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# Enhancing Substance Abuse Recovery Through Integrated Trauma Treatment

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# INTRODUCTION

The relationship between interpersonal violence/trauma and substance use disorders is significant and complex. The prevalence of physical and sexual abuse among women in substance abuse treatment programs is estimated to range from 30 percent to more than 90 percent, depending on the definition of abuse and the specific target population (Moncrieff, Drummond, Candy, Checinski, & Farmer, 1996; Najavits, Weiss, & Shaw, 1997; Rice et al., 2001; Root, 1989). In addition, alcohol and drug problems have been shown to increase women's vulnerability to violence through exposure to unsafe situations (Parks & Miller, 1997).

Trauma means experiencing, witnessing, or being threatened with an event or events that involve actual serious injury, a threat to the physical integrity of one's self or others, or possible death. The responses to these events include intense fear, helplessness, or horror.

There is a critical need to address trauma as part of substance abuse treatment. Misidentified or misdiagnosed trauma-related symptoms interfere with help seeking, hamper engagement in treatment, lead to early dropout, and make relapse more likely (Brown, 2000; Brown, Huba, & Melchior, 1995; Janikowski & Glover, 1994). The prevalence of predisposing trauma conditions in women entering substance abuse treatment programs points to the need to screen and assess clients for the possibility of trauma-related disorders. The Substance Abuse and Mental Health Services Administration (SAMHSA) is developing a Treatment Improvement Protocol (TIP) titled "Substance Abuse Treatment and Trauma*"* (forthcoming) in which a number of trauma screening and assessment instruments will be presented.

Herman (1992b) identified three stages of trauma treatment: (1) establishment of safety, (2) remembrance and mourning, and (3) reconnection with everyday life. The first stage focuses on establishing physical and psychological safety and on helping the client feel understood and safe within the therapeutic environment. One common fear of providers is that trauma treatment means "opening up" trauma memories – telling the story of what happened and processing the past. For women with active substance use and women in early recovery, the focus of trauma work should be on stabilization, safety, and understanding the links between trauma and substance use and abuse, not on the telling of the traumatic story. In this way, the client is strengthened, supported, and helped to learn new coping strategies, before she moves on to later stages.

The SAMHSA-funded Women with Co-Occurring Disorders and Violence Study (WCDVS) was one of the first large-scale studies to investigate promising models for treating women with these complex problems. Four trauma-specific and integrated models of treatment for substance abuse clients with trauma histories, symptoms, or posttraumatic stress disorder (PTSD) were utilized in the study. Each of these models focused on the first stage of treatment: establishing safety and stabilization.

This paper describes the four models developed and tested in the WCDVS as well as another frequently used model that can be integrated within substance abuse treatment and provides guidance for providers in choosing a model for their agency. The nine sites participating in the WCDVS also adapted their models and group curricula for specific local circumstances, including cultural and linguistic adaptations. These adaptations will be discussed in a future monograph.

## *TRAUMA-INFORMED APPROACHES TO SUBSTANCE ABUSE SERVICES*

Addressing trauma in substance abuse treatment involves both "trauma-informed" and "trauma-specific" approaches. Trauma-informed systems and services take into account knowledge about trauma—its impact, interpersonal dynamics, and paths to recovery—and incorporate this knowledge thoroughly in all aspects of service delivery. The primary goals of trauma-specific services are more focused: to address *directly* the impact of trauma on people's lives and to facilitate trauma recovery and healing. Ideally, substance abuse treatment programs will create trauma-informed environments, provide services that are sensitive and responsive to the unique needs of trauma survivors,

and offer trauma-specific interventions. Several such trauma intervention models are described in the next section.

***Trauma-Informed Services***—Basic principles of trauma-informed services include the following (see Harris & Fallot, 2001, for a more complete discussion):

- See trauma as a defining and organizing experience that can shape a survivor's sense of self and others. Such programs understand that many problem behaviors originate as understandable attempts to cope with abusive experiences and that the effects of trauma may be seen in life domains not obviously related to experiences of violent victimization (for example, in substance abuse, eating disorders, or relationship difficulties).

- Create an open and collaborative relationship between providers and consumers and place priority on consumer safety, choice, and control. Programs designed with these goals in mind are welcoming to trauma survivors, minimize the possibility of revictimization, and support consumer empowerment and skill development

- Trauma-informed substance abuse treatment brings these principles to the addiction treatment setting. Trauma-informed substance abuse service settings do the following:

- Integrate understanding of trauma and substance abuse throughout the program. Providers recognize the multiple, complex interactions between alcohol and drug use and interpersonal violence; understand that drugs and/or alcohol are often a part of children's physical, sexual, and emotional abuse (either because the perpetrator is using substances or induces the child to ingest alcohol or drugs); are aware that survivors often use substances to manage the emotional distress that follows from trauma; and understand that substance abusers become more vulnerable to revictimization through risks associated with addiction-related behavior.

- Simultaneously address trauma and substance abuse. In contrast, parallel models offer two distinct sets of services—one for trauma and one for addiction—often in different settings with different providers, and sequential approaches argue that the substance abuse problems must be addressed before turning to trauma-related difficulties. Both parallel and sequential approaches underestimate the realities of the close and often mutually reinforcing relationships between trauma and substance use. Helping people in recovery understand the range of possible connections between trauma and substance abuse is a key process in integrated services.

- Ensure consumers' physical and emotional safety. This means creating an atmosphere that is hospitable, engaging, and supportive from the outset, avoiding practices that may be physically intrusive and potentially retraumatizing (e.g., urine sample monitoring and strip searches), and avoiding shame-inducing confrontations that may trigger trauma-related responses of avoidance, withdrawal, depression, or rage.

- Focus on empowerment by empowering clients to engage in collaborative decision making for themselves during all phases of treatment. This means that the consumers choose where, how, and when they will receive services, and they have a voice in deciding on the specific provider of the services.

- Recognize that ancillary services are necessary components of comprehensive, whole-person interventions. Vocational and educational services, safe housing, parenting and other life skills training, health care, and legal services are among essential supports.

***Steps Toward a Trauma-Informed Approach***—Substance abuse programs adopting a trauma-informed model should ensure a leadership and administrative commitment to trauma-informed change as follows:

- Make trauma-related concerns a part of the interviewing and hiring process.

- Provide trauma training for all staff, including administrative and support personnel. A number of resources are now available for helping staff members learn more about trauma and recovery. *Risking Connection* (www.sidran.org), for example, is an informative curriculum that has been widely

used as an introduction to trauma for human services providers.

- Institute universal trauma screening to identify those consumers with histories of violent victimization.
- Review formal and informal service policies and procedures to ensure that they reflect a thorough understanding of trauma and the needs of trauma survivors.
- Ensure access to, and funding for, trauma-specific services such as those outlined in the next section.

## *Trauma Treatment Effectiveness*

Since the late 1980s, controlled clinical trials of the use of psychotherapeutic treatments have demonstrated reductions in PTSD symptoms, depression, and anxiety in combat veterans and victims of war and crimes (Hembree & Foa, 2003; Sherman, 1998). Modification and application of these treatment approaches with civilians did not emerge until recent years (Najavits, Weiss, Shaw, & Muenz, 1998), and the development and evaluation of trauma treatment models specifically aimed at individuals in mental health and substance abuse treatment settings is in its infancy (Zlotnick, Najavits, Rohsenow, & Johnson, 2003). Nonetheless, early findings on the effectiveness of integrated models of treatment in reducing substance abuse and related problems, general mental health problems, and PTSD symptoms are promising (Brady, Dansky, Back, Foa, & Carroll, 2001; Fallot & Harris, 2002; Najavits, Weiss, Reif, Gastfriend, Siqueland, & Barber et al., 1998; Rosenberg et al., 2001; Talbot et al., 1999; Zlotnick et al., 2003).

Najavits and colleagues (Najavits, Weiss, Shaw, & Muenz, 1998) followed a sample of 27 women who met the DSM-IV criteria for PTSD and substance dependence participating in *Seeking Safety*. At 3 months following treatment they found a significant increase in abstinence from substances and significant decreases in trauma-related symptoms and depression as compared with pretreatment symptom levels. In a separate study, 86 women with histories of childhood sexual abuse being treated in a mental health setting were assigned to a treatment as usual group versus a psychoeducational group intervention aimed at improving safety and self-care. In this setting, researchers found statistically significant reduction in mental health symptoms in the experimental group compared with the treatment as usual group (Talbot et al., 1999).

Researchers investigating the effectiveness of an individual exposure-based treatment (approaches that reactivate cues or memories associated with the traumatic event) in conjunction with a cognitive-behavioral relapse prevention model recruited 39 men and women seeking substance abuse treatment who had current diagnoses of PTSD and cocaine dependence. They found that those who completed 10 sessions of exposure treatment sustained statistically significant positive change 6 months later in alcohol, drug, and employment problems as measured by the Addiction Severity Index (ASI) composite scores and PTSD symptoms (Brady et al., 2001).

Pilot studies of the *Trauma Recovery and Empowerment Model (TREM)* demonstrate that this model also holds promise. In particular, preliminary findings indicate improvement in overall functioning, psychiatric symptoms, use of emergency services, and HIV risk behavior for individuals participating in the intervention as compared with pretreatment scores (Fallot & Harris, 2002, 2004). Recent findings also indicate decreased substance use among *TREM* participants. This decrease is significantly correlated with the development of trauma recovery skills.

Finally, a study including substance dependent women diagnosed with PTSD who were living in a residential treatment program within a minimum security prison also offers positive preliminary findings. The 17 women participating in *Seeking Safety* showed a significant decrease in alcohol and drug use from time of entry to a 3-month posttreatment followup point and a significant decrease in PTSD symptoms from treatment entry to exit from the program (Zlotnick et al., 2003).

# *Trauma Models*

Several integrated trauma-specific models of treatment for women in substance abuse treatment with trauma histories, symptoms, or PTSD have been developed and manualized within the last few years. Each of the models discussed below focuses, at least in part, on helping women establish safety early in their treatment. Four of the five were used in SAMHSA's WCDVS.

## *ATRIUM*

**Overview—**The Addictions and Trauma Recovery Integration Model (*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. 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.

**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.

## *Helping Women Recover*

**Overview**. *Helping Women Recover (HWR)* was developed by Stephanie S. Covington at the Institute for Relational Development (Covington, 1999). *HWR* is an integrated curriculum addressing trauma and addiction. The author has also developed adaptations for use in the criminal justice system and has a second-level trauma curriculum titled *Beyond Trauma: A Healing Journey for Women* (Covington, 2003). In addition, a curriculum for girls titled *Voices: A Program of Self Discovery and Empowerment for Girls* (Covington, 2004) will be available in the summer of 2004.

The *HWR* curriculum includes 17 sessions organized within the four modules of self, relationships, sexuality, and spirituality. Each module includes approximately four sessions each. The curriculum is based on a theoretical framework that integrates expressive arts, relational theory, and cognitive-behavioral theory. Groups are 90 minutes in length and include 4 to 10 women and 1 facilitator. It is recommended that the curriculum be implemented in closed groups, but this is not a requirement. The curriculum utilizes a women's journal that includes a summary of the material covered in each session and provides a place for women to complete exercises and record reflections.

**Settings—**All three of these curricula are designed as group intervention but can also be used individually. They are appropriate for both residential and outpatient settings. *HWR* has been implemented in substance abuse, mental health, and domestic violence settings, and *Voices* has been implemented in outpatient substance abuse, juvenile justice, and school settings.

## *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, 2002). 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.

**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*

**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.

**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*

**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.

**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.

## *CHOOSING A TRAUMA CURRICULUM*

Early investigations suggest that the trauma treatment models described above assist individuals with trauma histories and mental health challenges (Brady et al., 2001; Fallot & Harris, 2002; Najavits, Weiss, Shaw, & Muenz, 1998; Rosenberg et al., 2001; Talbot et al., 1999; Zlotnick et al., 2003) and with substance abuse problems (Brady et al., 2001; Najavits, Weiss, & Shaw, 1997, 1999; Zlotnick et al., 2003). However, more research is needed before being able to say with confidence which model is best in a given treatment environment. Without more research, treatment agencies are left with the question: How do we choose which model to implement?

The extent to which a particular curriculum has been evaluated and/or published is a legitimate consideration when selecting a model. However, given that most of the curricula are relatively new and, with the exception of *Seeking Safety*, are only beginning to gather empirical evidence of effectiveness, practical implementation issues may be the most salient consideration. Agencies considering adoption of a trauma treatment model should first become familiar with the curricula by reading the manuals, reviewing pertinent literature, and speaking to persons with direct implementation experience. As noted previously, all five models are cognitively-behaviorally based, stress safety first, and address trauma within the context of substance abuse.

Implementation issues an agency might consider including the following:

**Philosophical orientation—**The agency staff's philosophical orientation should be taken into account when selecting which trauma curriculum (or curricula) to implement. For example, some substance abuse treatment staff may have concerns that clients should be well into their recovery prior to involving them in trauma work. These concerns can be addressed through staff training; however, trauma group implementation may be easier (and possibly more effective) if, in such a setting, a model that deals primarily with coping skills (e.g., *Seeking Safety*), as contrasted to models that deal more directly with healing from abuse (e.g., *TREM*), is selected. On the other hand, agency staff may perceive the importance of deeper trauma work for their clients and elect to implement a curriculum designed to facilitate this deeper work. Similarly, if spiritual growth and well-being is a value held within the treatment setting, models that specifically incorporate issues of spiritual health (i.e., *ATRIUM* or *HWR*) might be particularly well suited.

**Curriculum length—**The length (or number of sessions) of the curricula should also be considered. If a treatment program lasts 3 months, but the curriculum (if delivered weekly) would take 6 months to complete, the curriculum is likely not suitable. On the other hand, if a longer model has other attributes that make it particularly well suited for the setting, program staff could consider offering sessions twice a week or dividing the curriculum into two or more phases. Much of these decisions are dependent upon program scheduling and anticipated attendance/retention issues.

**Curriculum format—**It is frequently recommended that trauma groups be closed to new participants after the first (or first few) sessions due to the sensitivity of the issues discussed and the need for trust among participants. However, in settings where clients rotate in and out of treatment, closed groups can significantly limit the numbers of clients who can participate. To address this issue, some models are specifically designed to allow new members to join when the group begins a new phase or segment (e.g., *Triad*). It is also conceivable that a particular model, while designed to be closed, might be adapted (ideally with the approval and guidance of the author) to accommodate new members joining at specific times.

**Group facilitators' expertise—**The background and training of staff members designated to facilitate the trauma groups is another important consideration when selecting a model. *TREM*, for example, was designed to be facilitated by professionals (e.g., clinicians), while *ATRIUM* was designed to be facilitated by either peers or professionals. However, substance abuse counselors could potentially facilitate any of these models if adequate training and supervision are available.

**Adaptations for specific populations—**Each curriculum has been used with women with co-occurring mental health and substance use disorders and trauma histories, and several have been used with men or adapted for men. Agencies or treatment programs may work with specific subpopulations or culturally diverse groups and desire a model that has already been adapted for use with the population they serve. Several such adaptations are available. For example, *HWR* provides a criminal justice-specific edition, and *TREM* provides adaptations for adolescents and Hispanic/Latina women. Treatment programs considering adoption of a specific curriculum should examine whether or not it has been used with the racial/ethnic/cultural group served, as well as issues of level of literacy required, vocabulary used, and language barriers presented.

**Cost—**Curriculum manual and material costs vary nominally across the models and thus should not be a deciding factor when deciding which curriculum to choose. Yet costs could be a determining factor depending upon the initial and ongoing training and/or supervision needed for implementing a specific curriculum. Additional embedded costs could also be incurred if adaptations—either internal or with guidance from the authors—are needed to best serve a particular population in a special type of setting. While training from the authors (or their designees) would likely be advantageous in any treatment setting, the absolute need for and extent of the training is dependent on the existing expertise of staff.

**Training—**While an agency's staff can use any of these curricula without guidance and training from the authors, some initial training by the author, her designee, or others experienced in facilitating the groups is strongly recommended. Guidance from the authors is particularly recommended if programs want to make particular adaptations to a model so that it will better fit their setting and/or population. Finally, although each curriculum is designed for group work, some have been piloted for individuals (*Seeking Safety*), and all could likely be adapted for individual work.

**Setting—**Different models, depending on length, curriculum structure, and population of women served, may be more appropriate or fit better within one treatment modality versus another. For example, longer length groups might work well in residential treatment but not as well in outpatient programs. Several WCDVS sites divided lengthier curricula into two phases (i.e., *Seeking Safety*) so some women would at least complete phase one. All five models are flexible and adaptable to changing the ordering of sessions and/or designing distinct phases. It is also possible to choose several different models to meet the needs of diverse clients in diverse settings or to pair sessions from several models as needed.

Some salient aspects of the trauma treatment models discussed above are shown in the table below.

| | *Atrium* | *Helping Women Recover* | *Seeking Safety* | *TREM* | *Triad* |
|---|---|---|---|---|---|
| **Overview and Theoretical Approach** | Addresses mind, body *and* spirit; based on cognitive-behavioral and relational theories | An integrated curriculum addressing trauma and addiction; based on relational and cognitive-behavioral theories and integrating expressive arts | Present-focused therapy promoting safety and recovery; integrates cognitive-behavioral theory with interpersonal and case management domains | Addresses areas of empowerment, the impact of trauma events, and skills building; utilizes cognitive-behavioral, psychoeducational, and skills training approaches | Promotes survival, recovery, and empowerment using a cognitive-behavioral approach |
| **Duration & Intensity of Services** | 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 4th session | Modified closed groups (open at beginning 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 and are 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 |
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## THE NATIONAL TRAUMA CONSORTIUM

The authors of all five trauma-specific curricula are available to assist with questions, adaptations, and consultation. In addition, the National Trauma Consortium (NTC) is available to assist agencies and treatment programs that are interested in introducing or strengthening a trauma approach. The NTC can assist in assessing the needs of a particular program or agency and in planning a strategy for becoming more trauma informed or introducing trauma-specific treatment models.

The NTC was formed with the vision of improving and enhancing the lives of individuals with trauma and co-occurring disorders and their families. Its mission is to develop and expand the capacity of communities and health and human service organizations to provide comprehensive, integrated, trauma-informed, and trauma-specific services. The NTC provides consultation, training, and technical assistance to national and State organizations, States, counties, community-based organizations, and other groups in the development and enhancement of services for individuals with mental health and substance abuse problems and histories of physical and/or sexual abuse and in the development and evaluation of a wide variety of trauma programs and policies.

Organizations in the NTC vary in size, serving from several hundred to almost 25,000 clients annually. As a whole, the populations served represent diverse communities with respect to race, ethnicity, language, and geographic settings. Primary areas of expertise include developing integrated and trauma-informed systems of care with an appropriate blend of service interventions, integrating consumer/survivor/recovering persons in all aspects of service planning and delivery, and program evaluation.

For further information about *The NTC* go to www.NationalTraumaConsortium.org. To discuss training and consultation opportunities, email Coleen Clark, PhD, NTC Director, at cclark@fmhi.usf.edu, or call 941-974-9022.

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