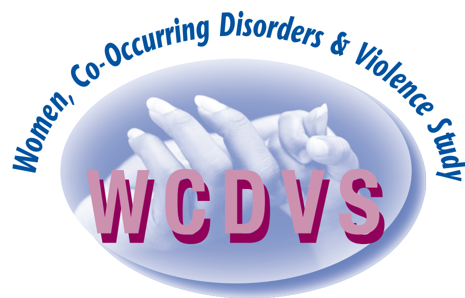

Creating Trauma Services for Women with Co-Occurring Disorders

Experiences from the SAMHSA Women with Alcohol, Drug Abuse and Mental Health Disorders who have Histories of Violence Study

Dawn Jahn Moses
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Beth Glover Reed
University of Michigan

Ruta Mazelis
The Cutting Edge: A Newsletter For People Living With Self-Inflicted Violence

Brandy D'Ambrosio
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August 2003

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Dawn Jahn Moses
Beth Glover Reed
Ruta Mazelis
Brandy D'Ambrosio

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Introduction

The devastating impacts of violence on women are profound. The deep-seated trauma that can result may shape every aspect of a woman's life, even years after the traumatic experience has occurred. The effects are especially acute when violence is repeated, begins in childhood, and/or is perpetrated by someone the person should be able to trust.

Many service providers do not recognize or understand the multiple, varied and complex impacts of violence. Symptoms may not be readily apparent or may be misunderstood when masked by seemingly unrelated behavior. Standard approaches to mental heath and substance abuse treatment and other human services may re-traumatize women who have experienced violence, setting back their recovery or causing them to refuse care.

Appropriate treatment for a woman who has experienced violence must be both trauma-specific and trauma-informed. Trauma-specific services are those designed to directly address the effects of trauma, with the goal of healing and recovery. Trauma-informed services are all the other services that might be offered, modified to consider and be responsive to the impacts of violence.

The Substance Abuse and Mental Health Services Administration (SAMHSA) *Women with Alcohol, Drug Abuse and Mental Health Disorders who have Histories of Violence Study (Women Co-Occurring Disorders and Violence Study)* seeks to implement and document effective treatment modalities and identify changes that must take place in systems, programs, and services to ensure appropriate care. Grounded in the real-world knowledge of women who have survived violence, teams at project sites adapted and developed treatment interventions and advocated for trauma-informed change.

This document describes project activities and presents preliminary findings from the process evaluation of the nine sites participating in Phase II of the study. Data from the project's outcome study on service/program effectiveness and client outcomes will be presented in separate papers. The first section (page 3) reviews what is known about the impacts of violence on women, the current state of service delivery, and the SAMHSA project goals and local study sites.

The next section on providing trauma-specific services (page 9) describes in detail four group intervention models that are the basis for trauma-specific services at the project's nine sites.

The section on trauma-informed services (page 19) describes how systems and services can be redesigned to be appropriate and effective for women who have experienced violence; it is illustrated by examples from project sites. The next section outlines the challenges and lessons learned by project sites as they implemented their trauma-specific and trauma-informed service interventions (page 31).

The final section (page 39) offers a list of resources (organizations, publications, etc.) for the interested reader.

The Impact of Trauma on Women's Lives

PREVALENCE OF VIOLENCE

Violence in the lives of women and children is so widespread it has been described as an "epidemic" in American society.[1] Interpersonal violence, including physical and sexual assault is so common for women, regardless of cultural affiliation and socioeconomic class, some consider it a "normative" part of female experience today.[2]

Twenty to 30 percent of women report sexual and/or physical victimization during their lifetime.[3,4] Ten to 12 percent of women have been sexually abused during childhood and 13 to 17 percent have been physically abused.[4,5,6] Twenty to 27 percent of women experienced sexual molestation during childhood, with 70 to 90 percent of those reporting the perpetrator as someone they know.[7]

Women who were abused as children are also at increased risk for violence in adulthood. Seventy to 80 percent of women who have experienced domestic violence have also survived physical and/or sexual abuse during childhood.[8] Women's greatest risk of violence comes from someone they know.[1] More than one-quarter of married couples report at least one occurrence of physical assault in that relationship.[9,10] Between 1988 and 1993, nearly four million women who were married or living with a partner were physically abused; two million were raped. According to the Federal Bureau of Investigation, more than one-quarter of murdered women are killed by current or former partners.[11]

Female victimization rates by non-intimates or strangers are lower, but still significant. In 2000, the U.S. Department of Justice reported that 32 percent of violent crimes and 28 percent of rapes/sexual assaults against women were committed by someone unknown to them.[12]

IMPACT OF TRAUMA

The literature is characterized by deficit-based discussions of victimized women, generally overlooking how they display tremendous strength and courage on a daily basis. Many trauma survivors have been silenced by a society unwilling to acknowledge this kind of abuse, and

Each woman affected by trauma is unique, displaying her own set of strengths and needs. Most exhibit remarkable resilience...

by service providers and systems that misdiagnose and mistreat them. Their survival is a testament to their strength and determination. In addition, women's courage and willingness to share their experiences have been instrumental in increasing awareness and facilitating improvements in service delivery.

The effects of trauma are substantial, impacting women's physical, mental, emotional, spiritual, social, and economic well-being. This is particularly true for those victimized in early childhood, especially if the abuse was perpetrated by family members or other intimates. Trauma survivors often live lives of great pain and confusion, and may not initially recognize trauma as the source of many of their struggles. Each woman affected by trauma is unique, displaying her own set of strengths and needs. Most exhibit remarkable resilience, but the effects of violence – especially when it is repeated – can appear in areas directly related to abuse and in areas that appear initially to be unrelated.[13] Though many women display incredible strength, the coping strategies used for immediate survival in dangerous situations are often less effective in the long term and may even appear to others as inappropriate (in the long run).[14,15,16,17,18]

Chronic physical and/or sexual abuse have been shown to play complex roles in the development of mental health symptoms, substance abuse, and a wide range of physical health problems. Carmen and Reiker discuss how children's attempts at understanding the basis for their victimization can allow them to survive and accommodate abuse experiences.[14] This can include denying that they are being abused, blocking off their memories of the abuse, minimizing its importance and consequences, and/or believing that the abuse was a reasonable response to something they did (and thus a result of their own behavior). These coping strategies may help them to endure the abuse while it is occurring (and are often encouraged by those perpetrating the abuse), but can be limiting for an adult, present barriers to treatment and recovery, and be perceived as pathological conditions in assessments that are not trauma-informed.

In addition, when initial coping mechanisms do not work, previously unexpressed anxiety and terror can break through. Methods used to soothe oneself when overwhelming feelings or numbness occur often appear to be inappropriate if the trauma context is not understood. Some survivors may create high-risk and painful situations in order to counteract feeling numb or dead inside. Other common reactions are sudden outbursts of anger or self-inflicted violence, being suicidal, extreme risk-taking behavior, re-enacting unhealthy relationships, and great difficulty in trusting anyone.[13,15,19,20,21,22,23,24]

Women with abuse histories and trauma symptoms may face a range of mental health issues including:

- Anxiety
- Panic disorder
- Major depression
- Substance abuse and dependence
- Personality disorders
- Dissociative disorders
- Psychotic disorders
- Somatization
- Eating disorders
- Post-traumatic stress disorder[17,19,25,26,27,28,29,30,31]

Interpersonal violence can also result in a range of physical problems and needs. In addition to immediate medical needs related to abuse (e.g. gynecological trauma, risk of pregnancy, HIV and other sexually transmitted diseases, bruises, cuts, concussions, broken bones, etc.), many survivors report a range of other physical problems.[32] Because bodies express what cannot be verbalized, traumatic memories are often transformed into physical outcomes including:[23,33]

- Chronic pain (especially pelvic)
- Gynecological difficulties
- Gastrointestinal problems
- Asthma
- Heart palpitations
- Headaches
- Musculoskeletal difficulties[34,35,36,37,38,39,40,41]

Chronic danger and anticipation of violence stresses the immune and other bodily systems, leading to increased susceptibility to illness.[42] Recent research also indicates that long-term stress as a result of childhood victimization possibly predisposes a woman to serious auto-immune disorders.[23]

Experiences of violence can also interfere with a woman's ability to complete educational and training programs (limiting her ability to obtain the skills/credentials needed to earn a living wage), maintain employment, and be economically self sufficient. Many women who have experienced violence are poor and have a range of support needs, including income, housing, education, and job training/vocational rehabilitation.

Many are extremely isolated and lack stable, positive supports and safe, anchoring relationships. Although many have children for whom they care deeply, they may not have the experiences, skills, and supports to parent consistently. Some may lose their children upon entering treatment settings.

VIOLENCE, MENTAL HEALTH, AND SUBSTANCE ABUSE

The relationship among mental illness, substance abuse, and violence is complex and multifaceted. At a minimum, experiences of abuse may increase the risk of substance abuse or mental health problems; substance abuse and mental health issues may put women at greater risk of victimization; and substance abuse and other self-injurious behaviors may result from underlying trauma issues.[43,44] The time-ordering of these events can vary tremendously, making it difficult to document and understand the relationship among violence, mental illness, and substance abuse. Regardless of cause and effect, the relationship is profound.

Between 50 and 70 percent of women hospitalized for psychiatric reasons, 70 percent of those seen in emergency rooms, and 40 to 60 percent of psychiatric outpatients report having experienced physical or sexual abuse.[31,45,46] Fifty-five to 99 percent of women substance abusers report being victimized at some point in their lives.[43,47,48,49] These figures are particularly startling in light of underreporting, denial, repression, and suppression of traumatic experiences. Women living with mental health, substance abuse, and trauma are likely to have more severe difficulties and to use services more often than women with any one of these problems alone.[50,51,52] In addition, trauma symptoms arising from past violence and the absence of a safe environment are major obstacles to treatment and recovery.[49,53,54,55] Trauma survivors often feel that service providers are not safe, trustworthy, or understanding.[19,56] Many women also fear they will lose their children if they seek services and treatment.

CURRENT SERVICES AND DELIVERY SYSTEMS

The human cost of society's failure to provide appropriate services for women with mental health, substance abuse, and trauma histories is enormous in both individual and institutional terms. Current service delivery systems are woefully inadequate in identifying and meeting the needs of women affected by trauma, mental health, and substance abuse. Most communities have few services designed to address experiences of violence and its resulting trauma. Services that do exist are not well integrated. They are most often focused on ensuring the immediate physical safety of survivors of domestic violence and rape or children who are in abusive situations, rather than on addressing the impact of trauma over time. In addition, children of women who have been abused often witness and/or experience violence and neglect and have their own treatment needs, which often go unaddressed.

Given the pervasiveness of violence, all social service programs and systems are likely to be serving trauma survivors. Nevertheless, most services and systems do not screen, assess or address histories of trauma. When systems serve women

The human cost of society's failure to provide appropriate services for women with mental health, substance abuse, and trauma histories is enormous...

Women are often treated as "passive recipients of services" who have little knowledge of their own needs.

without knowledge of their experiences of violence, inappropriate treatment and retraumatization can occur.[13] For example, an unaddressed trauma history can result in a woman resorting to drug use to manage her anxiety and flashbacks. If this is understood only as a relapse and/or a lack of commitment to sobriety, neither staff nor the woman will make the connections necessary to assist her to substitute other means of coping with or reducing these symptoms of trauma. In addition, survivors report that some traditional mental health practices such as forced seclusion or the use of restraints are coercive and are themselves traumatic in nature.[57,58]

Moreover, mental health, substance abuse, and trauma issues are usually addressed by separate service systems with differing treatment philosophies, eligibility criteria, and operating procedures that are not well coordinated.[59,60] Multiple problems are rarely treated simultaneously and providers do not work together effectively to respond to unmet needs.[50] Women's experiences and needs are compartmentalized and disconnected, making holistic treatment unlikely.

Many women find current service programs and systems to be extremely hierarchical, disempowering, or abusive. There are few opportunities for women to play active roles in their own treatment, and even fewer opportunities for them to be involved in planning, operating, and evaluating services. Women are often treated as "passive recipients of services" who have little knowledge of their own needs.[13,57,58]

Women suffer tremendously as a result of misdiagnoses, mistreatment, the absence of appropriate, integrated services, and the lack of a voice in their own treatment. Trauma survivors often cycle in and out of public mental health and substance abuse systems for years, using a tremendous number of services without experiencing any improvement. As treatment systems erode trust, self-efficacy, and a sense of safety, women begin to disengage and may refuse assistance.

THE WOMEN, CO-OCCURRING DISORDERS AND VIOLENCE STUDY

Recognizing the failure to address the complex needs of women with alcohol, drug abuse, and mental health disorders and histories of violence, SAMHSA launched the *Women, Co-Occurring Disorders and Violence Study*. The study's goal is the generation and application of empirical knowledge about the development of comprehensive, integrated service approaches, and the effectiveness of these approaches for women who have traditionally been "high-end" users of publicly-funded services.[61,62]

The first phase of the study was devoted to developing:

- A multi-site framework for service intervention.
- Local strategies for implementing the service framework.
- Local and cross-site process evaluation efforts.
- Standard methodology for the cross-site outcome evaluation.

Fourteen sites across the country, representing a range of organizations including residential and outpatient mental health and substance abuse service providers, hospitals, jails, public health agencies, universities and other community groups participated in the effort.

The second three-year phase has been dedicated to implementing integrated service interventions at local sites and comparing outcomes for women receiving care through the new service strategies to those receiving services as usual. Nine study sites received funding to fully implement their projects and test and compare outcomes for women in both conditions.

The cross-site framework requires all service interventions to be gender-specific, culturally competent, trauma-informed and trauma-specific, comprehensive, integrated, and informed by involvement from consumer/survivor/recovering (C/S/R) women*.

Each site must provide a core set of services that includes:

- Outreach and engagement
- Screening and assessment
- Treatment activities
- Parenting skills
- Resource coordination and advocacy
- Trauma-specific services
- Crisis intervention
- Peer-run services

From the study's inception, SAMHSA has placed strong emphasis on involving C/S/Rs in the local and cross-site efforts.[61,62] SAMHSA set a high standard that required the integration of C/S/Rs into all aspects of project design and implementation including both research and services. At the site specific and cross-site level, C/S/R voices had to be incorporated into their own treatment, the design of integrated systems of care, the creation and provision of services, and the design and implementation of evaluation efforts. Built into the project from the beginning was the idea that women with these experiences are vital sources of information on their own needs and how the system must be changed to provide responsive services.

** For the purposes of this study, C/S/R women are identified as C – consumers of mental health services; S – survivors of physical and/or sexual violence in childhood and/or adulthood; and R – recovering from substance abuse.*

Nine sites were awarded cooperative agreements to complete the second phase of this effort. Working within the agreed upon framework, each site has created a program responsive to the strengths and needs of their own communities. Study sites include:

- PROTOTYPES Systems Change Center
  Culver City, California
- Allies: An Integrated Services System of Care/ Women's Health Study
  Stockton, California
- New Directions for Families
  Thornton, Colorado
- District of Columbia Trauma Collaboration Study
  Washington, DC
- Triad Women's Project
  Avon Park, Florida
- Boston Consortium of Services for Families in Recovery
  Boston, Massachusetts
- Women Embracing Life and Living (WELL)
  Cambridge, Massachusetts
- Franklin County Women's Research Project
  Greenfield, Massachusetts
- Portal Project
  New York, New York

Built into the project from the beginning was the idea that women... are vital sources of information on their own needs and how the system must be changed...

WOMEN CO-OCCURRING DISORDERS AND VIOLENCE STUDY SITES

PROTOTYPES Systems Change Center
Culver City, California
A large multi-services agency providing residential, outpatient, and day treatment services for substance abuse, mental health, HIV/AIDS, and domestic violence and other trauma to women and children in Los Angeles County.

Allies: An Integrated Services System of Care/ Women's Health Study
Stockton, California
A small county safety-net provider of health care services for people with substance abuse and mental health service needs in northern California utilizing a Primary Treatment Network (PTN) of five substance abuse treatment programs.

New Directions for Families
Thornton, Colorado
A comprehensive residential and outpatient substance abuse treatment program serving women and children, including services for women with co-occurring disorders and trauma in the Denver metropolitan area.

District of Columbia Trauma Collaboration Study
Washington, DC
Two multi-service centers (including Community Connections, the lead agency) that offer mental health, trauma and substance abuse services for women with co-occurring disorders and histories of abuse in Washington, DC.

Triad Women's Project
Avon Park, Florida
A substance abuse prevention, intervention and treatment agency, and a local mental health provider are partnering to offer services in rural Florida.

Boston Consortium of Services for Families in Recovery
Boston, Massachusetts
A city health department-based integrated system of services housed within three substance abuse treatment modalities (outpatient counseling, methadone maintenance, and residential treatment) serving primarily Latina and African American women in metropolitan Boston.

Women Embracing Life and Living (WELL)
Cambridge, Massachusetts
Three large dually-licensed substance abuse and mental health comprehensive prevention and treatment agencies, each with multiple sites and treatment modalities serving women with co-occurring disorders and their children in eastern Massachusetts.

Franklin County Women's Research Project
Greenfield, Massachusetts
A peer-based systems and individual-level intervention developed to assist women recovering from histories of interpersonal violence, substance abuse and mental health issues located in rural Franklin County at three drop-in centers and linked with area hospitals and providers.

Portal Project
New York, New York
A large multi-service agency providing residential and outpatient mental health and substance abuse services to primarily African American and Latina women in New York City.

Providing Trauma-Specific Services for Women with Co-Occurring Disorders

Trauma-specific services serve as a cornerstone of the service intervention portion of the *Women, Co-Occurring Disorders and Violence Study*. For the purposes of this effort, trauma-specific services are defined as:

> interventions designed to address the specific behavioral, intrapsychic, and interpersonal consequences of exposure to sexual, physical and prolonged emotional abuse. These interventions may include but are not limited to: dissociative disorder inpatient units, trauma programs housed in battered women's shelters, cognitive behavioral therapies focused on trauma recovery, power therapies (EMDR), psycho-dynamically informed group and individual therapies tailored to trauma services, holistic therapies, and trauma recovery and empowerment groups (TREM).[62]

During the first phase of the initiative, sites spent considerable time determining which trauma-specific services would be implemented and evaluated during the second phase of the project and how those services would be provided. Sites reviewed existing trauma-specific services and, in some cases, created new services. These planning efforts were highly collaborative and included researchers, clinicians, program administrators, C/S/R women, and other key community stakeholders. Trauma-specific services were often piloted to determine appropriateness for use at a given site and then adapted accordingly.

Trauma-specific services provided by sites vary in terms of service setting, clinical approach, content, focus (i.e., domestic violence, past childhood abuse), and structure. Key trauma-specific services are described below.

GROUP INTERVENTIONS

Group interventions are the central feature of each site's trauma-specific services. These groups are for women only and emphasize empowerment. Although every site uses a group format that integrates trauma, mental health and substance abuse work, four distinct models are being used. In some instances sites have

In some instances sites have modified existing curriculum to meet specific program needs...

modified existing curriculum to meet specific program needs while continuing to provide the fully approved sequence of sessions. One site provides an abbreviated version of an existing curriculum and another site developed their own manualized group intervention. The group interventions are described below and summarized in a table on page 16.

Trauma Recovery and Empowerment Model (TREM)

The Trauma Recovery and Empowerment Model (TREM) is a multi-faceted intervention with psychoeducational, cognitive behavioral, and relational elements that emphasizes survivor empowerment. Created by Maxine Harris, Ph.D. and the Community Connections Trauma Work Group, this group approach is based on four core assumptions:

- Some current dysfunctional behaviors and/or symptoms may have originated as legitimate coping responses to trauma.
- Women who experienced repeated trauma in childhood were deprived of the opportunity to develop certain skills necessary for adult coping.
- Trauma severs core connections to one's family, one's community, and ultimately oneself.
- Women who have been abused repeatedly feel powerless and unable to advocate for themselves.[63]

Core Elements of TREM

- Basic education about physical and sexual abuse and how current behaviors are linked to past abuses.
- A reframing of current symptoms as attempts to cope with unbearable trauma.
- An appreciation of the problem-solving attempts locked and hidden in certain repetitive behaviors.
- Education focusing on basic skills in self-regulation, boundary maintenance, and communication.
- Basic education about female sexuality, correcting misperceptions and misconceptions.
- Creation of a healing community by providing recovery services within a group format.
- Rediscovery of and reconnection to lost memories, feelings and perceptions.
- An opportunity for women to experience a sense of competence and resolution as they face the demons from the past.
- An opportunity for women to trust their own perceptions about reality and to receive validation from others for those correct perceptions.[63]

TREM consists of 33 structured group sessions that cover a variety of topics. Each 75-minute session follows a framework that includes session goals, facilitated group discussions, and experiential group exercises. The 33-week program is divided into four core parts: Empowerment; Trauma Recovery; Advanced Trauma Recovery Issues; and Closing Rituals. A self-help workbook entitled Healing the Trauma of Abuse is available, allowing women to learn about the impact of trauma and work on their recovery through various readings and exercises.[64]

Pilot studies of TREM are promising, reporting a decrease in utilization of intensive services such as inpatient hospitalization and emergency room visits. Both group members and case mangers report decreased mental health symptoms among TREM participants and clinicians report lower rates of participant HIV high-risk behaviors. Over ninety percent of women who participated said the group was helpful, they felt supported by other group members, and they felt "more control" in their lives.[65]

Three project sites are using TREM (District of Columbia Trauma Collaboration Study, New Directions for Families, and the Boston Consortium of Services for Families in Recovery). One site is using the original format; two have made modifications. For example, New Directions for Families has adapted the model to better fit its residential treatment setting. The first 16 sessions are delivered twice a week during the first phase of treatment; the remaining sessions are held in the evening during the second phase of treatment while women participate in education, job training, and employment activities.

The number of TREM sessions offered ranges from 24 to 33, with each session running about 75 minutes in length. Groups of 8 to 12 women are facilitated by 1 to 3 mental health or substance abuse clinicians, some of whom are C/S/Rs. At two sites, groups are closed after the fourth week. The other site keeps the group partially open, with certain sessions designated as "no entry." Groups are held at outpatient mental health and substance abuse programs, residential substance abuse settings, and methadone maintenance programs.

The District of Columbia Trauma Collaboration Study and New Directions for Families both use Healing the Trauma of Abuse. In D.C., the workbook is used to supplement all trauma-specific services. New Directions for Families uses the workbook to help women who are entering TREM groups, especially those who enter a group later in the session sequencing. Additionally, the workbook is used individually with women who are not able to participate in a group intervention as well as those who request additional assistance with issues of trauma.

Seeking Safety

Seeking Safety is a cognitive behavioral psychotherapy treatment for individuals struggling with post traumatic stress disorder (PTSD) and substance abuse. The intervention is designed to help individuals with active substance abuse and PTSD to establish safety in their lives.

Guiding Principles of Seeking Safety

- Safety as the priority of "first stage" treatment.
- Integrated treatment of PTSD and substance abuse.
- A focus on ideals.
- Four content areas: cognitive; behavioral; interpersonal; and case management.
- Attention to therapist processes.[66]

Over ninety percent of women who participated [in TREM] said the group was helpful...

The study [of Seeking Safety] found significant improvements in substance use, trauma-related symptoms, suicide risk…social adjustment, family functioning, problem solving, depression…

Created by Lisa Najavits, Ph.D., Seeking Safety may be conducted either as a group or individual treatment. It covers 25 topics evenly divided among cognitive, behavioral, and interpersonal domains while simultaneously addressing the development of safe coping skills relevant to both substance abuse and PTSD. Each session is independent, allowing the order to be changed to match need. Topic titles include: Honesty; Asking For Help; Compassion; Taking Good Care of Yourself; Creating Meaning; Setting Boundaries in Relationships; and Integrating the Split Self.[66]

Each treatment session is divided into four parts. Sessions begin with a check-in process that explores how clients have been doing since the last session. A quotation is then read that reflects the topic of the session. The majority of the session is devoted to addressing the topic and relating it to participants' lives through role-plays, experiential exercises, discussion, and completion of a Safe Coping Sheet that requires clients to contrast old coping skills with new safe coping skills. The session ends with a two-part check-out that asks participants to identify one thing they got out of the session and make a commitment of one thing they will do during the next week to continue their recovery.

This treatment program has been conducted in a variety of formats and settings, including open and closed groups, 50 and 90 minute sessions, singly led and co-led, and outpatient or residential settings. It has been evaluated in five studies, one of which has been published. The completed study found significant improvements in substance use, trauma-related symptoms, suicide risk, suicidal thoughts, social adjustment, family functioning, problem solving, depression, cognitions about substance use, and didactic knowledge related to the treatment.[67] Participant satisfaction was very high.

Four sites (PROTOTYPES, Portal, Allies, WELL) are using the Seeking Safety model, modifying it to better meet the needs of the women they are serving and to mesh with other aspects of the intervention and service setting. Some have changed the order, pacing, and number of sessions. For example, the WELL Project has divided their Seeking Safety groups into two phases to allow women in residential settings to complete one phase during their stay. This has helped maintain group size by allowing groups to be combined into new groups for the second phase.

The number of sessions within a group cycle varies by site, ranging from 12 to 31. Sessions are held once or twice a week, depending on the service setting, and run from 75 to 90 minutes. Group size ranges from 8 to 12 women, although some sites begin groups once they have at least four women. Three of the sites do not permit new women to join a group once it has begun. The Allies project keeps the group open to new members for the first 12 weeks and then closes it for the remaining 12 weeks. Groups are provided in outpatient and residential settings.

PROTOTYPES, Portal and WELL have two individuals facilitate the group; Allies uses one or two, depending on the availability of a qualified and committed treatment program and drug counselor who can serve as a co-facilitator. Groups are often run by mental health and substance abuse clinicians/counselors. Projects often utilize co-facilitation of groups as a way to train new providers in this intervention. Several sites use counselors who are C/S/Rs.

Addictions and Trauma Recovery Integrated Model (ATRIUM)

The Addictions and Trauma Recovery Integrated Model (ATRIUM) is a manualized trauma recovery program that provides a bio-psychosocial framework to respond to the complex treatment needs of trauma survivors. Created by Dusty Miller, Ph.D. and Laurie Guidry, Ph.D., the model blends psychoeducational, process, and expressive activities to help women "recontextualize their experiences and adaptive strategies."[68]

It can be used with groups or individuals. The intervention is divided into four sections, each with three sessions:

Section One: The Theory of Trauma Reenactment; the role of traumatic stress in connecting problems of trauma, addiction and mental health; and an introduction to the construct of the Triadic Self and Protective Presence.

Section Two: The Impact of Trauma Reenactment on the Mind; the major mental health conditions of depression and grief, anger, fear and anxiety; addictions that are often present in these emotional states.

Section Three: The Impact of Trauma Reenactment on the Body; how Trauma Reenactment is expressed in the body through somatic distress (illness and chronic pain); how the legacy of trauma affects the ways in which women view their bodies (body image); how trauma is reenacted through the ways in which women experience touch and physical intimacy.

Section Four: The Impact of Trauma Reenactment on the Spirit, especially as spiritual well-being is understood as being in community; relationships with children, partners, friends, helpers, and with nature and animals.[68]

Components of ATRIUM

- The Theory of Trauma Reenactment.
- The Impact of Trauma Reenactment on the Mind.
- The Impact of Trauma Reenactment on the Body.
- The Impact of Trauma Reenactment on the Spirit.

Each session includes a didactic component, a process section to allow participants to share their own experience pertaining to the topic, an experiential component to teach new ways of responding to the issues addressed, and a "homework" assignment guided by a handout that reviews both the educational and experiential content of the session. Each participant is given a "workbook" to keep for her own use. At the end of the 12 weeks, the group may also add a topic important to them not yet covered.

Preliminary pilot testing suggests that individuals who participated in ATRIUM experienced improvements in their trauma symptoms. Group members experienced a decrease in behaviors designed to cope with and help manage the impact of trauma, including self-harm, substance abuse, suicidality and aggression, as well as a decrease in intrusive symptoms.[69]

The Franklin County Women's Research Project uses ATRIUM in its original format, featuring weekly 90-minute sessions held over 12 weeks at each of the project's three drop-in centers. Groups are co-led by two C/S/R women and are closed.

Triad Women's Group

The Triad Women's Group is a cognitive-behavioral integrated intervention for women with substance abuse and mental health disorders who have experienced violence. It is the only trauma-specific group model created by a SAMHSA study site specifically for the *Women, Co-Occurring Disorders and Violence Study*.

Preliminary pilot testing suggests that individuals who participated in ATRIUM experienced improvements in their trauma symptoms.

The [Triad] pilot study found an increase in adaptive coping skills and a decrease in avoidance behaviors...Women also experienced a decrease in mental health symptoms.

It is designed to promote survival, recovery, and empowerment, and to help women achieve six goals:

- Maintain immediate safety.
- Promote skill building.
- Maintain recovery and prevent relapse.
- Assist women to build on their own strengths.
- Build social supports and interpersonal effectiveness.
- Enhance members' capacities to cope with distress.[70]

Triad Women's Group Phases

- Mindfulness: Getting Comfortable With Yourself.
- Interpersonal Effectiveness Skills: Having Healthy Relationships with Yourself and Others.
- Emotional Regulation: Feeling Good.
- Distress Tolerance: Staying Healthy in a Stressful World.[70]

The group is divided into 4 phases. Each phase includes four sessions of two hours each to allow adequate time for exploration and processing of emotionally difficult issues. The structure of sessions varies. Facilitators lead a discussion, then women are encouraged to contribute to the discussion, share their recovery, and give supportive feedback. Women also participate in verbal, written, and expressive exercises.

Recommended group size is 5 to 10 women, allowing members to learn from each other without limiting individual "air time." The treatment can be used in inpatient and outpatient settings with either open or closed groups, depending on the setting. Open groups are suggested for inpatient settings to allow women to enter when they begin treatment.

A modified open format is recommended for outpatient settings, allowing new members to join only at the beginning of a phase.

The Triad Women's Group was piloted with 128 women during Phase I of the *Women, Co-Occurring Disorders and Violence Study*. The pilot study found an increase in adaptive coping skills and a decrease in avoidance behaviors associated with substance abuse and traumatized reactions, although these were preliminary results. Women also experienced a decrease in mental health symptoms.[71]

The Triad Women's Project is using the Triad Group model in its entirety within residential and outpatient settings. Groups are open in the residential settings; in non-residential settings, women can join groups at the beginning of each phase. Sessions are facilitated by a mental health or addiction professional. A co-facilitation model is used to train new facilitators.

Other Trauma-Specific Groups

Several sites provide other trauma-specific groups in addition to those described above. The most common are domestic violence groups that focus on understanding the cycle of violence within relationships and developing ways to stop the cycle. Topics often include anger, assertiveness, power and control, communication skills, and safety issues. Some of these groups are led by C/S/R women. Incest and sexual abuse survivor groups are also available at a few sites by referral.

The District of Columbia Trauma Collaboration Study has created a Spirituality in Trauma Recovery group.[72] This manualized group intervention of 11 sessions addresses spiritual and religious resources for empowerment and recovery from physical and sexual abuse. Group topics include: What It

Means To Be Spiritual; Spiritual Gifts; Spiritual Coping Strategies; Anger; Fear and Powerlessness; Shame and Guilt; Loneliness; Despair; Forgiveness and Letting Go; Hope and Vision; and Continuing the Journey of Healing.

INDIVIDUAL COUNSELING AND THERAPY

Six sites provide individual trauma-specific counseling and therapy. Most sites provide these services on an "as-needed" basis. Individual counseling is provided by program staff, consulting psychiatrists, and affiliated community providers.

PEER-RUN EFFORTS

Consistent with the overall focus on involving and integrating C/S/R women in all aspects of the project design, a number of peer-run trauma specific activities are underway at many sites. Many of the primary trauma-specific group interventions described above are run all or in part by C/S/R women, and many of the additional trauma-specific groups are peer-run.

OTHER TRAUMA-SPECIFIC SERVICES

A few sites provide non-verbal therapies such as relaxation and guided imagery work, either directly or through referral. Several sites have linked with trauma-specific services in their communities, such as battered women's shelters and rape crisis centers. Relationships between study sites and community services vary. Some refer women to the study. Others accept referrals from the study sites and provide direct services to women, or bring their services to the study site to assist with the intervention.

Consistent with the overall focus on involving and integrating C/S/R women in all aspects of the project design, a number of peer-run trauma specific activities are underway at many sites.

	PROTOTYPES Systems Change Center Culver City, CA	**Allies** Stockton, CA	**New Directions for Families** Thornton, CO	**DC Trauma Collaboration Study** Washington, DC
Model	Seeking Safety	Seeking Safety	TREM	TREM
Number of Sessions Duration Frequency	31 1 ½ hours 2x per week	24 1 ½ hours 1x per week	24 1 hour 15 minutes 2x per week (1-16)	33 1 hour 15 minutes 1x per week
Location	Residential and outpatient	Community agencies; outpatient	Residential	Community agencies
Leaders	2 leaders co-led by mental health professional and substance abuse counselor (typically a C/S/R)	1 leader (sometimes with co-facilitator); mental health professionals; peer substance abuse counselors; C/S/Rs	1 leader (sometimes co-facilitator); primary therapists	2 to 3 leaders; mental health professionals
Missed Session	Given handouts	Review individually with counselor; materials provided in person or by mail	Use workbook and process material with primary therapist	Does session in self-help workbook with optional help of a mental health professional or peer
Open/Closed	Closed	First 12 sessions are open; second set of sessions is closed	Partially open; some sessions designated "no entry"	Closed after 4 weeks
After-Group Supports	Other groups (DV, grief and loss); 1:1 with staff as needed	Provide list of other resources in the community	Residential treatment setting with 24 hour staff support and formalized C/S/R and alumni support following groups	Peer support; case managers if needed
C/S/R Involvement	Co-facilitators; available after groups	Involved in planning intervention and evaluation design; some serve as group facilitators	Available for additional support; can co-facilitate groups	Involved in development of intervention; available for peer support; meet with prospective participants
Supervision	Co-facilitators meet; meet with project directors 2x per month	2 hours weekly by LCSW	Team leader supervises group leaders individually 2x per month; use of audiotapes and fidelity checklist	New leaders co-lead with experienced clinician then meet after session

Interventions by Site

Triad Women's Project Avon Park, FL	**Boston Consortium of Services for Families in Recovery** Boston, MA	**Women Embracing Life and Living** Cambridge, MA	**Franklin County Women's Research Project** Greenfield, MA	**Portal Project** New York, NY
Triad Women's Group	TREM	Seeking Safety	Atrium	Seeking Safety
16 (can repeat) 1 1/2 - 2 hours 1x per week	25 1 hour 15 minutes 1x per week	25 1 hour 15 minutes 1x per week (sometimes 2x per week)	12 1 1/2 hours 1x per week	12 1 1/2 hours 1x per week
Residential; outpatient; transitional living settings; jail	Methadone maintenance; outpatient and residential substance abuse	Residential and outpatient	Drop-in resource centers	Residential
1 leader (co-facilitator as a training model); mental health or addictions professionals	3 leaders; mental health professionals (some are C/S/Rs)	2 leaders; substance abuse or mental health professionals (may be a C/S/R)	2 leaders; CSRs	2 leaders; mental health professionals
	No make-up; follow up to keep client engaged	Given written materials; review with case manager	Abbreviated make-up session	Contact woman who misses; remind before sessions
Open in residential; in non-residential can join at beginning of a phase	Closed after session 4	Modified closed (can join at beginning of each phase); some open	Closed	Closed
Case managers; crisis services if needed; 12-Step groups; WOW groups	Individual counselors; TREM facilitators	Integrated Care Facilitators and counseling staff; Well Recovery Group; other groups; referral to other trauma services	Drop-in centers' resources; Peer Resource Advocates; referrals to other trauma-centered groups	Peer run support group; individual sessions with mental health professionals
Some C/S/Rs are co-facilitators; participate in team meetings 2x per month	Co-facilitators	Involved in planning intervention; C/S/Rs available to speak to women before group	Multilevel involvement of C/S/Rs in the conceptualization, development and inplementation of the trauma-specific group intervention	Not with trauma intervention; provide other peer run services
2x per month meeting of facilitators; consultation from Triad coordinator	Weekly by director of clinical interventions; Community Connections consultation	Meet with Integrated Care Facilitators every 1-2 weeks	2x per month supervision by Dr. Dusty Miller	Individual and group supervision by trauma specialist and second clinician

Redesigning Systems and Services to be Trauma-Informed

Services to help women address the impact of trauma must be a component of any integrated service response for women with substance use, mental health problems, and histories of violence. Equally important, service providers must be knowledgeable about trauma and sensitive to its effects on women. A woman may be unable to participate in a substance abuse program, for example, if the program's practices act to worsen her trauma-symptoms or are perceived as dangerous or threatening.

The *Women, Co-Occurring Disorders and Violence Study* has provided significant insight into the many ways in which current service approaches, practices, and arrangements are insensitive to the presence of trauma as well as to how services can be modified to be responsive and successful in helping women heal. This section describes: definitions and principles of trauma-informed services as developed by a cross-site workgroup; profiles of various trauma-informed services for women with substance abuse and mental health disorders; strategies used by sites to make services trauma-informed; and other issues.

DEFINITIONS AND PRINCIPLES OF TRAUMA-INFORMED PROGRAMS AND PRACTICES

Trauma-informed services involve understanding, anticipating, and responding to the issues, expectations, and special needs that a person who has been victimized may have in a particular setting or service. At a minimum, trauma-informed services should endeavor to do no harm — to avoid retraumatizing survivors or blaming them for their efforts to manage their traumatic reactions.

The *Women, Co-Occurring Disorders and Violence Study* Workgroup on Trauma, comprised of representatives across project sites, has developed principles, guidelines, and definitions for trauma-informed approaches at both the service and systems levels. Along with changes at the service level (provider-survivor relationships and activities), change must also occur at the systems level (agencies, organizations, programs or service networks). Both levels must draw on knowledge about the role and impact of violence in order to develop services that are welcoming and appropriate, facilitate recovery and healing, and foster survivor empowerment.

In trauma-informed services, a woman must be a full partner in determining her goals and how she participates in services...

Service Level

Characteristics of Trauma-Informed Services

- Infused with knowledge about the roles that violence and victimization play in the lives of women.
- Designed to minimize the possibilities of victimization and re-victimization.
- Hospitable and engaging for survivors.
- Facilitate recovery.
- Operate on an empowerment model.
- Respect a woman's choices and control over her recovery.
- Based on a relational collaboration between the woman seeking services and the service provider that minimizes the power imbalance and in which goals are mutual and collaboratively established.
- Emphasize women's strengths.

In an empowerment model, a woman: experiences validation of her experiences and choices; increases her sense of inner-strength by building on her existing strengths; gains knowledge about herself and others; and increases her sense of self-worth and competence, and her ability to take action on personal goals. She is encouraged to move beyond herself in the healing process as she becomes more engaged with others, expands her resources and support networks, and understands her situation within a larger societal context. A woman may become an advocate for herself and for others, or on behalf of causes important to her.

Choice and control are major issues for survivors, since they may have had little of either within violent or exploitive relationships and situations. In trauma-informed services, a woman must be a full partner in determining her goals and how she participates in services, with the paramount aim of increasing her ability to make these choices.

Specific principles of trauma-informed services mentioned by sites include:

- Trauma-informed programs identify and recognize the presence of trauma, especially when it has occurred early and repeatedly, and acknowledge and respect managing trauma as a central concern in a woman's life.
- Symptoms are adaptations to traumatic events that seek to manage the experience of the event. Behavior adaptive in those situations may seem maladaptive in other situations and be the basis for a psychiatric diagnosis.
- Adaptive behavior should be viewed as a strength rather than a deficit. These responses should be reframed as positive coping with a past experience, while the woman is assisted in learning alternative responses appropriate to her current situation.
- Service providers need to understand how trauma is triggered, what women may need when it is triggered, and how to create safe spaces in which women can manage their symptoms.
- Violence, trauma, and recovery occur in relationships. As such, women can be healed in relationships that are empowering, and focus on supporting strengths and learning.
- Violence and trauma shape a person's belief system, feelings, self-perception, and relationships with others.
- Services must first validate a woman's feelings. Re-framing strategies should provide detailed information and involve the woman in making choices about her opinions, convey concern and caring, be respectful of boundaries, and provide hope for change.
- Providers need to meet the woman where she is, with readiness assessments, pacing, and patience.

Trauma-informed programs and services must screen for and respond to the consequences of past violence and related trauma in women's lives and attend to the presence of current violence. A woman will be unable to work on symptoms of past trauma while contending with current violence or lack of safety. Safety needs to be the priority, regardless of other issues. The possibility of active violence should be assumed and assessed for during initial screening and regularly thereafter — not only when a woman raises such concerns or if obvious cues are present. Options for shelter and legal assistance (e.g., restraining orders) should be readily available.

Trauma-informed programs must also be alert to the ways in which their practices and policies can put women in danger. Absolute confidentiality is a necessity when a woman is being stalked or her children are at risk of being taken by her batterer. Women should not be interviewed with family members or partners until it is clear if violence is present, who is perpetrating that violence, and who is in collusion. Women should not be referred to programs that also provide services to their perpetrators, especially in detoxification centers. It is not uncommon for a perpetrator to follow a woman into treatment to keep her under surveillance. Perpetrators are often threatened when a woman seeks treatment and violence may escalate when she makes progress on her own or tries to leave.

Cultural competence is important, since violence and trauma can have different meanings across cultures, and healing can only take place within a woman's cultural and relational context. In addition to general principles of cultural competence, staff should explore the meaning of violence within a woman's family and culture, and, if necessary, work to reframe it while being respectful of cultural norms and traditions. The Boston Consortium of Services for Families in Recovery infuses cultural examples throughout their curricula and provides Spanish-language versions of all project materials. A Spanish-language cultural adaptation of TREM was developed by this site and is available from the Boston Consortium of Services for Families in Recovery.

Systems Level Change

At the systems level, change towards a trauma-informed approach:

- Involves fundamental shifts in structure, culture, and practice.
- Usually precedes change at the service level (but may also occur in cycles).
- Facilitates, supports, and reinforces service level change.

Steps Towards Systems Level Change

- Administrative commitment to change.
- Development of policies that require and facilitate inclusion of C/S/R women in all aspects of service planning, delivery, policymaking, and evaluation.
- Universal screening.
- Wide-spread training and education.
- Hiring practices that give priority to candidates who understand and are committed to trauma-informed services.
- Review of all policies and procedures to ensure that trauma-informed practices are standard, and that alternatives to potentially harmful procedures are established.[13]

Training and education must occur at all levels of an organization, because administrators, supervisors, and policymakers must understand trauma and its impact, and take responsibility for necessary changes in policy and administration. The centrality of trauma should be included in mission statements or program philosophy and objectives.

The centrality of trauma should be included in mission statements or program philosophy and objectives.

Trauma should be acknowledged early on so that a woman can engage in services at her own pace.

TRAUMA-INFORMED SERVICES

Project sites worked to make the services women receive trauma-informed in order to support the trauma-specific interventions they were implementing, enhance engagement and retention in treatment services, and facilitate long-term quality of life and wellness. It is beyond the scope of this paper to document all the trauma-informed services provided by each site. Learning from site activities, we offer profiles of how the study's eight core services were adapted to be more trauma-informed along with examples from the study sites.

Outreach and Engagement

Outreach is especially important for trauma survivors since they may feel unworthy or uneasy about receiving assistance or unaware of what services might be helpful. Victimization undermines one's ability to trust, making the process of seeking help quite difficult. A survivor may make tentative contacts a number of times before she is able to fully engage in treatment.

Outreach strategies should incorporate knowledge about how trauma disrupts and alters engagement processes. Trauma should be acknowledged early on so that a woman can engage in services at her own pace. A woman should be asked about what helps her to feel safe. Initially, engagement may require some emotional distance.

All the sites reported the need to get much more specific about histories of violence and symptoms of trauma in all outreach and engagement contacts. This was found to help normalize the experiences and indicate that they would be addressed and respected should a woman decide to seek assistance.

Many sites found that C/S/R women served as an effective first contact point for services. The Women's Support and Empowerment Center, a part of the District of Columbia Trauma Collaboration Study, is a place where women can visit prior to an official intake appointment. A part of this peer-run drop-in center's mission is to serve as a welcoming location for potential clients to gather information about the agency and its services and make initial contact with other survivors. The D.C. site also developed a videotape (Women Speak Out) in which survivors describe the impact of trauma in their lives. This tape is used in outreach training efforts with community providers.

Screening and Assessment

All human service agencies screen potential clients to determine if they are appropriate candidates for their services and to identify individual service needs. Programs that are trauma-informed assume that everyone is likely to be a survivor of trauma and implement universal screening and precautions for trauma and related symptoms within their standard screening processes.

Sites grappled with how best to conduct trauma screening and assessment activities. It can be difficult to identify the presence of violence because women often underreport their traumatic experiences. Survivors may not remember some traumatic experiences or have covered them up by using alcohol or other drugs or psychosocial coping mechanisms. They may not understand their experiences to be violence, especially if perpetrators have told them they were being "disciplined" for bad behavior or if they have no normative experiences of being treated respectfully. Traumatic reactions often are diagnosed as pathological symptoms of mental illness or disruptive/delinquent behavior. Many survivors also have deep problems with trust, having been violated in previous contacts with systems and services that are uninformed about trauma. They may fear being stigmatized and experience shame about their experiences. Sites also were challenged with how to gather trauma-related information when routine

questions were sometimes experienced as intrusive or triggered traumatic reactions.

Sites found that it was important to conduct early and repeated assessments of histories of violence, the presence or threat of current violence, and the degree of trauma symptoms since these may not be disclosed initially. Screening must be done respectfully and the provider must explain why the information is important and how disclosure will benefit the client. It must be made clear throughout the process that a respondent can refuse to answer any questions. Sites found it important to allow women to be in charge of what types and how much information they convey. Even if a woman is unable to address trauma issues initially, screening and assessment for violence acknowledges its importance and signals that the program is prepared to hear about and respond to these painful experiences.

A number of sites modified their assessment processes to be more trauma-informed. PROTOTYPES Systems Change Center created an integrated readiness assessment that includes HIV risk behaviors, health issues, substance abuse, mental health, and violence. A woman assesses her readiness to work in all of the areas and the program begins with the ones she is most ready to address, while working toward readiness in all areas. The Boston Consortium of Services for Families in Recovery and the Franklin County Women's Research Project used trauma experts to assist with assessments at multiple project sites. New Directions for Families involved C/S/R women in the revision of their screening and assessment protocols; this helped to identify how certain language could trigger trauma symptoms and be experienced as disempowering. The Triad project created an interagency assessment tool that was used by many agencies in the community and provided training on its use. This ensured that clients received a similar, trauma-informed assessment and also facilitated information exchange across agencies. The Franklin County Women's Research Project has developed a trauma-informed screening and assessment brochure for use by area providers.

Substance Abuse and Mental Health Treatment Activities

In order to be trauma-informed, substance abuse and mental health services must reflect an understanding of how experiences of violence are integrally intertwined with issues of substance abuse and mental illness. Trauma must be understood as a core event that is often central in the lives of survivors and cannot be handled in a parallel fashion or addressed only if it interferes with other treatment efforts. Programs and staff must understand that relationships among substance abuse, mental health, and violence are often complex and multi-determined *(see the section on The Impact of Trauma on Women's Lives)*.

For women with this constellation of experiences, service plans need to address all of the issues concurrently and must be done in respectful and safe environments. Many commonly used mental health and substance abuse practices can trigger traumatic reactions and be experienced as unsafe and abusive. Public disclosure of symptoms and histories is often promoted in ways that do not allow survivors to control their own boundaries and that increase shame. In substance abuse settings, strongly confrontational approaches do not respect or support a woman's right to establish her own pace and can damage fragile coping mechanisms. In addition, these efforts can trigger defensive or flight behaviors that prevent a woman from staying in treatment. In mental health settings, physical and/or chemical restraints are often retraumatizing, triggering past experiences of violence that often cause further harm. Many symptoms associated with trauma can be perceived

...screening and assessment for violence acknowledges its importance and signals that the program is prepared to hear about and deal with these painful experiences.

Case managers need to be knowledgeable about the effects of trauma and strategies for managing trauma symptoms.

as resistance to treatment or signs of pathological thinking, not as survival mechanisms that worked in violent environments. Distinguishing between suicidal thinking and gestures and incidents of self-harm (common among survivors of violence, but not suicidal in intent) can be particularly difficult in both settings.

The Franklin County Women's Research Project's trauma liaison has worked closely with hospital staff and area agencies to reinterpret behaviors initially perceived as combative and/or reflecting a lack of motivation. Understanding these behaviors as reactions to fear allowed staff to respond to them differently, which then allowed the traumatic reactions to subside. Some sites have developed specific models for trauma-informed mental health and substance abuse treatment. For instance, the D.C. Trauma Collaboration Study has a 20-session manualized substance abuse intervention and a three session didactic on violence designed for inpatient psychiatric settings.

Programs must also work very hard to ensure current safety, in terms of relationships with others participating in the substance abuse or mental health treatment programs. This includes not allowing a woman's batterer to enroll in the same program and not interviewing a woman with family members present until active violence is ruled out. The WELL Project reports multiple examples in which they assisted a participating program, especially those engaged in detoxification activities, to find another treatment location for a woman's abusive partner. Sexual harassment policies are important to have and enforce in both overt and covert ways among program participants and staff. Women are likely to need some women-only spaces since experiences of violence are less likely to be discussed with men present and co-gender group dynamics can be disempowering for women survivors.

Parenting Skills

The introduction of trauma as a topic in parenting groups can initially result in a struggle between needing to attend to trauma issues while retaining a primary focus on building parenting skills. Training on parenting skills requires a careful balancing of material and approaches since developing empathy with a child often requires exploration of one's own experiences of being parented. Histories of trauma can affect a person's reasons for having a child and can lead to overprotectiveness, fear, and unrealistic behavioral expectations of the child and of one's self as a parent. The objective is to make a connection between the past and the present without delving more than is necessary into prior traumatizing experiences. The WELL Project found they needed more structure and a more directive style in their parenting groups once they introduced trauma as a topic. They also reduced the amount of material on parents' family-of-origin in order to reduce triggers for trauma reactions.

Resource Coordination and Advocacy

Case managers need to be knowledgeable about the effects of trauma and strategies for managing trauma symptoms. Although women can gain these skills through trauma-specific interventions, resource coordination staff may need to support a woman to use her skills in different situations. For example, trauma can be a barrier to seeking health care and remaining in treatment. Many health and dental procedures are perceived as invasive and dangerous by survivors. Staff can help by educating health care staff, helping women anticipate what to expect and prepare for it, and accompanying women or providing other support as they seek health care. HIV prevention providers should be aware that survivors may not be able to implement many of the recommended safe-sex practices within a context of violence.

Case managers with the New Directions for Families project have become more aware of the impact of trauma on women's experiences within services and activities outside the primary treatment program. They work hard to assist women in anticipating potential traumatic reactions to dental or medical procedures and to practice techniques for managing traumatic reactions should they occur. Triad Specialists work closely with staff in community agencies to develop trauma-informed follow-up plans. For example, in recognition that project-eligible women needed more continuous engagement and ongoing post-treatment contact, Triad staff discussed strategies with agency directors to identify and enable resources that permitted Triad Specialists to serve women after they were discharged from treatment. They suggested more home visits as part of their case management service model, as this promotes for many women a feeling of safety and a positive relationship with the caregiver. Triad Specialists also work hard to contact women who drop out of treatment to identify and address barriers to on-going participation.

Trauma-Specific Services

Sites found that it was not sufficient to just implement trauma-specific services. These services must be provided in ways that are sensitive to the impact of trauma and occur within a service setting that is trauma-informed. Trauma-specific groups must be conducted in spaces that are hospitable and safe. Participants must be allowed to set their own pace in the groups and determine when and how they share their trauma stories. Strategies for managing trauma symptoms must be reinforced and supported throughout other aspects of the program.

Crisis Intervention

Many women experience crises as they enter into services and may have others at various points throughout their recovery. Relapse and exacerbation of mental health symptoms are especially common. Various types of traumatic reactions as well as medical emergencies, court appearances, the appearance of a batterer/ perpetrator, and threat of abduction of a child during a custody dispute can all create crisis situations that must be addressed.

Sites found it useful to anticipate and prepare for these situations as much as possible. Many sites (especially nonresidential ones) adapted domestic violence safety plans that help women to keep copies of important papers, emergency supplies and clothing in safe, easily accessible locations and develop escape routes should they need to flee a violent situation. Safety for children and pets are important parts of these plans. Several sites also developed modified “advanced directives”, initially developed for end of life situations, in which women can specify how they wish a situation to be handled should they relapse or need to be hospitalized for mental health reasons. In these plans women indicate who should be called, where children should go, what other arrangements should be made, and what safety precautions are important.

In addition, some sites report developing particular types of services to reduce the likelihood that crises will occur. The Boston Consortium of Services for Families in Recovery implemented groups to assist women with co-occurring disorders in building skills to cope with two major sources of stress in recovery: financial management and the process of family reunification. These groups assist women in managing their financial situations and preventing financial crises and assist women in addressing the stress related to child custody issues. Curricula

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Participants must be allowed to set their own pace in the groups and determine when and how they share their trauma stories.

…involvement by women who have had traumatic experiences… draws on their unique knowledge about what service providers and policymakers do that is helpful or harmful.

for both groups were developed in English and Spanish. Many of the trauma-specific interventions have components that are designed to anticipate problems and develop coping skills that can help prevent some trauma-related emergencies.

Peer-Run Services

Several sites have developed peer-run services and supports to augment services being provided by professional staff. Peer-run services and supports can provide inspiring role models, safe activities for women and children in which they can observe parenting and learn to play, and safe spaces in which women can be heard and appreciated by other women. These can operate at times and locations in which formal services are not available. The Triad Project sponsors Wisdom of Women (W.O.W.) groups that are peer-run support groups for women living with trauma, mental health and substance abuse issues.

STRATEGIES FOR MAKING PROGRAMS AND SERVICES TRAUMA-INFORMED

Sites used a number of strategies to make their own services and those provided by other community agencies more responsive to the needs of trauma survivors. In some instances sites reported using similar strategies with adjustments in timing and sequence. In others, strategies differed based on environmental context, mix of programs, and existing relationships between groups and participating organizations. Many of these strategies are described below.

Strategies for Making Programs and Services Trauma-Informed

- C/S/R integration and empowerment.
- Assessing structures and practices.
- Promoting a shift in thinking.
- Systems "boundary spanning" strategies: interagency planning groups and co-location of services.
- Service "boundary-spanning" strategies: trauma specialists, multi-disciplinary service teams, and co-facilitation of trauma groups.
- Training and education.
- Supervision.
- Pilot work.

C/S/R Integration and Empowerment

Active involvement by women who have had traumatic experiences intertwined with other life problems draws on their unique knowledge about what service providers and policymakers do that is helpful or harmful. Their involvement in all aspects of policy, planning, and implementation enhances the overall effectiveness and quality of services and helps ensure that services, procedures and policies are trauma-informed. In addition, involving C/S/R women in program operations helps facilitate empowerment as women with similar experiences work to validate and support each other.

The most frequently used strategies for facilitating C/S/R involvement and empowerment at the *Women Co-Occurring Disorders and Violence Study* sites were:

- Hiring C/S/Rs as program staff.
- C/S/R membership on project committees.
- Training and other support for C/S/R women.

C/S/R women are woven throughout all aspects of the Franklin County Women's Research Project both as paid staff and volunteers. The site takes great pride in visitors not being able to identify participants from staff. Like most sites, the Allies Project created a C/S/R Advisory Council that was responsible for reviewing and providing feedback on all project procedures and materials.

Assessing Structures and Practices

Sites reported that to become trauma-informed, it was necessary to review organizational structures, policies, and practices (at all levels of the service system) and identify ways in which disempowering and unsafe situations occurred. Once identified, changes needed to be made to make program operations more responsive to the needs of survivors.

Several projects developed philosophy statements about the importance of trauma and organizations committed themselves to becoming trauma-informed. Some sites developed formal agreements with collaborating agencies that contained principles for trauma-informed practice.

For example, the WELL Project's State Leadership Council developed a set of principles that all major state agencies and provider agencies signed onto, committing them to examine their current policies and practices, funding guidelines, and licensing procedures. Provider self-assessment questionnaires were used by some sites to assess current practice and prioritize improvement efforts. PROTOTYPES Systems Change Center developed an "organizational readiness to change" assessment tool to help participating agencies and determine where they should begin their training efforts.

Promoting a Shift in Thinking

Several sites found that they needed to work towards a fundamental shift in how trauma was viewed and understood by their own staff and those from other organizations, as well as how survivors themselves were viewed and understood. The Portal Project reported that many staff members initially believed that trauma could not be addressed until substance abuse, practical life challenges, and major mental health symptoms were addressed and stabilized. This began to change with education and training and after witnessing the impact of trauma-specific and trauma-informed services. Sites report encountering substantial skepticism and resistance until new ways of thinking and practicing became more routine.

Systems "Boundary Spanning" Strategies: Interagency Planning Groups and Co-Location of Services

All sites created cross-agency workgroups to facilitate collaboration across organizational boundaries. Most sites established more than one workgroup to operate at different systems levels (e.g., administrators, policymakers, supervisors, etc.). These groups promoted systems change by developing a common vision statement, working on accessible language, reviewing existing community services to assess strengths and gaps, and overseeing project implementation.

The Portal Project created a Policy Action Committee made up of representatives from various agencies that identified policy and administrative

…sites found that they needed to work towards a fundamental shift in how trauma was viewed and understood...

The most common [service integration] efforts included the use of trauma specialists, multi-disciplinary service teams, and co-facilitation of trauma groups.

barriers and worked on ways to address them effectively. PROTOTYPES Systems Change Center established a Local Experts Group that is assisting them to diffuse trauma-informed practices throughout the service system. The Franklin County Women's Research Project held quarterly service integration meetings that were chaired by the project's trauma liaison and attended by representatives from the local hospital and area mental health and substance abuse providers. Some sites incorporated trauma perspectives into substance abuse and mental health services by delivering multiple services at a single site, often using staff from multiple programs. The Allies Project located their Seeking Safety groups within different mental health and substance abuse sites in the community and the Boston Consortium of Services for Families in Recovery provided TREM groups in various substance abuse treatment settings.

Service "Boundary-Spanning" Strategies: Trauma Specialists, Multi-Disciplinary Service Teams, and Co-Facilitation of Trauma Groups

Sites used a variety of mechanisms to help integrate mental health, substance abuse and trauma services thus ensuring that all services available to women were trauma-informed. The most common efforts included the use of trauma specialists, multi-disciplinary service teams, and co-facilitation of trauma groups.

A number of sites have one or more people on staff who are experts in trauma and whose job includes assisting participating agencies and staff in becoming more trauma-informed. These individuals conduct staff training, assist with supervision, attend staff meetings, and participate in case conferences. At the Franklin County Women's Research Project, the trauma liaison regularly participates in the mental health and substance abuse units of the local hospital, bridging the two services and incorporating trauma knowledge into their work. At the Boston Consortium of Services for Families in Recovery, the Trauma/Mental Health Services Coordinator helps conduct trauma assessments and participates in case conferences at all project sites, thus infusing staff education about trauma across the sites. The Boston Consortium also conducts a monthly Interdisciplinary Resource Team (IRT) meeting where anonymous cases are presented and the integration of trauma and mental health are discussed among the counselors and mental health providers. It is another avenue for staff education on trauma and hands on support for integrated treatment planning.

Some sites use a variety of multi-disciplinary teams to implement their integrated service efforts. These multi-disciplinary efforts include a strong emphasis and expertise on trauma, which makes them an effective strategy for helping to make services and programs trauma informed. Some sites developed multi-disciplinary teams with representatives from different agencies who collaborate on care planning, cross-agency problem-solving, and meeting supervision and education needs. These teams might be comprised of staff from a single organization, such as a hospital that was the primary site for both mental health and substance abuse services (Franklin County Women's Research Project) or from multiple agencies. The Portal Project conducted multi-disciplinary team case conferences in which staff from different disciplines and agencies could pool their knowledge to review and revise case plans.

At many sites the trauma-specific groups were co-facilitated by clinicians from different agencies and/or disciplines. Often, someone who was trained in working with trauma co-facilitated these groups with staff from the host agency thus

helping to educate agency staff on trauma. These staff in turn helped to make their home agencies more trauma-informed and responsive to the needs of survivors.

Training and Education

All sites reported the importance of early and repeated training and education in working to make services, programs, and systems more trauma-informed. All sites stressed the importance of providing training and education at all levels — clerical, support and line staff, policymakers, administrators, and supervisors — because services, program philosophies, policies, and internal and external barriers to change needed to be identified and addressed.

Training within programs not only increased knowledge and skills, but also helped to identify issues and establish a new culture. Cross-training across agencies involved exchanges among program staffs and outside experts who provided centralized cross-site educational sessions.

Sites found that becoming trauma-informed was a continuous process, not a one-time event. People and programs at differing stages of readiness require appropriate information and training. New approaches take time to be reinforced and deepen. In addition, high staff turnover at most sites and at collaborating agencies necessitated repeated training to provide knowledge and skills to new staff. On-going training activities also facilitated formal and informal networking across programs, allowing people to learn about each other and various programs' approaches and philosophies.

Supervision

Although some professional learning and development occurred during in-service and other training sessions, supervisory sessions were also important. Trauma-informed work requires higher levels of clinical skills than are often present at community-based programs. Regular, knowledgeable trauma-informed supervision is extremely important. Staff also need support to manage their own reactions to the traumas they hear about and those they have experienced themselves.

Empowerment approaches require regular reframing of typical interpretations of behavior. When the trauma liaison at the Franklin County Women's Research Project assisted emergency room staff to understand that "belligerence" from one woman was a response to fear and a way to maintain boundaries in a perceived high-threat situation, this understanding led to a different staff response and made it possible for the woman to receive the health care services she needed.

Pilot Work

All of the sites piloted trauma-specific interventions during the start-up phase of the project. Many reported making significant modifications as a result of these "trial runs", not just to the trauma-specific intervention, but also to organizational procedures surrounding the intervention. All sites reported the benefits of starting small and learning as they went. As their pilot efforts grew, original staff partnered with newcomers to share knowledge and experience. Recognizing and rewarding progress was not only important for morale, but also helped to disseminate strategies for success. The Boston Consortium of Services for Families in Recovery modified a number of aspects of its TREM groups so that they would be compatible with existing practices in agencies in which they were delivered. They also developed and pilot tested a Spanish translation and cultural adaptation of TREM.

Sites found that becoming trauma-informed was a continuous process, not a one-time event.

Program staff often had difficulty distinguishing between trauma-specific and trauma-informed services.

OTHER ISSUES

Program staff often had difficulty distinguishing between trauma-specific and trauma-informed services. In some instances, less experienced staff may not fully understand the distinctions, causing them to use the terms interchangeably.

As staff who are already knowledgeable about substance use or mental health problems become more skilled in working with trauma, they are better able to infuse trauma-specific techniques into their routine work. This might include using basic grounding and other trauma symptom management techniques into their group work on substance abuse issues. Thus, their practice is becoming both more trauma-informed and increasingly effective in directly addressing trauma-symptoms.

Some situations may require a practitioner to combine trauma-informed and trauma-specific approaches. This may be especially indicated in resource coordination and advocacy where the goal is to help women access the services they need. The resource coordinator or case manager must know enough about trauma to avoid triggering trauma symptoms and to understand the impact of trauma in multiple areas of a woman's life. They may also be called on to help a woman manage her symptoms so that she can take advantage of available resources. At the same time, a case manager may need to educate other providers about the impact of violence so they can understand how to assist a woman in a trauma-informed manner.

In addition to training about trauma, in a coordinated system of services, other types of cross-training are also necessary so that programs addressing violence against women become more knowledgeable about substance abuse and mental health issues.

As substance abuse and mental health programs make the commitment to become more trauma-informed, programs focusing on violence have to screen for substance use and mental health problems, and to learn how to support sobriety and emotional and physical well-being.

Challenges and Lessons

CHALLENGES IN DEVELOPING TRAUMA-SPECIFIC AND TRAUMA-INFORMED SERVICES

The *Women, Co-Occurring Disorders, and Violence Study* sites faced numerous challenges and barriers as they worked to create trauma-specific and trauma-informed services. Many of these challenges, and the strategies sites used to address them, are described below.

Challenges to Developing Trauma-Specific and Trauma-Informed Services

- Philosophical differences.
- Resistance at the service level.
- Resistance at the administration level.
- Limited resources.
- Consistent participation in trauma groups can be difficult.
- Staff turnover.
- Change is difficult.

Philosophical Differences

Philosophical differences between mental health and substance abuse created challenges for sites in determining the appropriate treatment approach for women with co-occurring disorders. Substance abuse and mental health treatment services are usually organized separately with varying treatment approaches. For example, substance abuse systems typically maintain a "disease" model of addiction, in contrast to mental health systems which are more likely to view addiction as a symptom of an underlying mental disorder or as result of self-medication needs. In addition, the substance abuse treatment approach is often confrontational, presenting clients with the consequences of their behaviors, while mental health traditionally operates under a bio-psychiatric and/or case management support model.[59] When these projects began, many sites were not operating within agencies that had focused on integrating mental health and substance abuse which required discussion and consensus around how to most effectively address the needs of women in

Many providers saw the initiation of trauma services as opening "Pandora's Box," creating needs that could not be met.

the study. Many aspects of the interrelationship between the two needed to be ironed out including the timing and course of treatment, treatment strategy and staffing.

Differences around issues of trauma also made it difficult for sites to implement their trauma agendas. At the project's inception, none of these communities had a commonly held philosophy about the impact of trauma and appropriate service responses. In addition, they did not use a common language. PROTOTYPES Systems Change Center had an additional focus on trauma and welfare reform efforts in Los Angeles County; using this as a crisis opportunity. However there was some tension between domestic violence and other types of trauma. Welfare reform only addressed issues of domestic violence, failing to consider that childhood trauma and community violence are also real issues for many women. PROTOTYPES found it difficult to negotiate bureaucratic definitions and still meet the service needs of women.

Sites found that a collaborative, open planning process was critical to reaching a shared understanding of the problem and developing appropriate service responses. It was important to carefully manage the change process, paying close attention to clinical and political realities. The Franklin County Women's Research Project reframed issues so they could be seen from the client's perspective and worked hard to find mutual ground among all stakeholders.

Resistance at the Service Level

Initially, all sites encountered resistance, hesitation, and concern at the service level — both within their own organizations and the larger community. Many providers saw the initiation of trauma services as opening "Pandora's Box," creating needs that could not be met. Some providers saw trauma-specific and trauma-informed services as highly specialized treatment areas that they did not feel equipped or qualified to provide. Other providers were concerned that assessing for trauma histories would trigger unmanageable symptoms and that providing trauma-specific groups would reduce women's safety by encouraging them to discuss traumatic events in detail. Several sites encountered providers who did not believe that trauma was a primary issue for women with co-occurring disorders or who believed that multiple disorders needed to be addressed in a sequential (not integrated) fashion. Many sites report that community providers are tremendously over worked, and the creation of new services and activities was viewed as yet another thing they had to do.

Sites believe that much of this concern stemmed from a lack of knowledge about the impact of trauma, and appropriate clinical and service responses. Several sites report that some resistance at the service level was the result of unresolved personal trauma issues that made it difficult for clinicians to feel comfortable working in this area.

Training and other educational strategies have worked well to address provider concerns, actively engaging them in trauma issues, and fostering a shared philosophy and vision. Sites have had the most success with provider training when they offer continuing education credits and release time to participate. Several sites noted that the opportunity to gain new knowledge and share information were key attractions for clinicians.

In Phase I of the project, Allies invited providers to participate in an entire TREM group so that they would both become familiar with the intervention and have a personal opportunity to address their own trauma issues. Some sites found that co-facilitation of trauma-specific groups helped to expand knowledge and support for trauma-informed and trauma-specific services. These efforts allow providers to understand the importance of addressing

trauma issues and feel confident that the project has developed an adequate response. Locating trauma-specific groups within other service organizations also helped to reduce resistance at the service level.

As noted, on-going, active supervision and on-site technical assistance and support by individuals who are knowledgeable and experienced in trauma issues has been critical. Involving C/S/R women as trainers and advocates has also been effective. The D.C. Trauma Collaboration Study trauma services referral handbook was designed to respond to provider concerns about not having places to send people once issues of trauma were uncovered. Distributed to providers throughout the city, it offered detailed information on the city's trauma services including service approach, duration, location, transportation, cost/insurance information, and contact people.

Resistance at the Administrative Level

Many sites met resistance from mid- and senior-level administrators. Sites encountered philosophical differences around the importance of trauma and the need for integrated services. Some administrators did not believe that services and systems could be altered without substantial funding and without hindering agency reimbursement and cash flow. Others believed their staffing resources were too limited to participate in new gender-specific services. Some administrators were receptive to the idea of trauma-informed and trauma-specific services, but believed it was too much for their organizations to implement because they were focused on crisis management. Several sites worked with state and local governments in constant flux with new staff, reorganizations, and budget cuts.

Once again, sites found that training and other educational efforts were very effective in addressing administrative resistance. Interagency planning groups also helped to gain administrative level support for trauma-based work. As with providers, locating trauma groups in other agencies and providing on-going consultation and support helped to increase acceptance. Triad used grant funds to support new staff positions to meet the growing service needs and increasing demand for integrated, gender specific, trauma informed and specific services. The project shared personnel resources in the form of in-kind positions to increase service availability as much as possible.

Limited Resources

Financial issues varied across sites, and were sometimes problematic as a result of different financing and reimbursement mechanisms. In some cases, sites were drawing upon service systems that were under-funded, making the job of accessing services difficult.

Some agencies did not want their staff to participate in planning and training activities because they were not billable activities. Limited resources for the new clinical interventions sometimes made it difficult to engage clinicians. In general, there were few resources to cover the staff time associated with the collateral and preparatory work needed to run the trauma groups well. It was also difficult to provide appropriate supervision because some managed care arrangements had no mechanism to pay for it. Outpatient providers are often paid a quota for face-to-face client time; clinicians have to attend to supervision on their own time.

Two Massachusetts sites, WELL and the Boston Consortium of Services for Families in Recovery, found it difficult to obtain reimbursement for new trauma-specific groups in outpatient substance abuse treatment programs that did not also have a mental health license since these groups are reimbursed under DSM IV (Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition) mental health diagnosis. In addition, managed care organizations frequently limit the amount of services, including groups, that a woman

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can receive at one time making it sometimes difficult to participate in multiple groups.

Limited clinician time was also a barrier, particularly in service systems with budget constraints. Clinicians cannot be asked to take on additional activities (trauma work) without being relieved of some existing responsibilities. This is difficult in most service systems that are already overburdened and understaffed.

Consistent Participation in Trauma Groups Can be Difficult

Securing ongoing participation in trauma groups was a challenge for many sites. For various reasons, getting women to attend groups on a consistent basis can be difficult. Transportation is often a significant barrier. Because most women do not own automobiles, they must rely on other forms of transportation to get them to and from groups. The communities in which sites are housed may have substandard public transit systems or no transportation at all. This may be most challenging in rural settings where transportation is extremely limited. Childcare issues may also make group attendance difficult for women.

Like many sites, PROTOTYPES Systems Change Center has found that staff flexibility has been helpful in addressing some of the difficult transportation barriers. Many staff have provided rides for women to and from groups or public transportation terminals. At the District of Columbia Trauma Collaboration Study, the women's drop-in center has created a safe and inviting space for women to go in between treatment or groups. Some sites also offer childcare such as New Directions for Families. Hesitation or fear about confronting trauma issues can also affect women's participation. Many may not be prepared to address past experiences with violence and abuse at this point in their recovery.

Other priorities, such as doing what is required for basic survival (obtaining employment, securing housing, etc.) may make group attendance seem less important. In an effort to respond to these needs, Community Connections, the lead agency for the District of Columbia Trauma Collaboration Study, has become a housing authority in D.C. with control over 150 Section 8 vouchers. These vouchers have been made available to women in the study.

Staff Turnover

Many sites identified staff turnover as a challenge, both within the immediate programs and the broader group of participating agencies. Like other sites, New Directions for Families found it difficult to maintain qualified staff to perform demanding work within a strong economy. There was a constant need to educate and train new people that required time and financial resources.

Change is Difficult

The Portal project found their change efforts required tremendous coordination, communication, cooperation, and time. Changing systems, services, and clinicians to become more responsive to trauma and its impact is difficult and time consuming. Sites found that time, commitment, on-going training and support, and the use of interagency coordinating bodies helped to create change.

LESSONS

Through their implementation efforts, the sites have learned much about making services more trauma-informed and creating new trauma-specific services within existing service delivery systems. While some of these learnings apply to any broad scale change process, others are more unique to the work of moving services and systems to become trauma-informed, and creating trauma-specific services. Significant shared learnings are outlined below.

Lessons from Developing and Providing Trauma-Informed and Trauma-Specific Services

- A shared vision and common language are important first steps.
- Trauma must be positioned as a central issue.
- Training, education, and supervision are necessary, but not sufficient.
- C/S/R women must be involved.
- Interagency committees are effective.
- Efforts must take a multi-level and multi-disciplinary approach.
- Change can be facilitated by one or two people.
- Change takes time, hard work, and focus.

A Shared Vision and Common Language are Important First Steps

Many sites noted the importance of developing a shared vision and common language on trauma among all key stakeholders. Everyone involved must work toward the same goals and use a shared philosophy to reach those goals.

The WELL Project began its collaborative work clarifying values in an effort to identify and reconcile potential sources of disagreement and tension. These efforts have helped keep a diverse group of players "at the table" working together. Several sites have noted the importance of ensuring that processes used to create a shared vision are safe and respectful of all points of view. Attention must be paid to framing issues in ways that they can be heard and used in different settings (organizational and cultural). Training activities (discussed below) were an effective way to provide this common language to all key players.

Trauma Must be Positioned as a Central Issue

Trauma must be seen as a central issue for women, but especially for those with mental health and substance abuse issues. Several sites found that trauma could not be viewed as an "add-on" or addendum to a woman's mental health and substance abuse needs, but as primary and interconnected. PROTOTYPES Systems Change Center found that it was important to make trauma a fundamental component (both in a practical and philosophical sense) of its integrated service approach, and that positioning trauma as a central issue helped to assure that services were trauma-informed.

Training, Education, and Supervision are Necessary, But Not Sufficient

Training and education about trauma, its impact, and appropriate service responses are critical to making services, programs and systems trauma-informed. Most sites found that training needed to be offered to a wide-range of individuals, including those not directly involved in the project, and provided at multiple levels, including consumers, clinicians, supervisors/program managers, administrators, and policymakers. Training must be on-going to continually revisit what has been learned, address emerging issues, and educate new

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staff. Training must be made accessible by offering it at low or no cost and by providing incentives such as continuing education credits.

The Allies project found it important to make their training multi-faceted, including group trainings, visual materials posted around treatment settings, written materials/resources, discussions at staff meetings, supervision, and informal discussions among individuals. Several sites believe that training not only improved practice, but led to more systemic change as individuals used this new knowledge as "agents of change" within their work settings.

On-going trauma-informed supervision of all staff is critical. Working on issues of trauma requires skills, experience, and knowledge. It can take staff a long time to recognize how trauma and violence manifest themselves in day-to-day living and in reactions to treatment. In addition, personal reactions to trauma often arise for staff, and must be addressed so as not to interfere with empathy or maintaining appropriate boundaries.

C/S/R Women Must be Involved

Every site found it both important and necessary to integrate C/S/R women into all aspects of their projects. Their first-hand knowledge was critical in devising new services, and altering existing clinical and program practices to make them more sensitive and appropriate for trauma survivors. Several sites found it effective to have C/S/R women help conduct trainings and other educational activities.

Depending on their backgrounds, C/S/Rs can benefit from empowerment-focused basic skills development. The Boston Consortium of Services for Families in Recovery conducted a recurring Women's Leadership Institute for C/S/Rs and many sites created mentoring programs and other mechanisms for providing on-going support for active C/S/R participation.

Interagency Committees are Effective

Interagency committees should include representatives from all key stakeholder organizations including C/S/R women, and be charged with various program planning and coordination efforts. Through the process of developing and implementing the intervention, members become educated on trauma issues and invested in the goals of the project. Participants often took this new awareness and commitment back to their organizations and made changes there, many of which went beyond the immediate scope of the project. Interagency committees helped to build relationships and fostered support critical to the success of local project efforts.

Efforts Must Take a Multi-Level and Multi-Disciplinary Approach

Efforts to create trauma-informed and trauma-specific services must include and focus on all levels of players from consumers, clinicians, supervisors/program managers, administrators, and policymakers. Most sites found it important to work simultaneously from the top down, the bottom up, and the middle out. Obtaining administrative level support for the work has been critical in recruiting front-line staff support for a new trauma agenda. If efforts to infuse trauma-informed knowledge and practices are not directed at all levels, practices in one area can undermine change in other areas.

Several sites found that placing trauma-specific services within primary substance abuse and mental health programs helped to make those programs more trauma-informed. The Portal Project used multi-disciplinary team case conferences composed of staff from various agencies to make collaborating agencies more trauma-informed. Clinical supervisors can assist clinicians to operationalize knowledge gained from trauma training and education efforts.

Change Can be Facilitated by One or Two People

Change can be stimulated and supported through one or two people who understand trauma, are committed to the issues, and can be persuasive about the need to alter clinical practice and program operations within their own agencies. The D.C. Trauma Collaboration Study was most successful in implementing their trauma-informed agenda in organizations in which they found individuals ("trauma champions") committed to trauma-informed change. The Boston Consortium of Services for Families in Recovery found that strategically placed leadership expedited important systems level policy changes. By working closely with all relevant providers and agencies, a "trauma liaison" within the Franklin County Women's Research Project had a significant impact on making services more trauma-informed.

Change Takes Time, Hard Work, and Focus

Changing the way providers, programs, and systems think about and respond to issues of trauma requires significant time, hard work, and focus. Time is needed to open channels of communication, build relationships, increase awareness, and alter current practice. In addition, these efforts must be well timed and coordinated. At the client level, issues of safety and self-efficacy are the highest priority. It may not be possible to address other issues until a woman is ready. In addition, staff and programs learn and change at different paces that must be respected.

On-going support for change is critical, including providing continuous training and educational opportunities. New Directions for Families found that the program must be willing and open to change and that it is important to be realistic about the change process and supportive of how difficult it can be for staff. As the Triad project notes, "the focus on trauma needs to be maintained and operationalized over the long-term. It can not be the 'flavor of the month'; it must be a persistent effort that is maintained over an extended period of time."

Time is needed to open channels of communication, build relationships, increase awareness, and alter current practice.

Resources

WOMEN, CO-OCCURRING DISORDERS AND VIOLENCE STUDY SITES

PROTOTYPES Systems Change Center
Principal Investigator: Vivian Brown
5601 West Slauson Avenue
Culver City, California 90230
310-641-7795
protoceo@aol.com
www.prototypes.org

Allies: An Integrated Services System of Care/ Women's Health Study
Principal Investigator: Jennifer P. Heckman
ETR Associates
777 North Pershing Avenue
Stockton, California 95202
Mailing Address: 2241 Greer Road, Palo Alto, CA 94303
650-858-2526
jennieheckman@cs.com

New Directions for Families/Arapahoe House
Principal Investigator: Nancy VanDeMark
8801 Lipan Street
Thornton, Colorado 80260
303-657-3700
nancyv@ahinc.org
www.arapahoehouse.org

District of Columbia Trauma Collaboration Study
Principal Investigator: Roger Fallot
801 Pennsylvania Avenue, SE
Washington, District of Columbia 20003
202-608-8796
rfallot@communityconnectionsdc.org
www.communityconnectionsdc.org

Triad Women's Project
Principal Investigator: Margo Fleisher-Bond
5241 US Highway 98 South
PO Box 879
Highland City, Florida 33846
863-701-1994
mfleisher-bond@tchsonline.com
www.fmhi.usf.edu/cmh/research/exemplary/triad.html

Boston Consortium of Services for Families in Recovery
Principal Investigator: Hortensia Amaro
Boston Public Health Commission
211 River Street
Boston, Massachusetts 02126
617-373-7601
h.amaro@neu.edu
www.tiac.net/users/bdph/index.htm

Women Embracing Life and Living (WELL) Project
Principal Investigator: Norma Finkelstein
349 Broadway
Cambridge, Massachusetts 02139
617-661-3991
normafinkelstein@healthrecovery.org
www.healthrecovery.org

Franklin County Women's Research Project
Principal Investigator: Rene Andersen
55 Federal Street, Suite 230
Greenfield, Massachusetts
413-536-2401
randersen@theconsortiumwmtc.org

Portal Project
Principal Investigator: Sharon Cadiz
10 Astor Place, 7th Floor
New York, New York 10003
212-979-8800
sharon.cadiz@palladiainc.org
www.palladiainc.org

Women, Co-Occurring Disorders and Violence Coordinating Center
Principal Investigator: Joseph J. Cocozza
Policy Research Associates, Inc.
345 Delaware Avenue
Delmar, NY 12054
518-439-7415
wvcc@prainc.com
www.prainc.com/wcdvs

TRAUMA-SPECIFIC RESOURCES

The following list describes various trauma-specific services and resources that *Women Co-Occurring Disorders and Violence Study* sites have chosen to include in their programs. Information about how to obtain the materials is also included.

GROUP-BASED TRAUMA SPECIFIC INTERVENTION MANUALS AND BACKGROUND MATERIALS

Trauma Recovery and Empowerment

Trauma Recovery and Empowerment: A Clinician's Guide for Working with Women in Groups
Maxine Harris and Jerri Anglin
Free Press, 1998
This group-based intervention combines social skills training, psychoeducational and psychodynamic techniques and peer support groups for working with survivors of trauma.

Healing the Trauma of Abuse: A Women's Workbook
Maxine Harris and Mary Ellen Copeland
Oakland, CA: New Harbinger, 2000
This self-help workbook for women recovering from physical, sexual, and emotional abuse is based on the Trauma Recovery and Empowerment Model. It can be used as an adjunct to the group-based sessions, independently by women themselves or with a counselor.

Trauma Recovery and Empowerment Profile (TREP) and Skill Building Strategies Menu
The TREP rating scale and strategies for skill building menu are clinical tools for clinicians and survivors to evaluate skill level and work towards skill development.

G-TREM: Trauma Recovery and Empowerment for Girls 12-14
G-TREM: Trauma Recovery and Empowerment for Girls 15-18
These two trauma interventions are based on the TREM model for adult women and have been adapted to reflect the struggles of teenagers. Both are 15 sessions in length and include more experiential exercises. Learning approaches and overall tone have also been modified to accommodate the learning style of adolescent girls.

All of the above are available from:
Community Connections
801 Pennsylvania Avenue SE Suite 201
Washington, DC 20003
202-546-1512
www.communityconnectionsdc.org

Trauma Recovery and Empowerment Cultural Adaptation Spanish Translation
The 25-session version of the Trauma, Recovery Empowerment Model (by Maxine Harris, PhD) was culturally adapted to better serve the needs of Latina-Spanish speaking women and translated. Content on HIV prevention was added.

Available from:
Rita Nieves
Boston Consortium of Services for Families in Recovery
211 River Street
Mattapan, MA 02126
617-534-7969
Rita_Nieves@bphc.org

Seeking Safety

Seeking Safety: A Treatment Manual for PTSD and Substance Abuse
Lisa M. Najavits
New York: Guilford Press, 2001
This cognitive behavioral group therapy model is designed to help individuals achieve safety from PTSD and substance abuse. Treatment is based on five key principles: safety as the overarching goal; integrated treatment; a focus on ideals; four content areas - cognitive, behavioral, interpersonal, case management, and attention to clinician processes.

Seeking Safety: Outcome of a New Cognitive-Behavioral Psychotherapy for Women with Post-traumatic Stress Disorder and Substance Dependence
L. Najavits, R.D. Weiss, S.R. Shaw, and L. Muenz
Journal of Traumatic Stress, 1998, 11:437-456
This article reports outcome results for 17 women who completed Seeking Safety. Results showed significant improvements in substance use, trauma-related symptoms, suicide risk and thoughts, social adjustment, family functioning, problem solving and depression.

Training Clinicians to Conduct the Seeking Safety Treatment for PTSD and Substance Abuse
Lisa M. Najavits
Alcoholism Treatment Quarterly, 2000, 18:83-98
This paper provides suggestions for training clinicians in the Seeking Safety psychotherapy for patients with post-traumatic stress disorder and substance abuse.

Seeking Safety: A New Psychotherapy for Post-traumatic Stress Disorder and Substance Abuse Disorder
Lisa M. Najavits
In Trauma and Substance Abuse: Causes, Consequences, and Treatment of Comorbid Disorders (P. Ouimette & P. Brown, Eds.)
Washington, DC: American Psychological Association Press (in press)
This article provides an overview of Seeking Safety and how it was developed, a comparison with other existing treatments, a review of the outcome research on the curriculum, and ideas for future direction.

Addictions and Trauma Recovery (ATRIUM)

Addictions and Trauma Recovery: Healing the Mind, Body and Spirit
Dusty Miller and Laurie Guidry
New York: W.W. Norton, 2001
This comprehensive recovery model for addiction and trauma incorporates a mind, body, spirit approach and offers psychoeducational processes and expressive interventions.

Triad Women's Group

Triad Women's Project Group Facilitator's Manual
Fred Fearday, Colleen Clark, and
Michelle Edington (Editors)
Louis de la Parte Florida Mental Health Institute
University of Southern Florida
13301 Bruce B. Downs Boulevard
Tampa, FL 33612
813-974-4602
October, 2001
This group intervention for women with substance abuse disorders, mental health issues, and histories of violence helps women work towards survival, recovery and empowerment.

PEER-RUN EFFORTS

Wisdom of Women Starter Kit
Wisdom of Women is a peer support group for women whose lives have been affected by trauma, substance abuse, or mental illness. The group topics are Safety, Serenity, Sense of Self, Support System, and Solving Life's Problems. The Starter Kit includes a preamble, guidelines for the group, and helpful information and tools regarding codependency, domestic violence, substance abuse, mental illness, and 12 Steps for trauma survivors. The kit is distributed to new group members and new W.O.W. Peer Leaders.

Available from:
Sharon Slavin
Consumer Coordinator
Triad Women's Project
863-452-3858

TRAUMA-INFORMED RESOURCES

Throughout the course of the project, the *Women, Co-Occurring Disorders and Violence Study* sites and Coordinating Center have developed a variety trauma-informed materials. These products, along with their ordering information are listed below.

PROTOTYPES SYSTEMS CHANGE CENTER

Serving Women with Many Needs: Lessons Learned on Systems Change to Better Serve Women with Co-Occurring Disorders and Trauma
This document describes the lessons learned and challenges encountered around providing integrated services to women with co-occurring disorders and histories of violence.

Changing and Improving Services for Women and Children: Strategies and Lessons Learned
This monograph highlights the challenges and lessons learned in providing comprehensive and integrated services to women in substance abuse residential treatment programs and their children.

Recruiting, Training and Maintaining Consumer Staff: Strategies and Lessons Learned
This document describes PROTOTYPES experiences in hiring and maintaining consumer staff. It discusses the benefits and challenges as well as the key lessons learned.

Available from:
PROTOTYPES Systems Change Center
5601 West Slauson Avenue
Culver City, CA 90230
310-641-7795

DISTRICT OF COLUMBIA TRAUMA COLLABORATION STUDY

Using Trauma Theory to Design Service Systems: New Directions for Mental Health Services #89
Maxine Harris and Roger Fallot (Editors)
Jossey-Bass, March 2001
This issue identifies the essential elements necessary for a system to begin integrating an understanding of trauma into core service programs.

Non-Traditional Parenting Interventions: The Impact of Early Trauma on Parenting Roles and Parenting at a Distance
This manual contains two distinct parenting interventions. The Impact of Early Trauma on Parenting Roles helps women explore the impact of trauma on feelings and expectations of motherhood and parenting. Parenting at a Distance is intended for women who are not primary caregivers to their children.

Trauma-Informed Addictions Treatment
This manualized group treatment intervention serves male and female survivors of physical, sexual and emotional abuse in the active treatment phase of addictions recovery.

Trauma Issues Associated with HIV Infection: A Leaders Guide
This 11-session group intervention is designed for women trauma survivors who have also been diagnosed with HIV.

An Introduction to Trauma Issues for Women on Inpatient or Short Stay Units
This 4-session group intervention is designed to introduce women trauma survivors to the connections between history of abuse, psychiatric symptoms, coping skills, and self-soothing strategies. It also helps women plan for future recovery work.

Women Speak Out: A 40 Minute Video
This 40 minute video highlights women "speaking out" about the impact of abuse on their lives, their personal struggles and losses, how abuse fosters secrets, lies and distortions, advice on letting go, and what's helped them feel empowered and able to move on.

Available from:
Community Connections
801 Pennsylvania Avenue SE Suite 201
Washington, DC 20003
202-546-1512
www.communityconnectionsdc.org

Innovations from the Sites
The Women's Support and Empowerment Center: A Drop-In Center for Women Living with Substance Abuse, Mental Illness and Trauma
This fact sheet describes the creation and operation of the consumer drop-in center at the District of Columbia Trauma Collaboration Study site.

Available from:
Women, Co-Occurring Disorders and Violence Coordinating Center
Policy Research Associates
345 Delaware Avenue
Delmar, NY 12054
518-439-7415
wvcc@prainc.com
www.prainc.com/wcdvs

TRIAD WOMEN'S PROJECT

Handbook for Addressing Parenting Needs
This handbook contains information for parents and providers about healthy child development, the child's needs at different developmental stages, and how development might be affected by maternal substance use, mental illness and trauma history. It also provides detailed information about the child protection and shelter processes and at what points a mother or advocate may be most influential.

Workbook for Successful Parenting
This resource includes information to assist mothers in setting and achieving parenting goals.

Triad Training Notebook
This resource contains materials from each of the fifteen Triad Training sessions held in late 1999 and early 2000. The training topics cover a variety of issues relevant for working with women with co-occurring disorders and histories of violence.

Available from:
Louis de la Parte Florida Mental Health Institute
University of Southern Florida
13301 Bruce B. Downs Boulevard
Tampa, FL 33612
813-974-7188

Innovations from the Sites
Wisdom of Women: Peer Support for Women with Co-Occurring Disorders and Histories of Trauma
This fact sheet looks at Wisdom of Women, a 12-step peer support group for women with co-occurring disorders and trauma histories developed by the Triad Women's Project site.

Available from:
Women, Co-Occurring Disorders and Violence Coordinating Center
Policy Research Associates
345 Delaware Avenue
Delmar, NY 12054
518-439-7415
wvcc@prainc.com
www.prainc.com/wcdvs

BOSTON CONSORTIUM OF SERVICES FOR FAMILIES IN RECOVERY

Women's Leadership Training Institute Curriculum and Facilitator's Guide (English and Spanish)
This comprehensive facilitator's manual describes a curriculum run by women in recovery for women in recovery. The goal of the training is to develop leadership skills so C/S/Rs can use their voices and experiences to improve services for families.

Service Provider's Cross-Training In Substance Abuse, Mental Health and Trauma: A Facilitators Guide
This facilitator's manual provides an introduction to the Consortium Service Integration Project, with emphasis on the need for an integrated and trauma informed system of care. This guide also has a focus on consumer participation, collaboration across disciplines, creating shared values and philosophy, and a common language for understanding trauma.

Co-Morbidity Trauma Fact Sheet for Providers
This educational fact sheet presents information and suggestions for helping women who show signs of trauma, substance abuse and emotional problems, and offers referral information.

Consumer Co-Morbidity Trauma Fact Sheet (English and Spanish)
This wallet size card contains educational messages and a list of resources, agencies and services available throughout the city of Boston and Massachusetts for getting help with trauma, substance abuse, and emotional problems.

Co-Morbidity Resource Card (English and Spanish)
This resource contains information about services for substance abuse, mental illness, depression, stress and violence available in the greater Boston area.

Case Studies on Treatment Planning and Treatment Issues for Women with Co-Occurring Disorders (English)
This document provides a collection of case studies developed by the Consortium's Interdisciplinary Resource Team and highlights issues that emerge in the treatment of women with co-occurring conditions. It is a useful resource for training clinical staff on issues related to integrated treatment planning and management of clinical issues that arise in serving women in this population.

Co-Morbidity Screen (English and Spanish)
This is a clinical screening tool intended to identify women presenting in health care facilities who may need further evaluation for substance abuse, mental health symptoms, a history of trauma, poverty and problems with children.

Economic Success in Recovery (English and Spanish)
This 8-session group focuses on the paths and options in planning for the future and financial success. The women explore their strengths, skills, job and educational opportunities, decision-making, and understanding of their past and present experiences with money.

Facing the Challenges and Opportunities of Family Reunification
This 10-session group focuses on the different scenarios that women in recovery may encounter in the process of reuniting with their children. It provides an overview of child custody regulations and policies and parental rights as well dynamics that emerge when the children are in the custody of family members and non-family members. It assists women in understanding the different stages of reunification and the possible reactions and emotions children and mothers might experience in the transitions related to changes in child custody and helps women gain skills to support children through the process.

Available from:
Rita Nieves
Boston Consortium of Services for Families in Recovery
211 River Street
Mattapan, MA 02126
617-534-9385
Rita_Nieves@bphc.org

WOMEN EMBRACING LIFE AND LIVING (WELL) PROJECT

Nurturing Families Affected by Substance Abuse, Mental Illness and Trauma
An adaptation of the Nurturing Program for Families in Substance Abuse Treatment and Recovery this parenting curriculum is designed to address the needs of families affected by substance abuse, mental illness and trauma.

WELL Project Training Curriculum for Providers: Developing Integrated Services for Women with Substance Abuse, Mental Illness and Trauma
This manual includes content and handouts for several training modules to familiarize service providers with the needs and issues presented by women with co-occurring substance abuse and mental health disorders and trauma.

Developing Trauma-Informed Organizations: A Tool Kit
Developed by the WELL Project State Leadership Council, this publication includes the following materials: Principles for the Trauma-Informed Treatment of Women with Co-Occurring Mental Health and Substance Abuse Disorders, Self-Assessment for Provider Organizations, Organizational Self-Assessment (for non-service providing organizations), and instructions for using the assessments to develop plans for becoming more trauma-informed.

WELL Recovery Manual
This manual offers guidance for consumers wishing to establish peer-run mutual help groups specifically for women in recovery from substance abuse, mental illness and trauma.

Available from:
Institute for Health and Recovery
349 Broadway
Cambridge, MA 02139
617-661-3991
www.healthrecovery.org

Innovations from the Sites
Nurturing Families Affected by Substance Abuse, Mental Illness and Trauma: A Parenting Curriculum for Women and Children
This fact sheet describes a psycho-educational, group-based parenting curriculum developed by the WELL Project specifically for families affected by substance abuse, mental illness and trauma.

Available from:
Women, Co-Occurring Disorders and Violence Coordinating Center
Policy Research Associates
345 Delaware Avenue
Delmar, NY 12054
518-439-7415
wvcc@prainc.com
www.prainc.com/wcdvs

FRANKLIN COUNTY WOMEN'S RESEARCH PROJECT

Trauma-Informed Practice Series: No. 1 Screening and Assessment
The Trauma-Informed Practice Series provides helpful guidelines for mental health and social workers that serve women with physical and/or sexual abuse histories. The screening and assessment series explains how to conduct an intake that is sensitive to the needs of trauma survivors.

Available from:
Denise Elliott
48 Sanderson Street
Greenfield, MA 01301
413-773-2066

OTHER RESOURCE MATERIALS

New Directions for Families Program Manual: Phase I of The Women, Co-Occurring Disorders and Violence Study
This piece documents the implementation of the *Women, Co-Occurring Disorders and Violence Study* in Thornton, Colorado during Phase I. It includes a review of the literature, a discussion of context, demographics, a description of the intervention staffing and programming considerations and lessons learned.

Available from:
Ellen Brown, Grant and Publications Specialist
Arapahoe House, Inc.
8801 Lipan Street
Thornton, CO 80260
303-781-1275 ext. 118

Referral Handbook for Trauma Services in Washington, DC
This resource features trauma services and contact information available in the greater Washington, DC area.

Available from:
Community Connections
801 Pennsylvania Avenue SE Suite 201
Washington, DC 20003
202-546-1512
www.communityconnectionsdc.org

Triad Specialist Manual
This manual outlines the standard Triad Specialist role and functions. It also contains a project summary, list of project staff, and materials that Triad Specialists use regularly.

Available from:
Julienne Giard
Louis de la Parte Florida Mental Health Institute
University of Southern Florida
13301 Bruce B. Downs Boulevard
Tampa, FL 33612
813-974-7995

Understanding Trauma: A Staff Training Curriculum
This comprehensive resource is designed to foster trauma-specific awareness and skill development among clinical and non-clinical staff who provide direct services to consumers within residential and outpatient settings.

Available from:
Sharon M. Cadiz
Palladia Inc. (formerly Project Return Foundation)
10 Astor Place, 7th Floor
New York, NY 10003
212-979-8800

Best Practices: Empowering Organizational Change for Integrated Service Delivery: Based on Experiences and Lessons Learned from the SAMHSA funded Portal Study

This resource is designed to guide organizations seeking to implement a blended perspective of treatment that has trauma as a central component. The content focuses on some building blocks of the change process and gives examples of information, forms and strategic planning tools that might be useful in preparing an organization's launch of an integrated care model.

Available from:
Sharon M. Cadiz
Palladia Inc. (formerly Project Return Foundation)
10 Astor Place, 7th Floor
New York, NY 10003
212-979-8800

Consumer/Survivor/Recovering Women: A Guide for Partnerships in Collaboration
This manual discusses the importance of integrating C/S/R women into systems, services and research and describes some of the common barriers to integration. It also provides useful strategies for facilitating C/S/R integration and includes helpful resources.

Available from:
Women, Co-Occurring Disorders and Violence Coordinating Center
Policy Research Associates
345 Delaware Avenue
Delmar, NY 12054
518-439-7415
wvcc@prainc.com
www.prainc.com/wcdvs

Women, Co-Occurring Disorders and Violence Study Web-Site
www.wcdvs.com
This online resource provides information about the Women Co-Occurring Disorders and Violence Study, links to study sites, publications and other resources related to substance abuse, mental illness, and trauma.

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