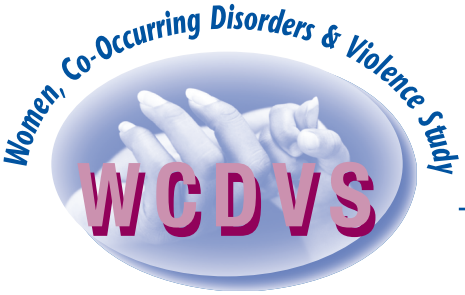

Developing Integrated Services for Women with Co-Occurring Disorders and Trauma Histories

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

April 2004

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April 2004

Acknowledgements

The Women, Co-Occurring Disorders and Violence Study brought together service providers, program administrators, researchers, policymakers, and C/S/R women from around the country to work together toward the common goal of improving services and systems for women with co-occurring disorders and trauma histories and their children. For five years, individuals and organizations struggled to better understand the impact of trauma and fashion service and systems responses that were comprehensive, integrated, and inclusive. These efforts were often difficult, but ultimately achieved much. This document attempts to capture many of the implementation learnings from this innovative, landmark endeavor. We hope it appropriately reflects the hard work, commitment, compassion, and sacrifice of all those involved.

We commend the Substance Abuse and Mental Health Services Administration for their vision, leadership, and support of this effort over the past five years. Melissa Rael and Joanne Gampel of the Center for Substance Abuse Treatment, Susan Salasin and Kana Enomoto of the Center for Mental Health Services, and Jeanette Bevett-Mills and Fred Seitz of the Center for Substance Abuse Prevention provided valuable guidance throughout the initiative.

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Executive Summary

Violence is pervasive in the lives of women and children. The effects of trauma are substantial, impacting one's physical, mental, emotional, spiritual, social, and economic well-being. The inter-relationships among violence, mental health, and substance abuse are profound. Despite this reality, current services and service systems are inadequate in identifying and meeting the needs of women affected by trauma, mental health, and substance abuse.

Recognizing the significant lack of appropriate services for women with alcohol, drug abuse, and mental health disorders and histories of violence, the Substance Abuse and Mental Health Services Administration (SAMHSA) launched the Women with Alcohol, Drug Abuse and Mental Health Disorders who have Histories of Violence Study (Women, Co-Occurring Disorders and Violence Study – WCDVS) in 1998. The goal of this five-year study was the generation of empirical knowledge about the development of comprehensive, integrated service approaches, and the effectiveness of these approaches for women with co-occurring mental health and substance abuse disorders who have experienced trauma.

A Coordinating Center and fourteen sites representing residential and outpatient mental health and substance abuse service providers, hospitals, jails, public health agencies, universities and other community groups participated in the planning phase of the project. Nine of these sites continued into the implementation phase, with four of them awarded separate cooperative agreements to implement and examine an intervention for children.

All sites were required to provide a core set of comprehensive services, and develop strategies for integrating these services at both clinical/individual and service system levels. Most sites were service-providing organizations, allowing them to augment treatment activities already in place. In general, sites developed new trauma-specific services, peer-run services, and resource coordination and advocacy approaches that were layered onto pre-existing services provided by the grantee and/or collaborating organizations. The project placed strong emphasis on integrating consumer/survivor/recovering (C/S/R) women in all aspects of planning, management, service delivery, and research thus pushing the frontier of the field.

The WCDVS was a ground-breaking endeavor and represents a critical step in improving services and systems for women. It was the first large-scale, multi-site effort to develop and rigorously evaluate comprehensive, integrated services for women with histories of trauma, mental illness, and substance abuse. Its orientation around the primacy of trauma, focus on service and systems integration, use of psycho-educational trauma groups, and efforts to empower and integrate C/S/Rs into all aspects of the project are noteworthy and innovative.

Because little previous work had been done in this area, all participants were faced with numerous and continuing challenges inherent in any ground-breaking effort. Over the course of the project, WCDVS sites learned much about creating and adapting services and systems of care to be more responsive to the needs of women. Some of these learnings apply to any broad scale change process; others are unique to the work of establishing services that are comprehensive, integrated, trauma-informed and trauma-specific, and consumer-involved.

This report details site level activities, highlighting challenges and responses in the project's four domains:

- service system integration
- clinical integration
- services
- consumer integration

It contains an array of lessons gathered from this innovative multi-site initiative that can help other communities who are working to integrate services for women with co-occurring disorders and histories of trauma.

A summary of broad cross-site lessons that were learned from this effort are listed below. More detailed lessons are contained in the body of the report.

SERVICE SYSTEM INTEGRATION

Establishing and maintaining "buy-in" over time was critical to the success of the project, but also a major challenge that required strong commitment and constant communication.

WCDVS sites found that establishing a new philosophy of care was a significant and difficult undertaking. Convincing potential partners to sign-on to an innovative yet unconventional approach to treatment was arduous. A substantial amount of time was needed to generate "buy-in" and create a common vision for the project. These efforts required constant communication among key stakeholders. Philosophical differences among various partners (mental health, substance abuse, violence/trauma, consumer, and research) challenged sites. Collaborative, open planning processes were critical to reaching a shared understanding of the problem and developing appropriate responses.

Relationship building early-on was key and impacted the degree to which systems change occurred over time.

Building relationships with potential partners early-on in the development process was critically important. While this process was time consuming, some sites believe their later systems achievements were the result of intense relationship building that occurred during the beginning of the project.

Systems integration efforts must go beyond substance abuse, mental health, and trauma systems to include a broader range of stakeholders.

Sites found it necessary to go beyond substance abuse, mental health, and trauma systems to include a broader range of stakeholders in planning and implementing the project. Criminal justice, health care, child protective services, and welfare were some of the many areas that were brought to the table. Interagency planning groups were used to facilitate collaboration across organizational boundaries and promote systems change.

Change can be facilitated by one or two people who inspire others and are persuasive about the need to alter practices and program operations within their agencies.

Many sites were supported by strong leaders who were committed to the issues and able to facilitate the involvement of individuals and agencies as well as a commitment from internal staff. Their impacts on the projects and the larger communities were significant and tangible.

CLINICAL INTEGRATION

Co-facilitation is an effective strategy that can enhance integration at both the service and systems levels.

At many sites, the trauma-specific groups were co-facilitated by clinicians from different agencies and/or disciplines, or by a clinician and a C/S/R. Often, someone who was trained in trauma co-facilitated groups with staff from a host agency. This model helped to directly integrate services and assisted agency staff in becoming educated in trauma. These individuals were also able to make their organizations more trauma-informed and responsive to the needs of women.

Multi-disciplinary case conferencing was an effective approach for promoting service and systems integration.

Multi-disciplinary case conferencing was important for both service and systems integration efforts. At one level, sites used multi-disciplinary teams to implement their integrated service efforts. At another level, teams were brought together to collaborate on care planning and cross-agency problem solving for particular cases, while also meeting supervision and education needs.

SERVICES

Sites experienced difficulty retaining women in services, especially the trauma groups, and were challenged to explore options for boosting retention.

Sites struggled with keeping women consistently engaged in services, especially the trauma groups. Some women experienced the groups as logistically and psychologically demanding and several sites had trouble keeping women attending them on a regular basis. The complexity of women's lives along with logistical challenges such as transportation and childcare were major deterrents to women's participation in services. Sites needed to develop strategies to promote consistent participation. Assistance with childcare and transportation and the placement of groups in convenient community locations helped. Providing assistance with basic needs (housing, food, income, etc.) and peer support services were other effective responses.

Group interventions can stimulate positive relationship formation among women to promote recovery.

Many sites found relationship building opportunities facilitated by group formats (trauma, parenting, peer-support, etc.) were a motivating factor for women to continue with treatment. In the trauma groups, many women shared openly for the first time painful experiences they never felt safe to voice. Women learned to build trusting relationships and supported one another through recovery. The relational aspects of group work were important in keeping women engaged in services and facilitating recovery.

Women had a need for continuing services and supports, especially after graduation from the trauma groups.

C/S/Rs and project staff voiced an interest and need for continuing supportive services for women once they "graduated" from the primary trauma group interventions. The trauma groups were extremely important and beneficial, but insufficient in effectively addressing women's trauma issues. Many sites created a range of follow-up services, many of which were peer-run support groups.

C/S/R INTEGRATION

C/S/R women made an immeasurable impact on the project to transform how services were designed, delivered, and evaluated.

Integrating C/S/R women into all aspects of WCDVS had a profound impact on the project. C/S/Rs 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. Many sites found the project transformed

the way C/S/R women were regarded by their own organizations, and how services were delivered for the project and the overall organization.

Sites would have benefited from more planning, training, and support to prepare C/S/Rs and non-C/S/Rs for this collaboration, and to help ensure its effectiveness.

While the unique collaboration between professional and C/S/R women was instrumental, sites would have benefited from a longer planning period, and more concerted training and support activities. Many challenges were encountered – initial resistance to C/S/R integration; establishing trust and building relationships; training and support needs for C/S/R women; training and support needs for non-C/S/Rs; creating vehicles for meaningful involvement; and shifting organizational culture to one that values, empowers, and includes consumers. These critical issues required thoughtful attention to establish an effective collaboration.

Challenges associated with serving in official C/S/R capacities required attention and support.

Women who served in official C/S/R capacities faced a variety of challenges due to the demanding nature of their jobs, as well as the more intrinsic difficulties that accompanied their roles. As representatives for women in recovery, C/S/Rs were the primary resource on women's issues and needs. This was a burdensome responsibility. C/S/R advisory groups and C/S/R coordinators were responsible for multiple tasks requiring a variety of skills. There were significant issues with staff burnout and turnover in these positions. C/S/Rs also faced difficulties around stigma and credibility. There were inherent challenges associated with being hired as a "person in recovery" and having painful experiences regarded as strengths. Many women serving in official C/S/R capacities struggled to find meaningful, valued roles to play within the projects, particularly during the implementation phase.

CROSS-CUTTING ISSUES

Many sites were confronted with administrators, service providers, and consumers who were initially resistant to a new philosophy and approach to care, particularly one that incorporated trauma.

Sites encountered resistance and concern from individuals hesitant to embrace a new approach to treatment. Some saw the initiation of trauma services as "opening up Pandora's box" and creating needs that could not be met. Others saw trauma and integrated services as highly specialized areas of care they were not equipped to provide. There were also concerns that questioning women about their trauma histories would trigger unmanageable emotional responses. There were disagreements about the ordering of services – whether an integrated or sequenced approach was best. Sites encountered resistance to active C/S/R involvement in all aspects of the project.

Cross-training was essential for staff to become familiar with the philosophies and concepts of mental health, substance abuse and trauma, and then create and implement an integrated response.

All sites reported the importance of early and repeated cross-training and education in the work of making services, programs, and systems more integrated. Training had to be provided at all levels – policymakers, administrators, providers – because services, program philosophies, policies, and internal and external barriers to change needed to be identified and addressed. Cross-training needs to be continuous because people and programs at differing stages of readiness required appropriate information and training. Staff turnover necessitated repeated training to educate new staff. On-going training also facilitated networking across programs.

A trauma-integrated intervention requires ongoing supervision, management, and support of staff.

While professional learning and development occurred during training sessions, continuing staff support and supervision were critical. Integrated, trauma-informed and trauma-specific work required higher levels of clinical skills than is often present at community-based programs. Regular, trauma-informed supervision is essential to ensure appropriate care and treatment of survivors as well as support for program staff working in this demanding, often personally challenging area.

We hope this report facilitates the translation of lessons from this research into improved systems and services that ultimately make a difference in women's lives.

Background on the Women, Co-Occurring Disorders and Violence Study

Since its creation in 1992, the Substance Abuse and Mental Health Services Administration (SAMHSA) has focused efforts on ensuring the unique needs of women living with mental health and substance abuse issues are understood and addressed. Through a series of policy and programmatic developments, the role of physical and sexual abuse became a priority within these efforts. A growing body of empirical and programmatic knowledge on the traumatic life experiences of many women with mental health and substance abuse issues, the devastating impact of these experiences, and the inability of traditional mental health and substance abuse models to meet the needs of these women began to emerge. In addition, consumers began to pressure the agency to "move" on the issues of violence and trauma. These, and other forces, pushed the agency to see trauma as a primary issue for its female constituents. (See Salasin, in press for a detailed description of the evolution of federal involvement in issues of violence and trauma).

As a result, SAMHSA launched the Women with Alcohol, Drug Abuse and Mental Health Disorders who have Histories of Violence Study (Women, Co-Occurring Disorders and Violence Study – WCDVS) in 1998. The goal of this five-year study was the generation of empirical knowledge on the development of comprehensive, integrated service approaches, and the effectiveness of these approaches for women with co-occurring mental health and substance abuse disorders who have experienced trauma.

In many ways, empirical learning and policy and program development on the impact of trauma and effective service responses has been additive (Salasin, in press). The WCDVS built upon this knowledge and represents the critical next phase in this process. It was the first large-scale, multi-site effort to develop and rigorously evaluate comprehensive, integrated services for women with histories of trauma, mental illness, and substance abuse. Its orientation around the primacy of trauma, focus on service and systems integration, use of psycho-educational trauma groups, and efforts to empower and integrate consumers into all aspects of the project are noteworthy and innovative.

Working within the agreed upon framework, each site created a local program responsive to the strengths and needs of their own communities.

The first phase of the study was devoted to developing: a cross-site framework for service intervention; local strategies for implementing the service framework; local and cross-site process evaluation efforts; and standard methodology for the cross-site outcome evaluation. A Coordinating Center and fourteen sites across the country participated in the effort, 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.

The project's second phase was dedicated to fully 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 sites participated in the "adult" portion of this phase; four of these sites were awarded separate cooperative agreements to implement and examine an intervention for children*.

Study sites operated within a cross-site framework for service intervention developed during the first phase of the project. The framework required all service interventions to be:

- Gender-specific
- Culturally competent
- Trauma-informed
- Trauma-specific
- Comprehensive
- Integrated
- Informed by involvement from consumer/survivor/recovering (C/S/R) women**

Each site provided a core set of services that included: outreach and engagement; screening and assessment; treatment activities; parenting skills; resource coordination and advocacy; trauma-specific services; crisis intervention; and peer-run services. Sites developed strategies for integrating services at two levels: clinical/individual; and service system. At the clinical level, integration efforts focused on the content of service delivery and the ways in which mental health, substance abuse, and trauma interventions are combined to enhance client outcomes. Service systems integration efforts were focused on linkages between core agencies and the full array of other agencies that need to be involved for the intervention to be comprehensive.

Working within the agreed upon framework, each site created a local program responsive to the strengths and needs of their own communities. A strong emphasis was placed on integrating C/S/R women in all aspects of planning, management, service delivery, and research at local and cross-site levels.

Study sites are described briefly below. For an in-depth discussion of individual site projects see Veysey & Clark, 2004 and Veysey & Clark, in press.

PROTOTYPES Systems Change Center, Los Angeles, 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. See Brown, Rechberger & Bjelajac, 2004.

Allies: An Integrated System of Care, Stockton, California – A project embedded within San Joaquin County's Health Care Services and implemented across five substance abuse treatment programs and mental health services. See Heckman, Hutchins, Thom & Russell, 2004.

** This document focuses on implementation experiences of the nine "adult" sites.*

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

Arapahoe House – New Directions for Families, Metro-Denver, 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. See VanDeMark, Brown, Bornemann & Willams, 2004.

District of Columbia Trauma Collaboration Study, Washington, DC – Two multi-service centers (including Community Connections, the lead agency) that offer mental health, trauma, substance abuse, and other support services for residents of Washington, DC including women with co-occurring disorders and histories of abuse. See Fallot & Harris, 2004.

Triad Women's Project, Central Florida – A substance abuse prevention, intervention and treatment agency collaborated with a local community mental health center to offer services in rural Florida. See Clark, Giard, Fleisher-Bond, Slavin, Becker, et. al, 2004.

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. See Amaro, McGraw, Larson, Lopez, Nieves, et. al, 2004.

Women Embracing Life and Living (WELL) Project, 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. See Finkelstein & Markoff, 2004.

Franklin County Women's Research Project, Greenfield, Massachusetts – A peer-based systems and individual-level intervention developed to assist women recovering from histories of inter-personal violence, substance abuse and mental health issues located in rural Franklin County at three drop-in centers and linked with area hospitals and providers. See Veysey, Andersen, Lewis, Mueller & Stenius, 2004.

Palladia/Portal Project, New York, New York – A large multi-service agency providing an array of services including residential and outpatient mental health and substance abuse services primarily to African American and Latina women in New York City. See Cadiz, Savage, Bonavota, Hollywood, Butters, et. al, 2004.

A strong emphasis was placed on integrating C/S/R women in all aspects of planning, management, service delivery, and research...

WOMEN CO-OCCURRING DISORDERS AND VIOLENCE STUDY SITES

Site	Lead Agency	Modality	Setting	Geographic Area Served
PROTOTYPES Systems Change Center	PROTOTYPES Centers for Innovation in Health, Mental Health and Social Services	Residential	Urban	Los Angeles County, CA
Allies	ETR Associates	Residential and Outpatient	Semi-urban	San Joaquin County, CA (intervention) Sacramento County, CA (comparison)
Arapahoe House	Arapahoe House	Residential	Urban	Metropolitan Denver, CO
DC Trauma Collaboration	Community Connections	Outpatient	Urban	Washington, DC (intervention) Baltimore, MD (comparison)
Triad Women's Project	Tri-County Human Services	Residential and Outpatient	Rural (semi-rural)	Central Florida
Boston Consortium	Boston Public Health Commission	Residential, Methadone and Outpatient	Urban	Boston, MA (intervention) Boston and Springfield, MA (comparison)
WELL Project	Institute for Health and Recovery	Residential and Outpatient	Mixed (urban, suburban and/ or rural)	Eastern Massachusetts
Franklin County	Western Massachusetts Training Consortium	Non-residential, community-based program	Rural	Western Massachusetts
Palladia/Portal	Palladia, Inc.	Residential and Outpatient	Urban	Metropolitan New York City

Purpose and Framework of this Report

In this report, we examine WCDVS sites' efforts to design, develop, field, and maintain integrated service packages for women with co-occurring mental health and substance use issues who were victims of violence. Study sites undertook work in four broad domains:

- Service System Integration – Coordinating services at the level of agencies or broader service systems.
- Clinical Integration – Coordinating services at the level of individual consumers.
- Services – Developing face-to-face therapeutic activities intended to help individual women.
- C/S/R Integration – Incorporating consumer experiences and perspectives into intervention design, development, and implementation.

This report describes activities conducted by the sites in each of the four domains, identifies the challenges they encountered, and presents the strategies they used to respond to those challenges. When possible, we illustrate promising strategies with examples from the sites' experiences. The primary audiences for this document are agency directors, front-line service providers, members of county and state agencies concerned with these issues, and others who may want to learn from the experiences of participating agencies.

Data for this report was collected through the WCDVS cross-site process evaluation. For each of the five years of the study, evaluators from the WCDVS Coordinating Center made site visits to each of the study sites, and held meetings with project stakeholders, including project leaders, project staff members, C/S/Rs involved in the project, consumers receiving services through the project, front-line service providers, and staff from the network of organizations who did not receive grant money directly but were involved in the project. Information from these sessions was collected by means of site visitors' notes, and by audio tape for some consumer sessions. These materials were summarized in annual reports and other project products.

Service System Integration Lessons

As used in this report, service system integration refers to the alignment of activities between or among different agencies or entire service systems. Activities geared towards improving coordination of services between agencies or systems or for multiple women are termed service system integration. Clinical integration refers to the coordination of services at the level of the individual consumer. Any procedures, practices, or activities undertaken by service providers to better coordinate disparate services for a particular woman are termed clinical integration. For example, a conference that brought together a number of providers from different backgrounds for cross training and working through hypothetical cases was considered a service system integration approach since it did not focus on an individual woman. An interdisciplinary case conference that brought together a mental health clinician, a substance abuse counselor, and a woman with whom both were working to develop a joint treatment plan was considered a clinical integration strategy. The distinctions, while not hard and fast, proved useful for WCDVS stakeholders.

WCDVS sites used a number of approaches to create and strengthen relationships among agencies or among organizational units within an agency to enhance service system integration. Three strategies were paramount:

- **Coordinating Bodies:** Groups composed of representatives from multiple agencies or from multiple units within an agency for purposes of general information exchange, coordination of services, needs assessment, concluding formal agreements on reducing barriers to services, eliminating duplication of services, or promoting access to comprehensive services.

- **Cross-Training:** Training of staff within one discipline or agency about the objectives, procedures, and services in other disciplines or agencies.

- **Memoranda of Understanding (MOUs):** Written agreements among agencies that may include agreements to collaborate, make or accept referrals, share client information, or coordinate services.

Service system integration work conducted...in Phase I set the stage for designing new service models...and implementing them in Phase II.

Other important service system integration strategies were:

- **Policy Work:** Educational, advocacy or community organizing efforts aimed at educating municipal, county, or state officials on the need for integrated, trauma services.
- **Co-location of Services:** A multi-service center in a single location providing a variety of services, including health, mental health, trauma, substance abuse, housing assistance, entitlements, etc.
- **Uniform Applications/Criteria:** A process or form that an individual completes one time to apply for or receive services from multiple agencies.

In general, sites focused more on activities such as coordinating body meetings, cross-trainings, and MOUs during Phase I. During Phase II, sites shifted to the clinical level of the intervention and the research that accompanied its implementation. Service system integration work conducted early in Phase I set the stage for designing new service models towards the end of Phase I and implementing them in Phase II.

CHALLENGES AND RESPONSES

Sites encountered a series of broad challenges as they wrestled with how to improve coordination among agencies or systems over the life of the project. We describe these broad challenges in temporal order below and for each challenge provide an overview of how sites responded to the challenge.

Service System Integration Challenges and Responses

Bringing the Right Partners to the Table
- Draw upon existing relationships.
- Budget extensive time for networking and relationship building.
- Involve a wide range of systems early on.
- Identify key individuals who might support – or derail – integration efforts.
- Use cross-training as a "hook" to entice agencies.
- Consider payments or in-kind transfers as inducements for participation.

Developing a Shared Vision of System Integration
- Allocate several months for vision building.
- Consider hiring an outside facilitator to smooth initial collaborative work.
- Consider using value clarification exercises.
- Have a respected leader champion system integration.

Developing a System Integration Approach
- Consider forming a broad based coordinating body and a smaller coordinating body that brings together major project players.
- Provide a range of cross-training opportunities from small informal lunches to large conferences.
- Formalize agreements with partnering agencies through written memoranda of understanding.

Maintaining System Integration Work Over Time
- Keep the integration work consumer-focused.
- Involve consumers in integration work.
- Push for change at the service and service system level simultaneously.

Securing Funding
- Advocate at the state level for changes in funding rules.
- Creatively use existing categorical funding streams to cover needed services.

Bringing the Right Partners to the Table

Challenge: To develop systems of care that could address the needs of women in an integrated manner, many WCDVS sites needed to involve a wide range of organizations in their intervention development efforts. However, they often lacked

existing networks of organizations to draw upon. Sites had to determine the appropriate size for their coalitions, the mix of organizations required, and which partners to invite to the table. Sites put extensive effort into identifying potential partners, networking with other organizations, conducting needs assessments of their local service environments, and interviewing or surveying local agencies. The WELL Project, for example, conducted a thorough needs assessment and extensive networking geared towards forming a motivated coalition with the necessary skills and resources to develop a trauma-focused system of care.

A number of factors made developing these coalitions challenging. First, the trauma focus of this project was new to many agency administrators and front-line providers, and people were sometimes slow to see the importance of the work and how it intersected with their own work. Second, unlike mental health and substance abuse treatment, there are generally no public entities with responsibility to provide trauma services for those without private means to obtain them. The lack of a public trauma service system reduced options for partnering with a single, centralized organization such as a county substance abuse office. Third, as with any other initiative, this project competed with other demands on decision-makers' time and attention. This competition was heightened in times of fiscal decline and uncertainty. Finally, turf issues and competitiveness among agencies over resources posed barriers to organizing coalitions.

Responses: While all WCDVS sites were successful in forming coalitions of some kind, the sites varied widely in the scope of their system integration efforts. Most sites eventually achieved relatively modest efforts in this area, forming relationships with a few organizations necessary for providing components of the clinical intervention. The types of organizations represented across the study sites included substance abuse agencies, mental health agencies, domestic violence programs, health centers, hospitals, inpatient psychiatric facilities, and government mental health, substance abuse, correctional, entitlement, and child protection agencies.

At sites where the lead agency provided a wide range of services in-house, less partnering was necessary to implement the clinical level intervention. At sites where the lead agency had a focus in a single area – a substance abuse treatment agency for example – partnering was essential to provide the full range of required services. Beyond the partnering necessary to mount the clinical intervention, some sites pursued systems level change and developed relationships with other agencies to build referral sources, link women to aftercare services, and increase trauma awareness in the community. A few sites took wide perspectives, focusing on changing policy at municipal, county, or state levels.

Besides varying in size, coalitions varied in the balance between intra-organizational and inter-organizational integration efforts. Most sites focused their efforts on inter-organizational work, forming coalitions composed of representatives from separate agencies. The WELL Project and the Boston Consortium each pulled together over 15 agencies to participate in their systems level work. The primary focus at a few sites was on intra-organizational integration, bringing together different programs, facilities, or departments already existing under a single umbrella organization. PROTOTYPES worked on this model, integrating separate programs within the PROTOTYPES organization. Similarly, the Palladia/Portal Project pulled together three programs within Palladia, Inc, a multi-site substance abuse treatment organization.

Many sites reported the importance of drawing upon existing relationships and partnerships. Coalitions at each study site included a mixture of agencies the grantees had worked with previously

Sites put extensive effort into identifying potential partners, networking with other organizations, conducting needs assessments of their local service environments, and interviewing...local agencies.

...forming interpersonal relationships between personnel from different agencies was the bedrock on which service integration was based.

as well as new agencies brought in for this effort. The work of forming coalitions was greatly facilitated by pre-existing ties. In cases where a strong tie did not already exist, sites found it important to spend time cultivating personal relationships with an agency's leadership and staff. Many sites reported that forming interpersonal relationships between personnel from different agencies was the bedrock on which service integration was based. The WELL Project coined a term for this approach – "relational systems change" – and site leadership stressed the importance of allocating sufficient time to do this important work.

As the project progressed, study sites found they needed to involve other systems beyond mental health, substance abuse, and trauma services such as criminal justice, health care, school systems, and child protective services. Because the women whom sites were hoping to help faced widespread and serious challenges, the involvement of other systems that touched their lives was necessary. Many women were dealing with custody issues concerning their children: some were facing the possibility of losing custody; many had previously lost custody and were motivated in their recovery by the hope of being reunited with their children; many were receiving mandated services as a result of custody hearings or other legal proceedings. As a result, child protective services as well as the criminal justice system were often important forces in their lives. While these organizations did not play central roles in sites' interventions, having them at the table enhanced the ability of the projects to help women navigate these systems and advocate for them when necessary.

Throughout the project, sites reported that their integration efforts were enhanced or significantly blocked by one or two individuals who held key positions in other agencies. Sites noted it was very important to identify such individuals early in the process and structure the coalition of partners to build on the work of supportive individuals or work around those who might obstruct the efforts.

Sites found a few strategies were most effective in motivating participation by other organizations. The most important of these was cross-training. The promise of receiving free cross-training, particularly training around the identification and treatment of trauma, was the "hook" that brought agencies to the table. Many agency directors and front-line service providers knew that trauma was a major issue for the people they served but felt they or their organizations did not have the expertise or resources to deal with it. Payments or in-kind transfers were also motivational. Another effective approach was to point out to agencies the effectiveness of trauma treatment. Besides being of incalculable value to the women served, such efforts also had direct tangible benefits for the organization, including increasing compliance with treatment, better outcomes, and fewer disruptive episodes that occur when a trauma survivor's symptoms are triggered. In general, however, most organizations did not need tangible incentives to participate in the WCDVS.

Developing a Shared Vision of System Integration

Challenge: Once sites brought partners together, it became apparent that preparatory work was needed before substantive work could proceed. Before they could begin designing an approach to integration, partners needed to develop a coherent vision of the problems they were addressing and what they were trying to achieve. As sites began to struggle with this task, three major challenges arose.

First, personnel from differing systems often had little knowledge of the assumptions, theories, and practices of other areas. For example, staff from substance abuse agencies in the Allies project reported that this project was the first time they had ever sat down with mental health providers to understand their point of view. Without a certain level of background knowledge about how other treatment systems saw the issues at hand and their services, it was difficult for meaningful work to proceed. Second, practitioners from different systems often

held profoundly different and contradictory beliefs concerning consumers, treatment, and the role of service providers. One key difference centered around the degree of flexibility to give consumers. Those from mental health and domestic violence backgrounds tended to view services as highly flexible to accommodate the consumer, while substance abuse practitioners believed that a "tougher" approach was more effective and necessary to avoid "enabling the client". Another difference concerned the appropriate timing of interventions. Some practitioners believed it was necessary to control substance abuse before addressing mental health and trauma issues, while others held that the experience of trauma was the driving force behind substance use for many women and must be addressed at the beginning of the treatment process. Differences in these principles had profound implications for how to design an integrated system of care. Finally, system integration work itself was not an area in which many of the project stakeholders had experience nor was there well-established guidance available. Thus, sites needed to build consensus on the nature of integration, appropriate goals for a systems integration project, and the means to accomplish these goals.

Responses: WCDVS sites invested time and resources on developing a shared understanding and mission among the different organizations involved in the project. The project structure mandated a two-year planning phase followed by a three-year implementation phase. Up to a year of the planning phase was generally spent in building cross-system understanding, awareness, and consensus. During the later years of the project, evaluators frequently heard from stakeholders about the importance of this initial work.

Early in the project, sites convened meetings to allow stakeholders to get to know one another, share information, and build a common vision. These meetings, which often grew into more formal regular meetings of a project coordinating body, were central in resolving misunderstandings and differences in philosophy. Some sites employed experienced facilitators from outside the project to ensure effective meetings and avoid having the lead agency take too prominent a role. Some sites used formal values clarification exercises in which stakeholders answered a common series of questions, and the answers were summarized and reported back to the group. This technique helped stakeholders from different systems understand the beliefs and values of those from other systems. Both Allies and the WELL Project reported success with these techniques.

Another important response was to have strong leaders – typically the head of the grantee agency – invest their professional prestige and the weight of their institutions behind the work of service system integration. At several sites, leaders with established professional histories of working on integration issues championed the cause of integrating trauma with mental health and substance abuse treatment for women. Project sites frequently reported that having a leader lay out a vision for integration, and work diligently to bring others along, was an important catalyst for change. A strong leader proved helpful at advancing integration at the larger system level by uniting people from varied professional backgrounds, at the program or agency level by championing integration within their own organization, and at the service level by advocating for clinical integration.

Developing a System Integration Approach

Challenge: Once sites had brought partners to the table and built consensus regarding the problem and a how to address it, they focused on designing their projects. Sites had to decide where and how to focus their efforts, and balance competing demands for project resources and the time and energy of participating organizations.

Responses: As noted above, three service system integration strategies proved central to almost all of the WCDVS interventions. Coordinating bodies were important forums for pursuing service system

...practitioners from different systems often held profoundly different and contradictory beliefs...

...trainings were one of the central strategies for making existing mental health and substance abuse services more trauma-informed.

integration. They were valued for providing a forum in which direct collaborative work could be undertaken, and in facilitating increased knowledge, understanding, and value sharing among providers and agencies. At PROTOTYPES, members of the Local Experts Group – a panel of high-level administrators from government, research/academic organizations, service agencies and C/S/Rs in Los Angeles County – met regularly to discuss macro-level issues that could be best addressed at the county level. At the Franklin County project, the Services Integration Committee brought together a range of community partners who reported success in sharing information, coordinating resources, and creating a more trauma-informed service system in the county. The Boston Consortium and the Triad Project utilized more narrowly focused committees that convened agencies directly involved in providing services to women in the project. Members of both projects reported great satisfaction in the process of working together over several years and addressing implementation issues, cross-agency conflicts, and broader systems issues. These findings illustrate two of the main types of coordinating bodies: broad-based groups that brought together a range of organizations in a community and smaller groups that involved agencies with direct roles in providing services. Several sites had two groups, with one fitting each of these functions.

Cross-training was another pillar upon which service system integration efforts rested. All sites trained mental health and substance abuse providers in each others' areas, and provided training on trauma, its effects, and its treatment to both groups. Trainings assumed a number of formats, ranging from large trauma conferences featuring nationally recognized experts to small "pizza lunches" held for providers at participating organizations during their lunch hour. These trainings were one of the central strategies for making existing mental health and substance abuse services more trauma-informed and were often seen by non-grantee participating organizations as a tangible benefit for their participation in the project. Sites found that cross-training was needed on a continuing basis, and that the new philosophies and approaches required for the project work took time to be accepted and to deepen. In addition, staff turnover necessitated repeated training to accommodate new staff. Ongoing training also facilitated increased informal contacts across agencies by providing a context in which a broad range of personnel could come together for a common purpose.

The use of written memoranda of understanding (MOUs) appeared later in the project as grantee organizations formalized arrangements with collaborating partners. Sites used these documents in several ways: to formalize referral arrangements; to formalize participation in service system or clinical integration activities; or to specify arrangements for providing services. For example New Directions developed memoranda with 13 community agencies specifying referral arrangements. The Palladia/Portal Project began by developing memoranda with six agencies formalizing their participation on the Project Advisory Council and in regular meetings called Multidisciplinary Case Conferences and concluded with participation from over 20 agencies. The Boston Consortium used MOUs to specify arrangements by which the four agencies physically hosting the intervention would collaborate, and to specify the use of a common screening tool developed by the project with a wider group of agencies.

Several sites sought to increase agencies' abilities to detect and react to co-occurring issues by developing a common screening instrument that assessed multiple domains for use by multiple agencies. At Triad for example, stakeholders developed a trauma-informed bio-psychosocial assessment form that was used by both mental health and substance abuse providers throughout a three county service area. Co-locating trauma, mental health, and substance abuse services in a single location – "one-stop shopping" – was another approach to enhance

integration. The PROTOTYPES project provided all of these services as well as medical care, vocational training, and entitlement advocacy on their residential campus.

The majority of WCDVS sites engaged in some form of advocacy for systems change with their city, county, or state governments. Often, coordinating bodies identified government policies or procedures that served to fragment service delivery, then sites worked towards removing these barriers. The WELL Project, for example, successfully advocated for new language in the guidelines that governed state contracts with substance abuse agencies to require contracting agencies to demonstrate their services were trauma-informed, and to make trauma-specific services available to their clients. The Boston Consortium was successful in getting the city health department to adopt mental health as an area that their programs should address. This resulted in a new coordinator of mental health at the health department and several new grants that expanded their work into mental health.

Maintaining Systems Integration Work Over Time

Challenge: Once the early planning work was complete, there was some tendency for participation on coordinating bodies and other service system integration activities to decline. As the projects matured, the question became not how to engage collaborators, but rather how to sustain and maintain the collaboration over time. In some cases, sites had difficulty retaining initial levels of enthusiasm and energy. This natural evolution was exacerbated in communities where government allocations for services were being reduced because of limited revenue. When core services were cut, agency administrators had little ability to focus on integrative work because they were consumed by maintaining their agencies' strength and viability. Because so much of the integrative work occurred at the level of personal relationships, WCDVS efforts were particularly susceptible to staff turnover. In several instances, turnover in key staff eroded relationships built up between agencies earlier in projects.

Responses: The decline in service system integration activities that occurred across the WCDVS sites was probably a reflection of change in the nature of the work that sites were undertaking. Phase I of the project was a period of relationship building and casting a wide net of participation. Once projects had planned and fielded their clinical level service packages, the primary task became one of maintaining and refining their interventions. This change was dictated largely by the logic of the WCDVS research design mandating that sites participate in a multi-site outcome study of their clinical interventions. During the maintenance phase, there were fewer opportunities for participation by coalitions of agencies.

One strategy that helped to maintain coalition involvement was to keep the focus of the work on the consumer, and on ways to improve services and outcomes. Since participating agencies generally had deep commitments to helping women in their recovery, continually framing project work in those terms helped keep organizations on board. Having C/S/R women on coordinating bodies kept the focus on consumers, maintained the urgency of the work, and helped to overcome turf and sectional issues among providers. This dynamic was at work on the Boston Consortium's Steering Committee, which continued to meet regularly throughout Phase II of the project.

Service system integration activities were also facilitated by simultaneous positive changes at clinical and service system levels. Several sites reported that a virtuous circle was developed in which positive changes at one level reinforced changes at the other. Strengthened connections at the organizational level, for example, made it easier to remove barriers to integration at the clinical level. At the same time, concrete improvements in service coordination and delivery inspired agencies to continue to participate. Evaluators frequently heard

...the question became not how to engage collaborators, but rather how to sustain and maintain the collaboration over time.

One of the most serious issues sites contended with was how to sustain funding for their innovative services...after federal grant money ended.

collaborating agency directors make statements such as "We're staying in this project because the women we serve love it. We've seen real improvements in people's lives."

Securing Funding

Challenge: One of the most serious issues sites contended with was how to sustain funding for their innovative services and integrative work after federal grant money ended. Time and again, sites reported that rigid, categorical funding streams were hamstringing their ability to obtain stable funding for intervention components. In addition to difficulties in securing funding for service integration activities, sites reported a paucity of funds for core WCDVS activities such as trauma groups, peer-run services, and C/S/R integration. Few dedicated funding streams provide trauma services beyond immediate domestic violence needs. Similarly, peer-run services and the wider array of C/S/R activities such as advisory boards and participation stipends lack established mechanisms for funding. These difficulties interacted with the general movement towards managed care in behavioral health that was an important contextual change occurring during the study period at some sites.

Responses: Sites responded to these challenges by advocating at the state level for changes in funding rules. The WELL Project obtained agreement from the state substance abuse authority to make trauma groups and trauma-informed parenting groups reimbursable within outpatient substance abuse treatment. At the time of this report, financing was being investigated due to severe budget cuts in human services funding in Massachusetts. Another approach was to creatively use existing categorical funding streams. At the time of this report, the DC Trauma Collaboration was attempting to fund their ongoing trauma groups through a mental health day-treatment funding source, and expected to be successful. Triad project practitioners slightly changed their multi-disciplinary conferences to include discussion of a particular consumer's situation, which made the sessions billable under the state guidelines.

Clinical Integration Lessons

From the inception of the WCDVS, it was clear to project stakeholders that enhancing clinical level integration among mental health, substance abuse and trauma services was essential to improve services for trauma-surviving women with histories of mental illness and substance use. Approaches used by WCDVS sites to enhance clinical level coordination of services are listed in the grid below.

Study Site	**Key Clinical Integration Strategies Used**
PROTOTYPES	Team-based case management Individual case managers
Allies	Group and individual case management
Arapahoe House	Peer case managers
DC Trauma Collaboration	Team-based case management *(Integrated Trauma Service Teams)*
Triad	Individual case managers *(Triad Specialists)*
Boston Consortium	Low intensity case management *(Trauma/Mental Health Services Coordinator)*
WELL Project	Individual case managers *(Integrated Care Facilitators)*
Franklin County	Peer Resource Advocates
Palladia/Portal	Integrated team-based case management *(Women's Treatment Specialists)*

Case-managers, using various models and identified by various terms, provided the primary means to integrate services at the clinical level. Case manager positions were multifaceted, involving: conducting assessments; creating joint, holistic treatment plans with consumers and other service providers; assisting women in making their appointments and meeting basic needs; advocating for women with entitlement programs and other agencies; and providing crisis services and ongoing counseling and support. These individuals often had experience and training with trauma issues, and brought a "trauma

...case management, resource coordination, and advocacy occurred through group-oriented models involving multidisciplinary teams...

perspective" to their work. For example, the Triad project's model featured Triad Specialists whose work involved outreach, intensive case management, and resource coordination and advocacy with maximum case loads of 30 women. The Triad case management model emphasized forming a supportive relationship with participants and helping women meet daily needs. At the height of the project, ten Triad Specialists were employed across three different agencies. Five of the positions were funded with project grant money and five were supported by hosting organizations. Similarly, clinical integration at the WELL Project was provided by six Integrated Care Facilitators (ICFs) working in pairs from three agencies (1.5 FTEs at each site). Extensive networking with local agencies during the project's initial development phase facilitated efforts to link women to services during the latter implementation phase. Each pair of ICFs had a caseload of approximately 30 to 45 women. Several ICFs also co-led trauma groups with local agency staff until local staff were able to lead these groups themselves.

At many sites, case management, resource coordination, and advocacy occurred through group-oriented models involving multidisciplinary teams of individuals meeting regularly to plan and monitor services for women. At PROTOTYPES, individual case managers conducted initial assessments and attended to immediate needs. After the initial intake period, women's care was transferred to a team of providers who worked with the woman to develop and implement a treatment plan. Teams included a primary substance abuse counselor, a mental health counselor, and an employment specialist who met weekly to monitor and coordinate services. The DC Trauma Collaboration also used a team-based model featuring Integrated Trauma Service Teams of cross-trained clinicians who worked collaboratively to provide mutual support and problem-solving. Women receiving services at the DC site would work closely with one of the clinicians while having contact with all members of a service team.

Taking a more consumer-driven approach, the Franklin County Women's Research Project provided clinical coordination primarily through drop-in centers staffed with Peer Resource Advocates who received training from project staff to provide guidance, support, and advocacy to help women access community resources.

CHALLENGES AND RESPONSES

For clinical level integration to proceed, the larger framework of participating organizations needed to be in place along with identification of the actual services to be integrated. Much of the work of the study sites focused on creating environments in which women could be treated holistically rather than in an uncoordinated and piecemeal fashion. As sites engaged in these efforts, they faced a number of challenges that are outlined below.

Clinical Integration Challenges and Responses

Developing an Effective Integration Model

- Convene a small committee to review integrative models and design an intervention. Have this model reviewed by a larger group.
- Seek out integrated interventions that simultaneously address mental health, substance abuse, and trauma.
- Consider psycho-educational groups as a relatively low-cost and promising approach.
- Use case managers and/or multidisciplinary case conferences to tie services together at the clinical level.
- Assign staff from different agencies and backgrounds to co-facilitate group interventions.

Managing Logistics of Coordinating Services

- Have weekly meetings of those who manage day-to-day operations at the agency level (typically not agency heads).
- Designate a "project liaison" at each participating agency.

- Consider co-locating services when possible to ease consumers' transportation barriers.
- When possible in rural areas, have clinicians travel to provide services to outlying communities.

Making Services Trauma-Informed

- Start trauma training early and repeat it often. Structure trainings for clinicians as well as non-clinical staff, administrators, and policymakers.
- Identify an individual with expertise in trauma (a trauma liaison) to raise awareness of trauma within agencies and serve as a project point-person on trauma issues.

Developing an Effective Integration Model

Challenge: To develop their clinical intervention service packages, sites had to determine how to implement required core services, which agencies would provide which services, and how services would be coordinated. Sites also had to determine if any services would be mandatory or optional, and how services would be sequenced and timed. This process often brought out partners, differences in philosophy and approach. With the absence of pre-existing models for integrating trauma, mental health, and substance abuse services, there was little guidance on how services should be coordinated and who should coordinate them. Sites were challenged to develop structures that were workable, effective for women receiving treatment, and accommodated the varied interests of project stakeholders.

Responses: To address the challenge of designing an integrated service package, sites generally relied on a committee of interested stakeholders who reviewed options and helped to frame a model. This was accomplished at some sites by a small group (e.g., four staff and a C/S/R at Arapahoe House) and at others by larger groups (e.g., the Services Integration Roundtable and the Steering Committee at the Boston Consortium).

Clinical integration models developed by the sites had certain common features. All the sites provided clinical services designed to address mental health, substance use, and trauma issues. Every site fielded a psycho-educational group intervention with a curriculum including material on all three of these domains. Because these groups interwove these issues and addressed the interactions among them, they can themselves be considered integrative mechanisms. Furthermore, groups were often co-led by practitioners from different backgrounds, further enhancing their integrative nature. These groups are discussed in detail in the services section of this report.

Another approach common to all sites was a mechanism to unify and coordinate services that addressed only one or two of the three core domains. As described above, the primary method to achieve this coordination was case management. The nature of the case management differed considerably across the sites, with some taking individual-based approaches while others utilized team-based approaches.

Many sites reported success with multi-disciplinary case conferences and co-facilitation. Multi-disciplinary case conferences brought together providers from different backgrounds to address the needs of a particular woman and/or a hypothetical case. These meetings served both as a clinical integration strategy and a service system integration strategy. Frequently, sites reported that the positive impacts of these conferences went beyond those for the woman served to include increased understanding, trust, and cooperation among providers. These meetings complemented didactic cross-training sessions by serving as a mechanism by which providers from different backgrounds could receive training from each other. Arapahoe House featured case conferences of practitioners from within their program that were valued by clinicians and likely to continue after federal funding ended. At the WELL Project, case conferences were

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...coordinating bodies [were]...essential in facilitating communication, heading off potential problems, and troubleshooting when problems did occur.

conducted on an as-needed basis when case managers felt further consultation with providers was necessary. The Boston Consortium used Interdisciplinary Resource Teams comprised of substance abuse treatment counselors, mental health specialists, and a trauma expert who facilitated monthly care presentation meetings.

At many sites, trauma group interventions were co-facilitated by clinicians from different agencies and/or disciplines, or by a clinician and a consumer. Often, a project staff person trained in a particular issue would co-facilitate groups along with a staff member from a collaborating agency with less experience in the area. This approach strengthened relationships among providers and provided extensive informal training opportunities. Allies, Triad, and PROTOTYPES used this strategy to embed their interventions within collaborating agencies and to infuse the local service environment with trauma-informed approaches.

Managing Logistics of Coordinating Services

Challenge: Sites needed to resolve a host of logistical details to integrate services at the clinical level. With services available at different locations, transportation for women became paramount. Many women did not have access to reliable private transportation, and public transportation was often time consuming, inconvenient, or non-existent. Scheduling of services was a continual concern, both in terms of making services convenient for women and coordinating schedules between different agencies. Because sites attempted to make services flexible and individualized for each woman, a single set schedule at any one site could not accommodate all the women receiving services. Logistical issues around enrolling women in services were also complex, as different "gateway" agencies had different procedures for intake and assessment that had to be coordinated.

Responses: Sites dealt with logistics in a variety of creative ways. A coordinating body composed of project managers from different agencies was one key strategy. This group often did not include agency heads or project directors but rather the people under them who had responsibility for day-to-day project activity. These groups met frequently, usually weekly, and stakeholders reported them to be essential in facilitating communication, heading off potential problems, and troubleshooting when problems did occur. Some groups developed a single coordinated schedule of services across the agencies they represented. Another approach was designation of a "project liaison" staff member at each collaborating agency to attend staff meetings at the collaborating agency to report on project activities, solicit project participation, and act as a conduit between agency directors.

Transportation issues were eased at some sites because their structure involved co-locating services at a single location. Residentially-based programs were able to consolidate many services within the facilities where women were housed. Rural sites were more likely to offer services in widely separate locations. To reduce travel burdens: the Franklin County project located drop-in centers in three different communities; the WELL Project sited their intervention at three different agencies in eastern Massachusetts; the Triad project conducted groups at agencies separated by several hours of driving time across a large county in rural central Florida; and the Boston Consortium provided transportation with agency vans and taxi vouchers.

Making Services Trauma-Informed

Challenge: WCDVS sites were mandated to provide trauma services, and make non-trauma services more trauma-informed. As described in *Creating Trauma Services for Women with Co-occurring Disorders* (Jahn Moses, Glover Reed, Mazelis & D'Ambrosio, 2003), "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 endeavor to do no harm – to avoid re-traumatizing survivors or blaming them for their efforts to manage their traumatic reactions" (p. 19).

All WCDVS sites worked to make existing mental health and substance abuse services more trauma-informed. Because trauma was often a new focus for providers and administrators, much work needed to be done in this area. Sites found little knowledge about traumatic experience and its effects, how to facilitate survivors' recovery, or how services could help or harm trauma survivors. There was a lack of awareness about trauma among many mental health and substance abuse providers, and within other systems touching women's lives such as child protective services and health care. Many service providers were initially resistant to dealing with trauma issues for a variety of reasons (see discussion of provider resistance in the services section below), largely around concerns about being unable to adequately handle trauma reactions. Besides being new to many in service professions, trauma work can be extremely difficult and emotionally demanding for providers. Many sites reported that working on trauma issues raised issues of staff members' own trauma histories.

Responses: Sites found that training on trauma for non-trauma service providers was the first and most important step in making services more 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. Sites also found that training needed to be repeated regularly to reinforce learning and compensate for staff turnover. In general, training was offered to service providers at no cost and sometimes included continuing education credits.

Another effective strategy to make services trauma-informed was to locate a "trauma liaison" or "trauma specialist" at collaborating agencies. These individuals performed both service system and clinical integration roles. They consulted with clinicians seeking advice on how to manage the trauma issues of a particular consumer, and provided informal training and information sharing within the agency on trauma and trauma treatment. The Franklin County project based a trauma liaison at a medical center who successfully linked women at the center to trauma services, raised awareness about trauma within the center, and infused a trauma perspective in the community. The Boston Consortium had a Trauma/Mental Health Coordinator who linked women to mental health services and provided some ongoing case management.

...training on trauma for non-trauma service providers was the first and most important step in making services more trauma-informed.

Service Lessons

To address the complex burdens and needs of women with co-occurring disorders and trauma histories, WCDVS sites had to ensure that a comprehensive set of services was available to all participants. This comprehensive service package included:

- **Outreach and Engagement:** An informed process that fosters community-wide education and trauma awareness while identifying target groups and individuals who enter service systems through a variety of "gateways" or "portals."

- **Screening and Assessment:** Screening for the presence of a substance abuse problem, mental illness, and history of trauma, and evaluation of the nature of the problems and personal characteristics that interact with the problems.

- **Treatment Activities:** Mental health, substance abuse, and trauma treatment services that are face-to-face, goal oriented, and therapeutic. Includes group, individual, and/or family therapy.

- **Parenting Skills Training:** Individual or group sessions introducing and providing practice on parenting skills and techniques. May include experiential classes (mother and child bonding) and relationship work.

- **Resource Coordination and Advocacy:** Working with a woman to respond to a wide range of needs, and to enhance her existing strengths and supports. This may include building linkages, facilitating access, advocacy and assistance in problem-solving with significant others, natural supports, and various service systems.

- **Trauma-Specific Services:** Services designed to address specific behavioral, intra-psychic, and interpersonal consequences of exposure to sexual, physical, and prolonged emotional abuse.

- **Crisis Intervention:** Services including screening, providing immediate direct intervention, and facilitating referrals necessary to address immediate safety (physical and emotional) needs. May include "warm lines."

...sites developed new trauma-specific services, peer-run services, and resource coordination and advocacy approaches that were layered onto pre-existing services...

- **Peer-Run Services:** Services may include crisis-respite, drop-in centers, peer counseling (individual, group, warm lines), educational sharing, services/systems advocacy, and mutual support. (SAMHSA, 2000)

Given the variation among study sites, it is not surprising that each chose to implement the eight core services in different ways. Since most of the sites were service-providing organizations, some ongoing treatment activities already in place were augmented with project resources. In general, sites developed new trauma-specific services, peer-run services, and resource coordination and advocacy approaches that were layered onto pre-existing services provided by the grantee and/or collaborating organizations. Among the ways in which sites provided the core services were:

Outreach and Engagement: Outreach efforts were conducted by a range of staff, including intake workers, case managers, C/S/R outreach staff, and program managers. Outreach staff visited local mental health and substance abuse providers, homeless shelters, welfare offices, child protective services, jails, etc. to inform staff and clients of the new program. Information was placed in newspaper and radio advertisements, and on flyers and "palm cards" placed in bus stops, stores, churches, and libraries.

Screening and Assessment: All sites worked to provide mental health, substance abuse, and trauma screening and assessments. Given that many survivors underreport their traumatic experiences, sites grappled with how best to conduct trauma screening and assessment. Sites were also concerned that such assessments could be viewed as intrusive or might trigger traumatic reactions. A number of sites modified their assessment processes to be more trauma-informed. For example, the Boston Consortium and the Franklin County project engaged trauma experts to assist with assessments at multiple project sites. Triad 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 facilitated information exchange across agencies.

Treatment: A range of mental health and substance abuse treatment services were provided in residential, day treatment, and outpatient settings, depending on the site. Services included psychopharmacological assessment and treatment, substance abuse detox services, individual and group mental health counseling, individual and group substance abuse counseling, and methadone treatment. Most sites offered relapse prevention and aftercare services.

Parenting Services: Parenting services were provided through psycho-educational parenting groups and by project staff (case managers, counselors/therapists, etc.) with expertise in parenting and child development. Several sites used the *Nurturing Families Affected by Substance Abuse, Mental Illness and Trauma* curriculum (Moore, Buchan, Finkelstein & Thomas, 2001; D'Ambrosio & Jahn Moses, 2002). The curriculum has three modules: one-on-one mentoring and intensive skills building; parenting groups; and parent-child skill building groups. Some sites provided parenting services directly, while others referred women to resources in the community.

Resource Coordination and Advocacy: Resource coordination and advocacy services were provided primarily through case managers who sometimes worked within integrated service delivery teams. Case managers conducted assessments, created treatment plans, and linked women to services and entitlements. They were often responsible for providing crisis services, and ongoing counseling and support as well. Many had experience and training in trauma issues and brought a "trauma perspective" to their work. A few sites engaged C/S/R women as peer advocates/case managers. (See section on clinical integration for more information).

Trauma-Specific Services: Trauma-specific services were a cornerstone of the WCDVS service intervention. Trauma services were provided primarily through psycho-educational groups that integrated education and treatment for mental health, substance abuse, and trauma-related issues. These trauma groups were empowerment oriented. They allowed women to normalize their trauma experiences and build positive, supportive relationships with other women both of which are critical to healing and recovery. Group work is now considered a "critical ingredient" in any effective trauma intervention (Salasin, in press). Importantly, the WCDVS represents the first, wide-scale implementation and evaluation of psycho-educational group interventions for women trauma survivors.

Four group models were used across the nine sites. Four of the sites used or adapted the Seeking Safety model, a cognitive-behavioral group intervention for women with PTSD and substance abuse disorders that educates participants about each disorder and their interactions, and increases daily life structure, coping skills, management of affect, and self-care (Najavits, 2001). It covers 25 topics evenly divided among cognitive, behavioral, and interpersonal domains while simultaneously addressing development of safe coping skills relevant to both substance abuse and PTSD. Topic titles include: Honesty; Asking For Help; Compassion; Taking Good Care of Yourself; Creating Meaning; Setting Boundaries in Relationships; and Integrating the Split Self.

Three sites based their interventions on the Trauma Recovery and Empowerment Model (TREM) that focuses on empowerment and skill development, and uses psycho-educational and cognitive-behavioral techniques to help women gain a greater understanding of the impact of trauma and abuse on their lives (Harris, 1998). The 33-week program is divided into four core parts: Empowerment; Trauma Recovery; Advanced Trauma Recovery Issues; and Closing Rituals. Each session follows a framework that includes session goals, facilitated group discussions, and experiential group exercises. The Boston Consortium developed a cultural adaptation and a Spanish translation of TREM.

One site used the ATRIUM model that features a bio-psychosocial framework that responds to the complex treatment needs of trauma survivors (Miller & Guidry, 2001). The model blends psychoeducational, process, and expressive activities to help women "recontextualize their experiences and adaptive strategies" (Miller & Guidry, 2001). 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.

Triad developed their own trauma-specific group intervention, the Triad Women's Group, designed to promote survival, recovery, and empowerment (Clark & Fearday, 2003). The group is divided into four phases: 1) mindfulness: getting comfortable with yourself; 2) interpersonal effectiveness skills: having healthy relationships with yourself and others; 3) emotional regulation: feeling good; and 4) distress tolerance: staying healthy in a stressful world.

Several sites provided other trauma-specific groups in addition to those described above. The most common were domestic violence groups. Many provided individual trauma-specific counseling and therapy on an as-needed basis. Sites supported a number of peer-run trauma-specific activities (see below). A few sites provided non-verbal therapies such as relaxation and guided imagery work either directly or through referral.

For more information on sites, trauma specific services, see *Creating Trauma Services for Women with Co-Occurring Disorders* (Jahn Moses, Glover Reed, Mazelis & D'Ambrosio, 2003).

[Trauma groups]...allowed women to normalize their trauma experiences and build positive, supportive relationships with other women both of which are critical to healing and recovery.

One of the most frequent roles for C/S/R women in providing services was co-leading therapeutic groups...

Crisis Intervention: In general, sites used existing, standard crisis intervention services for the women in the study. These services included face-to-face and telephone screening and referrals, and direct counseling and hospitalization services when needed. These services were available 24 hours a day, usually through a rotating on-call system. Some projects provided their own crisis intervention services, while others utilized services available in the community.

Peer-Run Services: Significant peer-run services were present at all of the study sites. One of the most frequent roles for C/S/R women in providing services was co-leading therapeutic groups (trauma-specific and other groups). A number of sites had peer-designed, peer-led support groups. While the focus of these groups varied, all provided peer-based support for women who were currently receiving program services or who had graduated from services and wanted ongoing contact and support. Another common position for C/S/Rs was peer advocate or peer case manager. These women often accompanied clients to appointments, helped them identify resources, and advocated for needed services. Consumer led drop-in centers played prominent roles at two sites.

CHALLENGES AND RESPONSES

WCDVS sites faced many challenges and barriers as they developed and implemented the comprehensive services required by the project. Many of these challenges, and the strategies sites used to address them, are described below.

Services
Challenges and Responses

Developing Trauma-Specific Services

- Share information with others working on trauma issues.
- Seek input from key stakeholders on community needs and appropriate responses.
- Create participatory, multi-disciplinary planning groups.
- Pilot test interventions and refine services as necessary based on feedback received.
- Allow enough time for participatory process.

Operating Trauma Groups

- Anticipate resistance and hesitation from providers and clients.
- Provide education, training and support for providers to ease resistance and increase skills.
- Offer education and opportunities for peer-to-peer support to address uneasiness among clients.
- Create peer designed and led support groups to provide post trauma group support.

Implementing Trauma-Informed Parenting Services

- Recognize the importance of children and the role of parenting in women's lives.
- Adapt "mainstream" parenting services to be responsive to the needs of women trauma survivors.
- Keep the focus on parenting; redirect issues of trauma.
- Provide trauma services prior to, or in conjunction with, parenting services.
- Provide training and support to parenting staff.

Developing and Maintaining Peer-Run Services

- Senior staff must show a visible commitment to peer-run services.
- Provide education and training to address staff concerns.
- Create a participatory process to determine what peer-run services to provide.
- Alter traditional peer support group models to meet the unique needs of the women being served.
- Provide both formal and informal education, training, and support for peer providers.

Addressing the Full Range of Women's Needs

- Understand the multiple and complex barriers women face, and how these impact their ability to access and remain in services.

- Provide intensive resource coordination and advocacy services to help women navigate and access multiple services and programs.
- Offer a broad array of services that include attention to women's basic needs for housing, income, food, etc.
- Re-focus program goals on recovery.

Engaging and Retaining Women in Services

- Launch broad, non-traditional outreach and engagement strategies that utilize C/S/R women.
- Offer services in the evening, and provide childcare and transportation.
- Understand that recovery is a nonlinear process, and design and operate services accordingly.
- Offer services that facilitate the formation of supportive relationships among women.
- Work to normalize and de-stigmatize trauma experiences (trauma groups, peer-run services, etc.).
- Maintain consistency of staff and service delivery.

Meeting the Needs of Women Living in Rural Areas

- Conduct aggressive outreach efforts to reach women living in isolated, rural areas.
- Provide groups that address trauma, mental health, and substance abuse in an integrated fashion to address the paucity of services.
- "Boundary-spanner" positions (trauma liaisons) can help introduce the concept of trauma to a broad array of community providers.
- Offer services in diffuse locations.

Engaging Providers

- Conduct provider training and education efforts on an on-going basis.
- Offer continuing education credits and release-time for all training activities.
- Make training multi-faceted, including group sessions, visual materials, written resources, discussions at staff meetings, supervision, etc.
- Provide active supervision and on-site technical assistance.
- Co-facilitation of trauma groups can expand knowledge and support.
- Facilitate interaction between providers and C/S/R women.

Supporting Staff

- Hold regular meetings for clinical staff to case conference and provide mutual support.
- Assist staff with self-care.

Developing Trauma-Specific Services

Challenge: All sites were required to provide trauma-specific services to women participating in the study. Developing these services proved to be difficult and time-consuming. Because very little concerted work had been done in the area of integrating trauma, mental health, and substance abuse services prior to the study, sites had little to draw upon. What had been done was not always well-documented or evaluated. Although extremely positive, the collaborative nature of the project made it difficult and time-consuming for sites to select their trauma service(s). Differing and conflicting orientations, treatment philosophies, and clinical approaches by various partners and stakeholders often led to the favoring of one trauma approach over another. Sites needed to attend to the unique characteristics of their programs – treatment modality (residential, out-patient, community resource center); setting (rural, urban, suburban); and the needs of a given population (Latina women, women ordered into treatment by a court, etc.) – and select trauma services that fit well with and were responsive to these dynamics. Sites had limited resources to meet the expenses associated with identifying, adapting, creating, and piloting their trauma services.

Responses: The first phase of the WCDVS provided many opportunities for sites to share information with each other, and with others working on trauma issues, through cross-site meetings, conference calls, and training materials. These opportunities ensured

Although extremely positive, the collaborative nature of the project made it difficult and time-consuming for sites to select their trauma service(s).

This participatory process helped ensure the services selected were responsive to the needs/dynamics of the local site and met the needs of all key stakeholders.

that sites had access to information on existing trauma interventions and their unique strengths and challenges.

All of the sites sought input from key stakeholders on community needs around trauma, mental health, and substance abuse, and possible service responses. Most sites brought together diverse, multidisciplinary groups of providers, administrators, researchers, and C/S/Rs at the local level to select/create the trauma services to be provided. This participatory process helped ensure the services selected were responsive to the needs and dynamics of the local site and met the needs of all key stakeholders.

For example, the Boston Consortium held five community hearings around the city to learn how substance abuse, mental health, and violence were perceived, and what services people thought were needed and they conducted focus groups and in-depth interviews with clients, clinicians, and administrators. These sessions allowed direct service providers to learn about trauma intervention models, ask questions, and provide feedback. Triad created a committee that included a trauma expert, staff from a dual disorders program, staff that would be responsible for providing integrated case management services and conducting the trauma groups, C/S/Rs, and research staff to create their trauma intervention (the Triad Women's Group).

All sites chose a psycho-educational group as the primary vehicle for providing trauma services to women. From a clinical perspective, group work provides women with an opportunity to normalize and validate their trauma experiences and build positive, supportive relationships, all of which are critical for women's healing and recovery. Administratively, group work was appealing because it is relatively inexpensive and can serve many women at a time. All sites piloted their trauma groups prior to implementation. Process and outcome assessments provided critical feedback on what worked and what did not, allowing sites to make changes in their trauma services prior to implementation.

These participatory and collaborative processes helped sites select/create trauma services responsive to local needs, strengths, and dynamics, and helped to gain "buy-in" for the intervention from key stakeholders. These processes were, however, very time consuming. The WELL Project found that setting up and running various pilots, eliciting and discussing feedback, developing and examining various options, making necessary adjustments, and getting stakeholders "on board" required more than two years.

Operating Trauma Groups

Challenge: Sites encountered challenges in implementing and operating their trauma services. Trauma work was new for providers: some were resistant to the changes it represented; others had no training or experience in delivering these services. Once trained, many providers found the work to be extremely intense and demanding, and required ongoing support and supervision. Trauma work was also new for most clients; some were hesitant to participate. Several sites found it difficult for women to begin trauma groups just after entering treatment (the nature and timing of the outcome study made this necessary), and believed it would have been better to allow time for women to become clean and sober first. Sites encountered a number of logistical challenges in running the trauma groups. Groups needed to be scheduled at times when women could attend, the group location needed to be safe, and transportation and child care needed to be arranged. Finally, many consumers found that the time-limited trauma group intervention was insufficient to meet their needs and interests, and they voiced a desire for continuing supportive services after they completed the primary trauma group.

Responses: Education and training for providers on trauma and specific trauma interventions helped to ease resistance, and increase knowledge and skills around trauma (see discussion on provider resistance below). Education, training, and opportunities for peer-to-peer relationships helped to address the uneasiness of many clients. The popularity and success of the groups fostered the support and endorsement of administrators, providers, and clients. In general, sites responded to women's interest for more trauma work through creation and support of peer-designed and peer-led support groups. For example, at Arapahoe House, C/S/Rs created a support group called the POWER (Power of Women Embracing Recovery) group in response to their need for continuing support after leaving residential treatment. C/S/Rs at the DC Trauma Collaboration created the Women's Support & Empowerment Center (see Jahn Moses, 2001a for a description) as a place where women could gather and support each other, and a more formal peer-led "After TREM" group in which former group participants could further explore trauma issues. At the Palladia/Portal Project, C/S/Rs co-facilitated the Connecting and Coping curriculum, a 12 week follow-up group for women who had completed the project's Seeking Safety groups.

Implementing Trauma-Informed Parenting Services

Challenge: Many sites struggled with developing trauma-informed parenting services for the women in the study. Traditionally, parenting and children have not been seen as central in the lives of women living with mental illness, substance abuse, and trauma. Treatment and services for these women have neither considered the importance of women's roles as mothers nor included their children. Current service models are largely based on women as individuals rather than as parents. As a result, very few appropriate parenting service models existed for sites to draw upon, use, or adapt. In addition, many sites found a paucity of parenting resources and services of any kind in their communities.

The multi-faceted, dynamic, and complicated relationships among mental illness, substance abuse, trauma, and parenting make most "mainstream" parenting interventions inappropriate for these women. When working with women affected by violence, issues of trauma can surface quickly and it is difficult to keep services focused on parenting. In addition, sites found that some of the parenting work could be triggering for women, and needed to be adjusted to be more sensitive and appropriate for trauma survivors.

Sites found that some women were reluctant to participate in the parenting services they offered. This was due in part to:

- Difficulty in acknowledging and talking about how substance abuse, mental illness, and trauma may have impacted their children.
- Concern over losing their children to child protective services.
- Difficulty in reflecting on how they were parented.
- Limited time to participate because of involvement in other treatment and support services.
- Lack of child care and transportation.

Finally, it is important to note that not all women who participated in the WCDVS were mothers. For some, the decision not to have children was due, at least in part, to their trauma experiences. Women's feelings around these issues were significant and needed to be considered and addressed in treatment.

Responses: Sites had limited success in dealing with the challenges of implementing trauma-informed parenting services. Although some launched successful parenting interventions, others were unable to provide these services consistently. Several sites adapted existing parenting interventions to make them trauma-informed and, therefore, more appropriate and responsive to the needs of the women in the study. The WELL Project created *Nurturing Families Affected by Substance Abuse, Mental Illness and Trauma* which builds upon their earlier work with

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...providers came to see the value of peer-run services as women began to make connections and build relationships that helped...sustain them through treatment...

families affected by substance abuse (Moore, Buchan, Finkelstein & Thomas, 2001; D'Ambrosio & Jahn Moses, 2002). The structure of this intervention was modified to include less exploratory work on women's past abusive experiences, information on and integration of mental health and trauma, and a stronger skills building component. In addition, material that was potentially triggering was removed, such as activities that asked women to close their eyes. The D.C. Trauma Collaboration Study created parenting groups for women addressing a variety of parenting issues including Parenting At A Distance, a group for mothers who are not primary caregivers to their children (Community Connections, 2001).

Parenting group facilitators worked hard to keep the focus primarily on parenting. When trauma issues began to dominate the discussion, women were redirected to their clinician or other contact person trained to address those particular needs. Several sites found that a woman's concurrent participation in a trauma group helped to provide a sense of safety and containment. Some found that it worked well to provide the parenting groups after women had completed a trauma group. Training, supervision, and support for group facilitators and other parenting staff was essential.

Developing and Maintaining Peer-Run Services

Challenge: Sites encountered a number of challenges in designing, implementing, and operating their peer-run services. Some sites encountered resistance or a lack for support for peer-run services from provider and management staff, as these services were not initially valued or seen as a central part of the service intervention. Because there were a limited number of models of peer-run services for women living with mental health, substance abuse and trauma, existing models needed to be adapted or new ones created. To be authentic and effective, this needed to be accomplished by C/S/Rs.

Sites found that the help and support needed to develop and operate these services was unique, and required on-going attention. Several sites found it difficult to identify qualified C/S/Rs to provide and manage these services. Many C/S/Rs who provided peer-run services found these roles to be complex and demanding. This was especially true for the peer support groups, where women often found it difficult to be responsible for managing and/or facilitating the group while also being a participant. Finally, sites struggled to find new resources to support the operation of peer-run services.

Responses: A commitment to peer-run services by senior staff, and education and training on the importance of C/S/R involvement and mutual support helped address some of the resistance encountered. Ultimately, the popularity and success of peer-run services facilitated acceptance and broad based support. Resistant providers came to see the value of peer-run services as women began to make connections and build relationships that helped support and sustain them through treatment and recovery.

All sites used a participatory process to determine what kinds of peer-run services should be provided. As a part of the D.C. Trauma Collaboration intervention planning process, the Empowered Survivors Council (the site's C/S/R advisory committee) was asked what types of peer support would be most meaningful and helpful to women in the study. From this, the Women's Support and Empowerment Center was created – a peer-run drop-in center providing a range of wellness-oriented activities that offer mutual support, skills development, and recreation (Jahn Moses, 2001a).

Many of the post-trauma group peer support efforts launched by the sites drew on traditional peer support group models (Alcoholics Anonymous, Narcotics Anonymous, AlAnon, Emotions Anonymous, etc.), but broke with tradition in important ways to be responsive and supportive to women

with mental health, substance abuse, and trauma experiences. For example, the Wisdom of Women (W.O.W.) peer support group which is part of the Triad Women's Project did not employ deficit-based approaches centered on limitations and labels ("I am an addict"; "I am a major depressive") (Jahn Moses, 2001b). Instead, W.O.W. participants presented themselves as women with specific challenges ("My name is _____ and I have these challenges").

W.O.W. allowed women to talk about addiction along with other challenges and experiences (e.g., trauma and abuse).

Sites found that providing education and training opportunities to C/S/R women helped expand the number of women who were qualified and comfortable with providing peer-run services. Many sites found it best for peer providers to be well-versed in trauma and how it relates to mental health and substance abuse, and have significant time in recovery. It was important to provide opportunities for on-going support for peer providers to help them manage their complex and multiple roles. Some sites provided this through formal supervision; others accomplished it through mutual support from other peer providers.

Addressing the Full Range of Women's Needs

Challenge: The effects of trauma are substantial, impacting women's physical, mental, emotional, spiritual, social, and economic well-being. Women face an array of mental health struggles, substance abuse, and physical health problems. Many are poor and do not have access to adequate food, safe housing, stable income, education, job training/vocational rehabilitation, or employment opportunities. Many women living with mental health challenges, substance abuse, and the repercussions of trauma are mothers. Some live with their children; others do not; some are involved in the criminal justice and child protective services systems. But their identities as mothers are primary to them, and many want to reunite with their children. Many of these women are extremely isolated and lack stable, positive supports and safe, anchoring relationships. Some may presently be in dangerous domestic situations. Many of the burdens women face require substantial time and resources to address, and the involvement of multiple programs and service systems.

WCDVS sites found these burdens often made it difficult for women to access and stay in services. For example, women who were struggling to meet their basic needs for food and shelter did not have time to participate in services that did not assist them with these issues. Others were hesitant to seek services for fear they might lose custody of their children. When a crisis hit (loss of housing, sick child, etc.) or their day-to-day struggles required their complete attention, some women found it difficult to continue to participate in services. Not surprisingly, it was hard for women to work on substance abuse issues when they were living in environments where drugs were rampant, and it was difficult to begin to address trauma issues while living in extremely dangerous situations (with batterers, on the streets, in homeless shelters, etc.).

Responses: WCDVS sites responded to women's complex, long-term burdens and the challenges these burdens presented to healing and recovery in a number of ways. All sites found their resource coordination and advocacy services to be critically important in helping women navigate multiple programs/systems, and access the services and resources they needed. For example, at the WELL Project, Integrated Care Facilitators (ICFs) were responsible for providing case management services for women in the study. ICFs networked extensively with providers in their target areas to serve as effective brokers of services. The three women's centers that participated in the Franklin County project kept extensive resource files listing a range of community services and opportunities that women could access (see section on clinical integration for more information).

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Over the course of the project, sites recognized the need to re-conceptualize their ideas of client "success".

In an effort to respond to unmet needs, many sites developed or accessed additional services beyond those required for women in the study. With access to 150 Section 8 vouchers, the DC Trauma Collaboration became a major provider of affordable housing for consumers in their service programs. PROTOTYPES incorporated income and job support within their treatment approach to help women work towards economic independence. Various support mechanisms assisted women through the different stages of the process – accessing TANF benefits, vocational and employment services, support for job seekers and new employees – allowing the program to address women's changing needs around income and employment as they progressed through treatment (D'Ambrosio, 2003). Triad staff built connections with the local judicial system by accompanying women to court to provide support, and educate judges on the challenges these women faced and the supports they were receiving from the project. These interactions prevented some women from going to jail and encouraged several judges to refer women to the project for help.

Over the course of the project, sites recognized the need to re-conceptualize their ideas of client "success." Sites began to see the goal of their efforts as facilitating and supporting women's recovery, as opposed to focusing solely on abstinence and symptom reduction. Programs began to understand that a woman's symptoms may intensify as they begin to understand and respond to their experiences of victimization and trauma. Sites moved toward being more open to and accepting of a nonlinear recovery process.

Engaging and Retaining Women in Services

Challenge: As mentioned above, women served by the WCDVS sites had complicated life circumstances and faced multiple burdens that often made it difficult for them to access and remain in services. Many had negative past experiences with social services that were unresponsive, re-traumatizing, and dehumanizing. Experiences of victimization and trauma make it difficult for women to trust other people, and may cause them to fear authority and become socially isolated, making it difficult to seek help and participate in services. Women of color and those from non-dominant ethnic/cultural backgrounds may be hesitant to seek services from programs that do not support or reflect their experiences, values, and beliefs. At some of the sites, many women were mandated by the courts or child protective services to participate in treatment. Sites found it challenging to engage, retain, and empower women forced into services.

Once in services, some women had difficulty staying. Healing and recovery are lengthy, difficult, and intense processes. It is the norm rather than the exception for women who have survived abuse to have relapses into substance use and, as they begin to heal, an intensification of the sequelae from the trauma they have survived. Treatment and services can be extremely painful and arduous. Some women found that the services provided simply did not meet their needs.

Responses: Many sites launched broad engagement efforts to recruit and retain women in services, including informing all community service providers of the new program, newspaper and radio advertising, and posting flyers in bus stations, laundromats, and community centers. Others worked with local welfare offices and court systems. Many sites involved C/S/R women in their outreach efforts (peer outreach workers, conducting presentations, holding pizza parties for interested women, etc.), which they found to be very effective. Sites responded to the logistical challenges women faced in receiving services by offering services in the evenings, and providing child care and transportation whenever possible. Most importantly, sites tried to create services and programs that were appealing and responsive. They created services and settings that were

individualized, flexible, empowering, and provided opportunities for involvement. Trauma groups, trauma-informed case management, and peer-run services facilitated formation of supportive relationships.

Trauma groups appear to have had a complex effect on women's likelihood of staying in services. On one hand, women often experienced the groups as logistically and psychologically demanding, and several sites found it difficult to maintain women's attendance. On the other hand, trauma groups helped to normalize and de-stigmatize trauma experiences and enhance a woman's likelihood of staying in treatment. Many women felt the groups were effective in addressing their needs and were motivated to attend them.

Sites learned the importance of maintaining consistency of staffing (women saw the same case manager and had the same trauma group leader each week, etc.) and service delivery (same day, time and location for groups, etc.). On-going follow-up with women was also helpful. For example, the Triad Women's Project called women the day before each group meeting to see how they were doing, remind them of the meeting, and ask if they needed assistance getting to the meeting. Several sites worked to ensure their services were culturally competent. The Boston Consortium developed a computerized client participation database to assess women's participation in various aspects of the intervention. Program counselors contacted women who were not actively participating to try and re-engage them in services.

Meeting the Needs of Women Living in Rural Areas

Challenge: Several of WCDVS sites provided services to women living in rural or semi-rural areas (Franklin County Women's Research Project, Triad, Allies, and WELL). These sites needed to address many challenges specific to rural communities when designing and implementing their integrated service interventions. First, there was a general lack of services in most of the rural areas. Domestic violence shelters, mental health services, and substance abuse treatment were limited or unavailable. Services that did exist were often not consumer-oriented and there were few organized consumer-driven efforts.

Communication of information regarding services was hampered by geographic distance and isolation. Some women did not have phones, or may have been afraid to use their phones because toll calls might alert and anger a controlling, abusive partner. Both women and the study sites struggled with transportation. Little or no public transportation made it difficult for women to access services. Severe weather, poor road conditions, and long distances also presented barriers.

People often know each other's "business" in small communities, discouraging some women from seeking help. This problem was compounded by the fact that service providers and law enforcement staff (the only assistance available to battered women in some communities) were often members of the same small communities.

Responses: Sites devised a number of strategies to better meet women's needs in rural settings. The trauma groups helped to address the paucity of services. The integrated approach proved to be an efficient way to assist women with mental health, substance abuse, and trauma issues. The Trauma Liaison at the Franklin County Women's Research Project established linkages between various service providers, serving as a "boundary spanner" and introducing the concept of trauma to a broad array of community providers.

Sites conducted aggressive outreach efforts to inform women living in rural areas about the project. Information was provided to service providers, courts, churches, businesses and social groups. Outreach was done through mailings, posters, newspaper and radio advertisements, and one-to-one contact.

Sites learned the importance of maintaining consistency of staffing... and service delivery...On-going follow-up with women was also helpful.

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

Sites offered services in diffuse locations throughout rural communities. The Triad Project held their trauma groups in multiple community locations throughout their three-county service area. The Franklin County Women's Research Project developed three drop-in centers that served women where they lived rather than expecting them to travel to the largest town.

Engaging Providers

Challenge: The cross-site service intervention framework used by WCDVS sites represented a significant departure from current service delivery practices. The most notable changes were:

- Provision of trauma-specific services.
- Integration of mental health, substance abuse and trauma issues.
- A shift toward trauma-informed care.
- Involvement of C/S/R women.

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 they did not feel equipped or qualified to provide. Other providers were concerned that assessing for trauma histories would trigger unmanageable symptoms and providing trauma groups would reduce women's safety by encouraging them to discuss traumatic events in detail. 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 reported 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.

Sites encountered providers who did not believe 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. Finally, some providers were uncomfortable working in settings that encouraged and provided opportunities for C/S/R women to be integrally involved in the design, delivery, and evaluation of services. They felt this questioned their authority and expertise as clinicians, and jeopardized the traditional provider/client relationship.

Responses: Implementing the new service intervention required a significant paradigm shift in the way providers approached and delivered services, and interacted with clients. This shift required the active commitment of senior staff, and a vigilant and persistent reframing of all aspects of service delivery.

Training and other educational strategies worked well to address provider concerns, actively engage them in the project, and foster a shared philosophy and vision. Sites had the most success with provider training when they offered continuing education credits and release time for participation. It was also important for training to be on-going to continually revisit what had been learned, address emerging issues, and educate new staff. Allies invited providers to participate in an entire TREM group so they would become familiar with the intervention and have an opportunity to address their own trauma issues. Allies training was multi-faceted, including group trainings, visual materials posted in treatment settings, written materials/resources, discussions at staff meetings, supervision, and informal discussions among individuals.

On-going, active supervision, on-site technical assistance and support by individuals knowledgeable and experienced in trauma, service integration, and C/S/R involvement were critical. The Franklin County Women's Research Project's trauma liaison 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 in a trauma context allowed staff to respond to them differently, which then allowed traumatic reactions to subside. This trauma education fostered greater understanding and less reactivity towards women receiving care, and helped create a safer environment for the women.

Some sites found that co-facilitation of trauma groups by substance abuse and mental health clinicians, and by clinicians and C/S/Rs, helped to expand knowledge and support for trauma-informed and trauma-specific services. Locating trauma groups within other service organizations also helped to reduce resistance at the service level. Formal and informal opportunities for providers and C/S/R women to interact helped providers to see the value of C/S/R involvement and become more open to the concept. C/S/Rs participated on most service planning committees and made a significant impact on the service design process. C/S/Rs were often involved in training and education activities. Several sites had C/S/Rs facilitate/co-facilitate trauma groups and serve as resource coordination and advocacy staff.

Supporting Staff

Challenge: Front-line staff at WCDVS sites found their work to be extremely rewarding, but very demanding and stressful. More so than other work, providers found the trauma-related work to be emotionally draining and difficult. In addition, many staff were responsible for multiple tasks that required a variety of skills. At many sites the same staff were responsible for providing resource coordination, advocacy services, and conducting trauma groups. As a result, many sites struggled with staff burnout and retention.

Responses: To alleviate some of the burden facing staff, sites developed various support strategies. Many sites implemented regular meetings for clinical staff as a forum for conferencing and support. The DC Trauma Collaboration held weekly meetings for clinicians to offer mutual support and share information. Allies staff met bi-weekly with a clinician for clinical supervision and support. The WELL Project had regular meetings between project staff and leadership. Some sites focused more on the personal stresses their staff faced. Arapahoe House explored a variety of ways to help staff with self-care as well as ways to make it safer for staff to disclose their own experiences with mental health, substance abuse, and trauma. The Palladia/Portal Project provided a range of stress reduction services, from built-in opportunities for project staff to debrief experiences and discuss staff support and stress to a partnership with an organization that provided wellness services at no cost.

...co-facilitation of trauma groups by substance abuse and mental health clinicians, and by clinicians and C/S/Rs, helped to expand knowledge and support...

C/S/R Integration Lessons

From its inception, the WCDVS placed a strong emphasis on integrating C/S/Rs in all aspects of the local and cross-site initiatives. The original GFA urged sites to include C/S/Rs in "all levels of problem definition, program planning, implementation, and evaluation" (SAMHSA, 1998). The Phase II GFA went further by stating that "the basic principle to be followed is that fostering C/S/R integration in all aspects of the project is a crucial element to its success." (SAMHSA, 2000)

Prescott (2001) outlines many of the benefits that can result from C/S/R integration efforts. At the services and systems levels, C/S/R integration:

- Improves quality of services and systems.
- Contributes systems knowledge.
- Creates customer-orientation.
- Positively affects policy development.
- Adds diversity to environmental climates.
- Reduces stigma.
- Provides positive role-modeling.
- Promotes increased awareness and education among co-workers.
- Provides knowledge about and linkages to community and alternative resources.
- Increases client engagement and retention.

For this project, C/S/Rs were defined as women who had experienced problems in all three of the study domains of mental illness, substance abuse, and trauma. Specifically, C/S/R women were identified as:

C = consumers of mental health services.
S = survivors of physical and/or sexual violence in childhood and/or adulthood.
R = recovering from substance use/abuse.

At the local level, sites generally employed a combination of six strategies to involve C/S/Rs in project work, including:

- Opportunities for C/S/R volunteers to work on the project.
- Material support in the form of stipends, transportation, and child care.
- Training on topics such as trauma, research, and leadership skills.
- Convening C/S/R advisory boards.
- C/S/R representation on project coordinating bodies and governing committees.
- Hiring C/S/Rs as staff members in full or part-time positions.

Providing stipends to compensate consumers for their time and expertise was important, as was training to help consumers participate meaningfully and effectively in project work...

All sites used a combination of these mechanisms. In general, the volunteer-based strategies were prevalent during the planning phase of the project and the hiring of C/S/Rs as staff members occurred later during implementation.

In Phase I, the sites generally had large committee structures geared towards obtaining participation and "buy-in" from a wide range of stakeholders. One or more C/S/Rs generally served on these committees, providing consumer input into the development of the interventions. Almost all of the sites formed some type of consumer advisory committee or board that often reviewed various aspects of program and research design, made recommendations, and undertook various self-initiated and directed projects.

Sites experimented with logistical arrangements (e.g. scheduling, location, child care) to find situations that facilitated consumer involvement. Providing stipends to compensate consumers for their time and expertise was important, as was training to help consumers participate meaningfully and effectively in project work, especially on the research portion of the project where many terms and concepts were unfamiliar.

During Phase II, C/S/R integration was more challenging for many sites. In Phase I, the wide committee structures and the nature of the work (planning/designing) provided obvious and ample opportunities for C/S/R involvement. In Phase II, the focus of project work shifted towards day-to-day running of the interventions. Committee structures were generally narrower and less central, and provided fewer opportunities for C/S/R involvement. Some sites accommodated this change by hiring consumers as full-time staff members with important implementation roles such as C/S/R integration coordinators, services providers, or research team staff members. At other sites, hiring was limited and opportunities for consumer integration were fewer. A more in-depth discussion of strategies for integrating C/S/Rs into the project is available in *Consumer/Survivor/Recovering Women: A Guide For Partnerships In Collaboration* (Prescott, 2001).

Franklin County's approach and philosophy on C/S/R integration was qualitatively different from other sites' in many ways. They saw C/S/R integration as the primary way to understand and respond to the impact of trauma on women's lives (Veysey, Andersen, Lewis, Mueller & Stenius, 2004). The project used a unique, peer-driven model that was created, operated, and evaluated by C/S/R women. The project was guided by the principle that, "women heal when they find the resources within themselves to define their lives and engage in activities and work that is meaningful to them" (Veysey, Andersen, Lewis, Mueller & Stenius, 2004). The Principal Investigator and most of the senior staff identified as C/S/Rs; local C/S/R women were active members of every project committee; the C/S/R Advisory Council provided input into the project; C/S/Rs (paid staff and volunteer) conducted most of the work associated with the project drop-in centers including facilitating the trauma and other groups, serving as Peer Resource Advocates, childcare workers, cooks, and office staff; the research team was directed by, and made up of C/S/R women; and the project conducted focus groups and other activities to ensure on-going C/S/R involvement.

Throughout Phase I and II, each site was required to have at least one C/S/R participate in the WCDVS Steering Committee. The Steering Committee, which met three times a year in-person and numerous times via conference call, was responsible for designing and implementing all aspects of the cross-site study (core service intervention, cross-site research design, measures, and outcomes, etc.). During the first year, C/S/R women were successful in advocating to become voting members of the group and secured a position for a C/S/R representative on the Steering Committee's Executive Committee. C/S/R women were actively involved in all of the subcommittees of the Steering Committee, serving as participants and co-chairs. C/S/Rs also planned and hosted C/S/R-only pre-meetings that allowed women to share information, receive training on issues that would be discussed at the larger meetings, and provide mutual support.

C/S/R integration improved the project in many ways. The Boston Consortium found that C/S/R representation on the project's Steering Committee, roundtables and working groups as well as project staff were major factors in facilitating integration among the various agencies. The presence of C/S/Rs and their ability to voice the needs of women was a major factor in keeping the committee's efforts focused and on track. C/S/R involvement mitigated the effects of institutional turf and professional bias, and promoted collaboration. PROTOTYPES found an important change in agency culture. Both women and staff reported that women felt more closely tied to one another, trusted each other more, and felt free and able to rely on each other for support.

CHALLENGES AND RESPONSES

WCDVS sites pushed the frontier on consumer integration in the design, delivery, and evaluation of mental health, substance abuse, and trauma services. Given this, it is not surprising they faced many barriers and challenges. Many are highlighted below along with a discussion of strategies sites used to address and overcome them.

C/S/R Integration
Challenges and Responses

Developing a Vision and Approach for C/S/R Integration

- Foster information exchange among C/S/Rs, among non-C/S/Rs, and among C/S/Rs and non-C/S/Rs.
- Ensure significant C/S/R involvement in planning committees.
- Create C/S/R advisory groups.
- Establish formal plans for C/S/R integration.
- Utilize multiple and sustained approaches.

Building Support for C/S/R Integration

- Identify barriers to C/S/R integration.
- Achieving meaningful integration requires a paradigm shift toward viewing C/S/Rs as a critical knowledge base.
- Provide opportunities for non-C/S/R and C/S/R interaction.

Creating and Maintaining C/S/R Advisory Groups

- Integrate C/S/R advisory groups into the central work of the project.
- Establish clear roles and responsibilities for the group.
- Show public support for C/S/R advisory group.
- Provide necessary support to ensure on-going participation.

Managing Disclosure of C/S/R Status

- Recognize the complexity of issues of disclosure.
- Provide safeguards and supports for those who disclose.

Serving in an Official C/S/R Capacity

- Provide training and support for C/S/R women, including supervision and opportunities for mutual support.
- Create formal job descriptions that outline a realistic set of job responsibilities.
- Utilize women with several years of recovery.

Providing Training and Support for C/S/Rs

- Offer multiple sources of formal and informal training on leadership development and the creation of specific substantive skills.
- Create opportunities for C/S/Rs to exchange information and support each other.
- Provide supports (financial compensation, childcare, transportation, etc.) that facilitate participation.
- Allot sufficient time and resources for C/S/R training.

Providing Training and Support for Non-C/S/Rs

- Recognize the challenges of learning to work in a C/S/R integrated environment.
- Create training opportunities for non-C/S/Rs.
- Facilitate information exchange.

Sustaining C/S/R Involvement Over Time

- Integration efforts must be on-going.
- Utilize multiple strategies for C/S/R integration.
- Alter organizational and administrative policies that present barriers to integration.
- Allocate the resources necessary to maintain involvement.
- Hire C/S/Rs as staff members.

WCDVS sites pushed the frontier on consumer integration...

Although some WCDVS sites had previous experience working with consumers...none had engaged C/S/Rs in such a substantial...manner.

Developing a Vision and Approach for C/S/R Integration

Challenge: Although some WCDVS sites had previous experience working with consumers on various aspects of their program operations, none had engaged C/S/Rs in such a substantial and multi-dimensional manner. This kind of integration was new for both project staff and the women themselves, and truly represented "uncharted water". Both C/S/Rs and non-C/S/Rs had no idea what they were getting into – what real C/S/R integration was, what it might look like, or how it might be achieved. Questions began at the most fundamental level: Who is a C/S/R? Must a woman be willing to publicly disclose her status to be considered a C/S/R? What is the status of women with professional certification in a relevant field who also are or have been consumers?

There were few models and little expertise for sites to draw upon to help them answer these and other critical questions. Because mental health and substance abuse communities came to this effort with different histories, philosophies, and approaches to consumer integration, it was difficult for sites to develop consensus. Sites had limited time and resources to support the participatory planning necessary to develop models and approaches for C/S/R integration.

Responses: Information sharing among C/S/Rs, among non-C/S/Rs, and between C/S/Rs and non-C/S/Rs was critical in developing models for C/S/R integration. Steering Committee meetings and C/S/R-only pre-meetings offered one important way for this to happen. C/S/R representation on site-based project planning committees was another, although it was a struggle to make this participation non-tokenistic (many planning committees had one C/S/R position within a group of 10 or more). Many sites created other mechanisms for consumer input, including C/S/R advisory boards and opportunities for C/S/R feedback. For example, Arapahoe House conducted a series of consumer focus groups and qualitative interviews conducted by C/S/Rs to help identify the programmatic changes that needed to be addressed to foster C/S/R integration.

Sites had to make formal plans for C/S/R integration; without such planning processes, C/S/R integration did not occur. These plans needed to define who was going to be involved, the goals of their involvement, what the involvement would look like, and strategies to facilitate and achieve this involvement. Sites found it important to use multiple and sustained approaches to C/S/R integration. Franklin County's approach to C/S/R integration was to create a fully peer-driven project.

C/S/Rs and non-C/S/Rs needed training and support (see below). Many sites sought technical assistance – on-site and through knowledge products – about C/S/R integration from the WCDVS Coordinating Center and other consultants during the first phase of the project.

Sites learned a lot about what worked and what did not through trial and error. Several sites recruited current clients to serve in an array of C/S/R roles in the first year. Many found this to be difficult for both the women and the programs, and concluded it was better to utilize women with several years in recovery and more stable life circumstances and supports.

Building Support for C/S/R Integration

Challenge: Sites encountered both overt and covert resistance to C/S/R integration. Initially, many non-C/S/Rs could not see the value of C/S/R integration. It was a new and unproven concept. For some staff, viewing and treating C/S/Rs as equal partners with valuable expertise represented a significant departure. Professional training often teaches staff to view clients in a very clinical and deficit-oriented way, granting professionals complete control over program and individual treatment decisions. Like

any effort to engage a disempowered and disenfranchised group, C/S/R integration was time-consuming, causing some to view these efforts as difficult and unproductive. Class, race, and gender were also issues as program administrators, service providers, and researchers often did not represent or reflect the women being served. A few sites noted development of an "us vs. them" mentality.

Responses: Achieving meaningful C/S/R integration required a paradigm shift in the way people thought and operated. It required a new orientation that understood C/S/Rs as contributing a critical knowledge base. Sites found it important to meet with key stakeholders at the beginning and on an ongoing basis to obtain "buy-in" and support for C/S/R integration.

Training and opportunities for non-C/S/Rs and C/S/Rs to interact helped to reduce resistance. Having C/S/Rs lead or co-lead training and information sharing sessions was very effective. Hearing from C/S/Rs and experiencing their competence and skills first-hand helped to break down stereotypes and misperceptions. These efforts also modeled the partnership and shared power sites were striving to achieve. The C/S/R consumer advisory board of the DC Trauma Collaboration was responsible for co-leading training and educational activities for clinicians throughout the project.

Integration of C/S/Rs in all project levels from senior management to clinical and research staff to program volunteers was an effective strategy for dealing with resistance to C/S/R involvement. C/S/R women were woven throughout the Franklin County project both as paid and volunteer staff, making it difficult and unnecessary to distinguish participants from staff.

All sites reported that resistance to C/S/R integration diminished significantly over time. Administrators and staff came to see the value of such involvement, and came to rely on women's input and participation. These experiences made permanent changes in the way programs and staff viewed and involved women.

Creating and Maintaining C/S/R Advisory Groups

Challenge: All but one WCDVS site established a C/S/R advisory group during the first phase of the project. Some of these groups were initially uninformed and disconnected from the project, making meaningful C/S/R involvement impossible. Some groups were given only perfunctory activities in which to participate, making C/S/R involvement appear tokenistic. Some groups struggled with how to organize and operate.

Once the C/S/R advisory groups were up and running, many were faced with having multiple functions and conducting diverse activities. It was not uncommon for a C/S/R advisory group to be responsible for overseeing development and implementation of peer-run services, providing input into the service and research aspects of the project, serving as a welcoming committee for women entering the study, and providing mutual support for members of the advisory group and women receiving services through the project. Many groups struggled with finding an appropriate and valued role during the implementation phase of the project. Over time, a lack of consistent, on-going participation from women presented barriers to the effectiveness of many C/S/R advisory councils.

Responses: C/S/R advisory groups worked well when they were integrated into the central work of the project, and had clear and meaningful roles and responsibilities. The C/S/R Integration Roundtable at the Boston Consortium had input into all major project activities, including research, clinical work, project steering committee decisions, and product development. They were involved in developing the co-morbidity screen, creating a resource card for women in the study, and a public education and advocacy event at the state house honoring women in recovery from substance abuse, trauma, and mental illness.

Administrators and staff came to see the value of [C/S/R] involvement, and came to rely on women's input and participation.

The decision to hire C/S/R women as experts...facilitated new thinking about strategies for integration, and resulted in more pertinent and meaningful service interventions and research design and analysis.

Advisory groups benefited from the public support of project leadership. The Women's Advisory Council of the Franklin County Project met monthly with the project director to discuss project activities, assess events in the community at-large, and review what was working and not working in the project. Several C/S/R advisory councils sought the advice and assistance of trusted allies and supporters to provide technical assistance and guidance on group structure, operations, and activities.

Many sites never found a way to appropriately and fully utilize their C/S/R advisory groups during project implementation. Once the service intervention was planned and in place, the research was designed, and women were enrolled in the study, some sites could not or did not find other roles for the C/S/R advisory groups, and their efforts and importance diminished. Sites tried a number of strategies to ensure consistent and active participation in C/S/R advisory councils. Women were provided stipends for their time, and assistance with childcare and transportation were often available. The Triad Consumer Action Board rotated the location of their monthly meetings to facilitate involvement of women throughout the rural project area. Arapahoe House struggled with a lack of participation in their C/S/R Council and turned to their peer-run support group as a way to obtain C/S/R input into program operations.

Managing Disclosure of C/S/R Status

Challenge: Early discussions of C/S/R integration brought out complex issues regarding definition and representation. Discussion was precipitated by SAMHSA's requirement that sites involve C/S/Rs in all aspects of the project. Study sites struggled with determining who fit the definition of a C/S/R. It was argued that women already serving in various service and research positions who met the criteria of consumer, survivor, and recovering person could serve the project in a dual capacity. Considerable tension ensued when some believed that C/S/R women needed to be known to the rest of the project. Many women serving in clinical and/or research roles believed that personal disclosure of their status as a C/S/R would jeopardize their professional standing and credibility, as stigma and misunderstanding remain strong in professional as well as lay communities. Some women felt compelled to disclose their life experiences to meet the criteria of the grant, even though they were unsure about their decision to do so.

Responses: Ultimately, women serving in the C/S/R position were required to be fully disclosed about meeting the definition of the term. This process enlightened members of the Steering Committee about the unique vulnerabilities and possibilities inherent in such a position. The decision to hire C/S/R women as experts based on experiential knowledge facilitated new thinking about strategies for integration, and resulted in more pertinent and meaningful service interventions and research design and analysis.

Serving in an Official C/S/R Capacity

Challenge: In addition to the difficult issues of disclosure, women who served in official C/S/R capacities (C/S/R coordinator, peer advocate, provider of peer-run services, C/S/R representative to the federal steering committee, etc.) at WCDVS sites faced other challenges. In general, these positions were extremely demanding and many required a diverse set of skills. Many C/S/R coordinators were responsible for overseeing the consumer advisory board, conducting training and public education efforts, providing peer-run services, providing mutual support and participating in the management of the project.

These jobs were deeply personal and profoundly important to the women who held them. They felt a responsibility to represent their fellow C/S/R women and to improve services and systems. They wanted to prove their competence to non-C/S/Rs,

show these new roles were important, and their involvement made a difference. They felt the burdens associated with serving in a new position with vague job descriptions and no commonly held measures of performance. Many of these women faced ongoing issues of stigma and credibility. It is not surprising that women in these roles experienced a high rate of burnout. C/S/R staff turnover was an issue for most sites. As one woman said, "It is really hard to have your personal experience be your job skill." For some women, these experiences were extremely difficult and damaging.

Several sites encountered problems when they hired women to serve in official C/S/R positions who were currently receiving services. This created difficult dynamics among women because other consumers were concerned about confidentiality of their treatment information. The intensity and stress of these positions had the potential to pose a threat to women's recovery. At least one site struggled with institutional hiring policies that required a level of educational attainment that presented barriers to hiring some C/S/R women.

Responses: Women who served in C/S/R roles brought more than their personal experiences to their jobs. An array of skills and expertise helped them meet the demands of these positions.

Sites offered a number of training and support activities for C/S/R women. All sites provided some level of formal supervision, but the nature and intensity varied greatly. At many sites, women created opportunities for mutual support among C/S/R project staff. The Boston Consortium created the C/S/R Roundtable for C/S/Rs who held professional positions. Part of their work focused on supporting women in their dual roles as consumers and providers. In spite of these efforts, many C/S/Rs felt unprepared and unsupported in their roles, and many sites found the need for support and supervision to be greater than they anticipated.

Many sites created formal job descriptions for their C/S/R positions. Some explored ways of making their organizations and work environments more supportive and empowering of women serving in these jobs. Several sites decided to fill their C/S/R positions exclusively with women who had several years in recovery.

Providing Training and Support for C/S/Rs

Challenge: Women involved in the WCDVS were extremely knowledgeable, skilled, and talented. As with anyone entering a new field or career, there was a range of knowledge and information they needed to participate effectively.

Sites often did not allot sufficient time or resources for C/S/R training and support activities. Some administrators were surprised and frustrated by the amount of time these efforts took. C/S/R women who did not receive the training and support they needed were placed in extremely difficult situations in which they were unprepared to contribute. These experiences left them feeling vulnerable and inadequate, and made it less likely they would participate in the future.

Unlike many of the professionals, most C/S/Rs were not familiar with other individuals working on the project at local and cross-site levels. Neither were they versed in the technical research language or commonly used professional jargon. Some women lacked access to computers and internet services, placing them at a significant disadvantage because most project information was disseminated via email.

Responses: Sites provided multiple sources of formal and informal training and support for C/S/R women. These focused on broad leadership development and skills in specific substantive areas. At the cross-site level, a portion of the C/S/R meetings was dedicated to training. For example, a "Research 101" session was conducted to address barriers that limited C/S/Rs participation in the project's research

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aspects. The session informed women about the study's research goals, why they were important, how they would be achieved, and how C/SRs could be helpful with the research. Research terminology was reviewed to provide women with the language they needed to participate.

Many sites provided empowerment-focused basic skills and leadership development training. The Boston Consortium conducted a recurring Women's Leadership Institute (Boston Consortium of Services for Families in Recovery, in press). This intensive, three day effort focused on helping participants understand leadership, their role as leaders in the community, and the value in the ability to speak out on issues based on their experiences. Peer-run curriculum-based groups provided intensive leadership and communications skills training.

Many C/S/Rs found it helpful to have opportunities to meet with other C/S/R women on a regular basis. These exchanges allowed women to share information on both the substantive work of the project and the personal challenges of serving in C/S/R roles, work collectively on difficult and demanding issues, and provide mutual support. This occurred at the cross-site level through C/S/R meetings held prior to each Steering Committee meeting, and at the individual-site level through C/S/R advisory group meetings and informal gatherings.

Sites provided an array of supports designed to facilitate C/S/R women's participation in project activities. Many sites provided financial stipends or compensation for the time women spent on the project. Childcare services were often available or reimbursement was provided. When possible, transportation was arranged.

The importance of training and support for C/S/Rs can not be overemphasized. Many C/S/R women found their experiences with the project to be empowering when their involvement was valued and well-supported. In contrast, the experience was destructive and damaging when women were treated in a tokenistic manner and not well supported. Many C/S/R women found they paid a large "personal price" for their involvement.

Providing Training and Support for Non-C/S/Rs

Challenge: C/S/R integration was also challenging for non-C/S/Rs. For some, there was initial resistance and discomfort around integrating C/S/Rs into the project. For some who were supportive and saw the value of such efforts, it was difficult to determine how to function in a C/S/R integrated environment or facilitate their involvement. This was an area in which no one had much experience or knowledge.

Responses: In large part, sites did not address this challenge in any formal manner. Most sites did not conduct training on C/S/R integration for non-C/S/Rs, and few formal supports were put into place to help non-C/S/Rs deal with these changes. In hindsight, many believe that such training and support would have been very helpful. Certainly, non-C/S/Rs gained a lot of knowledge from their interactions with C/S/Rs, and many asked C/S/Rs directly about how to facilitate and support their involvement. It is clear that non-C/S/Rs shared information and sought input from other non-C/S/Rs, but this was informal and up to individuals to pursue on their own.

Sustaining C/S/R Integration Over Time

Challenge: Some sites found it difficult to sustain meaningful C/S/R integration over the course of the project. In general, there was a greater emphasis on C/S/R integration during the organizing and planning phase than during implementation and evaluation. The difficulties associated with C/S/R integration in the transition from Phase I to Phase II reflect a transition from largely volunteer-based C/S/R activities in Phase I (mainly sitting on

committees that helped design the interventions) to largely staff-based roles in Phase II (providing services and conducting research). Project administrators and C/S/Rs struggled to create meaningful roles and activities for C/S/Rs during project implementation. Many of the C/S/R advisory groups with significant responsibility and authority became less central and active as a result. Considerable turnover in C/S/R leadership at both the individual and cross-site level caused sites to struggle with maintaining a core group of C/S/Rs.

Many sites were unable to implement sustainability plans for C/S/R integration once the project ended. This was due in part to the difficulty of finding "mainstream" funding sources for the C/S/R coordinator positions, C/S/R advisory groups, and training and support activities. Some C/S/Rs felt deserted and discarded once the project ended.

Responses: Sites ability to sustain C/S/R integration over the life of the project were only partially successful. C/S/R integration efforts must be on-going, include a variety of strategies (hiring as paid staff, designated C/S/R coordinator positions, advisory groups, C/S/R representation on various committees, peer-run services, etc.), and utilize the expertise of multiple C/S/Rs. Resources must be committed to supporting these efforts.

Organizational and administrative policies must be altered to facilitate C/S/R involvement. Arapahoe House changed internal hiring policies that required professional credentialing and did not recognize experiential knowledge. C/S/R integration must be internalized and institutionalized to become a reality. The DC Trauma Collaboration hired a number of C/S/Rs as staff members (paid positions with benefits) in various capacities throughout their agency. The Franklin County project integrated C/S/Rs in all aspects and at all levels of their project. The Boston Consortium facilitated the promotion of several C/S/R staff to senior positions which helped maintain C/S/R involvement after the project ended.

C/S/R integration efforts must be on-going, include a variety of strategies...and utilize the expertise of multiple C/S/Rs.

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The Women, Co-Occurring Disorders and Violence Coordinating Center

Operated by

Policy Research Associates, Inc.

The Women, Co-Occurring Disorders and Violence Study is generating knowledge on the development of integrated services approaches for women with co-occurring mental health and substance abuse disorders who also have histories of physical and/or sexual abuse.

This report is a product of the Women, Co-Occurring Disorders and Violence Study Coordinating Center, which is operated by Policy Research Associates in partnership with The National Center on Family Homelessness, and the Cecil G. Sheps Center for Health Services Research at the University of North Carolina, Chapel Hill. The Coordinating Center provides technical assistance to program sites, conducts cross-site process and outcome evaluations, and develops a range of application products from the study sites.

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