



Beyond Trauma: Providing Trauma-Informed Services to Women in Drug Treatment

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BEYOND TRAUMA: PROVIDING TRAUMA-INFORMED SERVICES TO WOMEN IN TREATMENT

PROJECT BACKGROUND

In May 2004, McAlister Institute for Treatment and Education (MITE) received funding from The California Endowment to provide specialized trauma-informed services to the women residing at their KIVA Women and Children's Learning Center, a residential treatment center. Recognizing the prevalence of trauma in the lives of women in recovery, MITE drew upon the expertise of Dr. Stephanie Covington, Co-Director of the Institute for Relational Development and the Center for Gender and Justice, to address the co-occurrence of trauma and substance abuse by training staff in her *Beyond Trauma (BT)* curriculum. The *BT* curriculum was integrated into the existing gender-responsive treatment model, with women attending the *BT* sessions upon completion of the *Helping Women Recover (HWR)* program component to deepen and expand the trauma work they had begun (also a model developed by Dr. Covington).

The Criminal Justice Research Division at the San Diego Association of Governments (SANDAG) was contracted in June 2004 as the outside evaluator to conduct the process and impact evaluation of KIVA's implementation of the *BT* curriculum. SANDAG was responsible for documenting whether the project design was implemented as planned and what effect these efforts had on the clients who completed the program. Because the focus of the funds was to provide direct services, SANDAG worked with the program staff to reduce the cost of the evaluation but also meet the needs of the grant. As such, MITE program staff were responsible for collecting all data, entering it, and contacting clients and conducting the follow-up interviews.

This report provides an overview of the curriculum; describes the characteristics and needs of the clients served, as well as how the program was implemented; and outlines improvements made in clients' lives after program participation. It also should be noted that the results described here were initially incorporated as part of MITE's final report to The California Endowment and are reproduced here, with their permission, for broader dissemination.

KEY FINDINGS

- The clients served by this program represented a variety of different backgrounds, but shared similar needs related to a history of abuse, depression and anxiety, economic instability, and prior contact with the justice system.
- The *BT* curriculum was implemented as planned with staff training in the model, including their own participation prior to leading groups, and oversight by a clinical social worker.
- Overall, clients felt they gained helpful tools in their recovery, including help from the staff, as well as the curriculum.
- Results from the impact evaluation suggest that participation in both *HWR* and *BT* helped women reduce their level of depression and take steps to reduce the impact from past traumas. These positive results support more comprehensive evaluations of the model in other sites.

CURRICULUM OVERVIEW

Helping Women Recover

Helping Women Recover (HWR): A Program for Treating Addiction, is an integrated, manualized curriculum for treating women with histories of addiction and trauma. It is designed for use in a variety of settings, including outpatient and residential substance abuse treatment programs, domestic violence shelters, and mental health clinics, as well as jails, prisons, and community corrections. *HWR* is grounded in research, theory, and clinical practice. The foundation of the treatment model is the integration of three theories: a theory of addiction, women's psychological development, and trauma. The therapeutic strategies include psycho-educational, cognitive-behavioral, expressive arts, and relational approaches.

The facilitator's manual for the 17-session program is a step-by-step guide containing the theory, structure, and content needed for running groups. Each session is designed to be 90 minutes in length and to include six to ten women with one facilitator. It is recommended that the curriculum be implemented sequentially in closed groups, but this is not a requirement. Each session includes an overview of the materials to be covered, a group check-in, a teaching component (to enhance understanding), an interactive component (that includes discussions and questions and answers), an experimental component (that includes exercises in a supporting environment), and closure (that includes questions for the women to think about prior to the next session). *A Woman's Journey*, the participant's workbook, allows women to process and record the therapeutic experience. The program model is organized into four modules: self, relationships, sexuality, and spirituality. These are the four areas that recovering women have identified as triggers for relapse and as necessary for growth and healing. The materials are designed to be

user-friendly and self-instructive. This allows the *HWR* program to be implemented by a staff with a wide range of training and experience.

Beyond Trauma

Beyond Trauma (BT): A Healing Journey for Women is a manualized curriculum for women's treatment based on theory, research, and clinical practice. While the materials are trauma-specific, the connection between trauma and substance abuse is recognized and integrated throughout the curriculum. The eleven-session program, divided into three modules including violence, abuse, and trauma, impact of trauma, and healing from trauma, is designed for use in outpatient, residential, and criminal justice settings. The model can be used alone or in conjunction with *HWR*. *BT* has a psycho-educational component that teaches women what trauma is, its process, and its impact on both the inner self (thoughts, feelings, beliefs, values) and the outer self (behavior and relationships, including parenting). The major emphasis is on coping skills, with specific exercises for developing emotional wellness.

The curriculum includes a facilitator manual, participant workbook, and three instructional videos (two for facilitators, one for clients). The facilitator's manual provides group leaders with session outlines, as well as background information about trauma, based on the assumption that having a basic understanding of the depth and complexity of the issues helps the facilitator work more effectively with the group. Utilizing a strength-based approach that seeks to empower women and increase their sense of self, the exercises are designed to give them a corrective experience of connecting with others in a safe environment. In using this model, the facilitator helps the women in the group to see the strengths they have and to increase the skills they need. The curriculum

also focuses on emotional development, and having clients deal with the expression and containment of feelings (fear, loss, grief, anger, shame) is a critical element. The program uses cognitive-behavioral techniques (CBT), expressive arts, and is based on the principles of relational therapy.

EVALUATION METHODOLOGY

Overview

SANDAG was responsible for conducting both a process and impact evaluation of this project. However, as noted earlier, KIVA staff had a significant role in this process. Not only were program staff responsible for all the data collection, they also were tasked with documenting how the program was implemented, including staff changes and any changes to the model. Because of their significant role collecting the data, SANDAG analysis was influenced by the data received. Specifically, a small number of clients were able to be located and tracked after leaving the program, which limited the outcome data available to measure rate of relapse, recidivism, or parental improvement. In addition, the data that were received should be viewed with caution as the attrition rate from intake to exit provided a small sample of convenience, comprised of those clients who were available to complete the forms, who agreed to do so, and who willingly participated in the program. Not represented are those women who left the program prior to completion and attended the groups but did not complete the assessment forms.

Mindful of these limitations, the evaluation did provide a profile of the women who entered KIVA, as well as preliminary information about the potential effectiveness associated with treatment models that are able to address both recovery and trauma issues of women. The results are positive and encourage further evaluation and research in this area.

Data Collection Strategies

In addition to reviewing program statistics provided by MITE staff and interviewing the Clinical Consultant, information from clients also was compiled at seven points in time, including 1) intake; 2) 45 days post-intake; 3) completion of *HWR*; 4) completion of *BT*; 5) Kiva program exit; 6) six-months post-exit; and 7) 12-months post-exit. A number of instruments were used to collect this information, including the San Diego County Alcohol and Drug Data System (SDCADDs), the Beck Depression Index (BDI), an AIDS/Hepatitis Assessment, the Addiction Severity Index for Females (ASI-F), the Trauma Symptom Checklist (TSC-40), the Rosenberg Self-Esteem Scale (SES), and a parenting questionnaire designed specifically for this study. Due to the resources available for focused data collection, the number of respondents providing feedback decreased over time, from 195 to 199 clients (of the 202 study clients who completed at least 45 days in the program) completing intake assessments, to 41 to 84 completing assessments at program exit. Six and 12-month follow-up interviews were limited to 29 and 11 clients, respectively. As such, the impact evaluation focuses on data compiled from clients that could have assessments matched at three points in time, (45 days, after completing *HWR*, and after completing *BT*)¹.

PROCESS EVALUATION OUTCOMES

How Many Clients were Served and What Types of Needs Did They Have?

Between August 2004 and October 2006, 283 women entered the Kiva program, with 202 completing the first 45 days and qualifying as study participants. Of these 202 clients, 157 exited Kiva (55% successfully, 36% with a

¹ Because the BDI is the only assessment that was administered at intake, change also was measured from intake to 45 days.

satisfactory² discharge, and 10% unsuccessfully), 108 had completed the *HWR* portion of the program, and 73 had completed *BT*. It should be noted that both *HWR* and *BT* were conducted in closed groups.

In terms of their characteristics and needs at intake, clients came from a variety of different backgrounds and were seeking treatment for a variety of reasons. However, they did share a number of similarities, including being economically vulnerable, having a history of abuse and few life resources to draw upon, and experiencing mental health issues, including depression and anxiety.

Demographics: The clients served as part of this project were ethnically diverse, with Whites composing approximately two-fifths of the group (41%), around one-third (31%) identifying as Hispanic/Latina, and 18 percent as Black/African-American. The average age of program clients was 30.1 years old (range 18 to 54) and the vast majority of clients had 12 years of education (44% had a high school degree or GED) or less (42%). When asked what their normal employment pattern was, most of the women reported full-time (38%) or part-time (23%) work, or not working at all (31%).

Current Living Situation: Most of the clients had never been married (68%) or currently were divorced or separated (21%). More than three-quarters (79%) reported having at least one child under the age of 18 and, of these 157 women, about half (52%) planned to bring their child(ren) with them to the program. In addition, 22 percent reported being pregnant at the time of intake. Around half (51%) of the clients reported not having

a permanent residence at time of intake. However, this number seems low when taking into account where clients reported living. Prior to intake, when asked specifically where they were residing, only 11 percent reported living in their own apartment, house, or a sober living center, more than half (59%) were staying with a friend or relative, 13 percent were transient (in a shelter, motel, or outdoors), 9 percent reported living in an “other” location, and 8 percent in an alcohol or drug program/treatment center or jail. These data indicate that approximately nine out of ten clients entering KIVA were living in fairly tenuous circumstances.

Prior Contact with the Criminal Justice System: Having a prior arrest is important to note when creating an exit plan for a client. A criminal history can restrict employment, housing, and public assistance, placing an additional burden on a client seeking to become self-sufficient. At time of intake, over half (55%) of the clients were on probation or parole and 90 percent had at least one prior arrest, with an average of 4.2 (*SD*=2.8). The most commonly self-reported prior charge type was for a drug-related offense (61%), followed closely by burglary or larceny (54%). Others reported previous arrests for weapons offenses (9%) and prostitution (8%).

History of Abuse: More than three in four clients (78%) reported experiencing some form of trauma in their lifetime, either by a stranger or someone they knew, with 61 percent experiencing one or more types of trauma³. Nearly two-thirds of clients had experienced emotional abuse (64%) or physical abuse (60%), 42 percent had been sexually abused, and 33 percent had

² To receive a satisfactory discharge, a client may have left the program before completing *all* of the graduation requirements, yet was able to complete treatment plan assignments, attend group, and participate during the time they were in program.

³ The level of trauma was measured by their self-report of being physically abused, which included threats and actual physical harm; sexually abused including rape or non-consensual sexual acts; emotionally abused including harsh words, humiliation, and manipulation; and being sexually harassed including stalking, coercive sexual contact, and inappropriate sexual contact.

experienced some form of sexual harassment. Nearly one-third (30%) of the clients reported being distressed by the physical abuse they had experienced, 23 percent were bothered by the sexual abuse that had occurred, and less than one in five was currently upset about a rape (15%) or a sexual harassment (13%) experience.

Mental Health Issues: When asked if they had experienced any mental health issues in the past 30 days or in their lifetime, the majority of clients reported dealing with what they considered a significant level of serious depression (42% at 30 days and 64% lifetime) and/or serious anxiety (42% at 30 days and 59% lifetime). Many also reported ever having a problem concentrating (49%), trouble controlling violent behavior (39%), and struggling with an eating disorder (16%). In addition, 31 percent reported experiencing *both* serious anxiety and serious depression in the past 30 days, as did 51 percent when asked about their lifetime experiences. As well, 41 percent had been prescribed medication for a psychological/emotional problem at some point in their lifetime. At intake, 20 percent of all study clients received a score on the BDI indicating they were currently dealing with a moderate to severe level of depression, and over one-third (36%) were experiencing a mild to moderate level of depression. Consistent with these scores is the finding that nearly one-third (32%) of the clients had thought about suicide in their lifetime and 28 percent had actually attempted it at one point in their life.

Substance Use History: All of the women in KIVA entered the program with the goal of addressing their alcohol and/or drug addiction. The majority of the women identified methamphetamine as their drug of choice (66%), with marijuana/hashish being the primary choice for 10 percent. The average age of first use for the primary substance problem was 18.1 years old (range 7 to 42 years old) and the women reported

having the problem for an average of 10.1 years (range <1 to 33 years). Sixty-five percent (65%) of the women also reported having a problem with a secondary substance. Of these clients, the most commonly reported substance was marijuana or hashish (45%). In addition, more than two-thirds (68%) of the women had received some form of treatment for their addiction in the past.

Risky Behavior: Clients also reported risky behavior associated with their drug use and sexual activity. In terms of their drug use, 15 percent of clients reported injecting drugs with a needle in the past six-months and, of those 30 women, 12 reported sharing their “works” with another person. In terms of risky sexual behavior, over one-third (36%) reported having sex in the 30 days prior to intake, with 73 percent of these clients reporting not having used a latex condom/barrier. The mean number of sex partners in the past 30 days was 1.5 (ranging from 1 to 6). These clients also were asked whether they had participated in a series of possible high-risk sexual activities (without using a latex condom/barrier) in the past 30 days. The most commonly reported sexual behavior was having sex while they, or their partner, were “high” on drugs or alcohol (67%), followed closely by having sex with someone who sometimes uses methamphetamine (63%). Forty-two percent (42%) of the women had sex with someone who was not her spouse or primary partner, with 14 percent having had sex with someone who injected drugs, and 12 percent for trade.

Reason for Seeking Treatment: Almost half of the clients reported being mandated to treatment, with 34 percent referred by the court/criminal justice system and 13 percent referred by the Department of Social Services, specifically Child Welfare Services (CWS). Forty-seven percent (47%) were described as self-referrals, and the other six percent were referred by other sources, including another alcohol or drug treatment program, an

employer/union, parole, or a health care provider.

How was *BT* Implemented as Part of the Kiva Curriculum?

To address this research question, an interview was conducted with the Clinical Consultant (Consultant), a Licensed Clinical Social Worker, who helped create the *BT* curriculum and was responsible for training, monitoring, and guiding the implementation of both *HWR* and *BT*. Interview questions focused on how the program was implemented, what quality assurance methods were used to ensure the model was implemented as designed, what level and type of staff training occurred, what the strength of the program was, and whether there were any areas that could have been improved. The interview was conducted on August 24, 2005, due to the Consultant's pending departure from the program.

Training: All of the line staff and the program director were trained on the model. As part of this training, staff members went through the *BT* curriculum themselves and then were instructed on how to facilitate the groups. This experiential approach was intended to provide sensitivity and awareness regarding what the clients would be experiencing during the groups. The Consultant felt the training was "very effective" in preparing the staff to implement the model. After this intensive training, ongoing quality assurance measures supported initial learning and provided additional guidance. However, in retrospect, the Consultant felt it might have been helpful to include management staff in this training as well, in order to provide them with a fuller understanding of how the model was being operationalized and possibly strengthen the cohesion of the program.

Staff Competencies: According to the Consultant, the staff was "very competent" in

adhering to the model and understood the connection between trauma and substance abuse. At first, creating this connection was a challenge; however, the training provided both educational material and experiences, which produced a paradigm shift in how staff felt about the role of trauma in a woman's recovery. Related to this was the staff's ability to create a safe environment in the groups, which was confirmed by clients who completed the satisfaction surveys.

Implementation and Model Fidelity:

According to the Consultant, the model was implemented as designed, with "complete" adherence to its original design. To maintain this fidelity, consistent and informed oversight of staff by the Consultant was essential. Staff were observed a few times in the beginning of the program and then weekly group and individual meetings were held with staff and the Consultant. The Consultant also monitored the participants' process to ensure that their needs were being addressed by the group facilitator. The Consultant also felt that the staff was "very competent" in being able to adhere to the model when facilitating the groups and that, although it was too soon to make any changes to the model, it was worth noting that some of the women had requested that the groups be a little longer to allow more time to process their feelings.

What was the Level of Clients' Satisfaction with the Services Received?

Overall Experience: Out of the 54 clients who completed an exit satisfaction questionnaire, 92 percent rated their experience at KIVA as being either "very positive" or "positive," and all of the clients said they would definitely (94%) or probably (6%) recommend KIVA to other women they know who have similar issues. Each of the women shared reasons why they felt positive about their experience. Clients listed the opportunity to grow and become familiar

with one's self (41%), support/unity (36%), the structure and tools learned (16%), and being reunified with their children (7%) as having contributed to their experience in the program. When clients were asked to share anything else about their experience at KIVA, all had something positive to say about the program. One client noted, "It was an experience that I wouldn't trade for the world."

Engagement and Relationships: A vital component in providing effective treatment for trauma is the ability to create a safe environment for the women, as well as forming nurturing relationships. The response from the clients who completed the CSQ indicates that the program was able to create a comfortable space in group where the client felt heard. Nine out of ten clients who responded said that, while in group, they felt "very much" or "for the most part" safe (98%), that they were being heard (93%), they were able to speak up in a group setting (93%), and what was said in the group stayed in the group (89%). Clients also gave program staff high ("very much" or "for the most part") ratings on a number of characteristics, describing them knowledgeable (100%), trustworthy (98%), supportive (98%), available (96%), and easy to talk to (94%).

Most and Least Helpful Program Aspects: Clients were asked to note the top three aspects of the *HWR* and *BT* programs that they found most and least useful. Forty-six percent (46%) felt that learning ways to heal in the *HWR* program helped them out the *most* and 20 percent felt that homework assignments did not. Around two in five (44%) clients found that having a place to talk about their experiences was the *most* useful, and one in four (28%) reported that homework assignments were the *least* useful component of the *BT* program. However, more of the women felt that there was nothing wrong with the *BT* and *HWR*

program and did not identify anything as *least* useful (44% each).

Self-Reported Improvements: Clients overwhelmingly felt better about their emotional and physical health and their parenting abilities after participation in the program. A little over three-fourths (78%) of the women surveyed said the parenting classes helped them feel better as a mother and 18 percent felt it helped them "somewhat." Ninety-one percent (91%) also stated that their emotional health had improved and 72 percent felt their physical health had improved since they started the program. When clients were asked to share anything else about their experience at KIVA, all had something positive to say about the program. Some examples of the women's comments include:

- "It was the most positive experience I've ever had in my life. I'll take home everything I've learned and apply it to my everyday life. I've learned something from each counselor in the program. I am so grateful for starting my recovery journey at KIVA."
- "I went through the hardest times in my life here. KIVA kept me safe. I can't imagine what my life would have turned out like without it."
- "I've learned a lot about myself and others. I feel more confident, stronger, and more open to life."
- "This program helped me get my child back and has helped me grow as a woman and mother. It has helped me believe in myself. "
- "KIVA is what you make it. The staff works very hard for the clients and I'm grateful for all their knowledge and heart."

IMPACT EVALUATION OUTCOMES

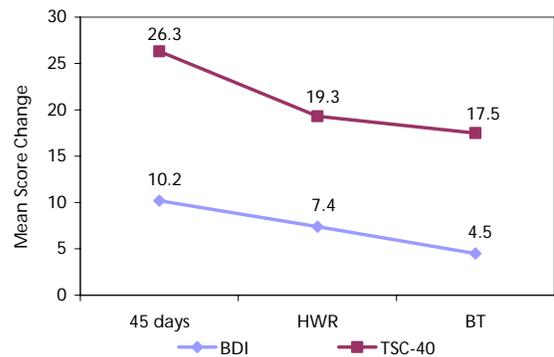
Were Positive Changes Realized After Successfully Completing the Program?

Overall, after participation in the *HWR* and *BT* components of KIVA, clients showed significant improvement in their level of trauma and depression. In addition, successful KIVA clients were more likely to report positive changes in other areas of their lives related to substance use, employment, and housing status. While sample size, sampling issues, and the lack of a comparison group limit the generalizability of these findings, they are promising and support the need for further evaluations of this model in other settings.

Trauma: The TSC-40 is a research tool that measures symptomatology in adults that are associated with childhood or adult traumatic experiences. The highest total score possible for the TSC-40 is 120, with a lower score indicating change in the positive direction. Of 41 women who completed all three assessment periods, the average score of the TSC-40 decreased significantly from 26.3 ($SD=20.4$) at 45 days to 19.3 ($SD=19.2$) after completion of *HWR* ($t(40)=2.908$) and continued to decrease to a mean of 17.5 ($SD=21.0$) after completing *BT* (Figure 1). Examination of the six subscales (dissociation, anxiety, depression, sexual abuse trauma, sleep disturbances, and sexual problems) at the three points in time indicates that the combination of completing *HWR* and *BT* produces a stronger effect than if the client only attended *HWR*⁴. Two subscale scores, “depression” (6.1 ($SD=4.6$) at 45 days) and (4.3 ($SD=4.7$) after *HWR*) ($t(40)=2.806$) and “sleep disturbances” (6.3 ($SD=5.4$) at 45 days) (4.3 ($SD=4.7$) at *HWR*) ($t(40)=3.057$), showed significant improvement after completion of *HWR*.

⁴ Because none of the study clients only received *BT* services, analysis cannot determine if receiving *BT* treatment alone has created any significant effects.

Figure 1
CLIENT IMPROVEMENT RELATED TO TRAUMA AND DEPRESSION OVER TIME



Depression: At program intake, the mean BDI score for the 186 study clients was 13.8 ($SD=9.3$), which falls within the range categorized as mild depression. This score decreased significantly at 45 days to 10.4 ($SD=8.7$) ($t(185)=5.711$), suggesting that securing some stability and routine within the treatment setting helped alleviate a client’s depressive symptoms. In addition, scores for those clients who completed an assessment at 45 days, at completion of *HWR*, and at the end of *BT* showed significant decreases at completion of each treatment component. Specifically, there was a decrease in the mean score from 45 days (10.2 ($SD=9.4$)) to the end of *HWR* (7.4 ($SD=8.2$)) ($t(43)=2.380$), with the score continuing to improve after participating in *BT* (4.5 ($SD=6.4$)) ($t(22) = 4.246$) (Figure 1).

Parenting: Upon exiting the program, nearly all (98%) of the women who successfully completed the program and who had some involvement in CWS reported that they were in compliance with their reunification plan. At the six-month follow-up interview, all of the clients interviewed who were working on reunification reported that they were in compliance.

Criminal Activity and Current Drug Use:

Almost all (99%) of KIVA clients who successfully completed the program reported remaining conviction- and drug- and alcohol-free during the program. This was similar to the 29 who completed a six-month follow-up, of which 97 percent reported not having a new conviction and 72 percent reported not using any alcohol or drugs since exiting the program.

Living Situation: At program entry, clients were encouraged to participate in community programs that would assist them in their recovery and were referred to outside services for general relief, food stamps, CALWORKS, vocational assistance (i.e., STRIVE), and stable living arrangements such as sober living. As a result, a greater percentage of clients were documented as receiving public assistance (general relief, CALWORKS, or food stamps), increasing from 7 percent at intake to 49 percent at exit. Additionally, nearly two-thirds (62%) of participants who came into the program unemployed left the program either employed, in school, or in employment preparation. For those clients who were available for follow-up, 83 percent reported being employed, in school, or in employment preparation. In addition, more clients reported living in a stable home environment at exit, with 60 percent of the clients owning or renting their residence, compared to 8 percent at intake. Thirty-nine percent (39%) reported living with a friend or relative. Only one percent indicated residing in jail or in a drug treatment facility, and none were considered to be transient (e.g., car, street, park, or motel).

SUMMARY

The current evaluation of the incorporation of trauma-informed services into a residential drug treatment program for female clients offers promising results. While the research design was limited in scope due to available resources, the results suggest substance abuse treatment programs that target women should consider integrating a curriculum that is able to address the trauma-related symptoms that many women in recovery must overcome. Although not within the scope of this project, a more rigorous research design would contribute significantly to understanding the impact *HWR* and *BT* have in a woman's recovery.