

Project WAVE

An Initiative to Embed Substance Use
and Co-Occurring Disorder Services in
Domestic Violence Settings

Project WAVE

An Initiative to Embed Substance Use
and Co-Occurring Disorder Services in
Domestic Violence Settings

Kath Schilling, M.Ed., CAS, LADC I
Project Director

Norma Finkelstein, Ph.D., LICSW
Principal Investigator

Amy Salomon, Ph.D.
Lead Evaluator

This publication was prepared under grant number TI 16403 of the Center for Substance Abuse Treatment (CSAT) of the Substance Abuse Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services (DHHS).

Acknowledgements

The authors would especially like to express our appreciation to Linda White-Young, M.S.W., LICSW, Project Officer, Center for Substance Abuse Treatment/Substance Abuse and Mental Health Services Administration, for her interest, encouragement and support of the WAVE initiative.

Further, we would like to express our continued gratitude to the Bureau of Substance Abuse Services of the Massachusetts Department of Public Health for their on-going support of our work to integrate substance use, co-occurring disorders and trauma/violence.

This document was developed through information provided by the collaborators, staff and clients of Project WAVE.

Special thanks to the following contributors:

Barnstable County Massachusetts

E. Mark Zielinski, County Administrator
Cindy Reynolds, Resource Development Officer
Pamela Mullin, Project Coordinator
Barnstable Co. Office of Health and Human Services

Gosnold on Cape Cod (CCAIRU, Inc.)

Raymond V. Tamasi, President and CEO

Institute for Health and Recovery

Norma Finkelstein, Ph.D., Principal Investigator
Kath Schilling, M.Ed., CAS, LADC I, Project Director
Laurie Markoff, Ph.D., Clinical Supervisor

Independence House

Lysetta Hurge Putnam, Executive Director

Advocates for Human Potential, Inc.

Amy Salomon, Ph.D., Lead Evaluator
Blossom Davies, Ph.D., Data Manager
Nick Huntington, M.A., Data Analyst

Safe Harbor: A Program of Community Action Committee of Cape Cod and the Islands (CACCI)

Estella Fritzingler, Executive Director, CACCI
Betsy Fontes, Program Manager, Safe Harbor

We would particularly like to thank the consumer representatives and provider members of the Project WAVE Advisory Board, the staff and administration of the collaborating organizations and, most of all, the women who participated in Project WAVE. This document would not have been possible without their generous and honest feedback.

Project WAVE: An Initiative to Embed Substance Use and Co-Occurring Disorder Services in Domestic Violence Settings

The Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Treatment awarded a targeted capacity expansion grant to Barnstable County Massachusetts in October, 2004. The purpose of this grant was to provide on-site integrated trauma-informed screening, outreach, engagement, assessment, education, intervention, referral and care coordination for substance use/co-occurring disorders to women seeking services from two domestic violence/sexual assault agencies on Cape Cod. The participating domestic violence agencies were Independence House, a community-based sexual assault/domestic violence agency, and Safe Harbor, a TANF-supported shelter for women and their children fleeing domestic violence. Women Achieving Vital Empowerment (Project WAVE) was overseen by the Institute for Health and Recovery, an organization actively engaged in developing training, policies and protocols for integrating domestic violence, sexual assault, mental health and substance use services. Other participating agencies were Gosnold, Inc., the substance abuse treatment agency on Cape Cod and Advocates for Human Potential, the evaluators who worked closely with project staff and program implementers. WAVE was among a handful of programs nationally which responded to an increasing awareness of the substance abuse needs of survivors of domestic violence through designing a program intervention located directly within non-clinical domestic violence programs (Swan et al., 2000). This paper describes Project WAVE from its inception to lessons learned and suggestions for replication.

Rationale

There is a growing array of evidence that women who experience domestic violence and/or sexual assault frequently have substance use and/or mental health problems. It has been documented that estimates of alcohol use among victims

of sexual assault range from 30–79% (Abbey et al., 1994; Crowell & Burgess, 1996). In 1997, the National Institute on Addictions identified that 80% of women with substance use disorders had been the victim of domestic violence. Also in 1997, the National Victim Assistance Academy, sponsored by the U.S. Department of Justice noted that 42% of victims of domestic violence contacting the police had used alcohol or other drugs on the day of the assault (Brookhoff, 1997).

On average, over half of women seen in a range of mental health settings are either currently experiencing or have experienced abuse by an intimate partner. Of women seen in a psychiatric emergency room, 42% had been abused by an intimate partner and 37% had experienced attempted or completed rape (Briere et al., 1997). Further, 70% of homeless women with severe mental illness had been physically abused by a partner (Goodman et al., 1995). Among male and female inpatients, 63% reported abuse by a partner and 29% reported domestic abuse within the past year (Cascardi et al., 1996). The National Co-morbidity Survey noted that 43–81% of adults with mental illness reported some type of victimization (Kessler et al., 1995). In 2001, it was reported that 33% of women with serious and persistent mental illness had experienced either physical or sexual abuse in the past year (Goodman et al., 2001).

The Women, Co-Occurring Disorders and Violence Study (WCDVS), a national initiative co-funded by the Centers for Substance Abuse Treatment, Substance Abuse Prevention and Mental Health Services of the Substance Abuse and Mental Health Services Administration (SAMHSA) of the federal Department of Health and Human Services, addressed the impact of violence on women's lives and demonstrated the effectiveness of an integrated, trauma-informed approach to services for women with co-occurring mental health and substance use

disorders and histories of physical and/or sexual abuse (Finkelstein et al., 2004; Finkelstein & Markoff, 2004; Markoff et al., 2005).

Trauma-Informed Approach

A trauma-informed approach to service delivery reflects and recognizes the prevalence and impact of experiences of violence and trauma. Trauma is defined as: *the subjective experience of a threat to life, bodily integrity or sanity resulting in extreme stress that overwhelms a person's ability to cope*. The use of substances and other self-injurious behaviors (cutting, head banging, eating disorders, medication abuse, unsafe sexual practices, smoking, gambling, etc.) as a means to cope is common. Sadly, the use of substances, including nicotine and prescribed medication, can lead to addiction in which the need for the chemical takes control of a person's life.

Survivors who are using alcohol and other drugs have a harder time taking control of their lives and keeping themselves safe. The goal of services is *safety* as the means to return a sense of autonomy and control to the client. Creating safety means minimizing revictimization by avoiding shaming, character/moral judgments, confrontation, intrusive monitoring and reducing triggering situations. The advantage of *safety* as a goal of services is that it is less threatening and carries no stigma. A strengths-based approach—focusing on what is working rather than what is not—has been proven to be highly effective in promoting safety and growth. Conversations that center on *safe vs. unsafe* choice-making (e.g., “Is the continued use of substances a safe or unsafe choice for you?”) are a key ingredient to a trauma-informed approach.

Trauma is frequently central to the development of addiction and mental health problems and can be pervasive, affecting many aspects of a person's life. Trauma impacts an individual's brain chemistry, her thought process, emotional self-regulation, life skills development, relational connection and an individual's beliefs about self, others and the world in general. Most survivors have little trust in others as well as themselves and perceive the world as an unsafe place.

Failure to understand and address trauma when providing services can lead to retraumatization, increased emotional symptoms, behavior management problems, relapse and recidivism. It is important for service providers to understand

that clients have done the absolute best they knew how to move through the world, but that some of the attitudes and behaviors they have adopted as attempts to cope are now interfering with their ability to create a safe and stable life for themselves and their families. The provider role is to explore and encourage alternative solutions, thus increasing an individual's menu of safe choices which can ultimately lead to healthier and more satisfying lives.

Project WAVE (Women Achieving Vital Empowerment)

The Institute for Health and Recovery's WELL Project was one of the sites for the WCDVS and created partnerships with three major substance abuse treatment agencies in three separate regions of eastern Massachusetts to provide integrated, trauma-informed treatment for women seeking their services. One of the WELL Project sites was Gosnold, Inc., located on Cape Cod in rural Barnstable County. To support the development of an integrated, trauma-informed service system in each community, a Local Leadership Council brought together representatives from substance abuse treatment, mental health treatment, sexual assault/domestic violence services, welfare, housing, child protective services, probation, court advocates, and local government to identify barriers to services and gaps in services, along with policy and procedural changes to support the provision of integrated care. The Cape Cod Local Leadership Council identified the inability of the sexual assault/domestic violence providers to address substance use as a significant gap in services for women and approached the Institute for Health and Recovery to coordinate a grant application that would address this. Consequently, a partnership developed between the Institute for Health and Recovery, Barnstable County, Gosnold, Inc., Independence House, Safe Harbor and Advocates for Human Potential to submit an application to offer substance use/co-occurring disorders services at two domestic violence sites which resulted in Project WAVE.

Population Served

Over the course of three years, a total of 550 women screened positive for risk of substance use problems upon entry into the two domestic violence programs and 252 of these women enrolled in WAVE. The women being served through the community-based domestic violence/

sexual assault agency and the TANF shelter differed in important ways on demographics and were broadly similar in terms of trauma, mental health and substance use status.

Across the two sites, the demographic characteristics of the population were as follows:

- The population was predominantly white (78.3%)
- The average age was 34, with a range of 17 to 63
- Most women were mothers (87.5% had children, with an average of 2.2 children per woman)
- 16% had children living with someone else due to a child protective order
- Women were moderately well-educated; 39% completed high school and 39% had some post secondary education
- Women had low levels of employment (23% employed full- or part-time) and income (avg. \$621/month).

As mentioned above, the population at the two program sites differed considerably in demographics. Compared to the population at the community-based program, women at the domestic violence shelter were younger, more likely to be non-white, more likely to be Latina, less likely to be in a relationship, more likely to have children or be pregnant, less likely to have completed high school, less likely to be employed, and much more likely to be unstably housed.

WAVE Intervention

At the heart of the intervention was a belief that women who have experienced traumatic abuse need foremost to regain control of their lives and symptoms. Furthermore, they can be expected to advance and retreat from clinical relationships, testing the challenges of developing trust over time. Program developers therefore designed the intervention to be longer than usual, with women allowed to participate for up to one year with the flexibility to extend beyond a year if needed. Interventions were individualized and varied considerably across clients. There was no prescription for required contacts; rather, the Family Care Coordinators conducted active outreach and built ongoing relationships while doing so. The project responded to difficulties with access due to lack of transportation in rural communities by meeting women in their homes or communities.

WAVE was designed as a two-tier intervention, targeting change at both the organizational and

individual client level. Recognizing the significant differences in philosophy and approach between the substance abuse and domestic violence systems of care, the organizational goal was to build the capacity of the domestic violence programs to understand and address the pervasive impact that violence/trauma can have on women and the relationship between this impact and the use of substances or other unsafe coping behaviors. To build this capacity, IHR provided early training on the benefits of integrated, trauma-informed substance abuse treatment for the domestic violence system staff, as well as training on screening for substance use disorders. IHR supervised WAVE staff, ensuring that WAVE services would be trauma-informed. WAVE staff trained domestic violence staff in conducting an integrated, trauma and substance use safety skill building group for women as well as an integrated parent/child intervention, using a train-the-trainer model. WAVE also provided case consultation, continuing care/aftercare planning and technical assistance on policies and procedures to enhance the domestic violence agencies' capacity to work with women with substance use and co-occurring disorders.

On the individual client level, the central program element was trauma-informed substance abuse counselors (called Family Care Coordinators, FCCs) hired by Gosnold, trained and supervised by IHR, and placed on-site at the two sexual assault/domestic violence programs. Women who screened positively for risk of substance use problems and who chose to enroll in WAVE were assigned to an FCC. The FCC conducted active outreach and provided integrated counseling, care coordination and other support services in the context of an ongoing supportive relationship. The FCC worked with the domestic violence staff and each woman to develop a service plan that addressed her identified needs. If a woman needed a level of substance use or co-occurring disorder treatment beyond outpatient, she was referred to Gosnold for inpatient or residential treatment.

In order to improve retention in services and reduce/manage relapse, service enhancements were also offered. These included *Seeking Safety*, a safety skill building group for substance abuse and trauma (Najavits, 2002), the *Nurturing Program for Families in Substance Abuse Treatment and Recovery* (Bogage et al., 2nd ed., 2002), a parenting

group for women, along with *WELL Child*, a children's self-esteem and resiliency building group developed during the Children's Sub-Study of the Women, Co-Occurring Disorders and Violence Study (Finkelstein et al., 2005; Noether et al., 2007; Van DeMark et al., 2005). If needed, screening/referral services for the children were provided at the request of the mother. FCCs initially co-facilitated the group interventions with domestic violence staff, in a train-the-trainer model, building capacity for the agencies to conduct the groups on their own. Education related to co-occurring disorders, the use of substances as a common means to cope and the relationship of these to violence/trauma was provided for women receiving domestic violence/sexual assault services to facilitate self-referral to substance abuse treatment.

Building on the themes of connection, mutuality, authenticity, and empathy, Project WAVE utilized the Relational/Cultural Model of Women's Psychology, as defined by the Stone Center at Wellesley College (Miller, 1986), as its philosophical base. Evidence-based practices such as Integrated Dual Diagnosis Treatment (Drake & Mueser, 2000), the Stages of Change Model (Prochaska & DiClemente, 2002) and Motivational Interviewing (Miller & Rollnick, 2002) were employed throughout. Staff frequently noted that the Motivational Interviewing interventions of open-ended questions, rolling with resistance, exploring ambivalence and developing discrepancies were particularly effective in engaging women in the change process.

By employing "safety" as the benchmark for outcomes, it was possible to gently challenge perceptions related to trauma symptom management, substance use, re-engaging with the batterer, effective parenting, life skill development, distorted thinking, self-esteem issues, sense of autonomy and self-sufficiency. Conversations around safety also elicited more opportunities to explore women's strengths, and to validate the reality that each woman had done the absolute best she could with the tools she had. FCCs expressed the belief that the self-harming behaviors including substance use were adopted by the survivor to protect herself and her sanity. They worked very well for a time. However, these adaptive behaviors/coping skills, which worked so well in

the past, were no longer helpful and had, in fact, become a "set-up" for continued victimization.

The women enrolled in WAVE were acutely aware of and in touch with the numerous ways they had been victimized. However, their awareness of and connection to the courage, creativity and determination to survive was markedly less accessible. Women who have survived violence are often so distracted by the emotional impact of the betrayal, abandonment, rejection and neglect inherent in experiences of violence that they may never have learned, or have forgotten, basic life skills. Awareness of these deficits increases shame and low self-esteem. In addition, the secrecy, silence and isolation that surround violence prevented them from reaching out for new information and more supportive coping tools. Due to the pervasiveness of experiences of violence, many of the women described their emotional experience as functioning from a "center of desperation."

In promoting and encouraging recovery and healing, FCCs learned to engage the survivor not by focusing on the horror of the violence (she already knew this . . . she lived it) but rather by highlighting the courage, creativity and determination of the survivor spirit. Consistency and follow through were essential in building trust and engaging the women. Listening for and repeatedly pointing out strengths became crucial in energizing the change process. Frequently, women were so beaten down they had disconnected from the ability to recognize positives about themselves.

WAVE's primary task became facilitating change in how the pervasive effects of the abuse were playing out in the present. Since actions in the present often involve some element of choice, modeling safer, more appropriate ways to accomplish tasks, partnering with women in their attempts to change and celebrating each step toward improved life skills and outcomes became an integral part of the WAVE intervention. Having conversations about where the choice points were and strategizing alternative options that lead to safer outcomes became a key component of the relationship between the woman and her Family Care Coordinator. Further, this encouraged the exploration of past safe, healthy choices that had allowed her to get to this point in her life.

Project Implementation

At the organizational level, the project was implemented much the way planners had foreseen. In year two, the training plan was adapted to become a collaborative effort between WAVE and the domestic violence staff to create more integrated and informal trainings.

At the organizational level:

- WAVE provided an initial series of 12 trainings at the domestic violence agencies to improve their capacity to support the mental health and substance use recovery of women receiving services.
- Satisfaction with these trainings was in the moderate to high range: 62% of attendees rated them as excellent and 32% as above average. Some respondents felt that the level at which the trainings were conducted could have been more tailored to the target audience. One staff person commented that IHR seemed unaware of the considerable experience that some domestic violence staff have in these topic areas.
- On the other hand, IHR was attempting to integrate a clinical program in non-clinical settings with very different cultures and recognized that it needed to work differently with each site. During the second project year, IHR responded to this feedback by developing a set of six “collaborative training” events for each partner site.

At the individual level:

- As the project plan intended, women participated in WAVE for long periods of time. The average length of stay was 248 days (eight months), considerably higher than typical for substance abuse treatment programs for adult women.
- The FCCs successfully delivered services to participants. FCCs had a total of 5,164 service contacts with participants over the life of the project. The average number of contacts per participant was 24, indicating that women had on average one contact every ten days spent in the program. Most contacts were in person; about one third were on the telephone. The most frequently delivered services were individual counseling, case management and treatment services.
- The program implemented 16 multi-session Seeking Safety Groups and 12 multi-session Nurturing Program for Families in Substance Abuse Treatment and Recovery Groups

(Nurturing Program Groups). About half (53%) of the women enrolled in Seeking Safety groups; 60% enrolled in Nurturing Program Groups. Due to the survivor dynamic of “come closer–stay away” and the sporadic use of services this creates, it was decided to make groups open-ended. However, the influx of new clients and the resulting need to repeat sessions presented some challenges and led to more limited implementation of co-facilitation between WAVE and the domestic violence staff in the train-the-trainer model than was intended.

Data Collection

The CSAT Government Performance Results Act (GPRA) interview was integrated within the local WAVE evaluation protocol. Initially, the baseline and follow-up protocol were administered by an evaluation staff interviewer. However, it became apparent that women in domestic violence programs, especially those fleeing active and ongoing violence, posed unique challenges to tracking and follow-up for GPRA data. In an effort to gather complete GPRA baseline data and improve follow-up rates, the evaluators turned to WAVE clinicians, who were the first point of contact with participants and often the best source of information about a woman’s whereabouts, given their pro-active and persistent client outreach.

Due to safety issues for WAVE’s target population and the ways in which a rural program context can compromise safety (i.e., lack of anonymity in small communities), the evaluation developed tailored procedures for safe tracking and retention. These included asking women to identify methods which would be safe for contacting them (i.e., mail, phone, door knocking, etc.), individuals who would be safe to contact, and safe settings for conducting the interview. Safety procedures were developed with review and input from consumer Advisory Committee members.

The evaluation team developed a trauma-informed approach to interviewing which was based on relational strategies and giving the participant as much control as possible over the evaluation experience. Extensive interviewer training addressed these issues. Strategies included things as simple as allowing a participant to choose where she sits for the in-person interview, asking

her to identify times and place for the interview, offering the options to stop the interview at any time and reschedule, or to decline to answer individual questions. Interviewers attempted to reach out to the participants through personal notes or holiday and birthday cards when they could not be reached for follow-up. Participant communication with the research staff was also encouraged by providing laminated cards and other “marketing” tools (e.g., pocket calendars) that included study contact information and a toll-free number to contact the interviewer.

Psychosocial Outcomes

WAVE resulted in improvements in women’s lives between baseline and follow-up assessments that were both statistically significant and practically important. All the statistically significant changes are in the positive direction, toward increased stability, decreased mental health symptoms and greater economic resources. The one domain where no changes were seen was in substance use. The baseline GPRA levels of reported use were quite low. It is possible that women were unwilling to admit to using drugs and/or alcohol to the research interviewer, particularly at the baseline assessment when the interviewer was unknown to them. Furthermore, women in the TANF shelter faced potential sanctions for using drugs or alcohol while enrolled, and indeed they were much more likely to report zero drug or alcohol use than women at the community-based sexual assault/domestic violence agency (79% vs. 58%).

In domains besides substance use, women made marked improvements in their status. Measures of symptoms associated with trauma and mental illness showed particularly strong changes. Using data from the Foa Trauma Symptom severity scale, the percentage of women meeting criteria for a PTSD diagnosis was more than cut in half—from 79% at baseline to 36% at follow-up. The percentage of women with Brief Symptom Inventory Global Severity Index scores outside the normal range, indicating the presence of significant psychological distress, dropped by almost ten percentage points from 72% to 63%. These improvements were not confined to one constellation of psychological symptoms: Scales indexing trauma symptoms, depression symptoms, and anxiety symptoms all showed statistically significant declines.

In the area of living conditions, more women felt safe in their current relationship at follow-up than at baseline (83% vs. 69%) and there was a marked improvement in housing stability. At baseline few women (39%) were stably housed, which is to be expected given the nature of the Safe Harbor shelter program. Indeed, at baseline only 3.8% of Safe Harbor participants reported being stably housed. Women at both sites increased their housing stability and at Safe Harbor the increase was particularly strong. By follow-up 56% of Safe Harbor women had their own housing in the community.

In the area of employment, education and income, women’s lives also showed an important improvement. The proportion of women employed part- or full-time increased from 26% to 42%. The proportion of women receiving income from work paralleled this change, while there were no changes in the proportions of women receiving income from public assistance or disability payments.

Retention of Participants and Satisfaction with WAVE Services

Because WAVE was designed to serve women with histories of trauma who may be particularly wary of service providers and of forming trusting relationships, engagement was a particularly important outcome for this project. Women stayed in Project WAVE for relatively long periods of time—on average 248 days between the first and last service contacts—indicating that the program was generally successful in retaining women in treatment over extended periods of time.

Women who were older, more educated, and stably housed stayed in services longer, and these three characteristics were positively correlated among themselves (i.e. older women were likely to be more stably housed and have more education). Symptom status at baseline was not related to future retention, indicating that the program was not “creaming” or unable to accommodate women with more severe mental health issues. Among program-related factors, site and discharge status were related to retention—which are both to be expected. Women enrolled at Safe Harbor stayed in services for a shorter time than women at Independence House, which is not surprising since Safe Harbor serves a younger, more transient population and provides short-term shelter services. Also unsurprisingly, women who were

Satisfaction Question	% Agree or Strongly Agree
I was able to get all of the services that I thought I needed	91.2
My FCC was sensitive to my culture/ethnic background	100
Treatment was provided in a way that respected my values and beliefs	98.0
My FCC talked to me about the relationship between domestic violence and the use of alcohol and drugs	95.6
My FCC helped me develop alcohol and drug-free ways of coping with my moods and emotions	92.8
I felt safe and comfortable when I met with my FCC	97.3
My FCC asked about any present day threats to my safety	96.4
I was asked what problems or issues are most important for me to work on at this time	97.3
I was asked about my personal strengths and coping skills	95.9
My FCC encouraged me to use self-help groups and consumer-run organizations	96.5
The services I receive through WAVE treat me as a whole person rather than pulling me apart into separate problems	97.3
I had a choice in the services I received	93.2
My FCC knows how to share information and communicate clearly with me	98.0
I felt free to complain	96.0
My FCC offered me skills to help me deal with symptoms resulting from violence and abuse	96.6

identified by clinicians as completing the program had longer lengths of stay than women who were discharged from the program before completing.

The generally high level of retention may also be related to the very high degree of satisfaction with services that WAVE participants reported during follow-up interviews. A section of the follow-up interview asked participants to rate different aspects of the services they received through WAVE.

Over 90% of participants agreed or strongly agreed with each of the satisfaction questions, indicating that women overwhelmingly approved of the WAVE services they were using. Two items on which women reported slightly lower levels of satisfaction were those that related to the scope of services available, rather than the characteristics of the services that were actually provided. Nine percent of the respondents disagreed or strongly disagreed with the item “I was able to get all of the services that I thought I needed,” and seven percent disagreed or strongly disagreed with “I had a choice in the services I received.”

Overall, women engaged with the WAVE Project and were highly satisfied with the services they received. Engagement and retention are likely important intermediate outcomes for any other outcomes to be achieved.

WAVE Strengths

Length of program services

There was general agreement among all key informants that having a 12-month intervention was critically important to the success of WAVE. Informants commented about how unusual it was to be able to work with women for this length of time and the women themselves really valued the longer-term services. The result was more continuous, ongoing services and the ability to develop strong relationships between participants and staff.

Quality of relationships with FCCs

The relationships between WAVE staff and program participants were repeatedly highlighted as a critical strength of the program. These relationships were characterized as non-threatening, supportive, trust-promoting, normalizing, and respectful. FCCs were often viewed as mentors, coaches or “lifelines” who were readily available over extended periods

of time. Women’s increased self-confidence and trust were considered key results from developing these strong, consistent relationships.

Program follow-up (pro-active outreach), especially doing home visits

There was general agreement that the ability to conduct repeated outreach and make home visits was particularly helpful in a rural community where transportation could be a serious access issue. Participants also reported that outreach calls helped to build their relationship with the FCCs and were generally understood as “caring” rather than intrusive.

Care management and case consultations

For some respondents (especially WAVE staff), the “advocacy piece” (i.e., working with the clients and other providers around care coordination) was viewed as an important program strength. Clients, on the other hand, really valued some of the less formal care coordination tasks, like assisting with transportation, accompanying them to court appearances, helping with sick children etc. There were some real differences of opinion between WAVE and partnering site staff on respective roles and on care management and the degree to which informal care should be delivered (see challenges below).

Group Interventions

Seeking Safety and *Nurturing Families* were seen as strong program components valued by partnering staff, participants and WAVE staff alike. The groups provided an opportunity to build relationships with other participants, learn strategies for working with trauma symptoms and substance use and make a difference in children’s lives—both through learning parenting strategies and improving the well-being of mothers.

WAVE Challenges

Program cultures differed broadly

Changing organizational systems, including attitudes and beliefs among staff, was more challenging and needed more significant up-front time than expected. The two partner sites were also very different programs that had different philosophies, needs and expectations. Informants highlighted the need for up front leadership from program administrators, as

well as including line staff, in sorting out and making differences explicit and developing solutions and strategies for overcoming them.

Program roles and responsibilities needed more clarity

This challenge presented some significant road blocks in the first project year as issues of potentially duplicative roles, and concerns from partner staff about marginalization, began to surface. The model for staff structure, especially the degree to which WAVE would be a stand-alone or integrated program component, was not well understood by program administrators or line staff. Understandably, resource poor programs were initially delighted to get more help through WAVE, but exactly who would be doing what and how it would be coordinated needed greater clarity and ongoing refinement.

Staff turnover exacerbated organizational challenges

Changes in staff and frequent management turnover at one partnership program contributed to challenges in gaining momentum around resolution of organizational issues. This was especially highlighted at Safe Harbor where new WAVE, management and on-line staff experienced significant challenges to satisfactorily defining ongoing roles and responsibilities.

Training was not ongoing and addressed content more than process of program development

While we found moderate to high satisfaction with the initial training content, respondents also reported that more and different types of training were needed. According to one, the project would have benefited from more bi-directional training, including domestic violence staff training WAVE staff. In this instance, training might have helped both staff better understand each other's competencies, attitudes and beliefs as well as begun to frame a way of working together as a team. The high levels of turnover also required more re-training than was available through program resources.

Frequent entry of new participants into groups challenged progress and momentum

At least for a portion of the project period, existing groups at Safe Harbor were particularly challenged by new participants being required

to join them. According to one respondent, Safe Harbor women rarely got the full *Seeking Safety* curriculum, while Nurturing Families suffered from a great deal of repetition.

Lessons Learned

Project WAVE provided a unique opportunity to learn about the process and impact of embedding substance use and co-occurring disorder services into a rural domestic violence service system. WAVE designed an ambitious multi-level intervention in an area of practice with very little documented evidence of successes or challenges. In this sense, WAVE program developers and partners were pioneers in expanding the individual work in trauma theory and integrated care. Project WAVE also placed the intervention within the challenging contextual reality of bringing together two very different and fragmented systems of care. Some things that heightened differences and led to resistance could have been managed differently. For example, many of the challenges described previously that created barriers could possibly have been avoided by setting aside funds to support a concentrated "infrastructure development and orientation" to the project that included both domestic violence and WAVE staff. This would have promoted mutuality, highlighted the strengths of each modality's philosophical base, provided opportunities to identify language differences, encouraged discussion on how the women were perceived and provided a setting for early identification of staff resistance.

Due to the focus on the multiple issues of substance use, mental health, past experiences of trauma/violence and current involvement in abusive relationships, issues of power and control permeated the WAVE initiative at every level and affected every person involved. The goal of being in charge of and achieving safety was the same for everyone, whether staff member, evaluator, or the women and their children. The parallel process of understanding emotional and physical safety, learning to differentiate safe from unsafe experiences, protecting the self from triggers, learning alternative ways to manage triggers, and valuing one's own history as a guideline to making safer, healthier choices also applied to all those involved.

The following lessons were developed through the evaluation's key informant interviews

and less formal discussions with WAVE staff, Advisory Committee members, program partners and consumers. They identify key lessons and provide important insight into implementing integrated trauma-informed cross systems care.

Implementing Trauma-Informed Care

Healing and recovery is a process often characterized by various entries and exits into formal services. A linear, short-term program model is not realistic for working with women with co-occurring disorders and trauma. Rather, flexible and extended services (for one year or more)—expecting periods of absence and welcoming women back when they return—helps to develop trust over time and ultimately supports healing and recovery.

- Safe change happens through collaboration and the establishment of healthier relationships with caregivers, family and other supportive persons in a woman's life. This, in turn, fosters assertive self-advocacy.
- Make “safety” a universal theme. Understand physical and emotional safety, give tools to manage substance use and trauma triggers, explore alternative choices and value self and others.
- Communicate early, often and by any method that works; phone, notes in boxes, e-mail, snail mail, transportation opportunities, meetings in the community, office visits, home visits, etc.
- Develop an appreciation for teachable moments. “Doorknob therapy” is often as effective or more effective than a more formal session.
- Acknowledge the prevalent and pervasive dynamics of hyper-vigilance, focusing on others rather than self, and suspicion of others. This is crucial to redirecting and re-framing negative perceptions of motives and outcomes.
- Use of non-judgmental language, observational rather than confrontational statements, inclusion rather than exclusion helps to eliminate secrets and splitting.
- Proactive and continuous outreach and engagement is critical. Staff need time and resources to do the intensive follow-up needed to keep women connected to the program. This is not an easy task and requires ongoing training, supervision and support.

- Consumers considered long-term, consistent relationships with the FCCs as the most important element in promoting their healing and recovery.
- Provide transportation and in-home services which help to facilitate access and avoid isolation in rural communities.
- Termination is an opportunity to create a positive experience that encourages women to seek other healthy relationships. Women and children affected by violence have endured repeated experiences of betrayal, abandonment, rejection and neglect. Relationships often end abruptly, violently or in a way that feels unfinished.
- Working with survivors of trauma/violence requires a heightened level of self-awareness regarding one's responses, both internally and externally (verbal and non-verbal). Parallel process and vicarious traumatization are common; notice them and work with them. Strong, supportive consistent supervision is highly recommended.

Cross System Work

A three-year time frame is inadequate to fully accomplish cross system work. The need for significant up-front time and effort to adequately integrate a new program into a host site should not be underestimated. Embedding a clinical substance use/co-occurring disorder intervention within non-clinical domestic violence programs requires systematic, up-front role definition and planning in order maximize effectiveness. Establishing a dedicated position (such as the Family Care Coordinator) provides the opportunity for one individual to flexibly meet women's needs on a variety of levels, including outreach, engagement, substance use/co-occurring disorder assessment and counseling.

- Significant up-front effort should be put into defining and agreeing on how people will be working together, sharing philosophies and building an integrated approach to service delivery, especially before the program begins serving clients.
- Buy-in needs to be achieved early on from both management/leadership and line staff at partner sites. Just as respect for the women

and honoring their experiences is crucial in establishing connection, so too is respect for the staff and guidelines of the host agency.

- Before engaging in any formal cross-training, direct care and supervisory staff should sit down together to determine training needs and the best approach for training delivery. One important lesson generated from early training challenges was that an integrated, collaborative and less formal training model was more readily accepted by non-clinical staff than the more didactic trainings originally envisioned for the project.
- Beginnings/“first impressions” are as important with the agency staff as they are with the individual woman. Begin slowly and gently. It is vital to the success of any initiative that grant staff develop an acute awareness of the fact that they are invited guests.
- Teamwork is more effective than individual work. Clients often work with multiple other providers to get their needs met. No one helping relationship is more important than any other. Clients are shared; they are not “mine,” “yours,” “ours,” “theirs,” or “the agency’s.”
- Modeling appropriate interaction and honest communication teaches women skills to navigate systems to get needs met in healthy ways. Mutuality promotes the validity of everyone’s viewpoint, their right to be right and the ability to respectfully agree to disagree.
- Continuity of staff is extremely important for effective program implementation. Initial in-depth staff trainings may be difficult to undertake once the program is up and running and new staff need to “hit the ground running.”
- Consistent, responsive and joint cross systems supervision is crucial to service integration, ensuring staff skills and program satisfaction.
- Endings are as important as beginnings. Ending well with the staff of the host agencies promotes willingness to participate in new projects, new ideas and new ways of delivering supportive services.

Summary

Project WAVE marked an ambitious and challenging attempt to expand substance use disorder services into the domestic violence service system at two very different program sites—one community-based and one residential. Program developers built the project on a history of collaboration among its major partners: a substance use disorder treatment agency, a community-based domestic violence and sexual assault program, a TANF-funded shelter for homeless victims of domestic violence and their children and the Institute for Health and Recovery, the state’s leading services, resources and training institute on gender-specific and trauma-informed substance abuse services. Barnstable County was the administering agency for the grant. Despite numerous challenges in implementation, the provision of services that addressed trauma, violence, substance use and mental health issues in an integrated way was highly successful. Participant satisfaction and retention in services were both unusually high. Participants demonstrated improvement in trauma symptoms, mental health status, residential stability, safety, employment and economic status. In addition to the statistical data documented in this monograph, the most effective demonstration of the success of Project WAVE is the fact that both domestic violence agencies continue to screen, assess and refer women seeking their services to substance use/co-occurring disorder treatment. Further, the substance use treatment agency is routinely screening for and referring women with current domestic violence/sexual assault. Staff from all three agencies who were trained in the train-the-trainer model continue to facilitate *Seeking Safety* (Najavits, 2002) and the *Nurturing Program* (Bogage et al., 2nd ed., 2006; Moore et al., 1995) parenting groups.

Although lack of a control group means we cannot definitely conclude that Project WAVE *caused* these changes, the findings suggest that embedding services that address these three issues in an integrated way into domestic violence settings has a positive impact. The experiences of the program developers can provide valuable information for designing and implementing future programs for women experiencing domestic violence who may also have substance use and co-occurring disorders.

Bibliography

- Abbey, A., McAuslan, P., & Ross, L.T. (1998). Sexual assault and perpetration by college men: The role of alcohol, misperception of sexual intent, and sexual beliefs and experiences. *Journal of Social and Clinical Psychology, 17*, 167-195.
- Abbey, A., Ross, L.T., McDuffie, D., & McAuslan, P. (1994). Alcohol's role in sexual assault. In R.R. Watson (Ed.), *Drug and Alcohol Abuse Reviews: Volume 5: Addictive Behaviors in Women* (pp 97-123). Totowa NJ: Humana Press.
- Alexander, M.J. (1996). Women with co-occurring addictive and mental disorders: An emerging profile of vulnerability. *American Journal of Orthopsychiatry, 66*, 61-70.
- Bogage, T., Marron, B., Donald, T., Finkelstein, N., & Abrams, B. (2006). *Nurturing program for families in substance abuse treatment and recovery* (2nd ed.). Park City, UT: Family Development Resources, Inc.
- Briere, J., Woo, R., McRae, B., Foltz, J., & Sitzman, R. (1997). Lifetime victimization, demographics, and clinical status in female psychiatric emergency room patients. *The Journal of Nervous and Mental Disorders, 185*, 95-101.
- Brookoff, D. (1997). *Drugs, alcohol and domestic violence in Memphis* (National Institute of Justice Research Preview). Washington, DC: U.S. Department of Justice.
- Cascardi, M., Mueser, K.T., DeGiralomo, J., & Murrin, M. (1996). Physical aggression against psychiatric inpatients by family members and partners. *Journal of the American Psychiatric Association, 47*, 531-533.
- Crowell, N.A., & Burgess, A.W. (1996). *Understanding violence against women*. Washington DC: National Academy Press.
- Derogatis, L.R., & Melisaratos, N. (1983). The *Brief Symptom Inventory*: An introductory report. *Psychological Medicine, 13*, 595-605.
- Derogatis, L.R. (1993). *Brief Symptom Inventory (BSI). Administration, scoring, and procedures manual* (4th ed.). Minneapolis, MN: National Computer Systems.
- DiClementi, C.C., & Velasquez, M. (2002). Motivational interviewing and the stages of change. In W.R. Miller & S. Rollnick (Eds.), *Motivational interviewing: Preparing people for change* (2nd ed.). New York, NY: Guilford Press.
- Domestic Violence/Substance Abuse Interdisciplinary Task Force of the Illinois Department of Human Services. (2000). *Safety and Sobriety: Best Practices in Domestic Violence and Substance Abuse*. Springfield, IL: Illinois DHS. Retrieved June 10, 2009, from http://new.vawnet.org/Assoc_Files_VAWnet/Illinois-Manual.pdf.
- Drake, R.E., & Mueser, K.T. (2000). Psychosocial approaches to dual diagnosis. *Schizophrenia Bulletin, 26*, 105-108.
- Drake, R.E., Mueser, K.T., Brunette, M.F., & McHugo, G.J. (2004). A review of treatments for people with severe mental illnesses and co-occurring substance use disorders. *Psychiatric Rehabilitation Journal, 27*, 360-374.
- Elliott, D.E., Bjelajac, P., Fallot, R.D., Markoff, L.S., & Glover Reed, B. (2005). Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. *Journal of Community Psychology, 33*, 461-475.
- Fazzone, P.A., Holton, J.K., & Reed, B.G. (1997). *Substance abuse treatment and domestic violence. Treatment Improvement Protocol (TIP) Series 25*. DHHS Publication No. (SMA) 97-3163. Rockville, MD: SAMHSA, Center for Substance Abuse Treatment.
- Finkelstein, N., & Markoff, L. (2004). The women embracing life and living (WELL) project: Using the relational model to develop integrated systems of care for women with alcohol/drug use and mental health disorders with histories of violence. *Alcoholism Treatment Quarterly, 22*(3/4), 63-80.
- Finkelstein, N., VandeMark, N., Fallot, R., Brown, V., Cadiz, S., & Heckman, J. (2004). *Enhancing substance abuse recovery through integrated trauma treatment*. Sarasota, FL: National Trauma Consortium, Center for Substance Abuse Treatment.

- Foa, E.B. (1997). Trauma and women: Course, predictors and treatment. *Journal of Clinical Psychiatry*, 58(suppl. 9), 25-28.
- Foa, E.B., Riggs, D.S., Dancu, C.V., & Tothbaum, B.O. (1993). Reliability and validity of a brief instrument for assessing post-traumatic stress disorder. *Journal of Traumatic Stress*, 6, 459-473.
- Goodman, L.A., Dutton, M.A., & Harris, M. (1995). Physical and sexual assault prevalence among episodically homeless women with serious mental illness. *American Journal of Orthopsychiatry*, 65, 468-478.
- Goodman, L.A., Salyers, M.P., Mueser, K.T., Rosenberg, S.D., Swartz, M., Essock, S.M., et al. (2001). Recent victimization in women and men with severe mental illness: Prevalence and correlates. *Journal of Traumatic Stress*, 14, 615-632.
- Harrington, N.T., & Lietenberg, H. (1994). Relationship between alcohol consumption and victim behaviors immediately preceding sexual aggression by an acquaintance. *Violence & Victims*, 9, 315-324.
- Herman, J.L. (1992). *Trauma and recovery*. New York, NY: Basic Books.
- Kessler, R.C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C.B. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. *Archives of General Psychiatry*, 52, 1048-1060.
- Mackey, R. (1992). Facts on alcohol, drugs and domestic violence. Piscataway, NJ: Rutgers University Resource Center and Clearinghouse Center of Alcohol Studies.
- Meuser, K.T., Goodman, L.B., Trumbetta, S.L., Rosenberg, S.D., Osher, C., Vidaver, R., et al. (1998). Trauma and posttraumatic stress disorder in severe mental illness. *Journal of Consulting and Clinical Psychology*, 66, 493-499.
- Markoff, L., Finkelstein, N., Kammerer, N., Kreiner, P., & Prost, C.A. (2005). Relational systems change: Implementing a model of change in integrating services for women with substance abuse & mental health disorders & histories of trauma. *Journal of Behavioral Health Services Research*, 32, 227-240.
- Miller, J.B. (1976). *Toward a new psychology of women*. Boston, MA: Beacon Press.
- Miller, J.B. (1986). *What do we mean by relationships?* *Work in Progress*, No. 22. Wellesley, MA: Stone Center Working Paper Series.
- Miller, J.B., & Stiver, I.P. (1997). *The healing connection: How women form relationships in therapy and in life*. Boston, MA: Beacon Press.
- Miller, W.R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change* (2nd ed.). New York, NY: Guilford Press.
- Moore, J., Buchan, B., Finkelstein, N., & Thomas, K. (1995). *Nurturing program for families in substance abuse treatment and recovery*. Park City, UT: Family Development Resources, Inc.
- Najavits, L.M., (2002). *Seeking safety: A treatment manual for PTSD and substance abuse*. New York, NY: Guilford Press.
- Noether, C.D., Brown, V., Finkelstein, N., Russell, L., VanDeMark, N. R., Morris, L., & Graeber, C. (2007). Promoting resiliency in children of mothers with co-occurring disorders & histories of trauma: Impact of a skills-based intervention program on child outcomes. *Journal of Community Psychology*, 35, 823-843.
- Salasin, S. (1995). Looking back, looking ahead: Shining a light on the abuse of woman. *Dare to Vision: Shaping the national agenda for women, abuse, and mental health services: 1994 Conference proceedings*. Holyoke, MA: Human Resources Association.
- Swan, S., Farber, S., & Campbell, D. (2000). *Violence in the lives of women in substance abuse treatment: Service and policy implications*. Retrieved August 21, 2008, from <http://www.womensconsortium.org/pdf/swan001025.pdf>.
- VanDeMark, N.R., Russell, L.A., O'Keefe, M., Finkelstein, N., Noether, C.D., & Gampel, J.C. (2005). Children of mothers with histories of substance abuse, mental illness & trauma. *Journal of Community Psychology*, 33, 445-459.

