Intervention Summary: Trauma Recovery and Empowerment Model (TREM)

Keywords: Co-occurring disorders, Mental health treatment, Substance abuse treatment, Criminal/juvenile justice, HIV/AIDS, Homelessness, Quasi-Experimental, American Indian/Alaska Native, Black or African American, Hispanic or Latino, Other/unspecified, White, Female, Residential, Urban, Mix of public and proprietary

All information below was current as of the date of review. To request more information, or to see if new studies or materials are available, please contact the developer or other representatives listed at the bottom of this page.

Descriptive Info | Outcomes | Ratings | Demographics | Studies/Materials | Replications | Contact Info

Descriptive Information

Topics	Co-occurring disorders, Mental health treatment, Substance abuse treatment
Populations	**Age:** **Gender:** Female **Race:** American Indian/Alaska Native, Black or African American, Hispanic or Latino, Other/unspecified, White
Outcomes	Outcome 1: Severity of problems related to substance use Outcome 2: Psychological problems/symptoms Outcome 3: Trauma symptoms
Abstract	The Trauma Recovery and Empowerment Model (TREM) is a fully manualized group-based intervention designed to facilitate trauma recovery among women with histories of exposure to sexual and physical abuse. Drawing on cognitive restructuring, psychoeducational, and skills-training techniques, the gender-specific 24-29 session group emphasizes the development of coping skills and social support. It addresses both short- and long-term consequences of

	violent victimization, including mental health symptoms, especially posttraumatic stress disorder (PTSD) and depression, and substance abuse. TREM has been successfully implemented in a wide range of service settings (mental health, substance abuse, criminal justice) and among diverse racial and ethnic populations.
Settings	Residential, Urban
Areas of Interest	Criminal/juvenile justice, HIV/AIDS, Homelessness
Replications	As of December 2006, this intervention or an adaptation of this intervention has been evaluated in three published studies.
Proprietary or Public Domain	Mix of public and proprietary
Costs	The cost per participant varies depending on local mental health service costs. TREM is usually conducted as a 75-minute group with 29 weekly sessions. Groups typically include 8-10 members and two or three co-leaders (typically counselors, social workers, clinicians, or community support specialists). The primary start-up cost is training and consultation for prospective group leaders. Community Connections (http://www.communityconnectionsdc.org/) negotiates training fees on an individual program basis, taking into account the number of trainees and location of the training, among other factors. In many cases, programs have collaborated to sponsor shared training in a particular area. For a 2-day training, costs usually range from around $3,000 (for smaller groups with one trainer) to $6,000 (for larger groups with two trainers) plus travel expenses. Follow-up consultation is often arranged by telephone at a cost of $125 per hour. The TREM manual is available through Community Connections for $25 or may be purchased through bookstores. The cost of evaluation materials varies depending on the specific outcomes assessed; most are in the public domain. Those materials developed by Community Connections are available at no charge.

Adaptations	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.
Adverse Effects	No adverse effects, concerns, or unintended consequences were identified by the applicant.
Implementation History	Community Connections Trauma Education staff have provided training in TREM to more than 1,400 clinicians in 20 States. Clinicians have come from a variety of disciplines and programs: approximately 40% have worked in mental health settings, 40% in substance abuse settings, and the remaining 20% in correctional settings, domestic violence programs, or homeless services programs. TREM groups have been implemented in a wide range of agencies, including residential and nonresidential substance abuse and mental health programs, correctional institutions, health clinics, and welfare-to-work programs, among others. TREM groups also have been successfully offered in programs located in urban, inner-city settings (e.g., in Philadelphia, Cleveland, Atlanta, Phoenix, and Denver) and rural settings (e.g., in Maine, South Carolina, Georgia, and Delaware). TREM group participants have typically been recipients of publicly funded mental health, substance abuse, and other human services and have been diverse in terms of overall life skills and functioning. They include the most disenfranchised clients who often are homeless and make heavy use of inpatient, crisis, and other high-cost services. Community Connections has been offering TREM continuously since 1997.
Date Reviewed	December 2006
Review Funded By	CMHS

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Outcomes

Outcome 1: Severity of problems related to substance use

Description	Severity of problems related to substance use was assessed in interviews using the Addiction Severity Index drug composite score (ASI-D) and alcohol composite score (ASI-A), which measure problem severity during the past 30 days. Possible scores range from 0 to 1, with higher scores indicating greater problem severity of substance use.
Key Findings	In one study, both groups showed significant reduction in drug addiction severity at 6- and 12-month follow-ups ($p < .01$) and remained significant after controlling for differences in baseline status. Both the intervention and comparison groups achieved significant improvement in alcohol addiction severity at 6- and 12-month follow-ups ($p < .01$). However, the difference was not significant after controlling for baseline differences. In a second study, the intention-to-treat analyses showed significant differences over time between the TREM and the comparison groups on both the alcohol and drug composite scores, $p = .008$ and $p = .0004$, respectively. Mean scores of the TREM group showed a significant reduction in severity of problems related to substance use from baseline to 12-month follow-up compared to the comparison group. One study reviewed yielded no significant findings for this outcome.
Studies Measuring Outcome	Study 1, Study 2, Study 3 *(**Note:** Study numbers correspond to the numbered citations in the Studies and Materials Reviewed section below)*
Research Designs	Nonequivalent control group design

Quality of Research Rating	2.9 (0.0-4.0 scale)

Outcome 2: Psychological problems/symptoms

Description	Psychological symptoms were assessed with (1) the Global Severity Index (GSI) of the Brief Symptom Inventory, a self-report scale that measures symptom dimensions; (2) self-rated health, a self-rating of one's overall physical health from excellent to poor; and (3) the Social Role Functioning index, consisting of nine questions assessing the difficulty respondents experience in daily living and role-functioning areas.
Key Findings	In one study, the reduction in symptoms was significantly greater in the intervention group (M = 0.93, SD = 0.74) than in the comparison group (M = 1.21, SD = 0.86) at 12-month follow-up, p = .008. In another study, TREM had significanty lower scores on GSI, indicating improved mental health at 12-month follow-up than treatment as usual (TAU), p = .021, effect size of .58. One study reviewed reported no significant findings for this outcome.
Studies Measuring Outcome	Study 1, Study 2, Study 3 *(**Note:** Study numbers correspond to the numbered citations in the Studies and Materials Reviewed section below)*
Research Designs	Nonequivalent control group design
Quality of Research Rating	2.7 (0.0-4.0 scale)

Outcome 3: Trauma symptoms

Description	Trauma symptoms were assessed with (1) the Posttraumatic Symptom Scale (PSS) of the Posttraumatic Diagnostic Scale, which asks respondents to indicate how often in the past month they experienced specific problems after a traumatic event; and (2) the Feeling-Dissociation Scale and Feeling-Trauma Coping Scale, which examine respondents' strategies for coping with the traumatic events in their lives.
Key Findings	In one study, reduced trauma symptoms were significantly greater for the intervention group (M = 5.6, SD = 13.7) than for the comparison group (M = 20.8, SD = 11.9) at 12-month follow-up, p = .029. In another study, the intervention group had significantly improved outcomes compared to the usual-care condition on trauma-related symptoms at 6-month follow-up (feelings of dissociation, p = .007, effect size = .63; sense of personal safety, p = .03, effect size = .48), and at 12-month follow-up (feelings of dissociation, p = .007, effect size = .61; trauma coping, p = .003, effect size = .54; sense of personal safety, p = .030, effect size = .38). In a third study, the intention-to-treat analyses showed significant differences over time between the TREM and comparison groups on trauma symptoms, p = .03. Mean scores of the TREM group decreased from baseline to 12-month follow-up relative to the comparison group.
Studies Measuring Outcome	Study 1, Study 2, Study 3

	*(**Note:** Study numbers correspond to the numbered citations in the Studies and Materials Reviewed section below)*
Research Designs	Nonequivalent control group design
Quality of Research Rating	2.7 (0.0-4.0 scale)

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Ratings

Quality of Research Ratings by Criteria (0.0-4.0 scale)

Outcome	Reliability	Validity	Fidelity	Missing Data/Attrition	Confounding Variables	Data Analysis	Overall Rating
Outcome 1: Severity of problems related to substance use	4	3.5	1.9	2.5	1.9	3.5	**2.9**
Outcome 2: Psychological problems/symptoms	3.6	3.4	1.9	2.3	1.9	3.5	**2.7**
Outcome 3: Trauma symptoms	3.3	3.2	1.9	2.3	1.9	3.5	**2.7**

Strengths: For the most part, each study employed commonly used measures with sound psychometric properties. Several of the studies noted baseline differences in the treatment conditions and the possibility of there being other unmeasured baseline differences that could have affected the results. Statistical analyses were appropriate, and sample size and power were adequate. The fact that integrated trauma services in different forms could provide positive results across nine sites is a program strength. Overall, the studies had very little attrition and missing data or used sophisticated statistical methods to adjust for the levels of attrition/missing data.

Weaknesses: While each of the three studies addressed fidelity, the discussion of psychometrics in two of the studies was brief. One study did not address missing data/attrition. All studies were quasi-experimental, so confounds are possible. There was no one clearly defined model. Other weaknesses include the lack of a randomized study design, the unknown quality of the program contrasts, and the fact that the authors did not measure or report how long participants had been in the project before the study. No information was given on the subscales or scales created for the study.

Readiness for Dissemination Ratings by Criteria (0.0-4.0 scale)

Readiness for Dissemination	Implementation Materials	Training and Support	Quality Assurance	Overall Rating
RFD Rating for Intervention	3.8	3.5	2.9	**3.4**

Strengths: The implementation materials serve as a practical, hands-on guide to the intervention. Both the video and treatment manual offer a rationale for the sequencing of treatment components. The videos include information for clinicians and administrators and describe organizational requisites for effective implementation. The training workshop offers the opportunity to practice leading groups and to receive feedback on performance. Training emphasizes clinician leadership style as a key factor in effective service delivery. Both fidelity and clinical process measures are provided, with the fidelity measure utilizing data from a variety of sources.

Weaknesses: The program videos rely on more didactic presentation rather than illustrative examples. There appears to be no training provided for clinical supervisors. No outcome measures or indicators are provided to support quality assurance.

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Study Demographics

The studies reviewed for this intervention included participants with the following demographics, as reported by the study authors.

Study	Age	Gender	Race/Ethnicity
Study 1	Data not reported/available	100% Female	34.6% White 31.5% Hispanic or Latino 30.4% Black or African American 3.5% Other/unspecified
Study 2	Data not reported/available	100% Female	52% White 18% Black or African American 16% Hispanic or Latino 8% American Indian/Alaska Native 6% Other/unspecified
Study 3	Data not reported/available	100% Female	82.5% Black or African American 17.5% Other/unspecified

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Studies and Materials Reviewed

Quality of Research Studies

Study 1

Amaro, H., Dai, J., Arevalo, S., Acevedo, A., Matsumoto, A., & Nieves, R. (n.d.). Effects of integrated trauma treatment on outcomes among Black, Hispanic, and White women in urban community-based substance abuse treatment. Manuscript submitted for publication.

Study 2

Toussaint, D., VanDeMark, N., Bornemann, A., & Graeber, C. (In press). 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.

Study 3

Fallot, R. D., McHugo, G. J., & Harris, M. (2005). DC Trauma Collaboration Study: Background and preliminary report. Unpublished manuscript.

Quality of Research Supplementary Materials

Amaro, H., Fallot, R. D., & Harris, M. (n.d.). Group intervention study for drug abuse and trauma. Report submitted to the National Institute on Drug Abuse.

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

Fallot, R. D., & Harris, M. (2001). Trauma Recovery and Empowerment Model (TREM) Group Intervention Fidelity Scale.

Fallot, R. D., & Harris, M. (2002). Trauma Recovery and Empowerment Model (TREM): Conceptual and practical issues in a group intervention for women. Community Mental Health Journal, 38(6), 475-485.

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. Report prepared for the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

McHugo. G. J., & Fallot, R. D. (n.d.). An RCT of the Trauma Recovery and Empowerment Model. A four-year (2004-2008) randomized controlled trial of TREM effectiveness funded by NIMH [National Institute for Mental Health]. Unpublished manuscript.

McHugo, G. J., Kammerer, N., Jackson, E. W., Markoff, L. S., Gatz, M., Larson, M. J., Mazelis, R., & Hennigan, K. (2005). Women, co-occurring disorders, and violence study: Evaluation design and study population. Journal of Substance Abuse Treatment, 28, 91-107.

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(10), 1213-1222.

National Trauma Consortium. (n.d.). Excerpt on TREM from Chapter 5: Cultural adaptations of trauma specific models, in Integrating trauma treatment into substance abuse services for women. Document prepared for the Substance Abuse and Mental Health Services Administration.

National Trauma Consortium. (n.d.). Excerpt on TREM from Chapter 3: Overview of trauma-specific group treatment models, in Integrating trauma treatment into substance abuse services for women. Document prepared for the Substance Abuse and Mental Health Services Administration.

Readiness for Dissemination Materials

Clinician Rating Scale for Substance Use

Copeland, M., & Harris, M. (2000). Healing the trauma of abuse: A women's workbook. Oakland, CA: Authors.

Fallot, R., & Harris, M. (2001). Trauma Recovery and Empowerment Model (TREM) Group Intervention Fidelity Scale.

* 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. Report prepared for the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

Harris, M. (1999). Trauma Recovery and Empowerment (Part I): Empowerment, Tape 1 [VHS]. Washington, DC: Community Connections.

Harris, M. (1999). Trauma Recovery and Empowerment (Part I): Empowerment, Tape 2 [VHS]. Washington, DC: Community Connections.

Harris, M. (1999). Trauma Recovery and Empowerment (Part II): Trauma recovery [VHS]. Washington, DC: Community Connections.

Harris, M. (1999). Trauma Recovery and Empowerment (Part III): Advanced trauma recovery issues and closing rituals, Tape 1 [VHS]. Washington, DC: Community Connections.

Harris, M. (1999). Trauma Recovery and Empowerment (Part III): Advanced trauma recovery issues and closing rituals, Tape 2 [VHS]. Washington, DC: Community Connections.

Harris, M., & Community Connections Trauma Work Group. (1998). Trauma Recovery and Empowerment: A clinician's guide for working with women in groups. New York: Community Connections, Inc.

Harris, M., & Fallot, R. (2001). Stages in Trauma Recovery Rating Scale. Washington, DC: Community Connections.

Harris, M., & Fallot, R. (2004). Trauma Recovery and Empowerment Profile (TREP) [Handout].

National Trauma Consortium. (n.d.) Overview of trauma-specific group treatment models. Excerpt from unpublished monograph.

TREM Training Outline and selected handouts

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Replications

As of December 2006, this intervention or an adaptation of this intervention has been evaluated in three published studies.

Note: Citations with an asterisk indicate that studies were reviewed as part of the Quality of Research ratings.

* Cocozza, J. J., Jackson, E., Hennigan, K., Morrissey, J. M., Reed, B. G., Fallot, R., & Banks, S. (2005). Outcomes for women with co-occurring disorders and trauma: Program-level effects. Journal of Substance Abuse Treatment, 28(2), 109-119.

* Morrissey, J., Jackson, E., Ellis, A., Amaro, H., Brown, V., & Najavits, L. (2005). Twelve-month outcomes of trauma-informed interventions

for women with co-occurring disorders. Psychiatric Services, 56(10), 1213-1222.

* Toussaint, D., VanDeMark, N., Bornemann, A., & Graeber, C. (In press). 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.

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