

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

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SUMMARY. Based on the relational model of women's development, WELL Project interventions include Integrated Care Facilitators providing resource coordination and advocacy services, *Seeking Safety* trauma groups, *Nurturing Families Affected by Substance Abuse, Mental Illness and Trauma* parenting groups, and *WELL Recovery*, a self/mutual help group for women with co-occurring disorders and trauma. Interventions were delivered at three agencies licensed to provide substance abuse and mental health services, impacting three communities. In preparation, consumers, providers and policymakers met in Local Leadership Councils in each community and in a State Leadership Council, participating

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in cross-training and collaborative discussions planning for integrated, trauma-informed care. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <<http://www.HaworthPress.com>> © 2004 by The Haworth Press, Inc. All rights reserved.]

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INTRODUCTION

The Institute for Health and Recovery (IHR), based in Cambridge, Massachusetts, is a statewide non-profit organization focused on the populations of families with alcohol and other drug (AOD) abuse and/or co-occurring disorders. IHR provides systems, policy and program development aimed at designing and developing services for families, especially women and their children. IHR takes as its theoretical basis the relational model developed by the Stone Center at Wellesley College (Finkelstein, 1996; Jordan et al., 1991; Markoff & Cawley, 1996). This model, which emphasizes the role of relationship in the lives of women and in bringing about change, informed and shaped the design of IHR's project to address the needs of women with co-occurring disorders and histories of violence, the WELL Project.

STATEMENT OF THE PROBLEM

The overarching goal of the Women, Co-Occurring Disorders and Violence Project (WCDV) is to test the hypothesis that trauma-informed, integrated services will lead to better outcomes than services as usual for women with co-occurring disorders and histories of violence and their children. During the first two years of the project, representatives from different sites across the county worked together to design the outcome study and to make decisions about the defining parameters of the intervention model. Individual sites would be able to choose an intervention model that fit their particular context within those parameters.

Each site, therefore, used the first two years of the project to design the interventions and the intervention model to be used in the second phase of the project. However, it was believed that it was not sufficient

to simply provide trauma-informed, integrated interventions; the service delivery system itself must be changed in order to support such interventions. Providing a trauma intervention could actually have a negative effect if the agency in which it is delivered was not trauma-informed (Harris & Fallot, 2001). For example, a woman might become triggered in a trauma group and choose to leave the group in order to ground herself. This attempt at self-care might be responded to in a punitive way in a setting in which “leaving group” is considered a rule infraction. By the same token, providing concurrent mental health and AOD abuse services, even in the same agency, can be detrimental if the underlying philosophies of the providers are not the same and women get conflicting messages about the best way to proceed. To avoid these pitfalls, it was necessary to spend the first two years of the project working to prepare the service delivery system for the delivery of trauma-informed, integrated care.

In Massachusetts, services are primarily funded directly by the state. For example, there is no county-based system of health/human services funding. Therefore, changes in the service delivery system are usually best brought about by working at the state level. Because the WELL Project was expected to eventually impact the entire service delivery system, it was designed to have a statewide focus. At the same time, services are delivered at the local community level, and communities differ in their makeup and their needs. Therefore, the WELL Project was implemented at three local sites, intending to impact three local communities. These local sites were three large, comprehensive private non-profit organizations licensed to provide both mental health and AOD abuse services: CAB Health and Recovery (CAB) in Northeast Massachusetts, Gosnold on Cape Cod and the Islands, and Stanley Street Treatment and Resources (SSTAR) in Fall River. In addition, two sites were participants in a Children’s Sub-Study, the WELL Child Project. A fourth site, Spectrum Health Systems, Inc., in Worcester, served as the Comparison site, and did not receive WELL Project interventions. All four sites were historically established to treat AOD abuse, offering a complete continuum of AOD abuse treatment services: (i.e., detoxification, residential and outpatient). Within the last few years, mental health outpatient and residential services have been added.

Although both mental health and AOD services were available at sites prior to implementation of the WELL Project, the degree to which they were integrated varied. Only one site provided an integrated assessment that could result in both a substance abuse and mental health diagnosis. All three intervention sites had some dual diagnosis services;

one site was in the process of establishing a dual diagnosis detoxification program, and another site had a dual diagnosis residential program.

Services for women experiencing domestic violence were available in all three communities, but were not integrated into mental health and AOD treatment. One site did have its own Women's Center that provided domestic violence counseling and advocacy and this made them more sensitive to issues of violence. For example, they were the only site that did ask about histories of abuse in their intake. Two of the sites also at times had conducted trauma groups; however, no attempt was made to assess or address trauma for women who requested AOD abuse or mental health services. Community providers of violence services did not assess for AOD and mental health problems. If such problems were known to exist for a particular client, violence providers would often refer the client out to AOD or mental health treatment providers because they did not feel they could meet their needs.

At the state level, funding streams for mental health, AOD and violence services are separate, which has resulted historically in treatment being provided in a parallel, non-integrated fashion. Some attempts at integrating AOD and mental health services were being made prior to the beginning of the WELL Project. The Massachusetts Department of Mental Health had received an Exemplary Practice grant from SAMHSA to create a Community Consensus-Building Collaborative to develop strategies for integrating AOD and mental health services. The contractor responsible for managing behavioral health funds for Medicaid had contracted with the Peer Educators Project of Vinfen, Inc., a comprehensive mental health agency, to develop "Double Trouble" Twelve Step self-help groups for individuals with co-occurring AOD and mental health disorders. Some attempts were also being made to meet the needs of women with both domestic violence and AOD problems. Two residential programs for these women and their children had been funded by the Department of Social Services and were in the start-up phase of implementation. However, for the most part, the AOD abuse, mental health and trauma service delivery systems were not integrated.

It was the task of the WELL Project to create a context at the agency, community and state levels that would support the delivery of trauma-informed, integrated services. This involved developing or enhancing linkages among state agencies and among provider organizations, educating provider organizations so that they could integrate an understanding of trauma into their services, and selecting the interventions to be used in the study.

PROGRAM MANAGEMENT STRUCTURE

IHR was the lead agency on the project and contracted with Health and Addictions Research, Inc. for project evaluation. The project was administered by a Project Steering Committee, which consisted of the Principal Investigator, Project Director, Project Research Director from Health and Addictions Research, administrators from each of the local sites and two consumer representatives. The WELL Project hired a Consumer Coordinator in March of 2000, who joined the Steering Committee at that time.

The Project Director supervised Integrated Care Facilitators (ICFs) who were housed at the three intervention sites. During the first phase of the project, these ICFs, Masters level clinicians knowledgeable about AOD, mental health, and trauma, were responsible for preparing the sites for the delivery of trauma-informed, integrated care. During the second phase they became responsible for delivering and/or supervising the integrated interventions.

PREPARING FOR THE DELIVERY OF TRAUMA-INFORMED, INTEGRATED CARE

Integration of services can only be accomplished within a service system that supports such changes (Minkoff, 2001). Integrating services requires change at the state, community and agency levels of the service system. Using the relational model, the WELL Project worked to bring about change by developing relationships, establishing linkages and working collaboratively with all stakeholders (i.e., consumers, providers, policymakers, advocacy organizations, clinical experts) to determine the best strategies and mechanisms for the delivery of integrated services.

Developing the Cross-Training Curriculum

IHR convened a group of experts called the Expert Resource Panel to provide clinical input into the intervention model and to develop and deliver cross-training for all stakeholders. As these experts began to interact, it became clear that even among professionals who had long histories of working in women's treatment, differences in points of view existed based on training and history of the discipline with which each was primarily identified. To work with this, the group decided to

engage in a values clarification exercise conducted by an outside facilitator. When this was accomplished, the group was able to produce a statement of principles, which could then be used to guide the development and delivery of the training curriculum.

In order to achieve integration of services, service providers and policymakers must have basic knowledge of the core content within the fields to be integrated (Cramer, 2001; Minkoff, 2001). Focus groups were conducted with both providers and consumers at each site to identify existing gaps in provider knowledge. Providers were asked what they needed to know in order to be better able to deliver services to women with co-occurring disorders and histories of trauma, and consumers were asked what providers would need to know more about in order to provide better services for them as consumers. Additional focus groups were also conducted with consumers at other AOD abuse treatment programs. These groups focused on what was and was not helpful for the women in treatment, and what products would be useful to help consumers to access appropriate care.

Based on results of these focus groups, a series of training modules were developed. Topics covered included domestic violence, trauma, impact of violence on children, PTSD and AOD, diversity, the trajectory of recovery from multiple issues, gender-specific treatment, and consumer integration. Later, these modules were compiled into a curriculum entitled *WELL Project Training Curriculum for Providers: Developing Integrated Services for Women with Substance Abuse, Mental Illness and Trauma* (Institute for Health and Recovery, 2001). The training based on this curriculum was then provided to the staff of the local sites, to a wider range of providers in the local communities through the Local Leadership Councils (described below) and to policymakers and consumer advocacy organizations through the State Leadership Council (also described below).

Developing Integration at the Agency Level

The primary mechanism for promoting integration at the local sites was the placement of an Integrated Care Facilitator (ICF) at each site. These individuals were employed by the WELL Project to work at and with the sites to move toward an integrated, trauma-informed system of delivering AOD, mental health and violence/trauma services. ICFs attended program and staff meetings, provided input, updated site staff regarding WELL Project activities and participated in case conferences. Their local site participation enabled them to understand and become

familiar with the working environment, so they could make informed suggestions regarding changes that might enhance treatment for women and children. They were also the on-site hosts for the cross-training. After approximately one year of cross-training, site representatives to the WELL Project Steering Committee observed that their employees were more knowledgeable about the issues, but were not necessarily able to implement what they had learned. In response, another intervention was developed. This intervention, called “integrated supervision,” was provided at each site for two hours each month by one of the clinicians on the WELL Project Expert Resource Panel. Local site clinicians could request a didactic presentation on a relevant topic, discuss challenging cases or discuss systems issues in developing integrated treatment during their integrated supervision time.

Developing Integration at the Community Level

ICFs were also responsible for improving integration of AOD, mental health and violence/trauma services in the community served by the local site. They did this by convening and then chairing a Local Leadership Council (LLC), in which participants could establish or strengthen their relationships and work collaboratively to develop strategies for providing integrated care. These Councils included consumers and representatives from all organizations that might come into contact with a woman with co-occurring disorders and a history of trauma or her children. Having learned from the experience of the Expert Resource Panel, the LLCs began with values clarification. Participants were divided into groups who primarily identified as members of the AOD, mental health or trauma/violence community. Each group was asked to come up with a set of statements about “what is necessary or helpful in order for women with co-occurring disorders and histories of trauma to heal.” The facilitator then led a discussion about the similarities and differences between the statements provided by the three groups. This discussion served a number of purposes. Participants were invariably surprised by the similarity of their beliefs, discovering that they viewed the other groups as more different than they actually were. The identified differences were recorded, so that they could be referred to later should disagreement arise. This allowed the source of disagreement to be worked with directly as differences in points of view. It was acknowledged that a diversity of points of view enhanced the creative process, and that everyone concerned wanted to keep the best of the knowledge that had been developed by each of the disciplines.

Following the values clarification process, the LLCs began participating in the cross-training. This would usually consist of one hour of training, followed by one hour of discussion, led by the ICF. Members brainstormed the needs of women with co-occurring disorders and histories of trauma and then the needs of the children of such women. Following this, they developed an ideal integrated continuum of care, maximizing the use of existing resources. This continuum included components or levels of care and enhancements that would be necessary in order for existing services to effectively serve this population. These three continua were eventually combined into one document, the “*Ideal Integrated Continuum of Care*.” Each LLC then created a service map that included all existing community services and their contact information. Service maps were compared to the integrated continuum to identify gaps in service components. From this process, each LLC developed a set of recommendations, including policy changes that would assist in the integration of care and pilot projects to fill gaps in services. These recommendations were forwarded to the State Leadership Council (discussed below). Each LLC then chose one recommendation to address locally. For example, one LLC developed a mechanism for agencies to continue cross-training each other on an exchange basis. Another LLC decided to promote universal screening for domestic violence by all service providers in the community. The third LLC decided to develop a brief document for the community on identifying domestic violence and developing safety plans.

Developing Integration at the State Level

The mechanism for promoting integration at the state level was the State Leadership Council (SLC). Convened by IHR, the Council included representatives from a large number of state agencies that serve women with co-occurring disorders and their children, including the Department of Public Health/Bureau of Substance Abuse Services, the Department of Public Health/Sexual Assault Prevention and Survivor Services, the Department of Mental Health, Department of Social Services (Child Protection Agency), the Department of Probation, Office of Child Care Services and others. Provider advocacy organizations, such as Jane Doe, Inc. (also known as the Massachusetts Coalition of Providers of Domestic Violence and Sexual Assault Services) and the Children’s League were included, as well as legislators and consumer advocacy organizations, such as the Massachusetts Organization for Addiction Recovery, Parent’s Advocacy League and the National Alli-

ance for the Mentally Ill. The Council was chaired by the Principal Investigator of the WELL Project and followed a process similar to that of the LLCs. Cross-training was conducted initially, followed by discussion of the needs of women and their children, and barriers to providing integrated, trauma-informed care.

The SLC accepted the recommendations of the LLCs with minor revisions, and began working on developing and implementing strategies for promoting identified changes. Building on the work of the Expert Resource Panel, the SLC also developed a set of principles to underscore the need for trauma-informed care and outline the specifics of such care. The *Principles for the Trauma-Informed Care of Women with Co-Occurring Mental Health and Substance Abuse Disorders* were drafted in subcommittee and then revised and approved by the SLC. Members of the SLC brought these Principles to their agencies and organizations, asking them to sign a statement of support. To date, 38 organizations have signed such statements, including all of the state agencies principally involved in delivering services to women and children. As a follow-up to this, the SLC developed a WELL Project Tool Kit that includes self-assessments for both provider organizations and state agencies and instructions for using such an assessment to develop an implementation plan to move in the direction of providing trauma-informed, integrated services.

Consumer Integration

In addition to promoting integration of AOD, mental health and violence/trauma services, the WELL Project had as a goal promoting the integration of consumers into service planning and delivery. One means of promoting this was to model it. The WELL Project had consumers in significant numbers on its Steering Committee and on its Local Leadership and State Leadership Councils. For many providers who were members of these Councils, this was a new experience and providers frequently expressed appreciation for this consumer input. However, to integrate consumers successfully, some support services were found to be necessary. Providers needed training regarding the importance of integrating consumers and principles of successful integration. This training was developed by consumers on the Steering Committee with the Project Director and delivered to the local sites. Consumers also needed training on how to be effective advocates. A two-module Leadership Training was developed by consumers on the Steering Committee with the assistance of an expert consumer consultant and delivered to the

WELL Project consumers as a group. Both of these trainings were later included in the *WELL Project Training Curriculum for Providers: Developing Integrated Services for Women with Substance Abuse, Mental Illness and Trauma*.

While consumers actively participated in LLC meetings, they requested time to meet with each other for support and to develop their own advocacy projects. In order to expand these activities and in recognition that consumers on the Steering Committee were volunteers with other full-time jobs, a Consumer Coordinator was hired. The Consumer Coordinator became responsible for recruiting, training, and retaining consumers, for facilitating consumer subcommittees of the LLCs, and for obtaining consumer feedback on all WELL Project procedures and documents.

DELIVERY OF TRAUMA-INFORMED, INTEGRATED SERVICES

Phase II of the WELL Project involved delivering trauma-informed, integrated services at the intervention sites, so that outcomes of women receiving services at those sites could be compared with those of women receiving services as usual at the comparison site. At all four sites, women were screened at intake for AOD abuse, mental health problems, and histories of violence. Women who screened positively in all three areas were offered the opportunity to meet with a research interviewer and could then decide whether or not to participate in the study. Women who chose to participate in the study at the integrated sites were offered the WELL Project interventions.

Women in the Study

In all, 328 women participated in the study, 218 at the intervention sites and 110 at the comparison site. Women ranged in age from 18 to 61, with a mean of 35. Eighty-five percent were White, 8% were African American, 5% were Native American, 1% were Native Hawaiian or other Pacific Islander, and less than 1% were Asian. Seven percent of the women were Latina. The average woman had completed high school. The least educated women had completed seventh grade, while the most educated women had some post-college education. The majority (72%) were not employed. Seventy-one percent of the women had

living children under 18, although only 48% were living with one or more of their children upon entering the study.

Eighty-nine percent of the women had been physically abused at some point in their lives. Seventy-four percent had been inappropriately touched or made to touch someone in a sexual way, and 80% had had sex because they felt forced in some way.

In terms of substance abuse, alcohol was the most common drug of choice, accounting for 32% of the women. The average age at first use of alcohol to intoxication was 15, which was the same as average age of first marijuana use. The average age of first use of illegal drugs other than marijuana was slightly older, at age 17. Fifteen percent of the women had used injection drugs in the 30 days prior to the initial interview. Because substance abuse treatment was the point of entry for the study, all women in the study were seeking such treatment upon entry. Of those for whom data is available (264), 65% had prior treatment for alcohol abuse, with an average of 10 starts; 80% had prior treatment for drug abuse, with an average of 12 starts; and 45% had been treated for alcohol and drugs simultaneously, with an average of 9 starts.

Fifty-nine percent of the women had been hospitalized for a psychiatric problem and the average number of hospitalizations was four. The average woman began having mental health problems at age 12. Most women (77%) were receiving mental health services when they entered the study.

Integrating Existing Services

Resource Coordination and Advocacy

Women who chose to participate in the WELL Project were assigned to an ICF, who provided care/resource coordination and advocacy services. According to the relational model, the best context for emotional growth for women is within one or more mutual, empathic, authentic relationships (Jordan et al., 1991; Covington & Surrey, 2000; Miller, 2002). The ICF provided such a connection for each woman, while assisting her in setting goals and accessing services to support her healing. The ICFs followed the women continuously as they moved through the continuum of care, providing the long-term support that trauma survivors often need (Harvey & Harney, 1997). Initially, the ICF conducted a comprehensive interview that covered all aspects of a woman's life: AOD, mental health, trauma (including current safety), relationships (including children), medical, vocational/economic, spiritual and lei-

sure. The ICF then worked collaboratively with the woman to identify areas of her life that she would like to change, setting goals in each area and then prioritizing them. The ICF suggested resources to assist each woman in achieving her goals, including, but not limited to, the integrated interventions discussed below, and helped to address barriers (both internal and external) to accessing those services. Each woman was seen as an expert on her own life and was empowered to make her own choices (Finkelstein, 1994). At the same time, the ICF might help a woman consider the ways in which her trauma, mental illness and AOD abuse interact, and suggest that certain symptoms may have originally developed as a means to cope with trauma, helping the woman to develop a more empowering view of her life experiences. Once an initial integrated service plan was developed, an ICF continued to meet with each woman regularly to assist in overcoming any obstacles to her progress. If a woman was involved with many service providers, the ICF, with the woman's permission, would maintain contact with those providers to ensure that all providers understood her needs in a similar way and that services were coordinated.

Interagency Service Planning

Prior to the intervention phase of the project, subcommittees of the LLCs, called Resource Coordination Councils (RCCs), that included major providers of AOD abuse, mental health and children's services within the local community, met several times to develop plans for interagency referral, information sharing and interagency service planning. These agencies signed Memoranda of Understanding agreeing to participate in this collaborative effort. During the project implementation phase, RCCs continued to meet to discuss progress in integration and to make any needed adjustments to procedures. When necessary, either at a woman's or provider's request, an ICF would convene an interagency service planning meeting with the woman, her treatment providers, and a consumer advocate to address difficulties with the service plan or other barriers to the woman's recovery.

Integrated Interventions

In addition to mechanisms developed to integrate existing services, specific interventions were designed to address AOD, mental illness and trauma simultaneously. Three integrated interventions were made available to women in the WELL Project.

Trauma-Specific Groups

One critical piece was the availability of a group intervention that would help women build skills needed for coping with trauma symptoms, as well as other mental health symptoms and AOD abuse (Bollerud, 1990; Finkelstein et al., 1997; Harris, 1994). Group interventions are particularly helpful as they allow women to develop mutual, authentic, empathic relationships with other women and, in the process, help women to become more empathic with themselves (Fedele & Harrington, 1990). After reviewing and piloting a number of curricula in Phase I, it was decided to use an adapted version of *Seeking Safety* (Najavits, 2002), a curriculum developed by Dr. Lisa Najavits of McClean Hospital and Harvard Medical School, for women with PTSD and AOD abuse. *Seeking Safety* consists of 25 group sessions focused on topics from four content areas: cognitive, behavioral, interpersonal and case management. Najavits and her colleagues (Najavits et al., 1998) reported that the intervention resulted in reductions in AOD use, trauma-related symptoms, suicide risk, and improvements in social adjustment. This curriculum was chosen because it is highly structured, skill-based (rather than uncovering), and directly addresses AOD abuse in every session, making it appropriate even for women in very early recovery. The adaptations involved changes in language to broaden the curriculum to be more inclusive of forms of mental illness other than PTSD, elimination of the case management section as this function was performed by the ICFs, and division of the curriculum into two twelve-session phases. Division of the curriculum was necessary in order to have closed groups and still maintain sufficient numbers of women in each group to be clinically appropriate. When there were drop-outs, women from different phase one groups were combined into a phase two group.

Seeking Safety groups were offered at both residential and outpatient settings. Sessions were either 50 or 75 minutes, based on site constraints. ICFs initially conducted the groups with site clinicians as co-facilitators. As site clinicians became comfortable with the curriculum, they were able to lead groups on their own with ICFs providing supervision.

Parenting Groups

Women are often motivated to seek treatment by the desire to improve the relationships in their lives, particularly relationships with

their children (Beckman & Amaro, 1986; Mulford, 1977). Because AOD abuse, mental illness and trauma can have an impact on a woman's ability to parent, an integrated parenting intervention can support women in achieving the goals they define as important in their lives (Lyons-Ruth & Block, 1996; Seval-Brooks & Fitzgerald, 1997; Van Bremen & Chasnoff, 1994). In 1995, IHR adapted Dr. Stephen Bavolek's parenting curriculum, the *Nurturing Program*, creating the *Nurturing Program for Families in Substance Abuse Treatment and Recovery* to address the needs of women with AOD abuse problems (Moore et al., 1995). This adapted curriculum is used widely in the AOD abuse treatment system in Massachusetts as well as nationally. Camp and Finkelstein (1997) reported that this intervention, one of CSAP's model/exemplary parenting programs, improved parenting as measured on objective scales and also enhanced parents' satisfaction and competency (Camp & Finkelstein, 1997; Moore & Finkelstein, 2001). As part of the WELL Project, IHR adapted this curriculum to include information on co-occurring disorders and trauma. Some sessions were rewritten, increasing the focus on skill-building and limiting the amount of self-exploration/self-disclosure, in order to reduce the risk of traumatic memories being triggered. This new program, entitled *Nurturing Families Affected by Substance Abuse, Mental Illness, and Trauma*, is designed to increase women's awareness of the impact of AOD abuse, mental illness, and trauma on themselves and their children and develop skills to promote healing in relationships with their children. The fourteen, 90-minute sessions consist of experiential exercises followed by participatory discussions on topics such as safety and protecting children, self-esteem, setting boundaries, children's feelings, and guiding behaviors. The group offers opportunities to address shame and guilt, self-acceptance, impact of trauma on women and children, children's developmental milestones, appropriate expectations, effective discipline strategies, and parenting techniques. This parenting intervention was offered at the three sites in both residential and outpatient settings. Groups were led by Parent-Child Specialists from IHR, co-facilitated by local site clinicians when available.

Peer-Led Mutual Help Groups

Women with co-occurring disorders and histories of trauma often report that existing self-help groups do not meet their needs. Some object to some of the 12-step language, especially references to powerlessness. Others find a bias against medication among members or do not feel it

appropriate to discuss either mental illness or trauma in that forum. Therefore, a third intervention developed was a gender-specific mutual help model specifically for women with these three issues developed by consumers familiar with self-help. The Director of the Peer Educators Project at Vinfen and the Consumer Coordinator of the WELL Project worked together to develop a model called WELL Recovery. WELL Recovery meetings have a format similar to other self-help groups such as AA or Double Trouble, but do not include the twelve steps. Trained consumers facilitate the meetings in which participants share their strength, experience and hope around specific topics chosen by the group. The WELL Recovery manual, available from IHR, describes how to start and run a WELL Recovery group and contains lists of suggested topics and quotes to use in conjunction with the groups.

The Consumer Coordinator of the WELL Project recruited, trained, and supervised peer facilitators who led groups in the communities served by the three local sites. Peer facilitators were paid for their work by Vinfen under a contract from Massachusetts' Medicaid managed care vendor.

WELL Child Project

The WELL Child Project, one of four sites funded by SAMHSA as a Children's Sub-Study, was located at two of the WELL Project sites. This project, part of a cross-site, exploratory, pooled data study, provided clinical screening and assessment services, individualized resource coordination and advocacy, and a skill-building/trauma-informed group intervention to children ages 5-10 of mothers who were WELL Project participants and who agreed to their children's participation. Two staffpersons called Child Clinician Advocates (CCAs) worked with the children and their mothers with the goal of influencing positive outcomes in safety, self-care, relationships and identity. The WELL Child Project served 26 children at the two intervention sites and enrolled 21 at the comparison site.

CONCLUSION

What has been demonstrated by the WELL Project is the possibility of using a relational, collaborative model to bring about change at multiple levels of a service delivery system. Strategies such as bringing all stakeholders to the table, especially consumers, and then engaging in values clarification, providing cross-training, and creating a safe envi-

ronment for dialogue are effective in preparing the ground for change. Working together, stakeholders can then create a model for service delivery that best meets the needs of all concerned.

The response of participating agencies as the WELL Project draws to a close provides some information about its impact. Executive Directors of all three agencies were unanimous in concluding that the resource coordination and advocacy services were enormously helpful to the women and agency staff, and they expressed a strong desire to find a funding source to continue these services. One Executive Director included resource coordination and advocacy services in a successful federal drug court grant application. All three Executive Directors were equally enthusiastic about *Seeking Safety* groups and plan to continue them after the project ends. The Director of a women's residential program at one site indicated she believed the trauma groups had an important impact on staff at her program, increasing their comfort in dealing with trauma symptoms such as self-harm and flashbacks. She is currently working on adapting *Seeking Safety* for use with adolescents, so that groups can be conducted in an adolescent residential program at her agency as well.

Members of the LLCs are also reluctant to see the WELL Project end. A member agency of one of the LLCs has offered to provide space, minutes and mailings so that the work can continue. In another community, the Regional Domestic Violence Council chose to absorb the LLC as a "Subcommittee on Integration" so the LLC work can continue.

The WELL Project has increased the awareness of administrators, providers and consumers of the benefits of trauma-informed, integrated services. Outcome data from the WCDV study will be useful in further fueling, directing, and disseminating efforts to make such services available to all women with co-occurring disorders and histories of violence.

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