

Findings from a National Evaluation of Services to Improve Outcomes for Women with Co-Occurring Disorders and a History of Trauma

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In this special issue of the *Journal of Community Psychology*, the second of a two-part series, we have been allowed the opportunity to assemble articles on empirical findings from the Women, Co-Occurring Disorders and Violence Study (WCDVS). The WCDVS was a 5-year initiative jointly supported by the three centers of the Substance

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Abuse and Mental Health Services Administration (SAMHSA)—the Center for Substance Abuse Treatment (CSAT), the Center for Mental Health Services (CMHS), and the Center for Substance Abuse Prevention (CSAP)—to identify and evaluate comprehensive, integrated, trauma-informed service systems designed to address the needs of women with co-occurring disorders and a history of trauma.

Nine sites were selected to participate in the national evaluation. With technical assistance from the study's Coordinating Center, these sites focused on the design and full-scale implementation of integrated service models, as well as multisite evaluation protocols. Each site employed a quasi-experimental design in which an integrated, trauma-informed intervention designed specifically for the needs of these women was compared to usual treatment at a substance abuse or mental health agency. For purposes of the evaluation, all sites administered the same assessments at baseline, 6 months, and 12 months, along with any additional site-specific measures. In addition, CSAT funded a Children's Subset Study, which involved four of the WCDVS study sites, to examine the effectiveness of a standardized intervention program for promoting emotional and behavioral strengths in children who have been exposed to interpersonal violence and whose mothers have histories of co-occurring disorders and trauma.

In the first special issue of the *Journal of Community Psychology*, published in July 2005, we laid out the rationale and theoretical foundations for intervention with this population, described the population, discussed conceptual and pragmatic considerations in implementing the intervention, explored special concerns and compromises in designing the evaluation, and provided a voice for the "C/S/R" women—women who were Consumers of mental health services, Survivors of trauma and abuse, and in Recovery from substance use. We emphasized the importance of empowering these women through the design of the intervention program, the roles of C/S/Rs at the agencies that participated in the study, and the way in which the study governed itself nationally.

In the current issue, we provide empirical results. The first article, by Chanson Noether and representatives from the sites in the study, provides findings from the Children's Subset Study. At 6 months, children's improvement was predicted by their mothers' improvement and recovery. At 12 months, regardless of their mothers' outcomes, children at the intervention sites showed greater positive change than children at the comparison sites. The article highlights the importance of preventive intervention with children of mothers with co-occurring disorders and histories of trauma.

The other five articles focus on findings for the women who had experienced co-occurring disorders and exposure to trauma. Retention of women in treatment is notoriously challenging with this population. In their article, Hortensia Amaro, Miriam Chernoff, and colleagues present findings from two sites (Boston and Los Angeles) that show better treatment retention for women who received integrated, trauma-informed treatment compared to women who received substance abuse treatment-as-usual. If integrating a trauma-specific group into residential substance abuse treatment keeps women in treatment longer, this result by itself has important implications for program design. These findings make sense in light of clients' open-ended comments that described participating in the trauma-specific group as a unique experience that addressed their special needs in a way that previous treatment episodes had not. They felt respected and believed they had been given tools that were empowering.

The next two articles present 12-month findings from single sites, Los Angeles (Margaret Gatz, Vivian Brown, and colleagues) and Denver (Danielle Toussaint, Nancy

VanDeMark, and colleagues). The sites differed in their choice of a trauma-specific intervention: The trauma-specific intervention at the Los Angeles site was Seeking Safety, and the trauma-specific intervention at the Denver site was the Trauma Recovery and Empowerment Model (TREM). Both evaluations showed advantages for women in the integrated, trauma-informed services condition with respect to trauma-related symptoms and coping skills, but no differences between intervention and comparison groups on outcomes related to drug and alcohol use. These site-specific results offer an elaboration on the overall 12-month cross-site findings (Morrissey et al., 2005), in which effect sizes for mental health and trauma symptoms indicated statistically significant improvements for women in the intervention condition relative to those in the comparison condition but did not indicate corresponding improvements for substance use severity. Meta-analytic findings pointed to the provision of integrated counseling services as key to improvement. Based on the site-specific articles in this issue, the importance of integrated counseling may lie in the ways that women are taught to keep themselves safe and to manage their own trauma symptoms.

The final two articles discuss additional outcomes that were not the primary focus of the intervention but were central issues in the lives of the women in the study. Hortensia Amaro, Mary Jo Larson, and colleagues looked at HIV sexual risk behaviors in women participating in the study at the Boston site and found that trauma-informed treatment led to reduction in sexual risk behaviors compared to treatment-as-usual. Analyzing data from all nine sites, Inka Weissbecker and Colleen Clark found physical health improvement in women in both treatment conditions, as indicated by subjective evaluations of physical health, health-related behaviors, and health care utilization. These two articles remind us that treating women in this population requires a wide array of service components. They also demonstrate that an intervention for women with multiple and complex problems may have unanticipated positive effects in domains other than the ones initially targeted.

As we try to put this special issue and the previous one into perspective, we note that the Women, Co-Occurring Disorders and Violence Study represented an important federal commitment of funds and expertise. The primary goal of the WCDVS was to develop and implement a comprehensive, integrated, and trauma-informed service delivery model within the existing public mental health and substance abuse treatment systems and to evaluate the effectiveness of this model. The evaluation results presented in this special issue afford reason for modest optimism about the model. As a result of participation in integrated, trauma-informed services, women with mental health and substance abuse disorders who had been victims of traumatic violence stayed in treatment longer, experienced meaningful gains in both physical and mental health, and, quite importantly, were able to contribute to their children's well-being. These findings offer hope that the cycle of violence, impairment, and dysfunction can be broken and improvements maintained for both the women and children whose lives have been drastically altered by the experience of traumatic violence.

Based on the findings from the WCDVS, SAMHSA launched the national Center on Women, Violence and Trauma (CWVT). The major goals of this center are to develop leadership networks, spread information about emerging best practices, and stimulate local change. In September 2005, as part of its mission to disseminate information, the CWVT sponsored a Web-based technical assistance teleconference to describe the trauma treatment models utilized by the nine WCDVS study sites: TREM, the Addictions and Trauma Recovery—Integration Model (ATRIUM), Seeking Safety, and

the TRIAD women's group model. Thus, the processes initiated by the Women, Co-Occurring Disorders and Violence Study do seem to be making a difference in the treatments available for women.

REFERENCE

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