continue to be longitudinally assessed. Because of the nature of trauma work, with its high premium on avoiding retraumatization in the face of the posttraumatic stress symptoms of hyperarousal and avoidance, it is always recommended that trauma survivors be informed of what is about to happen in treatment before it actually occurs. Appropriate joining / engagement allows for any and all questions, concerns, doubts or fears to be discussed and addressed in order to cover this base so that the trauma-specific services candidate comes into treatment with their “eyes wide open” about what to expect.

Of the available informational resources utilized to assist with joining / engagement work with trauma group candidates at Washtenaw County CSTS, the SAMHSA publications entitled, “Helping Yourself Heal: A Recovering Women’s Guide to Coping With Childhood Abuse Issues” (CSAT, 2003), and “Helping Yourself Heal: A Recovering Man’s Guide to Coping With the Effects of Childhood Abuse” (CSAT, 2004) were found to be quite useful. No-cost copies may be downloaded from the internet at the url addresses found in this publication’s reference listing.

5. Group co-facilitation

The critical importance of safety, and the potential need to manage dysregulated emotion during trauma group work makes co-facilitation an absolute requirement, rather than a luxury. If the realities of staffing levels do not allow for two Master’s-level clinicians to co-facilitate each trauma group, other options can be effectively considered, including the use of interested Bachelor’s-level staff, student interns, and/or qualified Peer Support Specialists to fill the secondary co-facilitator or observer role during group. Of course, such individuals should also receive the necessary level of training and ongoing debriefing and clinical supervision that is indicated to equip them to be optimally effective.

At Washtenaw County CSTS, the co-facilitator role was aptly filled in most of the ways mentioned above – by Master’s-level clinicians rotating through the primary and secondary facilitator/co-facilitator roles; by Bachelor’s-level staff with a passion for trauma work; and by interested Social Work and Psychology student interns as part of their field placement educational experience. At the time of this publication, the participation of Peer Support Specialists already on staff are being sought to further expand and enhance trauma-specific group treatment services.

6. Debriefing

Although already referred to several times, the need for facilitators/co-facilitators to debrief in between trauma-specific treatment sessions cannot be overemphasized. Secondary traumatization and compassion fatigue are very real risks that must be managed in order for staff to stay healthy and effective over the long haul. Intentional, regular time for processing/venting/discussing how things went during the treatment session just past is a need that should not be ignored. Facilitators/co-facilitators have often found that the most naturally occurring and sustainable version of this is to simply spend some time (typically 10-20 minutes) talking immediately following group, while still allowing for the option of additional debriefing communication if there is a delayed reaction or subsequent issue that comes up and requires attention. Regularly scheduled and/or as-needed clinical supervision time can also be a resource for covering this base sufficiently.

At Washtenaw County CSTS, group co-facilitators have typically worked out an arrangement by which they touch base to debrief following group, as well as being available to each other as needed during the week before the next group session. Formal monthly clinical supervision is also provided in a peer supervision format as another option for processing/debriefing to guard against the real risk of clinicians developing secondary traumatization and compassion fatigue. Other ideas, including regularly available telephone or video conferencing, and/or e-mail listserv participation, are also being explored as additional ways to further meet this important debriefing need.

7. Regular clinical supervision

Regularly scheduled and/or as-needed clinical supervision is also important to assist trauma-specific treatment providers with trouble-shooting/problem-solving difficult situations, as well as with sharing knowledge, experience, perspective and support. One very effective venue for covering these needs is in a peer supervision setting, where an oversight role is played by a recognized and experienced clinical expert, but also where active participation and sharing of knowledge, perspective and support takes place among and between fellow trauma-specific treatment providers, regardless of their depth of experience. This can serve as an excellent way to build a support network within the agency that can expand the options for as-needed debriefing and even service delivery substitution to assist with covering when trauma clinicians may be in need of sick- or vacation-time absences.

At Washtenaw County CSTS regularly occurring clinical supervision is scheduled on a monthly basis at each site where trauma-specific treatment services are provided, and involves the gathering of all trauma service provider staff at that site. The agenda usually covers how the group has been doing over the prior month, case consultation on difficult client situations, sharing of pertinent clinical knowledge in areas of identified need, and service design/development considerations.

8. Tiering of services, and appropriate transitioning

As with other types of long-term recovery, successful trauma treatment proceeds at the pace and level of intensity that is the best fit for each needful individual. And in order to best avoid retraumatization during treatment, it is of critical importance that the readiness of an individual to move faster or more intensely in their trauma recovery be thoroughly and longitudinally evaluated. To this end, it is strongly recommended that trauma services be structured according to a tiered framework, starting at a “Tier I” level that is largely psychoeducational with a focus on coping skills, with participants showing mastery of a sufficient knowledge base and distress tolerance skills before graduating to a “Tier II” level that may be more psychodynamic and process-oriented. As may be obvious, both the content and the format of trauma group work would need to be intentionally designed and delivered to maintain consistency with such a framework. Length of time would not in itself be the sole indication of an individual’s readiness to transition from Tier I to Tier II services. The benefit of this sort of service structure is that it allows for a high amount of longitudinal assessment to occur while a service recipient is engaged at the Tier I level, in order to best inform the decision to transition to a Tier II level so that the outcome is optimally therapeutic rather than high risk for retraumatization.

The majority of the trauma groups that have been developed and launched at Washtenaw County CSTS fit the Tier I description. Both the Seeking Safety and the TREM approaches have proven to be excellent fits for Tier I trauma treatment service delivery. Only one CSTS trauma group developed thus far could be described as operating at a Tier II level, and it is staffed by one of our most trauma-experienced, Master’s-level clinicians, and co-facilitated by a second Master’s-level staff. This women’s trauma group is populated by participants who have all been longitudinally evaluated over extensive periods of time in a Tier I group setting prior to “graduating” to the Tier II group, and individual therapy contacts are available to each of these Tier II group members. As may be evident, the requisite resource level to support this sort of arrangement is significant, and may not be easily sustainable in many public-sector settings. The client cohort served by this Tier II group is comprised of homeless women whose histories include problematic substance abuse and, in most cases, involvement with the legal system. The cost of the Tier II level of resources is considered a worthwhile treatment investment as a client-centered strategy to mitigate against a higher frequency of higher cost crisis services and other high-expense treatment episodes that would otherwise be much more likely to occur.

9. Individual therapy component

As mentioned above, there is the resource-related question of the role of individual therapy in the overall treatment of trauma. Numerous treatment modalities take the position that optimal gains occur with the combination of both group and individual therapies occurring concurrently. This may also be true with regard to trauma work, and yet the public community mental health system is one in which resources are typically scarce, and tension

always exists when making decisions about how to deploy staffing to bring about the “greatest good for the greatest number.” Given the high prevalence of trauma within the populations served by the public community mental health system, the argument can be well made that addressing this treatment need deserves the highest prioritization, and that the outcome of effective trauma treatment may well mitigate the need for other higher-cost and/or less-effective services, particularly those at the crisis-response end of the continuum. For the purposes of launching value-added trauma services in a resource-scarce environment, the established success of group treatment modalities such as Seeking Safety and TREM/M-TREM helps make the case that effective, Tier I trauma treatment can occur in a group format without the additional commitment of individual therapy resources for group participants. Individual support may be indicated on a case-by-case basis for certain service recipients, and may be particularly recommended for those needing help with advancing recovery elements necessary to become more viable candidates for trauma group involvement. In the overall view of the costs and benefits associated with addressing trauma treatment needs vs ignoring them, this may be viewed as an absolutely worthwhile investment.

When considering how best to design and resource Tier II trauma treatment, the inclusion of regular individual therapy may need much stronger consideration, and the development of this level of clinical care may have to proceed with an eye toward such a resource requirement. However, both the existing research on the Seeking Safety and TREM/M-TREM models (*see references listed in Chapter V*), and the observed and reported experiences emerging from this trauma initiative strongly support the position that positive clinical outcomes are available with the use of what is described as Tier I trauma group work, without the co-occurrence of regular individual therapy.

Launching CSTS Trauma Groups

As the above 9 elements were established within the service array of our community mental health organization and trauma groups were launched, information about how to make referrals was disseminated across the agency through various means, including presentations to different service sites and teams, as well as via e-mail, with pertinent information posted to the agency WIKIPEDIA as it became available. The following is replication of an earlier version of the “**TRAUMA-INFORMED AND TRAUMA-SPECIFIC SERVICES AT CSTS**” WIKIPEDIA page:

If you are working with a consumer with trauma recovery needs, please consider contacting any of the following staff to discuss the appropriateness of a referral to an existing group, and/or to discuss the need for adding additional treatment services to address presently unmet needs.

PORT/JPORT - Women's Groups

Flo Hepola - hepolaf@ewashtenaw.org

Linda Bacigalupi - bacigalupil@ewashtenaw.org

Carol Ludwig - ludwigc@ewashtenaw.org

ACT - Women's Group

Wendy Svatora - svatoraw@ewashtenaw.org

Sarah Starkey - starkeys@ewashtenaw.org

Men's Group

Steve Wiland - wilands@ewashtenaw.org

Nathan Rahn - rahnn@ewashtenaw.org

Mike Ferriter - ferriterm@ewashtenaw.org

One useful [Centering Exercise](#) [see **Appendix D.1: Trauma Group Centering Exercise**] can be accessed via this link, to be utilized at the beginning of trauma group.

Anyone considering direct treatment service work with trauma-surviving consumers would be strongly encouraged to review the items on the [Checklist for Facilitators](#) [see **Appendix D.2: Checklist for Trauma Treatment Practitioners**] provided via this link.

Existing Trauma Groups

By the end of the grant-funding period, the CSTS service array included the following trauma-specific therapy groups, meeting on a regular weekly basis:

1. Tier I Fourth Street Women's Trauma Group

- Meets weekly at the Project Outreach Team (PORT) site;
- Staffed by PORT and Justice/Project Outreach Team (J-PORT) clinicians, with weekly debriefing and monthly clinical supervision;
- Focused on serving homeless, female trauma survivors, but open to other referrals;
- Utilizes an eclectic mix of adapted content materials from Stephanie Covington's *Beyond Trauma* approach, from Lisa Najavits' *Seeking Safety* model, and from Maxine Harris' *Trauma Recovery and Empowerment Model (TREM)*.

2. Tier II Fourth Street Women's Trauma Group

- Meets weekly at the PORT site;
- Staffed by J-PORT clinicians, with weekly debriefing and monthly clinical supervision;
- Individual counseling also available to group participants;
- By invitation only, with referrals typically graduates of the Tier I group;

- Utilizes an eclectic mix of adapted content materials from Stephanie Covington's *Beyond Trauma* approach, from Lisa Najavits' *Seeking Safety* model, and from Maxine Harris' *Trauma Recovery and Empowerment Model (TREM)*.

3. Tier I Fourth Street Men's Trauma Group

- Meets weekly at the PORT site;
- Cross-staffed by PORT and Assertive Community Treatment (ACT) clinicians, with weekly debriefing and monthly clinical supervision;
- Open to referrals of male clients from all Adult Services teams across the agency (has also accommodated a male trauma survivor referred from the Developmental Disabilities department);
- Primarily utilizes the *Trauma Recovery and Empowerment Model for Men (M-TREM)*, with some minor supplementation from adapted content of Najavits' *Seeking Safety* and Linehan's *Dialectical Behavior Therapy (DBT)*.

4. Tier I Incarcerated Women's Trauma Group

- Meets weekly in repeating, 6-session periods in the local County jail;
- Staffed by J-PORT clinicians, with weekly debriefing and monthly clinical supervision;
- Open to referrals of trauma surviving female inmates, including CSTS service recipients, and non-CSTS service recipients;
- Utilizes an eclectic mix of adapted content materials from Stephanie Covington's *Beyond Trauma* approach, from Lisa Najavits' *Seeking Safety* model, and from Maxine Harris' *Trauma Recovery and Empowerment Model (TREM)*.

5. Tier I Ellsworth Women's Trauma Group

- Meets weekly at the primary Ann Arbor Adult Services site;
- Staffed by Adult Services and ACT Step-down clinicians, with weekly debriefing and monthly clinical supervision;
- Open to referrals from ACT and other teams;
- Primarily utilizes adapted content material from Najavits' *Seeking Safety* model, with some minor supplementation from adapted contents of Harris' *TREM* approach.

In addition to the groups referenced above, another local group was launched by staff associated with the local Michigan Prisoner Re-entry Initiative (MPRI). A contracted primary clinician, and a Parole Department staffperson were provided with trauma-specific training and ongoing clinical supervision in support of this effort.

6. Tier I MPRI Women's Trauma Group

- Meets weekly at the local Catholic Social Services office;
- Staffed by contracted MSW Therapist and Probation Department staff, with weekly debriefing and monthly clinical supervision;
- Receives referrals of returning MPRI women with trauma histories, including CSTS service recipients, and non-CSTS service recipients;
- Primarily utilizes content material from Najavits' *Seeking Safety* model.

On the Drawing Board

At the time of the writing of this publication, 3 additional groups were being planned for launch sometime during the first quarter of calendar year 2010, as follows:

• **Tier I Towner Women's Trauma Group**

- *Will meet weekly at the primary Ypsilanti Adult Services site;*
- *Will be staffed by Adult Services clinicians, with weekly debriefing and monthly clinical supervision;*
- *Will be open to female clients from all Adult Services teams across the agency;*
- *Will primarily utilize adapted content material from Najavits' Seeking Safety model, with some minor supplementation from adapted contents of Harris' TREM model and Covington's Beyond Trauma approach.*

• **Tier I Towner Men's Trauma Group**

- *Will meet weekly at the primary Ypsilanti Adult Services site;*
- *Will be staffed by Adult Services clinicians, with weekly debriefing and monthly clinical supervision;*
- *Will be open to referrals of male clients from all Adult Services teams across the agency.*
- *Will primarily utilize the Trauma Recovery and Empowerment Model for Men (M-TREM), with some minor supplementation from adapted content of Najavits' Seeking Safety and Linehan's Dialectical Behavior Therapy (DBT).*

• **Tier I Ellsworth Women's DBT/Trauma Group**

- *Will meet weekly at the primary Ann Arbor Adult Services site;*
- *Will be staffed by Adult Services DBT clinicians, with weekly debriefing and monthly clinical supervision;*
- *Will be focused on serving female trauma-surviving clients who are graduates of existing DBT treatment;*

- *Will utilize a combination of adapted TREM, Seeking Safety, Triad and DBT content.*

VIII. Continuing Forward

The way forward will attempt to build on the progress accomplished thus far, both with the expansion and the quality of trauma-informed and trauma-specific services. Trauma-informed service delivery will benefit from the upgrading of many of the involved service delivery processes and forms that is hoped to occur consistent with the upgrading of our system's Electronic Health Record (EHR) in the Spring of 2010. Trauma-specific treatment service delivery will benefit from putting into practice the trial-and-error learning gained thus far, as well as from increased attention to outcome measurement and what that tells us about the efficacy of the treatment interventions that have been established.

Engagement and retention

Experience has shown that many of the trauma-surviving individuals referred for group treatment come with a certain degree of ambivalence, which may serve as an obstacle to regular group attendance and participation. In order to optimally engage and retain participants, a pre-group joining/engagement protocol was developed, which included referred candidates for group meeting individually with one or both group co-facilitators to accomplish the following:

- Begin to develop **familiarity and rapport** with a clinician they will be seeing regularly in the group setting;
- Explore and **strengthen motivation for participation**, using motivational interviewing tools and techniques, including addressing any obstacles to ongoing involvement;
- Receive an **orientation to the content** that will be covered in group, **and** to the **format** of how the group operates, including general behavioral and attendance expectations;
- Assess the level of **distress tolerance/coping skills** to proactively address relapse risk for either mental health or addictive disorders;
- Address any **questions or concerns** a referred individual may have;
- Offer the **opportunity to visit group** without obligation to continue if it doesn't seem a good fit at this time in the trauma survivor's recovery.

Many trauma survivors are uncomfortable with unexpected surprises, which can trigger anxieties or even be experienced as disempowering or re-traumatizing. This dynamic makes it all the more important that appropriate time and attention be invested in this engagement phase.

Retention has also proven to be an issue that needs to be dealt with not only proactively before starting group sessions, but also concurrently with ongoing group participation. One strategy adopted by many of the existing trauma groups is to utilize some form of a Session Rating Scale at the end of each group. Patterned after the seminal work of Duncan and Miller et al (2003), this is typically a quick and easy way to get session-by-session feedback, the obtaining of which is valuable in at least two ways – (1) it establishes a feedback loop that equips the group facilitators to make any indicated adjustments to positively enhance the group experience for

participants, and (2) it sends an empowering message to group participants that their needs are important, and that their voice is heard and responded to. Both of these dynamics are therapeutic in and of themselves in counteracting the disempowerment with which many trauma survivors struggle, and both dynamics will likely result in better engagement and retention than otherwise would be the case.

Outcome measurement

One of the supreme challenges of delivering behavioral healthcare services in a scarce-resource, managed-care environment is to demonstrate that the treatment investment being made is bringing an optimally beneficial return in the lives of the consumers we serve. It is no longer acceptable to simply “feel” or “believe” that treatment is efficacious, without backing up such contentions with empirical data.

“The plural of anecdote is not data” – This quotation (widely attributed widely to Roger Brinner), addresses some of the challenge that behavioral healthcare providers are increasingly needing to address with regard to clinical service provision, and trauma treatment is no exception. Despite the heart-warming and encouraging personal testimonies from recovering trauma-survivors that have emerged over the past year, these anecdotes by themselves are not sufficient to more convincingly make the case that the benefits associated with delivering trauma-informed and trauma-specific services are worth the costs. And yet it continues to be a challenge to determine what outcome measures are the most valid and reliable to monitor in order to prove treatment efficacy, and over what span of time.

Attempts thus far – Outcome tracking and measurement will continue to be an important focus for CSTS moving forward, as we hope to build upon existing efforts to date. These include piloted use of the following outcome-measurement strategies, each of which has their advantages and disadvantages, though none are mutually exclusive:

Stages of Treatment: Involves monitoring movement over time along the recovery-oriented stages of treatment, and hoping to see forward movement through the sequential stages, as defined by observable, behavioral markers.

- 1. Pre-engagement:** *The person does not have contact with a case manager, or mental health clinician.*
- 2. Engagement:** *The person has contact with an assigned case manager or mental health clinician, but does not have regular contacts. The lack of regular contact implies lack of a working alliance.*
- 3. Early Persuasion:** *The person has regular contacts with a case manager or mental health clinician at least once a month. Regular contacts imply a working alliance and a relationship in which target symptoms and behaviors can be discussed.*
- 4. Late Persuasion:** *The person is engaged in a relationship with a case manager or mental health clinician, is discussing target symptom(s) and behavior(s), and shows*

evidence of reduction in their targeted symptom and behavior, as agreed on in their PCP, for at least one month. External motivation (e.g. eyes on meds, ATO, probation or parole) may be involved in the reduction.

5. Early Active Treatment: The person is engaged in treatment, has been discussing targeted symptom and behavior reduction for at least one month, and is making consistent progress toward PCP goals, even though he or she may still be experiencing targeted symptoms or behaviors.

6. Late Active Treatment: The person is engaged in treatment, has acknowledged that their targeted symptom and behavior are a problem, and has achieved reduction in the targeted symptom and behavior but for less than six months.

7. Relapse Prevention: The person is engaged in treatment, has acknowledged that their symptom and behavior is a problem, and has achieved a reduction in their targeted symptom or behavior for less than one year but greater than six months. Episodic symptoms or behaviors occur but do not reach the level of a crisis contact.

8. In Remission or Recovery: The person has the skills to cope with their illness while engaging in ongoing life goals (e.g. independence, volunteering, work, school, etc.) for over one year.

Trauma Symptom Scales: Involves rating participants' status at treatment initiation and subsequently, and comparing scores over time, utilizing one or more pertinent instrument addressing PTSD symptoms or trauma sequelae.

Copies of the PTSD Checklist-Civilian Version (*Weathers et al, 1994*), and the Trauma Symptom Checklist-40 (*Briere & Runtz, 1989*), can be found on the Seeking Safety website, <http://www.seekingsafety.org>. Simply navigate to the "Training Materials" section, then to the "basic handouts" link – both instruments are included as part of the basic handouts document.

National Outcome Measures (NOMs): Involves monitoring the status of SAMHSA's NOMs indicators upon treatment initiation, and then on a quarterly basis, and comparing findings over time in one or more of the 10 involved domains:

- 1) Abstinence from drug use and alcohol abuse, and/or decreasing symptoms of mental illness and improved functioning;
- 2) Resilience and sustaining recovery, as evidenced by getting and keeping a job or enrolling and staying in school;
- 3) Resilience and sustaining recovery, as evidenced by decreased involvement with the criminal justice system
- 4) Resilience and sustaining recovery, as evidenced by securing a safe, decent, and stable place to live
- 5) Resilience and sustaining recovery, as evidenced by social connectedness to and support from others in the community such as family, friends, co-workers, and classmates

- 6) Increased access to services for both mental health and substance abuse
- 7) Retention in services for substance abuse or decreased inpatient hospitalizations for mental health treatment
- 8) Quality of services provided, per client perception of care
- 9) Quality of services provided, per measures of cost-effectiveness
- 10) Quality of services provided, as evidenced by the use of evidenced-based practices in treatment

Session Rating Scale (SRS) and Outcome Rating Scale (ORS): Based upon the premise that the therapeutic relationship is the most significant indicator of treatment success, improvement over time on SRS and ORS scores is understood to correlate with positive treatment outcomes.

Copies of the Session Rating Scale (*Duncan et al, 2003*) and the Outcome Rating Scale (*Miller et al, 2003*) are available as part of the respective articles describing their design and research base, which may be viewed or downloaded from the Scott D. Miller website, <http://www.scottdmiller.com>. Simply navigate to the “Scholarly Publications, Handouts, Vitae” section, then to the links for “*The session rating scale: Preliminary psychometric properties of a ‘working alliance’ inventory,*” and “*The outcome rating scale: A preliminary study of the reliability, validity, and feasibility of a brief visual analog measure.*”

IX. References and Resources

- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders: DSM-IV (4th ed.)*. Washington DC: APA.
- American Psychological Association. (2009). *Psychologically healthy workplace program*. Washington DC: APA Practice Organization.
- Arledge, E. & Wolfson, R. (2001). *Care of the clinician*. In M. Harris & R. Falot (Eds.), *Using trauma theory to design service systems*, (3-22). San Francisco: Jossey-Bass.
- Bass, E. & Davis, L. (1988). *The courage to heal: A guide for women survivors of child sexual abuse*. New York: Harper & Row.
- Bebout, R.R. (2001). *Trauma-informed approaches to housing*. In M. Harris & R. Falot (Eds.), *Using trauma theory to design service systems*, (3-22). San Francisco: Jossey-Bass.
- Borrego, J. & Urquiza, A.J. (1998). *Importance of therapist use of social reinforcement with parents as a model for parent-child relationships: An example with Parent-Child Interaction Therapy*. *Child and Family Behavior Therapy*, 20(4), 27-54.
- Borrego, Jr., J., Urquiza, A.J., Rasmussen, R.A. & Zebell, N. (1999). *Parent-Child Interaction Therapy with a Family at High-Risk for Physical Abuse*. *Child Maltreatment*, 4(4), 331-342.
- Brady, K.T., Dansky, B.S., Sonne, S.C. & Saladin, M.E. (1998). *Posttraumatic stress disorder and cocaine dependence*. *American Journal on Addictions*, 7, 128-135.
- Brady, K.T., Killeen, T., Saladin, M.E., Dansky, B.S. & Becker, S. (1994). *Comorbid substance abuse and posttraumatic stress disorder: Characteristics of women in treatment*. *American Journal on Addictions*, 3, 160-164.
- Bremner, J.D., Southwick, S.M., Darnell, A. & Charney, D.S. (1996). *Chronic PTSD in Vietnam combat veterans: Course of illness and substance abuse*. *American Journal of Psychiatry*, 153, 369-375.
- Briere, J.N. & Runtz, M.G. (1989). *The trauma symptom checklist (TSC-33): Early data on a new scale*. *Journal of Interpersonal Violence*, 4, 151-163.
- Brown, P.J. & Wolfe, J. (1994). *Substance abuse and posttraumatic stress disorder comorbidity*. *Drug and Alcohol Dependence*, 35, 51-59.
- Center for Substance Abuse Treatment. (2000). *Substance abuse treatment for persons with child abuse and neglect issues*. Treatment Improvement Protocol (TIP) Series Number 36. DHHS Publication No. (SMA) 00-3357. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment. (2003). *Helping yourself heal: A recovering woman's guide to coping with childhood abuse issues*. DHHS Publication No. (SMA) 03-3789. Rockville, MD: Substance Abuse and Mental Health Services Administration.
[available online at <http://kap.samhsa.gov/products/brochures/pdfs/HelpingHeal-Womens.pdf>]
- Center for Substance Abuse Treatment. (2004). *Helping yourself heal: A recovering man's guide to coping with the effects of childhood abuse*. DHHS Publication No. (SMA) 06-4134. Rockville, MD: Substance Abuse and Mental Health Services Administration.
[available online at <http://kap.samhsa.gov/products/brochures/pdfs/HelpingHeal-Womens.pdf>]
- Child Sexual Abuse Task Force and Research & Practice Core, National Child Traumatic Stress Network. (2004). *How to implement trauma-focused cognitive behavioral therapy*. Durham, NC and Los Angeles, CA: National Center for Child Traumatic Stress.

[available online at http://www.nctsn.org/nctsn_assets/pdfs/TF-CBT_Implementation_Manual.pdf]

Clark, C. & Fearday, F. (Eds.). (2003) *Triad women's project: Group treatment manual*. Tampa, FL: Louis de la Parte Florida Mental Health Institute, Dept. of Mental Health Law & Policy, University of South Florida.
[no-cost copy available by contacting Colleen Clark at cclark@fmhi.usf.edu, 813-974-9022]

Clark, D.B. & Kirisci, L. (1996). *Posttraumatic stress disorder, depression, alcohol use disorders and quality of life in adolescents*. *Anxiety*, 2, 226-233.

Cline, T.L. (2007). *SAMHSA matrix of priorities: A life in the community for everyone: Building resilience & facilitating recovery*. DHHS. Rockville, MD: Substance Abuse and Mental Health Services Administration.
[available online at http://www.samhsa.gov/Matrix/matrix_brochure.pdf]

Cocozza, J.J., Jackson, E.W., Hennigan, K., Morrissey, J.P., Reed, B.G. & Fallot, R., et al. (2005). *Outcomes for women with co-occurring disorders and trauma: Program-level effects*. *Journal of Substance Abuse Treatment*, 28, 109-119.

Cohen, J.A., Deblinger, E., Mannarino, A.P. & Steer, R.A. (2004a). *A multisite, randomized controlled trial for children with sexual abuse-related PTSD symptoms*. *Journal of the American Academy of Child and Adolescent Psychiatry*, 43(4), 393-402.

Cohen, J.A., Deblinger, E., Mannarino, A.P., Wilson, C., Taylor, N. & Igelman, R. (2007a). *Trauma-focused cognitive behavioral therapy: Addressing the mental health of sexually abused children*. DHHS, ACYF, Children's Bureau. Washington, DC: Child Welfare Information Gateway, and the Chadwick Center for Children and Families.
[available online at <http://www.childwelfare.gov/pubs/trauma/trauma.pdf>]

Cohen, J.A. & Mannarino, A.P. (1993). *A treatment model for sexually abused preschoolers*. *Journal of Interpersonal Violence*, 8, 115-131.

Cohen, J.A. & Mannarino, A.P. (1996). *A treatment outcome study for sexually abused preschool children: Initial findings*. *Journal of the American Academy of Child and Adolescent Psychiatry*, 35(1), 42-50.

Cohen, J.A., Mannarino, A.P. & Knudsen, K. (2004b). *Treating childhood traumatic grief: A pilot study*. *Journal of the American Academy of Child and Adolescent Psychiatry*, 43(10), 1225-1233.

Cohen, J.A., Mannarino, A.P. & Knudsen, K. (2005). *Treating sexually abused children: 1 year follow-up of a randomized controlled trial*. *Child Abuse and Neglect*, 29(2), 135-145.

Cohen, J.A., Mannarino, A.P., Perel, J.M. & Staron, V. (2007b). *A pilot randomized controlled trial of combined trauma-focused CBT and sertraline for childhood PTSD symptoms*. *Journal of the American Academy of Child and Adolescent Psychiatry*, 46(7), 811-819.

Cook, J.M., Walser, R.D., Kane, V., Ruzek, J.I. & Woody, G. (2006). *Dissemination and feasibility of a cognitive-behavioral treatment for substance use disorders and posttraumatic stress disorder in the Veterans Administration*. *Journal of Psychoactive Drugs*, 38, 89-92.

Copeland, M.E. / Center for Mental Health Services (2005). *Dealing with the effects of trauma: A self-help guide*. Consumer Information Series, Volume 7. DHHS Publication No. SMA- 3717. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Copeland, M.E. & Harris, M. (2000). *Healing the trauma of abuse: A women's workbook*. Oakland, CA: New Harbinger Publications.

Covington, S.S. (2003a). *Beyond trauma: A healing journey for women – Facilitator's guide*. Center City, MN: Hazelden.

Covington, S.S. (2003b). *Beyond trauma: A healing journey for women – Participant's workbook*. Center City, MN: Hazelden.

- Covington, S.S. (2003c). *Beyond trauma: A healing journey for women – Facilitator videos 1 & 2*. Center City, MN: Hazelden.
- Covington, S.S. (2003d). *Beyond trauma: A healing journey for women – Client video*. Center City, MN: Hazelden.
- Community Connections, (1998). *Domestic violence: A 10 session group treatment intervention*. Washington, DC: Community Connections.
- Community Connections, (1999). *Trauma issues associated with HIV infection: An 11 session group treatment intervention*. Washington, DC: Community Connections.
- Dansky, B.S., Brady, K.T. & Saladin, M.E. (1998). *Untreated symptoms of PTSD among cocaine-dependent individuals: Changes over time*. *Journal of Substance Abuse Treatment*, 15, 499-504.
- Dansky, B.S., Byrne, C.A. & Brady, K.T. (1999). *Intimate violence and posttraumatic stress disorder among individuals with cocaine dependence*. *American Journal of Drug and Alcohol Abuse*, 25, 257-268.
- Davis, L. (1990). *The courage to heal workbook: For women and men survivors of child sexual abuse*. New York: Harper & Row.
- Davis, T.M. & Wood, P.S. (1999). *Substance abuse and sexual trauma in a female veteran population*. *Journal of Substance Abuse Treatment*, 16, 123-127.
- Dayton, T. (2000). *Trauma and addiction: Ending the cycle of pain through emotional literacy*. Deerfield Beach, FL: Health Communications.
- Deblinger, E. & Heflin, A.H. (1996). *Treatment for sexually abused children and their non-offending parents: A cognitive-behavioral approach*. Thousand Oaks, CA: Sage.
- Deblinger, E., Lippmann, J. & Steer, R. (1996). *Sexually abused children suffering posttraumatic stress symptoms: Initial treatment outcome findings*. *Child Maltreatment*, 1(4), 310-321.
- Deblinger, E., Stauffer, L.B. & Steer, R.A. (2001). *Comparative efficacies of supportive and cognitive behavioral group therapies for young children who have been sexually abused and their nonoffending mothers*. *Child Maltreatment*, 6(4), 332-343.
- Duncan, B.L., Miller, S.D., Sparks, J.A., Claud, D.A., Reynolds, L.R., Brown, J. & Johnson, L.D. (2003). *The session rating scale: Preliminary psychometric properties of a “working” alliance measure*. *Journal of Brief Therapy*, 3(1), 3-12. [available on line at <http://www.scottdmiller.com/uploadedFiles/documents/SessionRatingScale-JBTv3n1.pdf>]
- Evans, K. & Sullivan, J.M. (1995). *Treating addicted survivors of trauma*. New York: Guildford Press.
- Eyberg, S.M. (1988). *Parent-child interaction therapy: Integration of traditional and behavioral concerns*. *Child and Family Behavior Therapy*, 10, 33-46.
- Eyberg, S. & Robinson, E.A. (1982). *Parent-child interaction training: Effects on family functioning*. *Journal of Clinical Child Psychology*, 11, 130-137.
- Fallot, R. (Ed.). (1998). *Spirituality and religion in recovery from mental illness*. *New Directions for Mental Health Services*. Number 80, Winter. San Francisco: Jossey-Bass.
- Fallot, R. & Harris, M. (2001). *A trauma-informed approach to screening and assessment*. In M. Harris & R. Fallot (Eds.), *Using trauma theory to design service systems*, (3-22). San Francisco: Jossey-Bass.
- Fallot, R. & Harris, M. (2009). *Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol*. Washington DC: Community Connections, unpublished. [available online at <http://www.annafoundation.org/CCTICSELFASSPP.pdf>]

- Fallot, R., Harris, M., Affolter, H.U., Anglin, J., Arledge, E., Bebout, R., Dende, J., Freeman, D., Green, W. & Lee, M. (2001). *Men's trauma recovery and empowerment model (M-TREM): A guide to working with male trauma survivors in groups*. Washington, DC: Community Connections.
- Felitti V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., Koss, M.K. & Marks, J.S. (1998). *Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study*. American Journal of Preventive Medicine; 14(4), 245-258. [related information available online at <http://www.acestudy.org> www.acestudy.org]
- Figley, C.R. (1995). *Compassion fatigue*. New York: Brunner/Mazel.
- Finkelstein, N., VandeMark, N., Fallot, R., Brown, V., Cadiz, S. & Heckman, J. (2004). *Enhancing substance abuse recovery through integrated trauma treatment*. Sarasota, FL: National Trauma Consortium, Center for Substance Abuse Treatment. [available online at <http://www.nationaltraumaconsortium.org/documents/IntegratedTrauma.pdf>]
- Floen S.K., & Elklit, A. (2007). *Psychiatric diagnoses, trauma, and suicidality*. Annals of General Psychiatry, 6:12 doi:10.1186/1744-859X, 6-12. [available online at <http://www.annals-general-psychiatry.com/content/6/1/12>]
- Freeman, D.W. (2001). *Trauma-informed services and case management*. In M. Harris & R. Fallot (Eds.), *Using trauma theory to design service systems*, (3-22). San Francisco: Jossey-Bass.
- Fullilove, M.T., Fullilove, R.E., Smith, M., Winkler, K., Michael, C., Panzer, P.G. & Wallace, R. (1993). *Violence, trauma, and posttraumatic stress disorder among women drug users*. Journal of Traumatic Stress, 6(4), 533-543.
- Grawitch, M.J., Gottschalk, M. & Munz, D.C. (2006). *The path to a healthy workplace: A critical review linking healthy workplace practices, employee well-being, and organizational improvements*. Consulting Psychology Journal: Practice and Research. Vol. 58(3), Summer 2006, 129-147.
- Harris, M. (1999a). *"Trauma recovery & empowerment: Part I – Empowerment" videos 1 & 2*. Washington DC: Community Connections.
- Harris, M. (1999b). *"Trauma recovery & empowerment: Part II – Trauma recovery" video*. Washington DC: Community Connections.
- Harris, M. (1999c). *"Trauma recovery & empowerment: Part III – Advanced trauma recovery issues and closing rituals," videos 1 & 2*. Washington DC: Community Connections.
- Harris, M. (1999d). *"Women speak out" video (40 min.)*. Washington DC: Community Connections.
- Harris, M. (2001). *A menu of strategies for improving a woman's trauma recovery and empowerment profile: Skill building exercises to address specific needs*. Washington DC: Community Connections.
- Harris, M. and Fallot, R. (2001a). *Envisioning a trauma-informed service system: A vital paradigm shift*. In M. Harris & R. Fallot (Eds.), *Using trauma theory to design service systems*, (3-22). San Francisco: Jossey-Bass.
- Harris, M. and Fallot, R. (Eds.) (2001b). *Using trauma theory to design service systems*. New Directions for Mental Health Services. San Francisco: Jossey-Bass.
- Harris, M., Fallot, R., Holzapfel, A., Mitchell, C., Singleton, K. & Wolfson, R. (2001a). *Trauma-informed addictions treatment: A 20 session psycho-educational group intervention designed to address substance abuse issues within a trauma-informed perspective*. Washington DC: Community Connections.
- Harris, M. & Landis C. (eds) (1997). *Sexual abuse in the lives of women diagnosed with serious mental illness*. New York: Brunner-Routledge.

- Harris, M. & The Community Connections Trauma Work Group (1998). *Trauma recovery and empowerment: A clinician's guide for working with women in groups*. New York: Simon & Schuster/The Free Press.
- Harris, M. & The Parenting Work Group (2001b). *Non-traditional parenting interventions: The impact of early trauma on parenting roles, and parenting at a distance*. Washington DC: Community Connections.
- Harris, M. & Wolfson-Berley, R. (eds.) (2005). *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*. Washington DC: Community Connections.
- Hembree-Kigin, T. & McNeil, C.B. (1995). *Parent-Child Interaction Therapy*. New York: Plenum.
- Hensler, C., Wilson, C. & Sadler, B. (2004). *Closing the quality chasm in child abuse treatment: Identifying and disseminating best practices: The findings of the Kauffman best practices project to help children heal from child abuse*. San Diego: Chadwick Center.
[available online at <http://www.chadwickcenter.org/Documents/Kaufman%20Report/ChildHosp-NCTA brochure.pdf>]
- Herman, J.L. (1992). *Trauma and recovery*. New York: Basic Books.
- Hien, D.A., Cohen, L.R., Miele, G.M., Litt, L.C. & Capstick, C. (2004). *Promising treatments for women with comorbid PTSD and substance use disorders*. *American Journal of Psychiatry*, 161, 1426-1432.
- Hoagwood, K.E. & the CATS Consortium. (2008). *Impact of CBT for traumatized children and adolescents affected by the World Trade Center disaster*. Manuscript submitted for publication.
- Holdcraft, L.C. & Comtois, K.A. (2002). *Description of and preliminary data from a women's dual diagnosis community mental health program*. *Canadian Journal of Community Mental Health*, 21, 91-109.
- Hunter, M., (1990a). *Abused boys: The neglected victims of sexual abuse*. Lexington, MA: Lexington Books.
- Hunter, M. (Ed.). (1990b). *The sexually abused male: Application of treatment strategies, volume 2*. Lexington, MA: Lexington Books.
- Jordan, B.K., Schlenger, W.E., Fairbank, J.A. & Caddell, J.M. (1996). *Prevalence of psychiatric disorders among incarcerated women: II. Convicted felons entering prison*. *Archives of General Psychiatry*, 53, 513-519.
- Kahn J.P. & Langlieb A.M. (Eds). (2003). *Mental health and productivity in the workplace: A handbook for organizations and clinicians*. San Francisco: Jossey-Bass.
- Kessler, R.C., Sonnega, A., Bromet, E., Hughes, M. & Nelson, C.B. (1995). *Posttraumatic stress disorder in the National Comorbidity Survey*. *Archives of General Psychiatry*, 52, 1048-1060.
- Kilpatrick, D.G., Acierno, R., Saunders, B., Resnick, H.S., Best, C.L. & Schnurr, P.P. (2000). *Risk factors for adolescent substance abuse and dependence: Data from a national sample*. *Journal of Consulting and Clinical Psychology*, 68, 19-30.
- King, N.J., Tonge, B.J., Mullen, P., Myerson, N., Heyne, D. & Rollings, S., et al. (2000). *Treating sexually abused children with post-traumatic stress symptoms: A randomized clinical trial*. *Journal of the American Academy of Child and Adolescent Psychiatry*, 39(11), 1347-1355.
- Kolko, D.J. (1995). *Multimodal partial/day treatment of child antisocial behavior: Service description and multilevel program evaluation*. *Continuum*, 2, 3-24.
- Kolko, D.J. (1996). *Individual cognitive behavioral therapy and family therapy for physically abused children and their offending parents: A comparison of clinical outcomes*. *Child Maltreatment*, 1, 322-342.

- Kolko, D.J. & Swenson, C.C. (2002). *Assessing and treating physically abused children and their families: A cognitive-behavioral approach*. Thousand Oaks, CA: Sage Publications.
- Langeland, W. & Hartgers, C. (1998). *Child sexual and physical abuse and alcoholism: A review*. *Journal of Studies on Alcohol*, 59, 336-348.
- Lew, M. (1988). *Victims no longer: Men recovering from incest and other sexual child abuse*. New York: Harper & Rob.
- Linehan, M.M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.
- Love, P. & Robinson, J. (1990). *The emotional incest syndrome: What to do when a parent's love rules your life*. New York: Bantam Books.
- Miller, D. & Guidry, L. (2001). *Addictions and trauma recovery: Healing the body, mind & spirit*. New York: Norton.
- Miller, S.D., Duncan, B.L., Brown, J., Sparks, J.A. & Claud, D.A. (2003). *The outcome rating scale: A preliminary study of the reliability, validity, and feasibility of a brief visual analog measure*. *Journal of Brief Therapy*, 2(2), 91-199. [available online at <http://www.scottdmiller.com/uploadedFiles/documents/OutcomeRatingScale-JBTv2n2.pdf>]
- Morrissey, J.P., Jackson, E.W., Ellis, A.R., Amaro, H., Brown, V.B. & Najavits, L.M. (2005). *Twelve-month outcomes of trauma-informed interventions for women with co-occurring disorders*. *Psychiatric Services*, 56, 1213-1222.
- Najavits, L.M. (2002a). *A woman's addiction workbook: Your guide to in-depth healing*. Oakland, CA: New Harbinger Publications.
- Najavits, L.M. (2002b). *Implementing seeking safety therapy for PTSD and substance abuse: Clinical guidelines*. The Behavioral Health Recovery Management project. Illinois Department of Human Services, Office of Alcoholism and Substance Abuse. [available online at <http://www.bhrm.org/guidelines/PTSD.pdf>]
- Najavits, L.M. (2002c). *Seeking safety: A treatment manual for PTSD and substance abuse*. New York: Guilford Press.
- Najavits, L.M. (2005a). "A client's story" video (20 min.), and "Teaching grounding to a client" video (16 min.). Brooklyn MA: Treatment Innovations. [for ordering information see <http://www.seekingsafety.org>]
- Najavits, L.M. (2005b). "Example of a group session: Asking for help" video (60 min.). Brooklyn MA: Treatment Innovations. [for ordering information see <http://www.seekingsafety.org>]
- Najavits, L.M. (2005c). "Safe coping skills" poster. Brooklyn MA: Treatment Innovations. [for ordering information see <http://www.seekingsafety.org>]
- Najavits, L.M. (2005d). "Seeking safety: Therapy for trauma/PTSD and substance abuse" video (120 min.). Brooklyn MA: Treatment Innovations. [for ordering information see <http://www.seekingsafety.org>]
- Najavits, L.M. (2005e). "Sessions for adherence scale rating: Healthy relationships" video (55 min.). Brooklyn MA: Treatment Innovations. [for ordering information see <http://www.seekingsafety.org>]
- Najavits, L.M., Gallop, R.J. & Weiss, R.D. (2006). *Seeking Safety therapy for adolescent girls with PTSD and substance use disorder: A randomized controlled trial*. *Journal of Behavioral Health Services & Research*, 33, 453-463.
- Najavits, L.M., Gastfriend, D.R., Barber, J.P., Reif, S., Muenz, L.R., Blaine, J., Frank, A., Crits-Cristoph, P., Thase, M. & Weiss, R.D. (1998a). *Cocaine dependence with and without posttraumatic stress disorder among subjects in the NIDA Collaborative Cocaine Treatment Study*. *American Journal of Psychiatry*, 155, 214-219.

- Najavits, L.M., Schmitz, M., Gotthardt, S. & Weiss, R.D. (2005). *Seeking Safety plus exposure therapy: An outcome study on dual diagnosis men*. *Journal of Psychoactive Drugs*, 37, 425-435.
- Najavits, L.M., Weiss, R.D. & Shaw, S.R. (1997). *The link between substance abuse and posttraumatic stress disorder in women: A research review*. *American Journal on Addictions*, 6, 273-283.
- Najavits, L.M., Weiss, R.D., Shaw, S.R. & Muenz, L.R. (1998b). *"Seeking Safety": Outcome of a new cognitive-behavioral psychotherapy for women with posttraumatic stress disorder and substance dependence*. *Journal of Traumatic Stress*, 11, 437-456.
- Ouimette, P.C., Ahrens, C., Moos, R.H. & Finney, J.W. (1998). *During treatment changes in substance abuse patients with posttraumatic stress disorder: The influence of specific interventions and program environments*. *Journal of Substance Abuse Treatment*, 15, 555-564.
- Ouimette, P.C., Finney, J.W. & Moos, R.H. (1999). *Two-year posttreatment functioning and coping of substance abuse patients with posttraumatic stress disorder*. *Psychology of Addictive Behaviors*, 13, 105-114.
- Prescott, L. (2001). *Defining the role of consumer-survivors in trauma-informed systems*. In M. Harris & R. Fallot (Eds.), *Using trauma theory to design service systems*, (3-22). San Francisco: Jossey-Bass.
- Ruzek, J.I., Polusny, M.A. & Abueg, F.R. (1998). *Assessment and treatment of concurrent posttraumatic stress disorder and substance abuse*. In V.M. Follette, J.I. Ruzek & F.R. Abueg (Eds.), *Cognitive-behavioral therapies for trauma*, (226-255). New York: Guilford Press.
- Saakvitne, K.W., Pearlman, L.A. & Staff of the Traumatic Stress Institute. (1996). *Transforming the pain: A workbook on vicarious traumatization for helping professionals who work with traumatized clients*. New York: Norton.
- Saunders, B.E., Berliner, L. & Hanson, R.F. (Eds.). (2004). *Child Physical and Sexual Abuse: Guidelines for Treatment (Revised Report: April 26, 2004)*. Charleston, SC: National Crime Victims Research and Treatment Center.
[available online at http://academicdepartments.musc.edu/ncvc/resources_prof/OVC_guidelines04-26-04.pdf]
- Stewart, S.H. (1996). *Alcohol abuse in individuals exposed to trauma: A critical review*. *Psychological Bulletin*, 120, 83-112.
- Stewart, S.H., Conrod, P.J., Pihl, R.O. & Dongier, M. (1999). *Relations between posttraumatic stress symptom dimensions and substance dependence in a community-recruited sample of substance-abusing women*. *Psychology of Addictive Behaviors*, 13, 78-88.
- Swenson, C.C. & Kolko, D.J. (2000). *Long-term management of the developmental consequences of child physical abuse*. In R. Reece (Ed.), *The treatment of child abuse*. Baltimore, MD: Johns Hopkins University Press.
- Toussaint, D.W., VanDeMark, N.R., Bornemann, A. & Graeber, C.J. (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.
- Triffleman, E. (1998). *An overview of trauma exposure, posttraumatic stress disorder, and addictions*. In H.R. Kranzler & B.J. Rounsaville (Eds.), *Dual diagnosis and treatment: Substance abuse and comorbid medical and psychiatric disorders* (263-316). New York: Marcel Dekker.
- Urquiza, A.J., Zebell, N., McGrath, J. & Vargas, E. (1999a). *Parent-Child Interaction Therapy: Application to high-risk and maltreating families*. Unpublished treatment manual.
[Author. Child Protection Center, Department of Pediatrics, University of California Davis Medical Center, 3300 Satocton Blvd., Sacramento, CA 95820]
- Urquiza, A.J., Zebell, N., McGrath, J. & Vargas, E. (1999b). *Parent-Child Interaction Therapy: Application to high-risk and maltreating families*. Videotape series.

[Author. Child Protection Center, Department of Pediatrics, University of California Davis Medical Center, 3300 Satocton Blvd., Sacramento, CA 95820]

Urquiza, A.J. & McNeil, C.B. (1996). *Parent-child interaction therapy: An intensive dyadic intervention for physically abusive families*. *Child Maltreatment*, 1(2), 132-141.

Veysey, B. & Clark, C. (Eds.).(2004) *Responding to physical and sexual abuse in women with alcohol and other drug and mental disorders: Program building*. Binghamton, NY: Haworth Press.

Veysey, B. & Heckman, J., with Mazelis, R., Markoff, L. & Russell, L. (2006). *It's my time to live: Journeys to healing and recovery*. Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. [available online at http://download.ncadi.samhsa.gov/ken/pdf/nctic/ItsMyTimeToLive_07.pdf]

Weathers, F., Litz, B., Huska, J. & Keane, T. (1994). *Psychometric properties of the PTSD Checklist – Civilian Version*. Boston: National Center for PTSD – Behavioral Science Division.

Weller, L. A. (2005). *Group therapy to treat substance use and traumatic symptoms in female veterans*. *Federal Practitioner*, 27-38.

Wiland, S. (1999). *The role of childhood trauma in the disorders of dually diagnosed adults served in a community mental health setting*. Eastern Michigan University: unpublished.

Williams, M.B. & Pojula, S. (2002). *The PTSD workbook: Simple, effective techniques for overcoming traumatic stress symptoms*. Oakland, CA: New Harbinger Publications.

Zlotnick, C., Najavits, L.M., Rohsenow, D.J. & Johnson, D.M. (2003). *A cognitive-behavioral treatment for incarcerated women with substance abuse disorder and posttraumatic stress disorder: Findings from a pilot study*. *Journal of Substance Abuse Treatment*, 25, 99-105

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APPENDIX A.1: Competitive Grant Proposal Narrative

1. SUMMARY (5 points): Provide a brief summary of the proposed project.

The proposed project, “Addressing Trauma Within the Community Mental Health Population: A Toolkit for Practitioners,” is intended to address the need for developing trauma-informed and trauma-specific services to populations served by Washtenaw County’s community mental health provider, Community Support and Treatment Services. We plan to review existing evidence-based practice models, to make indicated adjustments for efficacious use with the severely and persistently mentally ill populations we serve, and to lay the foundation for service delivery by educating and training staff at all levels and scopes of practice. Appropriate clinical supervision support will be established, group and individual treatment protocols will be designed, and gender- and trauma-specific treatment will be initiated.

2. NEEDS IDENTIFICATION AND CONSUMER INVOLVEMENT (20 points): Explain how the need for the proposed project was identified, including how primary consumers had meaningful involvement in the process used to identify the need. If this is a service project, address the gap or barrier in the present system that will be filled.

Nationally recognized experts in the area of trauma, such as Roger Fallot and Maxine Harris, have helped to raise awareness of the need for greater trauma-informed and trauma-specific services. National community-based surveys find that between 55% and 90% of the general population have experienced at least one traumatic event in their lifetime. The prevalence percentages only increase among those populations made more vulnerable by risk factors including mental, emotional, and developmental disorders, co-occurring addictions, and poverty, all of which are risk factors with disproportionately high representation among the populations served by our public sector community mental health system.

The need for this proposed project has been evident locally for a number of years, most recently emphasized through CSTS’ work with consumers in treatment for co-occurring mental health and substance use disorders, over half of which report historical experiences of trauma. Additionally the work of CSTS’ Project Outreach Team (PORT) uncovered an even higher prevalence of traumatic experiences among the homeless populations they serve. Several consumers of CSTS’ ACT and PORT teams and DBT-track services have reported unresolved/under-resolved historical experiences of sexual or physical trauma, as well as the witnessing of significant violence, and have asked for assistance in addressing this as part of their co-occurring disorders treatment. Although CSTS is among the leaders in the State of Michigan in the implementation of integrated dual disorders treatment, the lack of greater trauma-informed and trauma-specific services represents a gap in the current clinical treatment continuum.

3. RECOVERY (20 points): Address how the project will support consumers in the recovery process. Explain how the project will address the values of Michigan’s public

mental health system to promote recovery and wellness; reduce stigma; facilitate access; seek support arrangements that facilitate independence, personal responsibility, and full participation in community life; and promote consumer choice.

This project will improve the support available to numerous CSTS' consumers in their recovery from co-occurring mental health and/or substance use disorders, as unresolved/under-resolved trauma has been found to be a significant obstacle to a more satisfying, higher-functioning and sustainable state of wellness and recovery. Trauma poses a significant relapse risk for both the recurrence of mood-disorder and personality-disorder symptoms, as well as for relapse of addictive disorders. Effective trauma-informed and trauma-resolution services will address the shame and stigma often experienced by trauma survivors that can impede their efforts to make their recovery needs known in this realm. This project will improve access to available services that can make an important difference in consumers' lives, leading to greater independence, empowerment, and fuller participation in community life. This training project will better facilitate healing from the incredibly disempowering effects of trauma.

4. REGIONAL SERVICES (10 points): Explain how the project will assure more uniformity of the availability of evidence-based or improving practices across the PIHP/CMHSP region.

This project will be developed and piloted within Washtenaw County Community Support and Treatment Services, and the trauma-informed and trauma-specific treatment services and implementation processes that are developed will subsequently be made more widely available, not only to CSTS' direct regional affiliates, but to PIHPs across the State of Michigan as well.

5. SPECIFIC CATEGORY REQUIREMENTS (15 points): Address all special requirements listed in the programmatic specifications contained in the RFP for the primary category for which this proposal is submitted.

Statistics show that at least 80% of consumers with a serious mental illness have had some form of trauma in their life. Addressing trauma early, and in conjunction with the treatment of a mental illness, is critical in the recovery, growth, and wellness of consumers. A trauma-informed system of care includes: flexible treatment plans, value of consumers' unique histories, the avoidance of negative care approaches, positive understanding of coping methods, etc. This project proposes to increase the awareness and knowledge base of staff across the entire CSTS organization such that appropriate and effective accommodation can better occur in interactions with consumers at all points of service contact, from reception to assessment to service planning to the delivery of trauma-informed and trauma-specific clinical treatment practices.

The impact of trauma touches many life domains and is life-shaping and dramatic. A truly trauma-informed system assumes that the experience of historical trauma is the expectation, rather than the exception. This proposed project will include and meaningfully involve trauma survivors in the development and implementation of staff training and service design. CSTS staff with lived experience as survivors of trauma will be significantly involved in the project, and consumers with lived experience as trauma survivors will also be regularly consulted and included in the project.

This trauma initiative will provide education about, and clinical training for, the treatment of trauma within the CSTS system, with end products then available to PIHP regional affiliates, and even more broadly across the State of Michigan. The interactive aspects of mental illness, co-occurring addictions, and trauma will be emphasized in all aspects of the project. Change recommendations for the CSTS organization will be generated and moved forward, and peer-led support groups in the local community will be encouraged.

- 6. SUSTAINABILITY (15 points): If this is a service project (all two-year and three-year proposals), describe the firm commitment from the PIHP/CMHSP that the services will continue after grant funds have ended. Describe how any positions for consumers funded under the proposal will remain in place after the grant period is over. If this is a service project, discuss how this new development will impact the current service array.**

This is a training project that will equip existing staff with the knowledge and competencies necessary to develop and deliver improved trauma-informed and trauma-specific treatment services. The current service array will therefore be expanded to be more effective, and the staff training and improved services that are developed will be sustained, moving forward as part of CSTS' commitment to continuous improvement in the development and implementation of efficacious evidence-based clinical practices.

- 7. COMMUNITY COLLABORATION (15 points): Describe community collaboration and support in developing, planning, implementing, and monitoring the project. The goal of the collaboration is for consumers to be connected to services and supports needed to meet their needs. Proposals that involve collaboration with other community organizations must include letters of support that specifically describe what and how partners will contribute to the project, both in terms of human and financial commitment.**

As primarily a training and education project to equip staff with needed clinical knowledge and competencies, immediate community collaboration is not required for successful completion of this first phase. Other community stakeholders have expressed a recognition of the need for greater and more accessible services in this critical area, including the local chapter of the National Alliance for the Mentally Ill, and the local Survivors of Incest Anonymous peer-led 12-Step fellowship. CSTS has sought, and received, verbal commitment from Roger Fallot of Community Connections in Washington, DC, to come and provide trauma-informed and trauma-specific training for staff during

the upcoming Fall/Winter of 2008. Available community collaborators who could be available to support the efforts of this project include Ruth Shabazz (Ann Arbor Shelter Association/Delonis Center) and Beth Glover Reed (PhD, University of Michigan).

- 8. STAFF SUPPORT (15 points): Describe how the planned level of staff support was determined. Include position descriptions of key project personnel. Describe the knowledge and experience of key project personnel related to recovery, the target population, and the proposed intervention. Describe how Certified Peer Support Specialists and/or other consumers will be involved in the program. Address any requirement or priority for filling key positions with primary consumers.**

Steve Wiland, LMSW, CAC-R, Clinical Practices Administrator for CSTS, will lead this project, and facilitate agency-wide trauma-informed educational efforts for staff, as well as the development and launch of trauma-specific treatment services and associated clinical supervision and oversight. Steve has 7 years of direct clinical service and clinical supervision experience with trauma survivor populations, both as lead facilitator of treatment groups for the Touchstone Program of Washtenaw County's Assault Crisis Center, and as Clinical Director of the More Than Conquerors faith-based ministry to sexual abuse survivors. Steve has also done research on the prevalence of undiagnosed and under-treated trauma within the CMH system (*The Role of Childhood Trauma in the Disorders of Dually Diagnosed Adults Served in a Community Mental Health Setting, 1999, unpublished*).

A cohort of interested clinicians has already been identified, including many existing IDDT group facilitators, including PORT staff **Carol Ludwig, Sara Silvennoinen, Flo Hepola, Linda Bacigalupi,** and **Mike Ferriter**; and ACT staff **Nathan Rahn, Wendy Svatora,** and **Sarah Starkey**. Interested Peer Support Specialists will be sought, and their meaningful participation in service provision solicited as soon as possible. Additionally, trauma-survivor consumers will be consulted throughout the project to inform the development and implementation of services in as effective a manner as possible.

Staff across the agency in all positions and scopes of practice will be provided with education and awareness as to how the practice of their role can take place in a more optimally trauma-informed manner.

- 9. WORKPLAN (20 points): The response to this area must be typed in a separate document for each fiscal year of grant funding requested. Do not include the workplan within the numbered Competitive Proposal Narrative document. The workplan will be reviewed for:**
- **clear description of the outcomes to be achieved by the project;**
 - **clear goals statements and measurable objectives;**
 - **timelines and assignment of responsibility for completion of objectives and activities for each quarter;**
 - **the number of consumers who will be impacted;**

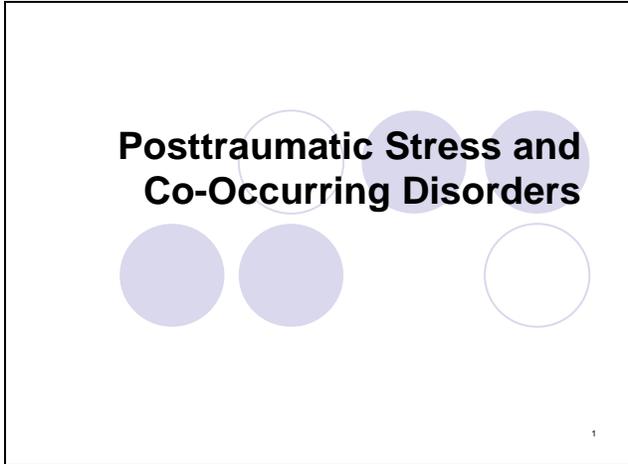
- a description of the methods that will be used to evaluate the impact of the project, describing the use of data, and the involvement of consumers; and
- a description of how the results of the project will be shared with MDCH for possible dissemination throughout the state.

Quarter	Outcome	Measure
1 – (10/1/08-12/31/08)	<p>Confirm identification of “trauma champions” with supervisory and administrative support;</p> <p>Trauma Initiative Workgroup begins to meet;</p> <p>Acquire and review training and educational materials;</p> <p>Interview and hire video tech (UM graduate student in Film Studies);</p> <p>Development of “Understanding Trauma,” and “Staff Support” modules</p> <p>Complete planning for agency-wide kick-off training;</p> <p>Establish clinical supervision infrastructure elements, and protocols for access to trauma services / managing individual and group work scenarios, etc.</p>	<p>List of names with supporting documentation of communications;</p> <p>Documented minutes of Trauma Initiative Workgroup;</p> <p>Receipt of ordered materials;</p> <p>Identification of the process of creating the Training DVD;</p> <p>Documentation of module content;</p> <p>Documentation of arrangements for local FalLOT training conference;</p> <p>Documentation of clinical supervision/support resources and availability; documentation of trauma service protocols.</p>
2 – (1/1/09-3/31/09)	<p>Conduct agency-wide training conference;</p> <p>Begin videotaping all training events;</p> <p>Arrange for ongoing consultation with FalLOT/Community Connections;</p> <p>Develop and schedule additional in-house inservice presentations with staffing groups;</p> <p>Conduct CSTS “Trauma-Informed Program Self-Assessment Scale”</p> <p>Trauma Initiative Workgroup continues to meet.</p>	<p>Documentation of CSTS staff participation;</p> <p>Minutes and quality of unedited video recordings</p> <p>Documentation of arrangements made;</p> <p>Documentation of arrangements made;</p> <p>Completed “Trauma-Informed Program Self-Assessment Scale;”</p> <p>Documented minutes of Trauma Initiative Workgroup.</p>

3 – (4/1/09-6/30/09)	<p>Finalize CSTS Action Plan, informed by results of completed “Trauma-Informed Program Self-Assessment Scale;”</p> <p>Continue to develop, schedule and present additional in-house inservices with staffing groups;</p> <p>Continue to videotape any and all training activities;</p> <p>Trauma Initiative Workgroup continues to meet.</p>	<p>Documented CSTS Action Plan;</p> <p>Documentation of arrangements, involved handouts and other presentation materials;</p> <p>Numbers of events and minutes of video recorded;</p> <p>Documented minutes of Trauma Initiative Workgroup.</p>
4 – (7/1/09-9/30/09)	<p>Trauma Initiative Workgroup continues to meet and implement CSTS Action Plan;</p> <p>Continue to develop, schedule and present additional in-house inservices with staffing groups</p> <p>Video tech and Project Director select footage and edit recordings to produce final product;</p> <p>Write the “Addressing Trauma Within the Community Mental Health Population: A Toolkit for Practitioners” manual.</p>	<p>Documented minutes of Trauma Initiative Workgroup;</p> <p>Documentation of arrangements, involved handouts and other presentation materials;</p> <p>Final product that is a culmination of the best training footage;</p> <p>Copy of completed manual, available for dissemination in pdf format.</p>

The manual that will be generated as a deliverable of this project will describe the process of advancing trauma-informed and trauma-specific service development at CSTS, and will offer guidelines for effective implementation. This will be made available in pdf format to any/all interested parties in the MDCH network. Additionally, the DVD that is created from the Training events will be promoted on our website and available by mail.

APPENDIX A.2: Posttraumatic Stress and Co-Occurring Disorders Slides



Posttraumatic Stress and Co-Occurring Disorders



- A national study (NCS) of individuals with co-occurring mental health and substance abuse disorders found that 60% of the men and 50% of the women with co-occurring disorders report at least one traumatic event in their lifetime.

3

Posttraumatic Stress and Co-Occurring Disorders

- Trauma, addiction and mental health difficulties go hand in hand.
- Most individuals seeking mental health and/or substance abuse services DO NOT identify trauma as their major concern.



2

What is Trauma?

Trauma is the physical and emotional reaction to an event that is:

- Life threatening, or
- Seriously jeopardizes the physical, emotional or spiritual well-being of that person or someone close to them, and
- The person experiences intense fear, helplessness or horror.



4

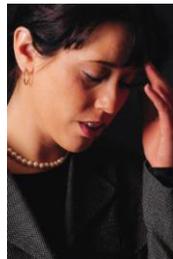
Traumatic Events include:

- War, battles, combat (death, explosions, gunfire...)
- Natural disasters (floods, tornados, fires...)
- Catastrophe (harmful/fatal accidents, terrorism)
- Violent attack (animal attack, assault with or without a weapon, battery and domestic violence, rape, threats of bodily harm with or without a weapon)
- Abuse (physical, sexual, mental and/or verbal)

5

What is Trauma?

- Trauma is an experience that overwhelms our capacity to have a sense of control over ourselves and our immediate environment, to maintain connection with others and to make meaning of our experience.



6

How do people react to trauma?

PTS: Post Traumatic Stress

- PTS is the emotional and physical reaction from the memories of a traumatic event experience, and the shattered sense of personal safety. Symptoms can include:

- Anxiety
- Flashbacks
- Dissociation

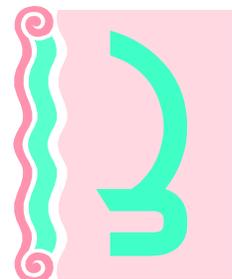


- While discomfoting, these reactions do not disrupt the individual's overall ability to function.

7

How do people react to trauma?

- **PTSD: Post Traumatic Stress Disorder** – characterized by three clusters of symptoms . . .



8

PTSD – Intrusive Symptoms

- **Intrusive memories and emotions** interfere with normal thought processes and social interactions.



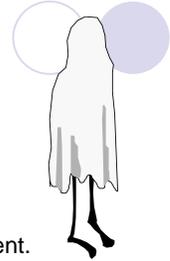
- **Flashbacks** feature auditory and visual hallucinations and can be triggered by ordinary stimuli such as the sound of an airplane flying overhead (combat), violent scenes on TV, the smell of a certain cologne.



1

Avoidant Symptoms

- Avoiding emotions
- Avoiding relationships
- Avoiding responsibility to and for others
- Avoiding situations that are reminiscent of the traumatic event.



- *People with PTSD commonly avoid stimuli and situations that remind them of the traumatic event because they trigger symptoms.*

11

PTSD – Intrusive Symptoms

- **Nightmares and night terrors** also feature aspects of the traumatic event (*often literal, but can be figurative*).



- **Dissociative symptoms** include psychic numbing, depersonalization and amnesia.



10

Hyper-arousal Symptoms

- Sleep disturbance
- Explosive outbursts
- Irritability
- Panic symptoms
- Extreme vigilance
- Exaggerated startle response



- *People experiencing hyper-arousal (constant “flight or fight”) are always on the alert for danger or threat, and are easily startled.*

12

Types of PTS/PTSD

Type I or Simple PTS/D

- The response to one or more traumatic events that are NOT linked in any way (e.g., one rape, one car accident, one sudden loss).

Type II or Complex PTS/D

- The response to a combination of specific traumatic events that ARE linked to each other in some way (e.g., father is sexually abusive, child resists and the parent kills their cat, mother finds out about the abuse and blames the child and kicks her out of the house).



13

Risk Factors for developing PTSD

- The severity, type and duration of the traumatic event.
- Repeated exposure to stress and/or multiple traumatic events.
- Lack of adequate and competent support for the person after being exposed to a traumatic event.
- A predisposing mental health condition.



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Types of PTS/D

PTS/D can also be classified as:

- Acute** – symptoms last less than 3 months.
- Chronic** – symptoms last more than 3 months
- Delayed** – symptoms first appear at least 6 months after the traumatic event occurred (*this is very common with individuals who were sexually abused as children*)



14

Prevalence

- Studies estimate that approximately 70% of people (adults and children) living in the US are exposed to one or more traumatic events during their lifetime.
- Approximately 61% of men and 51% of women have experienced at least one traumatic event in their lifetime.
- An average of 8 - 11% of adult Americans have/will have PTSD at some point in their lives.



16

Gender differences

- For **women**, the most common events were rape, sexual molestation, physical attack, being threatened with a weapon, and childhood physical abuse.



- **Women** not only experience a greater number of PTSD symptoms than men, but they also experience them more frequently and for longer durations.

17

Posttraumatic Stress and Co-Occurring Disorders

- Depression precedes drug abuse more often for women
- Drug abuse appears to precede depression more often for men.
- Women more often than men are diagnosed with depression and other disorders well before they began using drugs or alcohol.
- Women are significantly more likely to have a diagnosis of panic disorder before the onset of substance abuse.



19

Gender differences

- The traumatic events most often associated with PTSD in **men** were rape, combat exposure, childhood neglect, and childhood physical abuse.



18

Posttraumatic Stress and Co-Occurring Disorders

- Trauma survivors often attempt to control their internal state of hyperarousal and emotional pain through the use of substances.
- All drugs of abuse affect many of the same receptors in the brain as do traumatic memories.
- While substances initially seem to restore a sense of control, they actually prevent the individual from accessing their memories and integrating the experience in a meaningful, resolving manner.



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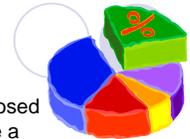
Posttraumatic Stress and Co-Occurring Disorders



- Co-occurrence increases the severity of trauma symptoms.
- Alcoholism and drug abuse can temporarily mimic PTSD, and can mask symptoms.
- Substance use/abuse increases a person's potential to be re-victimized and/or re-traumatized.
- Mental health difficulties also increase one's vulnerability for re-victimization and/or re-traumatization.
- The three conditions combined (PTSD, mental illness and substance abuse) if inadequately addressed and treated can result in a vicious, debilitating cycle of chronic, unmanageable distress.

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Posttraumatic Stress and Co-Occurring Disorders



- 48% of men and 70% of women diagnosed as chemically dependent will also have a co-occurring affective or anxiety disorder.
- 46% of women and 24% of men addicted to cocaine have lifetime PTSD.
- PTSD preceded the cocaine dependence in 77% of the women and 38% of the men.
- Victims of childhood sexual assault are twice as likely to become heavy consumers of alcohol than non-victims

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Connecting PTSD and COD



- People with PTSD are 2-4 times more likely to have an additional psychiatric diagnoses than people without PTSD.
- The NCS also found that 59% of men and 44% of women with PTSD also met criteria for 3 or more other psychiatric diagnoses.
- 56-63% of women seeking inpatient psychiatric services and 40% of women in outpatient mental health treatment report a history of childhood abuse.
- Between 1/3rd and 1/2 of depressed individuals also suffer some form of substance abuse or dependence.

22

Posttraumatic Stress and Co-Occurring Disorders



- 1 in 4 women and 1 in 6 men will experience a sexual assault in their lifetime.
- Overall, studies indicate that 30-60% of treatment-seeking substance abusers have PTSD, and that as many as 2/3 of the men and women in substance abuse treatment experienced child abuse and/or neglect.
- The probability for developing alcohol problems in adulthood is 80% for men who have experienced sexual abuse.
- 55-99% of female substance abusers have been victimized and traumatized by physical and/or sexual abuse.

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Posttraumatic Stress and Co-Occurring Disorders

- A combination of psychotherapy, medication, bibliotherapy, self-help and support groups, skill-building and homework are commonly used to treat PTS/D alone, or when co-occurring with other mental health and/or substance use disorders.



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APPENDIX A.3: “Seeking Safety” Model Description and Resources**Seeking Safety**

Seeking Safety is a present-focused therapy to help people attain safety from trauma/PTSD and substance abuse. The treatment is available as a book, providing both client handouts and guidance for clinicians.

The treatment was designed for flexible use. It has been conducted in group and individual format; for females, males, and mixed-gender; with adults and adolescents; using all topics or fewer topics; in a variety of settings (outpatient, inpatient, residential); and for both substance abuse and dependence. It has also been used with people who have a trauma history, but do not meet criteria for PTSD.

Seeking Safety consists of 25 topics that can be conducted in any order: 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, Healing from Anger, 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.

Book

Najavits, L.M. (2002c). *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse*. New York: Guilford. Published as a book from Guilford Press, and includes all materials needed to conduct the treatment (clinician guide and client handouts). The book can be ordered at www.seekingsafety.org, or at www.guilford.com, or any online or local bookstore (e.g., amazon.com). Discounts for multiple copies are available at Guilford Press (800-365-7006).

Empirical studies

At this point, Seeking Safety is the most studied treatment for PTSD-substance abuse. Nine published studies are completed (all evidencing positive results across multiple domains), including:

Pilot studies: women in prison; outpatient women; men; men and women veterans;

women in community mental health

Randomized controlled trials: low-income urban women; adolescents

Multisite trial: women in community treatment

All studies can be freely downloaded from www.seekingsafety.org (“Studies” section). Other studies are currently underway.

Resources

- The website (www.seekingsafety.org) has freely downloadable materials (articles, information on training, etc.). See next section for description

- A set of videos on Seeking Safety are available, including (a) a 2-hour training video; (b) example of a Seeking Safety session; (c) adherence rating Seeking Safety session; (d) demonstration of teaching grounding technique; (e) one client's story
- Spanish translation of Seeking Safety
- Training: There are numerous trainings scheduled around the country (typically 1-2 days in length). The website has a complete training calendar and contact information on how to register. Also, if you would like to schedule a training on Seeking Safety, contact Lisa Najavits (info@seekingsafety.org) (617-731-1501); description of various training options are also on the website – see the “Training” section

Website

The website www.seekingsafety.org has the following sections:

Seeking Safety

About *Seeking Safety*

Reviews of the *Seeking Safety* book

How to obtain the *Seeking Safety* book (which includes client handouts and clinician guide)

Sample *Seeking Safety* topics

Adapting / reprinting from *Seeking Safety*

Spanish-language version of the book

Seeking Safety multimedia training package for clinicians

How to refer clients to local *Seeking Safety* treatment

Becoming or finding a contact person for *Seeking Safety* in your area

About Lisa Najavits

Studies

Results of each study of *Seeking Safety* completed thus far

Research

Grant materials

Articles

Downloadable articles on *Seeking Safety*, PTSD/substance abuse, and other topics

Training

Calendar of trainings and information on how to set up a training

Other Books/Videos

A Woman's Addiction Workbook, videos on PTSD/substance abuse, etc.

Assessment

The *Seeking Safety Adherence Scale*, and links to other measures

Contact:

Lisa Najavits, PhD

info@seekingsafety.org (e-mail)

617-731-1501 (phone)

www.seekingsafety.org (web)

APPENDIX A.4:

“M-TREM” Slides

M-TREM

Trauma Recovery and Empowerment
Model for Male survivors of trauma

Core Assumption #1

- Many of the short-term and longer-term sequelae of trauma are similar for men and women. However, significant differences in gender role expectations affect not only the experience of trauma itself but also the victim-survivor’s understanding of and responses to trauma.

**Core Assumptions of M-TREM**

- Eight assumptions inform use of the M-TREM model in working with male survivors of trauma.

**Core Assumption #2**

- Male trauma survivors are faced with a “disconnection dilemma.” In order to retain the feelings of fear, vulnerability, and powerlessness associated with trauma, they must disconnect from male gender role expectations that preclude such feelings. Alternatively, in order to retain the sense of masculine identity attached to fulfilling gender roles, survivors must disconnect from unacceptable feelings of vulnerability, fear powerlessness.



Core Assumption #3

- Partly because of the disconnection dilemma, many male trauma survivors develop all-or-nothing responses, especially in the emotional and relationship worlds (e.g., rage vs. timidity). A key trauma recovery skill for men is the development of a broader range of options for expressing emotions and for being in relationships.



Core Assumption #5

- We assume that people who experienced repeated trauma in childhood were deprived of the opportunity to develop certain skills necessary for adult coping.



Core Assumption #4

- We assume that trauma severs core connections to one's family, one's community, and ultimately to oneself. For men, these experiences of separation are colored by gender role socialization that often supports at least the appearance of interpersonal self-sufficiency and lack of emotional expression.



Core Assumption #6

- While certain abilities may have been adversely affected by violence and abuse, trauma survivors bring an array of skills and strengths to the recovery process.



Core Assumption #7

- We assume that some dysfunctional behaviors and/or symptoms may have originated as legitimate coping responses to trauma.



Trauma Recovery Skills

1. Self-Awareness
2. Self-Protection
3. Self-Soothing
4. Emotional Modulation
5. Relational Mutuality
6. Accurate Labeling of Self and Others
7. Sense of Agency and Initiative-Taking
8. Consistent Problem-Solving
9. Reliable Parenting
10. Possessing a Sense of Purpose and Meaning
11. Judgment and Decision-Making

Core Assumption #8

- All attempts to cope with trauma have advantages and disadvantages, benefits and costs.



Self-Awareness

- The ability to recognize bodily and motivational states and to articulate that awareness to others in a clear manner



Self-Protection

- The ability to recognize, avoid, and/or manage potentially harmful situations and to establish safe and manageable interpersonal boundaries



Emotional Modulation

- Strategies to control the intensity and expression of affective states



Self-Soothing

- The ability to manage and diminish feelings of distress, pain, and hurt



Relational Mutuality

- The capacity to engage in a reciprocal meeting of interpersonal needs



Accurate Labeling



- The capacity to use accurate words to label one's own feelings and behavior and the behavior of others

Consistent Problem-Solving



- The ability to combine cognitive, affective, and social skills in resolving personal and interpersonal situations

Sense of Agency



- The ability to see oneself as the primary source of action and initiative in one's life

Reliable Parenting



- The ability to respond to the needs of dependent children and grandchildren in a reliable and consistent way

Sense of Purpose and Meaning

- The ability to actively seek and meet one's needs and goals in an appropriate manner and to view one's actions in a larger context of meaning



Active Trauma Recovery

- Understanding relationships between gender role expectations and trauma
- Understanding emotions and relationships
- Understanding trauma and its often broad-based impact
- Understanding recovery skills and their use



Judgment and Decision-Making

- The ability to form reliable judgments based on thoughts, feelings, and perceptions and to use those judgments to make beneficial decisions



Men's Trauma Recovery and Empowerment Model (M-TREM): A Group Intervention

- History and development of TREM and M-TREM
- Theoretical approach
- Group format and structure
- Key group leader behaviors



M-TREM – Part One Sessions

- Introduction
- Male Myths
- Friendship
- **Anger**
- Fear
- Trust
- Loss
- Hope
- Shame
- Sex
- Intimacy



M-TREM – Part One

- **Goals:**
 - ◆ To facilitate a sense of safety and trust in the group
 - ◆ To develop a shared emotional vocabulary especially with the “softer” emotions
 - ◆ To introduce key relationship themes, especially the limitations of independence
 - ◆ To discuss the importance of gender roles
 - ◆ To begin preliminary discussion of the role of violence and abuse in members’ lives

Topic 4: Anger

- **Rationale:** For many men, anger is the predominant and defining emotion; it is the “emotional funnel” toward which and through which other emotions are often channeled. Anger is not only accessible, but it may serve as the conscious motivation for a range of behaviors. Many men who are trauma survivors find that this is the only emotion they are able to feel or feel free to express.



Topic 4: Anger

■ Goals:

- ◆ Members will appreciate that anger is a complex emotion, that it is not an all-or-nothing phenomenon.
- ◆ Members will begin to consider that anger may be a screen for other less accessible emotions.
- ◆ Members will appreciate the advantages and disadvantages of expressing anger.
- ◆ Members will learn some ways of handling anger more effectively.



Topic 4: Anger

■ Sample Questions:

- ◆ Name the situations that are likely to make you feel angry. (Develop an anger continuum.)
- ◆ Discuss what other emotions you, or someone else, might feel in these same situations.
- ◆ What negative consequences have you experienced as a result of being angry? What benefits?
- ◆ What are some effective ways you've learned to handle your anger?



M-TREM – Part Two



■ Goals:

- ◆ To help members deepen an understanding of trauma and its broad-ranging impact
- ◆ To identify characteristic ways of coping with traumatic events
- ◆ To help members understand the connections among trauma and other life difficulties
- ◆ To reframe certain problem behaviors or symptoms as coping attempts
- ◆ To build on personal strengths in discussing alternative coping methods

M-TREM – Part Two Sessions



- Gaining an Understanding of Trauma
- What is Emotional Abuse?
- What is Physical Abuse?
- What is Sexual Abuse?
- Abuse and Psychological or Emotional Symptoms
- Trauma and Addictive or Compulsive Behavior
- Abuse and Relationships



Topic 16: Abuse, and Psychological or Emotional Symptoms

- **Rationale:** In order to understand fully the impact that trauma has had on their lives, men need to see the possible links between current problematic feelings and behaviors and early or ongoing adult experiences of abuse. In many cases, what are now labeled as symptoms were either responses to trauma or else a strategy for coping with trauma.

Topic 16: Abuse, and Psychological or Emotional Symptoms

- **Sample Questions:**
 - ◆ Name some emotional “symptoms” you have experienced. What abuse do you think may be related to these symptoms?
 - ◆ Take the same symptoms and think of how they might have been reasonable coping responses to the abuse.
- **Exercise:** “Symptom Cards”

Topic 16: Abuse, and Psychological or Emotional Symptoms

- **Goals:**
 - ◆ Each member will begin to explore the possible link between past abuses and intense feelings or dysfunctional behaviors.
 - ◆ Each member will consider that currently labeled “symptoms” may have developed originally as responses to trauma.



M-TREM – Part Three

- **Goals:**
 - ◆ To apply an understanding of trauma’s impact to a variety of life domains
 - ◆ To develop, practice, and consolidate recovery skills
 - ◆ To deepen the mutual help functions of the group



M-TREM – Part Three Sessions

- Revenge, Acceptance, and Forgiveness
- Negotiating Family Relationships
- Communication Skills
- Positive Problem-Solving: Overcoming Self-Defeating Behaviors
- **Managing Feeling Out of Control/Self-Soothing**
- Realistic Goals and Empowerment



Topic 23: Self-Soothing, and Managing Feeling Out of Control

■ Goals:

- ◆ Members will begin to understand the triggers and consequences of feeling out of control.
- ◆ Members will begin to consider ways in which they might be able to soothe distress and modulate their emotions.



Topic 23: Self-Soothing, and Managing Feeling Out of Control

- **Rationale:** Men often do not have a healthy range of options for easing stress and comforting themselves. Some men may not even realize that self-comfort is a legitimate goal. Men also need assistance in identifying those triggers that lead to a feeling of being out of control. They need to consider that there are many feelings besides anger and rage that are associated with feeling out of control.



Topic 23: Self-Soothing, and Managing Feeling Out of Control

■ Sample Questions:

- ◆ What does being out of control feel like to you?
- ◆ How do you behave when you feel out of control? How would others describe you at those times?
- ◆ What triggers feelings of being out of control?

- **Exercise:** Active Movement or Relaxation Exercise



Topic 23: Self-Soothing, and Managing Feeling Out of Control

- After an episode in which you have been out of control, how do you respond? What are some of the positive ways you have used to restore control?
- When you feel bad, how do you take care of yourself? How do you help yourself feel better, more calm, less upset?



Steps in Recovery at Each Stage

- Recognize
- Understand
- Choose
- Practice
- Evaluate



Future Orientation

- Consolidating skills in new activities and relationships
- Setting realistic goals
- Planning steps to meet vocational, educational, and residential needs
- Realistic appraisal of future relationships
- Assessment of future services and sources of help

Sustaining Trauma Recovery

- Developing a Trauma Recovery Community of Staff and Consumers
 - ◆ Shared Understanding
 - ◆ Shared Values
 - ◆ Shared Skills
 - ◆ Shared Commitment



APPENDIX B.1: Trauma-informed Services Conference Brochure

You may be wondering, "Why is it important to address the occurrence of trauma with our affected consumers?" There is significant evidence implicating the experience of trauma with increased prevalence of mental health and substance use disorders, with negative treatment outcomes, as well as with other negative outcomes in many life domains.



*Social Work CEUs pending;
CEU certificate available
upon completion of
conference evaluation.*

For more information please contact:

Anne Rogers: (734) 368-8690

Angie Zander: (734) 544-6712

PLEASE pre-register as space is limited.
Registration is due by **Wednesday,
March 4th, 2009.**

To register for this conference on-line,
follow this link:

[http://www.zoomerang.com/Survey/
survey-intro.zgi?p=WEB228SJE9X42S](http://www.zoomerang.com/Survey/survey-intro.zgi?p=WEB228SJE9X42S)

Thanks to grant funding provided by
the Michigan Department of
Community Health (MDCH),
your participation in this conference is
free of charge.



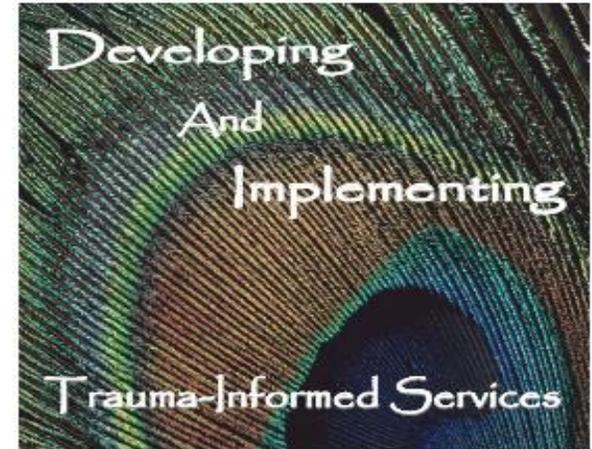
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March 19 or 20, 2009
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In Partnership with Community
Connections of Washington, D.C.
and
Washtenaw County Community
Support and Treatment Services
(CSTS)



Supported by a MDCH Block Grant
Fiscal Year 2008-2009

APPENDIX B.1: Trauma-informed Services Conference Brochure

AS A RESULT OF THIS TRAINING, PARTICIPANTS WILL BE ABLE TO:

1. Specify the **Core Principles** of a trauma-informed approach to care.
2. **Describe** specific ways in which trauma-informed services have been implemented in mental health and substance abuse programs.
3. Describe the elements of **Self-Care and Agency Support** for staff providing trauma-informed services.
4. **Assess** the extent to which current service approaches in their agency or program are trauma-informed.
5. Plan and prioritize trauma-informed **Change Efforts**—at both the systems and services level—in their agency or program.
6. **Evaluate** the progress of their agency or program in meeting the goals of trauma-informed change.



AGENDA

8:30 - 9:00 am	Registration and Continental Breakfast
9:00 - 10:15 am	Creating a Culture of Trauma-Informed Care
10:15 - 10:30 am	Break
10:30 am - Noon	How Do We Get There? <i>(Facilitated Break-Out Groups*)</i>
Noon - 1:00 pm	Lunch
1:00 - 2:15 pm	Self-Care, and Agency Support for Staff
2:15 - 2:30 pm	Break
2:30 - 4:00 pm	Trauma-Informed Skill Development <i>(Facilitated Break-Out Groups*)</i>
4:00 - 5:00 pm	Break-Out Group Findings and Next Steps

[*Break-Out Groups Facilitated by Trauma-Experienced CSTS Clinicians]

YOUR PRESENTERS



Roger D. Fallot, PhD

Roger D. Fallot, Ph.D. is a clinical psychologist and Director of Research and Evaluation at Community Connections, a private, not-for-profit agency providing a full range of human services in the District of Columbia. A graduate of Yale University (B.A., M.S., and Ph.D.), his professional areas of specialization include the development and evaluation of services for trauma survivors and the role of spirituality in recovery. Dr. Fallot, in collaboration with others, has also developed a men's version of the Trauma Recovery and Empowerment Model (M-TREM).

Lori L. Beyer, MSW

Lori Beyer, LICSW, MSWAC is a supervisory trauma clinician and lead trainer at Community Connections, a private, not-for-profit agency providing a full range of human services in metropolitan Washington, D.C. Ms. Beyer specializes in providing workshops, trainings, and ongoing supervision and consultation to agencies and clinicians nationally on issues related to trauma-specific and trauma-sensitive service provision. Ms. Beyer has over 15 years of experience working with adults who are dually diagnosed with a serious mental illness and substance abuse disorder, who have histories of homelessness and violent victimization. She was an original member of the Community Connections Trauma Work Group which developed the Trauma Recovery and Empowerment Model (TREM).

APPENDIX B.2: Trauma-informed Program Self-Assessment Scale (Version 1.4, 5-06)**DOMAIN 1: PROGRAM PROCEDURES AND SETTINGS***“To what extent are program activities and settings consistent with these five guiding principles of trauma-informed practice?”***DOMAIN 1-A: SAFETY – ensuring physical and emotional safety***“To what extent do the program’s activities and settings ensure the physical and emotional safety of consumers and staff?”*

Criterion	1	2	3	4	5
1. Program Review: The program has conducted a specific and systematic review of its physical setting and its activities in order to evaluate its physical and emotional safety and to make changes necessary to ensure consumer and staff safety.	No specific systematic review has been conducted.	A systematic program-wide review has been conducted, including both consumer-survivor and line staff input.	In addition to (2), an action plan to maximize safety has been developed.	In addition to (3), the action plan has been partially implemented.	In addition to (4), all steps of the action plan have been implemented.
2. Incident Review: The program systematically reviews those incidents that indicate a lack of safety (e.g., verbal and physical confrontations, assaults) and makes changes to prevent their recurrence.	No incident reviews have occurred.	A plan has been developed for identifying and reporting incidents that indicate a lack of safety (incl. both consumer and staff reports).	In addition to (2), a plan has been developed for clinical and administrative review of incidents that indicate a lack of safety.	In addition to (3), the plan has been implemented.	In addition to (4), the incident reviews are used to modify potentially unsafe practices or settings.
3. Consumer Ratings of Safety: In program satisfaction surveys, consumers rate program safety at the “agree” (or comparable, better than neutral) point on the rating scale or higher	No consumers rate program safety at the “agree” or higher point.	Fewer than 40% of consumers rate program safety at the “agree” or higher point.	40-70% of consumers rate program safety at the “agree” or higher point.	71-90% of consumers rate program safety at the “agree” or higher point.	More than 90% of consumers rate program safety at the “agree” or higher point.
4. Staff Ratings of Safety: In staff surveys, staff rate program safety at the “agree” or comparable point on the rating scale or higher.	No staff members rate program safety at the “agree” or higher point.	Fewer than 40% of staff members rate program safety at the “agree” or higher point.	40-70% of staff members rate program safety at the “agree” or higher point.	71-90% of staff members rate program safety at the “agree” or higher point.	More than 90% of staff members rate program safety at the “agree” or higher point.

DOMAIN 1-B: TRUSTWORTHINESS – maximizing trustworthiness through task clarity, consistency, and interpersonal boundaries

“To what extent do the program’s activities and settings maximize trustworthiness by making the tasks involved in service delivery clear, by ensuring consistency in practice, and by maintaining boundaries that are appropriate to the program?”

Criterion	1	2	3	4	5
<p>1. Program Review: The program has conducted a specific and systematic review of its physical setting and activities in order to evaluate factors related to program trustworthiness (esp. clear tasks, consistent practices, and staff-consumer boundaries) and to make changes necessary to ensure that trustworthiness is maximized. (Peer-run programs usually have different boundary concerns than those with professional staffs; they need to adjust the understanding of trustworthiness accordingly. See Self-Assessment and Planning Protocol.)</p>	No specific, systematic review has been conducted.	A systematic program-wide review has been conducted, including consumer-survivor input.	In addition to (2) an action plan to maximize program trustworthiness has been developed.	In addition to (3), the action plan has been partially implemented.	In addition to (4), all steps of the action plan have been implemented
<p>2. Informed Consent: The program reviews its services with each prospective consumer, based on clear statements of the goals, risks, and benefits of program participation, and obtains informed consent from each consumer.</p>	No consumers have provided informed consent for service participation	Fewer than 30% of consumers have provided informed consent.	30-60% of consumers have provided informed consent.	61-90% of consumers have provided informed consent.	More than 90% of consumers have provided informed consent.
<p>3. Review of Alleged Boundary Violation: The program has a clear procedure for the review of any allegations of boundary violations, including sexual harassment and inappropriate social contacts.</p>	No policy exists regarding review of alleged boundary violations.	A plan has been developed for identifying and reporting incidents than indicate possible boundary violations.	In addition to (2), a plan has been developed for clinical and administrative review of alleged boundary violations.	In addition to (3), the plan has been implemented.	In addition to (4), the incident reviews are used to modify practices that may lead to boundary violations.
<p>4. Consumer Ratings of Trust and Clarity of Tasks and Boundaries: Consumers rate the program and its staff as trustworthy – offering clear information and maintaining appropriate professional relationships – at the “agree” (or comparable, better than neutral) point on the rating scale or higher.</p>	No consumers rate program trustworthiness at the “agree” or higher point.	Fewer than 40% of consumers rate program trustworthiness at the “agree” or higher point.	40-70% of consumers rate program trustworthiness at the “agree” or higher point.	71-90% of consumers rate program trustworthiness at the “agree” or higher point.	More than 90% of consumers rate program trustworthiness at the “agree” or higher point.

DOMAIN 1-C: **CHOICE** – maximizing consumer choice and control

“To what extent do the program’s activities and settings maximize consumer experiences of choice and control?”

Criterion	1	2	3	4	5
1. Program Review: The program has conducted a specific and systematic review of its physical setting and its activities in order to evaluate consumer choice and control and to make changes necessary to maximize consumer choice.	No specific systematic review has been conducted.	A systematic program-wide review has been conducted, including consumer-survivor input.	In addition to (2), an action plan to maximize consumer choice has been developed.	In addition to (3), the action plan has been partially implemented.	In addition to (4), all steps of the action plan have been implemented.
2. Program Options: Staff review the program’s service options (e.g., types of services offered, locations, housing possibilities, choices regarding clinicians) with each consumer prior to the development of an initial service plan.	Service options have been reviewed with consumers.	Fewer than 30% of consumers have reviewed the program’s service options with staff.	30-60% of consumers have reviewed the program’s service options with staff.	61-90% of consumers have reviewed the program’s service options with staff.	More than 90% of consumers have reviewed the program’s service options with staff.
3. Consumer Ratings of Choice and Control: In program satisfaction surveys, consumers rate their experience of choice and control in the program at the “agree” (or comparable, better than neutral) point on the rating scale or higher.	No consumers rate consumer choice at the “agree” or higher point.	Fewer than 40% of consumers rate consumer choice at the “agree” or higher point.	40-70% of consumers rate consumer choice at the “agree” or higher point.	71-90% of consumers rate consumer choice at the “agree” or higher point.	More than 90% of consumers rate consumer choice at the “agree” or higher point.

DOMAIN 1-D: COLLABORATION – maximizing collaboration and sharing power

“To what extent do the program’s activities and settings maximize collaboration and sharing of power between staff and consumers?”

Criterion	1	2	3	4	5
1. Program Review: The program has conducted a specific and systematic review of its activities in order to assess the quality of collaboration in staff-consumer relationships and to identify opportunities for enhancing this collaboration.	No specific, systematic review has been conducted.	A systematic program-wide review has been conducted, including consumer-survivor input.	In addition to (2), an action plan to maximize consumer-staff collaboration has been developed.	In addition to (3), the action plan has been partially implemented.	In addition to (4), all steps of the action plan have been implemented.
2. Consumer Ratings of Collaboration: Consumers rate the program and its staff as collaborative – sharing power and respecting consumer perspectives – at the “agree” (or comparable, better than neutral) point on the rating scale or higher.	No consumers rate program collaboration at the “agree” or higher point.	Fewer than 40% of consumers rate program collaboration at the “agree” or higher point.	40-70% of consumers rate program collaboration at the “agree” or higher point.	71-90% of consumers rate program collaboration at the “agree” or higher point.	More than 90% of consumers rate program collaboration at the “agree” or higher point.

DOMAIN 1-E: EMPOWERMENT – prioritizing empowerment and skill-building

“To what extent do the program’s activities and settings prioritize consumer empowerment and growth?”

Criterion	1	2	3	4	5
1. Program Review: The program has conducted a specific and systematic review of its activities in order to assess the extent to which the program facilitates consumer empowerment and skill-building and to identify opportunities for enhancing this priority.	No specific, systematic review has been conducted.	A systematic program-wide review has been conducted, including consumer-survivor input.	In addition to (2), an action plan to maximize consumer empowerment and skill-building has been developed.	In addition to (3), the action plan has been partially implemented.	In addition to (4), all steps of the action plan have been implemented.
2. Identifying Consumer Strengths: The program identifies each consumer’s strengths and resources as part of routine assessment.	No consumer’s assessment has identified strengths and weaknesses.	Fewer than 30% of consumers’ assessments have identified strengths and weaknesses.	30-60% of consumers’ assessments have identified strengths and weaknesses.	61-90% of consumers’ assessments have identified strengths and weaknesses.	More than 90% of consumers’ assessments have identified strengths and weaknesses.

<p>3. Consumer Ratings of Empowerment: Consumers rate the program and its staff as facilitating empowerment and skill-building at the “agree” (or comparable, better than neutral) point on the rating scale or higher.</p>	<p>No consumers rate consumer empowerment and skill-building at the “agree” or higher point.</p>	<p>Fewer than 40% of consumers rate consumer empowerment and skill-building at the “agree” or higher point.</p>	<p>40-70% of consumers rate consumer empowerment and skill-building at the “agree” or higher point.</p>	<p>71-90% of consumers rate consumer empowerment and skill-building at the “agree” or higher point.</p>	<p>More than 90% of consumers rate consumer empowerment and skill-building at the “agree” or higher point.</p>
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DOMAIN 2: FORMAL SERVICE POLICIES

“To what extent do the formal policies and procedures of the program reflect an understanding of trauma and recovery?”

Criterion	1	2	3	4	5
<p>1. Eliminating Involuntary Treatment: The program has developed written policies that seek to eliminate involuntary or coercive practices (seclusion and restraint, involuntary hospitalization or medication, outpatient commitment).</p>	<p>No relevant policies have been developed.</p>	<p>Policies designed to eliminate involuntary treatment have been developed.</p>	<p>In addition to (2), policies are consistently implemented.</p>	<p>In addition to (3), instances of involuntary treatment are regularly reviewed in order to improve practice.</p>	<p>In addition to (4), survivor-consumers are routinely involved in this review of both policy and practice.</p>
<p>2. Consumer Crisis Preferences (A): The program has a written policy and formal procedure for inquiring about and respecting consumer preferences for responding in crisis situations.</p>	<p>No policy or procedure has been developed.</p>	<p>A relevant policy, specifying a procedure (e.g., a standard form) for inquiring about consumer crisis preferences, has been developed</p>	<p>In addition to (2), this procedure includes steps to ensure the staff’s awareness of and attention to these preferences.</p>	<p>In addition to (3), instances of crisis response are regularly reviewed in order to ensure consideration of consumer preferences.</p>	<p>In addition to (4), crisis response procedures are adjusted as necessary to maximize attention to consumer preferences.</p>
<p>3. Consumer Crisis Preferences (B): Each consumer has been asked about crisis preferences and their responses are available to all appropriate direct service staff.</p>	<p>No consumer is asked about crisis preferences.</p>	<p>Fewer than 30% of consumers are asked OR their preferences are not known by all relevant staff.</p>	<p>30-60% of consumers are asked OR 30-60% of consumer preferences are not known by all</p>	<p>61-90% of consumers are asked OR 61-90% of consumer preferences are not known by all</p>	<p>More than 90% of consumers are asked AND more than 90% of consumer preferences are not known by all</p>

			relevant staff.	relevant staff.	relevant staff.
4. De-escalation Policy: The program has a written de-escalation policy that minimizes possibility of retraumatization; the policy includes reference to a consumer’s statement of preference for crisis response.	No written de-escalation policy exists.	The program has a written de-escalation policy that minimizes retraumatization and includes consumer crisis preferences.	In addition to (2), this policy is regularly implemented.	In addition to (3), de-escalation situations are regularly reviewed in order to ensure attention to consumer preferences.	In addition to (4), the de-escalation policy is adjusted as necessary to maximize attention to consumer preferences.
5. Confidentiality (A): Policies regarding confidentiality (including limits) and access to information are clearly written and maximize legal protection of consumer privacy.	No written confidentiality policy exists OR it is written in a way difficult for consumers to understand.	A written confidentiality policy exists and is clearly written.	In addition to (2), the policy maximizes the legal protection of consumer privacy.	In addition to (3), instances that reflect limits of confidentiality are routinely reviewed.	In addition to (4), confidentiality policy is adjusted to maximize clarity and consumers’ privacy within legal limits.
6. Confidentiality (B): Program confidentiality policies, including limits of confidentiality, are communicated to each consumer.	No consumer has been given information about confidentiality and its limits.	Fewer than 30% of consumers have been given information about confidentiality and its limits.	30-60% of consumers have been given information about confidentiality and its limits.	61-90% of consumers have been given information about confidentiality and its limits.	More than 90% of consumers have been given information about confidentiality and its limits.
7. Consumer Rights and Responsibilities (A): The program has a clearly written and easily accessible policy outlining consumer rights and responsibilities.	No written consumer rights and responsibilities policy exists OR it is written in a way difficult for consumers to understand.	A written statement of consumer rights and responsibilities exists and is clearly written.	In addition to (2), the statement is readily available for consumers.	In addition to (3), the statement is reviewed for possible revision on at least an annual basis.	In addition to (4), consumer-survivors are involved in the writing of the statement.
8. Consumer Rights and Responsibilities (B): The program’s policy regarding consumer rights and responsibilities has been communicated to each one.	No consumer has been given the statement of rights and responsibilities.	Fewer than 30% of consumers have been given the statement.	30-60% of consumers have been given the statement.	61-90% of consumers have been given the statement.	More than 90% of consumers have been given the statement.

DOMAIN 3: TRAUMA SCREENING, ASSESSMENT, AND SERVICE PLANNING

“To what extent does the program have a consistent way to identify individuals who have been exposed to trauma, and to include trauma-related information in planning services with the consumer?”

Criterion	1	2	3	4	5
<p>1. Universal Trauma Screening: Within the first month of service participation, every consumer has been asked about exposure to trauma.</p>	No consumer has been asked about trauma exposure.	Fewer than 30% of consumers have been asked, within the first month of service participation, about trauma exposure.	30-60% of consumers have been asked about trauma exposure.	61-90% of consumers have been asked about trauma exposure.	More than 90% of consumers have been asked about trauma exposure.
<p>2. Trauma Screening Content: The trauma screening includes questions about lifetime exposure to sexual and physical abuse.</p>	No standardized trauma screening approach exists.	A standardized screening for trauma has been approved but not implemented.	A standardized screening approach has been implemented but does not include questions about sexual or physical abuse.	The screening includes questions about EITHER sexual OR physical abuse OR about abuse in general OR about a specific time period.	The standardized screening includes questions about lifetime exposure to both physical and sexual abuse.
<p>3. Trauma Screening Process: The trauma screening is implemented in ways that minimize consumer stress; it reflects considerations given to timing, setting, relationship to interviewer, consumer choice about answering, and unnecessary repetition.</p>	No discussion of the screening process has occurred.	A plan for minimizing stress in screening has been developed.	A screening plan that includes flexible responses to consumers has been implemented.	The screening process is routinely reviewed to ensure that it minimizes consumer and staff distress.	Consumers and staff report satisfaction with the screening process.
<p>4. Trauma Assessment: Unless specifically contraindicated due to consumer distress, the program conducts a more extensive assessment of</p>	The program has conducted no trauma assessments.	A plan for conducting trauma assessments has been developed.	An assessment plan that includes both trauma history and service needs and preferences has been implemented.	The assessment process is routinely reviewed to ensure that it minimizes consumer and staff distress.	Consumers and staff report satisfaction with the assessment process.

trauma history and needs and preferences for trauma-specific services for those consumers who report trauma exposure.					
5. Trauma and Service Planning: The program ensures that those individuals who report the need and/or desire for trauma-specific services are referred for appropriately matched services.	No referrals for trauma-specific services are made.	A plan for referrals, including the accessibility of trauma-specific services, has been developed.	In addition to (2), fewer than 30% of those needing or requesting trauma-specific services are referred for accessible services.	In addition to (2), 30-80% of those needing or requesting trauma-specific services are referred for accessible services.	In addition to (2), more than 80% of those needing or requesting trauma-specific services are referred for accessible services.
6. Trauma-Specific Services: The program offers, or has identified other programs that offer, trauma-specific services with four “criterion” characteristics: effective, accessible, affordable and responsive to the preferences of the program’s consumers.	No trauma-specific services are offered or identified.	Offered or identified trauma-specific services have one of the four criterion characteristics.	Offered or identified trauma-specific services have two of the four criterion characteristics.	Offered or identified trauma-specific services have three of the four criterion characteristics.	Offered or identified trauma-specific services have all four of the four criterion characteristics.

DOMAIN 4: ADMINISTRATIVE SUPPORT FOR PROGRAM-WIDE TRAUMA-INFORMED SERVICES

“To what extent do agency administrators support the integration of knowledge about trauma and recovery into all program practices?”

Criterion	1	2	3	4	5
1. Written Policy Statement: The program has adopted a formal policy statement that refers to the importance of	No senior level discussion has occurred.	Senior level administrators have participated in discussion of	In addition to (2), administrators have reviewed draft statement.	In addition to (3), administrators have approved adoption of statement.	In addition to (4), statement is prominently displayed in program

trauma and the need to account for consumer experiences of trauma in all aspects of program operation.		statement.			description.
2. Support for Trauma-Informed Leadership: The program has named a trauma specialist or workgroup(s) to lead agency activities in trauma-related areas and provides needed support for trauma initiatives.	No trauma specialist or workgroup has been identified.	Specialist or workgroup has been identified and given a clear mission.	In addition to (2), resources (staff, time, budget) have been allocated.	In addition to (3), action plan has been adopted and initial steps taken.	In addition to (4), initial action plan has been substantially completed.
3. Administrative Participation in and Oversight of Trauma-Informed Approaches: Program administrators monitor and participate actively in responding to the recommendations and activities of the trauma leadership.	No reporting or monitoring of trauma-related activities occurs.	Administrators are informed of trauma specialist or workgroup activities.	In addition to (2), administrators meet periodically with trauma specialist or workgroup.	In addition to (3), administrators routinely monitor implementation of trauma activities.	In addition to (4), administrators include trauma initiatives in formal reports and publications.
4. Trauma Survivor-Consumer Involvement (A): Administrators work with a Consumer Advisory Board (CAB) that includes consumers who have had lived experiences of trauma.	No Consumer Advisory Board exists.	Consumer Advisory Board exists but has no self-identified trauma survivor-consumers.	Consumer Advisory Board has one member who self-identifies as a survivor-consumer.	Consumer Advisory Board has at least two members who self-identify as survivor-consumers.	In addition to (4), administrators ensure that trauma initiatives are addressed in meetings with the CAB.
5. Trauma Survivor-Consumer Involvement (B): Consumers who have lived experiences of trauma are actively involved in all aspects of program planning and oversight.	No survivor-consumers are involved in program or agency planning.	Survivor-consumer workgroup has been formed.	In addition to (2), this workgroup makes recommendations to administrators regarding trauma initiatives.	In addition to (3), survivor-consumers are represented on major agency standing committees.	In addition to (4), survivor-consumers have paid positions in the agency; positions draw explicitly on lived experience.

<p>6. Needs Assessment and Program Evaluation: Program gathers data addressing the needs and strengths of consumers who are trauma survivors and evaluates the effectiveness of the program and trauma-specific services.</p>	<p>No data are gathered.</p>	<p>The program has gathered data regarding the prevalence of trauma and needs of survivors.</p>	<p>In addition to (2), the program has developed a plan to monitor the process (including consumer satisfaction) and outcomes of trauma services.</p>	<p>In addition to (3), the program regularly monitors process and outcomes.</p>	<p>In addition to (4), the program incorporates program evaluation results in its planning for trauma-related services.</p>
<p>7. Trauma and Consumer Satisfaction: Administrators include at least five key principles of trauma-informed services in consumer satisfaction surveys: safety, trustworthiness, choice, collaboration, and empowerment (see Domain 1)</p>	<p>None of the five areas is included in surveys (or surveys are not standardized).</p>	<p>One of the five areas is included in surveys.</p>	<p>Two or three of the five areas are included in surveys.</p>	<p>Four of the five areas are included in surveys</p>	<p>All five of the areas are included in surveys.</p>

DOMAIN 5: STAFF TRAUMA TRAINING AND EDUCATION

“To what extent have all staff members received appropriate training in trauma and its implications for their work?”

Criterion	1	2	3	4	5
<p>1. General Trauma Education for All Staff (A): All staff (including administrative and support personnel) have participated in at least three hours of “basic” trauma education that addresses at least the following: (a) trauma prevalence, impact and recovery; (b) ensuring safety and avoiding retraumatization; (c) maximizing trustworthiness (clear tasks and boundaries); (d) enhancing consumer choice; (e) maximizing collaboration; and (f) emphasizing empowerment.</p>	<p>No trauma education designed for all staff has been offered.</p>	<p>Fewer than 30% of staff have participated in basic trauma education OR more than 50% of staff have received trauma education that includes only one of the content areas.</p>	<p>30-60% of staff have participated in basic trauma education OR more than 50% of staff have received trauma education that includes two or three of the content areas.</p>	<p>61-90% of staff have participated in basic trauma education OR more than 50% of staff have received trauma education that includes four or five of the content areas.</p>	<p>More than 90% of staff have participated in basic trauma education that includes all six content areas.</p>

2. General Trauma Education for All Staff (B): All new staff receive at least one hour of trauma education as part of orientation.	No new staff have received trauma education in orientation.	Fewer than 30% of staff have received trauma education in orientation.	30-60% of staff have received trauma education in orientation.	61-90% of staff have received trauma education in orientation.	More than 90% of staff have received trauma education in orientation.
3. Education for Direct Services Staff (A): Direct service staff have received at least three hours of education involving trauma-informed modifications in their content areas (e.g., care coordination, housing, substance use).	No direct services staff have received this education.	Fewer than 30% of direct services staff have received this education.	30-60% of direct services staff have received this education.	61-90% of direct services staff have received this education.	More than 90% of direct services staff have received this education.
4. Education for Direct Services Staff (B): Direct services staff have received at least three hours of education involving trauma-specific techniques (e.g., grounding, teaching trauma-recovery skills).	No direct services staff have received this education.	Fewer than 30% of these staff have received this education.	30-60% of direct services staff have received this education.	61-90% of direct services staff have received this education.	More than 90% of staff have received this education.
5. Support for Direct Services Staff: Direct service staff offering trauma-specific services are provided adequate resources for self-care, including supervision, consultation, and/or peer support that addresses secondary traumatization.	No specific support for direct services staff is offered.	Administrators have developed a plan for offering support.	General support is offered but does not address secondary traumatization.	Trauma-focused support is offered and made accessible for staff.	Staff report that trauma-focused support is adequate to meet their needs.

DOMAIN 6: HUMAN RESOURCES PRACTICES

“To what extent are trauma-related concerns part of the hiring and performance review process?”

Criterion	1	2	3	4	5
1. Prospective Staff Interviews: Interviews include trauma-related questions. (What do applicants know about trauma,	Interviews do not address trauma.	Fewer than 30% of interviews address trauma.	30-60% of interviews address trauma.	61-90% of interviews address trauma.	More than 90% of interviews address trauma.

<p>including sexual and physical abuse? About its impact? About recovery and healing? Is there a “blaming the victim” bias? Is there potential to be a trauma “champion?”)</p>					
<p>2. Staff Performance Reviews: Staff performance reviews include trauma-informed skills and tasks, including the development of safe, trustworthy, collaborative, and empowering relationships with consumers that maximize consumer choice.</p>	<p>Performance reviews do not address trauma-informed skills.</p>	<p>Fewer than 30% of performance reviews address trauma-informed skills.</p>	<p>30-60% of performance reviews address trauma-informed skills.</p>	<p>61-90% of performance reviews address trauma-informed skills.</p>	<p>More than 90% of performance reviews address trauma-informed skills.</p>

**APPENDIX B.3: Developing and Implementing Trauma-informed Services:
Breakout Session # 1 – “How do we get there?”**

Organization: _____

1. How does my organization ensure ***physical and emotional safety*** for consumers and staff?

Ideas for improvement?

2. How does my organization maximize ***trustworthiness*** with consumers through task clarity, consistency and interpersonal boundaries?

Ideas for improvement?

3. How does my organization maximize appropriate ***consumer choice and control***?

Ideas for improvement?

4. How does my organization maximize **collaboration** and appropriate **sharing of power** with the consumers we serve?

Ideas for improvement?

5. How does my organization prioritize **empowerment and skill building** with the consumers we serve?

Ideas for improvement?

**APPENDIX B.4: Developing and Implementing Trauma-informed Services:
Breakout Session # 2 – “Trauma-informed Skill Development”**

Job position / role / scope of practice: _____

1. How do I ensure ***physical and emotional safety*** for consumers?

Ideas for improvement?

2. How do I maximize ***trustworthiness*** with consumers through task clarity, consistency and interpersonal boundaries?

Ideas for improvement?

3. How do I maximize appropriate ***consumer choice and control***?

Ideas for improvement?

4. How do I maximize **collaboration** and appropriate **sharing of power** with the consumers I serve?

Ideas for improvement?

5. How do I prioritize **empowerment and skill building** with the consumers I serve?

Ideas for improvement?

APPENDIX C.1: Compassion Satisfaction/Fatigue Self-Test for Helpers

**Compassion Satisfaction/Fatigue
Self-Test for Helpers**

Adapted with permission from Figley, C.R., (1995). *Compassion Fatigue*, New York: Brunner/Mazel.
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<http://www.dartmouth.edu/~bhstamm/index.htm>.

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*Helping others puts you in direct contact with other people’s lives. As you probably have experienced, your compassion for those you help has both positive and negative aspects. This self -test helps you estimate your compassion status, which includes your risk of burnout, compassion fatigue and satisfaction with helping others. Consider each of the following characteristics about you and your current situation. Print a copy of this test so that you can fill out the numbers and keep them for your use. Using a pen or pencil, write in the number that honestly reflects how frequently you experienced these characteristics **in the last work week**. Then follow the scoring directions at the end of the self-test.*

0 Never	1 Rarely	2 A Few Times	3 Somewhat Often	4 Often	5 Very Often
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Items About You

- _____ 1. I am happy.
- _____ 2. I find my life satisfying.
- _____ 3. I have beliefs that sustain me.
- _____ 4. I feel estranged from others.
- _____ 5. I find that I learn new things from those I care for.
- _____ 6. I force myself to avoid certain thoughts or feelings that remind me of a frightening experience.
- _____ 7. I find myself avoiding certain activities or situations because they remind me of a frightening experience.
- _____ 8. I have gaps in my memory about frightening events.
- _____ 9. I feel connected to others.
- _____ 10. I feel calm.
- _____ 11. I believe that I have a good balance between my work and my free time.
- _____ 12. I have difficulty falling or staying asleep.
- _____ 13. I have outburst of anger or irritability with little provocation
- _____ 14. I am the person I always wanted to be.
- _____ 15. I startle easily.
- _____ 16. While working with a victim, I thought about violence against the perpetrator.
- _____ 17. I am a sensitive person.
- _____ 18. I have flashbacks connected to those I help.
- _____ 19. I have good peer support when I need to work through a highly stressful experience.
- _____ 20. I have had first-hand experience with traumatic events in my adult life.
- _____ 21. I have had first-hand experience with traumatic events in my childhood.
- _____ 22. I think that I need to "work through" a traumatic experience in my life.

- _____ 23. I think that I need more close friends.
- _____ 24. I think that there is no one to talk with about highly stressful experiences.
- _____ 25. I have concluded that I work too hard for my own good.
- _____ 26. Working with those I help brings me a great deal of satisfaction.
- _____ 27. I feel invigorated after working with those I help.
- _____ 28. I am frightened of things a person I helped has said or done to me.
- _____ 29. I experience troubling dreams similar to those I help.
- _____ 30. I have happy thoughts about those I help and how I could help them.
- _____ 31. I have experienced intrusive thoughts of times with especially difficult people I helped.
- _____ 32. I have suddenly and involuntarily recalled a frightening experience while working with a person I helped.
- _____ 33. I am pre-occupied with more than one person I help.
- _____ 34. I am losing sleep over a person I help's traumatic experiences.
- _____ 35. I have joyful feelings about how I can help the victims I work with.
- _____ 36. I think that I might have been "infected" by the traumatic stress of those I help.
- _____ 37. I think that I might be positively "inoculated" by the traumatic stress of those I help.
- _____ 38. I remind myself to be less concerned about the well being of those I help.
- _____ 39. I have felt trapped by my work as a helper.
- _____ 40. I have a sense of hopelessness associated with working with those I help.
- _____ 41. I have felt "on edge" about various things and I attribute this to working with certain people I help.
- _____ 42. I wish that I could avoid working with some people I help.
- _____ 43. Some people I help are particularly enjoyable to work with.
- _____ 44. I have been in danger working with people I help.
- _____ 45. I feel that some people I help dislike me personally.

Items About Being a Helper and Your Helping Environment

- _____ 46. I like my work as a helper.
- _____ 47. I feel like I have the tools and resources that I need to do my work as a helper.
- _____ 48. I have felt weak, tired, run down as a result of my work as helper.
- _____ 49. I have felt depressed as a result of my work as a helper.
- _____ 50. I have thoughts that I am a "success" as a helper.
- _____ 51. I am unsuccessful at separating helping from personal life.
- _____ 52. I enjoy my co-workers.
- _____ 53. I depend on my co-workers to help me when I need it.
- _____ 54. My co-workers can depend on me for help when they need it.
- _____ 55. I trust my co-workers.
- _____ 56. I feel little compassion toward most of my co-workers
- _____ 57. I am pleased with how I am able to keep up with helping technology.
- _____ 58. I feel I am working more for the money/prestige than for personal fulfillment.
- _____ 59. Although I have to do paperwork that I don't like, I still have time to work with those I help.
- _____ 60. I find it difficult separating my personal life from my helper life.
- _____ 61. I am pleased with how I am able to keep up with helping techniques and protocols.
- _____ 62. I have a sense of worthlessness/disillusionment/resentment associated with my role as a helper.
- _____ 63. I have thoughts that I am a "failure" as a helper.
- _____ 64. I have thoughts that I am not succeeding at achieving my life goals.
- _____ 65. I have to deal with bureaucratic, unimportant tasks in my work as a helper.
- _____ 66. I plan to be a helper for a long time.

Scoring Instructions

Please note that research is ongoing on this scale and the following scores should be used as a guide, not confirmatory information. Cut points are theoretically derived and should be used with caution and only for educational purposes.

1. Be certain you respond to all items.
2. Mark the items for scoring:
 - a. Circle the following 23 items: 4, 6-8, 12, 13, 15, 16, 18, 20-22, 28, 29, 31-34, 36, 38-40, 44.
 - b. Put a check by the following 16 items: 17, 23-25, 41, 42, 45, 48, 49, 51, 56, 58, 60, 62-65.
 - c. Put an x by the following 26 items: 1-3, 5, 9-11, 14, 19, 26-27, 30, 35, 37, 43, 46-47, 50, 52-55, 57, 59, 61, 66.
3. Add the numbers you wrote next to the items for each set of items and note:
 - a. Your potential for Compassion Satisfaction (x): 118 and above=extremely high potential; 100-117=high potential; 82-99=good potential; 64-81=modest potential; below 63=low potential. **Your score** _____
 - b. Your risk for Burnout (check): 36 or less=extremely low risk; 37-50=moderate risk; 51-75=high risk; 76-85=extremely high risk. **Your score:** _____
 - c. Your risk for Compassion Fatigue (circle): 26 or less=extremely low risk, 27-30=low risk; 31-35=moderate risk; 36-40=high risk; 41 or more=extremely high risk. **Your score:** _____

APPENDIX C.2: Self-Care Assessment Worksheet***Self-Care Assessment Worksheet***

Source: *Transforming the Pain: A Workbook on Vicarious Traumatization*. Saakvitne, Pearlman & Staff of TSI/CAAP (Norton, 1996)

This assessment tool provides an overview of effective strategies to maintain self-care. After completing the full assessment, choose one item from each area that you will actively work to improve. Using the scale below, rate the following areas in terms of frequency:

5 = Frequently; **4** = Occasionally; **3** = Rarely; **2** = Never; **1** = It never occurred to me

Physical Self-Care

- Eat regularly (e.g. breakfast, lunch and dinner)
- Eat healthy
- Exercise
- Get regular medical care for prevention
- Get medical care when needed
- Take time off when needed
- Get massages
- Dance, swim, walk, run, play sports, sing, or do some other physical activity that is fun
- Take time to be sexual—with yourself, with a partner
- Get enough sleep
- Wear clothes you like
- Take vacations
- Take day trips or mini-vacations
- Make time away from telephones
- Other:

Psychological Self-Care

- Make time for self-reflection
- Have your own personal psychotherapy
- Write in a journal
- Read literature that is unrelated to work
- Do something at which you are not expert or in charge
- Decrease stress in your life
- Let others know different aspects of you
- Notice your inner experience—listen to your thoughts, judgments, beliefs, attitudes, and feelings
- Engage your intelligence in a new area, e.g. go to an art museum, history exhibit, sports event, auction, theater performance
- Practice receiving from others
- Be curious
- Say “no” to extra responsibilities sometimes
- Other:

Emotional Self-Care

- Spend time with others whose company you enjoy
- Stay in contact with important people in your life

- ___ Give yourself affirmations, praise yourself
- ___ Love yourself
- ___ Re-read favorite books, re-view favorite movies
- ___ Identify comforting activities, objects, people, relationships, places and seek them out
- ___ Allow yourself to cry
- ___ Find things that make you laugh
- ___ Express your outrage in social action, letters and donations, marches, protests
- ___ Play with children
- ___ Other:

Spiritual Self-Care

- ___ Make time for reflection
- ___ Spend time with nature
- ___ Find a spiritual connection or community
- ___ Be open to inspiration
- ___ Cherish your optimism and hope
- ___ Be aware of nonmaterial aspects of life
- ___ Try at times not to be in charge or the expert
- ___ Be open to not knowing
- ___ Identify what is meaningful to you and notice its place in your life
- ___ Meditate
- ___ Pray
- ___ Sing
- ___ Spend time with children
- ___ Have experiences of awe
- ___ Contribute to causes in which you believe
- ___ Read inspirational literature (talks, music, etc.)
- ___ Other:

Workplace or Professional Self-Care

- ___ Take a break during the workday (e.g. lunch)
- ___ Take time to chat with co-workers
- ___ Make quiet time to complete tasks
- ___ Identify projects or tasks that are exciting and rewarding
- ___ Set limits with your clients and colleagues
- ___ Balance your caseload so that no one day or part of a day is “too much”
- ___ Arrange your work space so it is comfortable and comforting
- ___ Get regular supervision or consultation
- ___ Negotiate for your needs (benefits, pay raise)
- ___ Have a peer support group
- ___ Develop a non-trauma area of professional interest
- ___ Other:

Balance

- ___ Strive for balance within your work-life and workday
- ___ Strive for balance among work, family, relationships, play and rest

APPENDIX D.1:

“Beyond Trauma” Inservice Flier

Introduction to Stephanie Covington’s
“Beyond Trauma” program
Friday, January 30th, 2009

Presenters: Steve Wiland LMSW/CAC-R, Flo Hepola
LMSW/CAAC, and Linda Bacigalupi, M.S./L.L.P.

- I. 9:00-9:30 *Introduction/overview of the “Trauma-Informed and Trauma-Specific Services” Grant Project*
 - A. Why did we apply for the grant?
 - B. What does the grant entail?
 - C. What does the grant mean for CSTS consumers and staff?

- II. 9:30-10:15 *Introduction/overview of the Covington model*
 - A. 11 modules (hand-out)
 - B. The impact of trauma (hand-out)
 - C. Signs and symptoms of trauma (hand-out)

10:15-10:30 ****Break****

- III. 10:30-10:45 *Facilitator Training Video Excerpts and Discussion*

- IV. 10:45-11:30 *Client Video and Discussion*

- V. 11:30-12:00 *Q & A*

- VI. 12:00-1:00 *Follow-up Discussion over Lunch (provided)*

APPENDIX D.2: “Beyond Trauma” Video Content and Program Modules

Facilitator Training Video Contents

1. Background Information [30 min]
2. Program Introduction [5 min]
3. **Session Outlines (Modules) [1 min]**
 - a. *Connection between Violence, Abuse & Trauma [5 min]*
 - b. *Power and Abuse [12 min]*
 - c. *Reactions to Trauma [9 min]*
 - d. *How Trauma Impacts our Lives [6 min]*
 - e. *The Addiction-Trauma Connection [4 min]*
 - f. *Grounding and Self-Soothing [8 min]*
 - g. *Abuse and the Family [20 min]*
 - h. *Mind / Body Connection [8 min]*
 - i. *The World of Feelings [6 min]*
 - j. *Healthy Relationships (Wheel of Love) [3 min]*
 - k. *Endings and Beginnings [11 min]*

Client Video Contents

1. Session 1: Introduction – What is Trauma? Group Comments [12 min]
2. Session 2: Reading “Fantasy”; Debriefing [11 min]
3. Session 3: Trauma and the Brain; Group Comments [3 min]
4. Session 5: Spirals; Group Comments [5 min]
5. Session 7: Family Sculpture [13 min]
6. Session 10: Conclusion [2 min]

APPENDIX D.3:

“Seeking Safety” Inservice Flier

Introduction to “Seeking Safety,” Lisa Najavits’ Trauma Treatment Model

Friday, February 27th, 2009

Facilitators: Steve Wiland LMSW/CAC-R,
Wendy Svatora LMSW/CAC-M

I. 2:00-2:35 - *Background context of trauma and PTSD (Najavits video)*

II. 2:35-3:20 - *“Seeking Safety” as a treatment model (Najavits video)*

III. 3:20-3:35 - *Group Discussion (All)*

3:35-3:45 ** Break **

IV. 3:45-4:00 - *“Seeking Safety” group work at CSTS (Svatora, Wiland)*

V. 4:00-4:15 - *Overview of the “Trauma-Informed and Trauma-Specific Services” Grant Project (Wiland)*

VI. 4:15-4:45 - *“A Client’s Story” video and Group Discussion (All)*

APPENDIX D.4: CSTS Trauma Recovery and Seeking Safety – Session 1

WOMEN'S TRAUMA RECOVERY GROUP Session One

TRAUMA RECOVERY and SEEKING SAFETY

About the Seeking Safety Treatment

What is the Seeking Safety Treatment?

This treatment is designed as a healing journey to help women recover from trauma that has impacted their life. The basic philosophy of seeking safety is this: When a person is experiencing the effects of a trauma that they've gone through, whether in the past or the present, the most urgent need is the need for safety. Some people will develop Post-Traumatic Stress Disorder (PTSD) as a result of their trauma; you will learn more about PTSD.

Why is it called Seeking Safety?

The #1 goal of this group is to help you become safe. Safety includes the ability to:

- Manage trauma symptoms (such as flashbacks, nightmares, and negative feelings).
- Cope with the stressors of life when you're feeling powerless.
- Take good care of yourself (such as eating well and getting exercise).
- Finding safe people who can be supportive of you.
- Free yourself from domestic violence or other abusive relationships.
- Prevent self-destructive acts (such as cutting, suicidal impulses).
- Find ways to feel good about yourself and to enjoy life.

What does being safe mean to you?

Group Format

The group format will be the following:

- 1) A quotation for the group members to reflect on
- 2) Check-In Time – Giving your name, how you are feeling, what good coping skills you've done this week, opinion about the quotation – what you feel about it.
- 3) We will pass out the handout with session topic **and have a short break**
- 4) Discussion of the topic for that day. Examples of topics are: Normal Reactions from Trauma (Shame), Safety, Empowerment, Setting boundaries in relationships, Recovery thinking, Respecting yourself – Taking back your power, Strengths from adversity, Managing your feelings and behaviors.
- 5) Check-outs – What you learned from today's session.
 - We will begin promptly at 11AM and end promptly at 12PM.
 - Group Rules – What rules should we establish for all of us to follow each session?

Grounding Exercise

Handout and exercise

What is Trauma?

Trauma is defined as the physical or emotional reaction to an event in which a person experienced, witnessed, or was confronted with an event - or events - that was life-threatening or seriously jeopardized the physical, emotional or spiritual wellbeing of that person or someone close to them. The person's response involved intense fear, helplessness, and horror and may be re-experienced by the person. Trauma generally leaves you feeling powerless, helpless, paralyzed. It tends to be sudden and overwhelming; it "owns" you. Most times, you cannot think clearly during and after a severe trauma; at the same time, you are forced to focus your consciousness in an attempt to deal with it. Trauma is different for different people – one person may not be affected in the same way as another person experiencing the exact same type of trauma. We all react differently to trauma.

The handout explains the DSM-IV criteria for PTSD. Some common examples of trauma include: sexual, physical and emotional abuse, rape, incest, violent attacks (such as with a gun or other object), car accident, seeing another person violently injured, and so on.

Handout #2 is the common process of trauma when a person experiences a traumatic event. We will focus more on this in the next few sessions as a way to learn how a traumatic event can change us.

What causes PTSD to develop?

The simple answer, of course, is trauma. But it's more complicated than that. During a traumatic experience, you adapt and choose new approaches that are survival-oriented for the situation you're in. The problem comes after the trauma, when those approaches and response are no longer functional. Recovery involves recognizing what responses are and aren't functional, and getting rid of the ones that hurt you. In effect, trauma reprograms your reactions very quickly; recovery is a kind of process of deprogramming.

Will I get a chance to talk about my trauma?

Yes, but the aim will be to talk about the impact of your trauma on your current life. Sometimes people want to talk a lot about the past, but then are unable to manage overwhelming feelings and memories that come up. Our goal is to help you establish safety first and to learn strategies to cope with intense negative feelings. Once you have mastered these, you can – and should – move on to talking about the past. These guidelines are particularly true if you are in a group treatment such as this group, because the details of past traumas can be too upsetting to other group members.

What if I miss a session?

Our hope is that you will attend each session, but if you need to miss a session, you can call to have the session material mailed to you. Our goal is that you get the most from this treatment!

Handouts – How To Get The Most Out Of This Treatment / Who Developed This Treatment and What Research Has Shown So Far / Statistics

Question – What do you hope to get out of this group?

Closing – Comments, Questions.

Sessions meet every Thursday from 11AM until 12PM at CSTS.

APPENDIX D.5:

“TREM/M-TREM” Inservice Flier

Introduction to “Trauma, Recovery and Empowerment Model” (TREM)

Friday, July 24th, 2009

Facilitators: Steve Wiland, LMSW/CAC-R,
Mike Ferriter, LMSW, CAAC

11:00-11:10 am - *Background and Status of Trauma Grant Project*

11:10 - Noon - *Overview of the TREM Model’s 33 Modules*

1. Empowerment (1-11)
2. Trauma Recovery (12-21)
3. Advanced Trauma Recovery Issues (22-30)
4. Closing Rituals (31-33)

----Lunch provided----

12:00 - 1:00 pm - *Working with SMI populations*

General Principals
Specific Issues
Issues of Diagnosis

1:00-1:30 pm - *Working with Male Survivors: M-TREM’s 24 Modules*

1. Male Messages, Emotions, and Relationships (1-11)
2. Trauma Recovery (12-18)
3. Recovery Skills (19-24)

1:30-2:00 pm - *Group Discussion and Next Steps*

APPENDIX D.6: Session Modules for TREM and M-TREMT.R.E.M.**PART I: EMPOWERMENT**

1. Introductory Session
2. What It Means to Be a Woman
3. What Do You Know and How Do You Feel About Your Body?
4. Physical Boundaries
5. Emotional Boundaries: Setting Limits and Asking for What You Want
6. Self-Esteem
7. Developing Ways to Feel Better: Self-Soothing
8. Intimacy and Trust
9. Female Sexuality
10. Sex with a Partner
11. Transition Session from Empowerment to Trauma Recovery

PART II: TRAUMA RECOVERY

12. Gaining an Understanding of Trauma
13. The Body Remembers What the Mind Forgets
14. What Is Physical Abuse?
15. What Is Sexual Abuse?
16. Physical Safety
17. What Is Emotional Abuse?
18. Institutional Abuse
19. Abuse and Psychological or Emotional Symptoms
20. Trauma and Addictive or Compulsive Behavior
21. Abuse and Relationships

PART III: ADVANCED TRAUMA RECOVERY ISSUES

22. Family – Myths and Distortions
23. Family Life: Current
24. Decision Making: Trusting Your Judgment
25. Communication: Making Yourself Understood
26. Self-Destructive Behaviors
27. Blame, Acceptance, and Forgiveness
28. Feeling Out of Control
29. Relationships
30. Personal Healing

PART IV: CLOSING RITUALS

31. Truths and Myths About Abuse
32. What It Means to Be a Woman
33. Closing Ritual

M.-T.R.E.M.

PART I: MALE MESSAGES, EMOTIONS, AND RELATIONSHIPS

1. Introduction
2. Male Messages
3. Trust
4. Anger and Behavior
5. Anger and Thinking
6. Fear
7. Hurt and Loss
8. Hope
9. Shame
10. Sex
11. Intimacy

PART II: TRAUMA RECOVERY

12. Gaining an Understanding of Trauma
13. What Is Emotional Abuse?
14. What Is Physical Abuse?
15. What Is Sexual Abuse?
16. Abuse and Psychological or Emotional Symptoms
17. Trauma and Addictive or Compulsive Behavior
18. Abuse and Relationships

PART III: RECOVERY SKILLS

19. Revenge, Acceptance and Forgiveness
20. Negotiating Family Relationships
21. Communication Skills
22. Positive Problem Solving: Overcoming Self-defeating Behaviors
23. Managing Feeling Out of Control / Self-soothing
24. Realistic Goals and Empowerment

THEORETICAL BASIS

Shame	Self-Esteem	Grandiosity
Vulnerability	Self-Protection	Invulnerability
Rigid Self-Control	Self-Direction	Impulsivity
Dependence	Mutuality	Independence
Under-Responsibility	Responsibility	Over-Responsibility

APPENDIX E.1: Trauma Group Centering Exercise

- Centering is a one-minute, twelve-breath exercise that transitions your mind from fretting about the past and future to being focused on the present – where your body must be. Centering in the present clears your mind of regrets about the past and worries about anticipated problems in the so-called future.
 - As you withdraw your thoughts from these imagined times and problems, you release yourself from regrets about the past and worry about the future. You experience a stress-free vacation in the present. Whenever you experience moments of the joyful abandon in play, the easy flow of creativity, or a state of concentration that leads to effortless optimal performance, you are practicing a form of centering. Use this exercise each time you start an activity. Within time, your body and mind will learn to naturally let go of tension and focus on working efficiently and optimally, fully in the here and now.
1. Begin by taking three slow breaths, in three parts – 1: inhale, 2: hold your breath and muscle tension, and 3: exhale slowly, relaxing your muscles, floating down into the chair. With each exhalation – let go of the last personal interaction or telephone call and float down into the chair. With your next exhalation, let the chair hold you and let go of any unnecessary muscle tension. Let go of all your thoughts and images about work from the past. Clear your mind and your body of all concerns about what “should have” or “should not have” happened in the past. Let go of old burdens. Let go of trying to fix your old problems. Take a vacation from trying to fix other people. Let each exhalation become a signal to just let go of the past.

Say to yourself as you exhale: “I release my mind and body from the past.”

2. With your next three breaths, let go of all images and thoughts about what you think may happen in the future – all of the “what ifs.” Which each exhalation, clear your muscles, your heart, and your mind of the work of trying to control the so-called future.

Say to yourself as you exhale: “I release my mind and body from the future.”

3. With the next three breaths, say: “I am choosing to be in this present moment, in front of this work.” I let go of trying to control any other time or striving to be any particular way. I notice how little effort it takes to simply breathe comfortably and accept just the right level of energy to focus on this moment and this task – in the only moment there is: now.

Say to yourself as you exhale: “I bring my mind into the present.”

4. For the next few minutes, there is nothing much for your conscious mind to worry about within this sanctuary. You are safe from the past and the future. Just allow the natural processes of your mind and body to provide you with focused concentration. Access your inner strength and creative resources.

Say to yourself as you exhale: “I am centered and ready for what comes next.”

5. With your next three breaths, count from one to three – 1: becoming more alert with each breath, 2: curious and interested to learn what comes next, and 3: eager to begin, curious and interested about how much will be accomplished with what comes next.

*Adapted from: © Neil Fiore, PhD, 1988 – 2002 Self Leadership Seminars™ –
Putting You in Charge of Your Time and Your Life. www.neilfiore.com*

APPENDIX E.2: Checklist for Trauma Treatment Practitioners

This checklist is geared toward those who work with survivors of sexual abuse in a helping capacity. Knowing oneself well is important before embarking upon the often-challenging venture of coming alongside a survivor in his/her healing process.

- Do I believe, at a core, gut level, that healing is possible for survivors of sexual abuse?
- Am I willing and able to witness great pain? Do I know how I will respond to intense grief and/or rage when it occurs?
- Am I willing and able to believe the “unbelievable”?
- Have I examined, or am I willing to examine, my own attitudes about sexual abuse, sexuality, feelings toward men, feelings toward women, stigma, taboos, good and evil, religion, and God?
- Have I explored, or am I willing to explore my own history and fears regarding sexual abuse?
- If I have not been sexually abused as a child, have I, or am I willing to explore those experiences in my history that come the closest (perhaps including emotional humiliation, physical abuse, family secrets, other childhood betrayals, adult experiences of rape or abuse)?
- Am I willing and able to let each survivor be the “best expert” regarding the pace and direction of their recovery? Am I willing and able to empower each survivor to actively function in this role?
- Am I willing and able to validate the needs of survivors (whether or not I am in a position to actually meet them)?
- Am I willing and able to deal with the gender-related issues that may be directed at me because of my gender?
- Am I willing and able to help survivors seek and develop appropriate support systems, and involvement in individual therapy and/or other groups?
- Am I willing and able to believe the survivor, to withhold skepticism, doubt, or judgment that what is being reported did not really occur?
- Am I willing and able to consistently convey the message that the survivor was and is not to blame for the abuse?

(adapted from Bass & Davis, 1988)