

Mental Health, Substance Abuse and Domestic Violence ...Connecting the Dots

Final Impact and Outcome Evaluation of the
California Department of Public Health
Domestic Violence Unserved/Underserved
Mental Health and Substance Abuse Technical
assistance and training Project

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For



6/30/2009

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EXECUTIVE SUMMARY

BACKGROUND

ONTRACK Program Resources, Inc., a nonprofit organization that contracted with the California Department of Public Health (CDPH), Maternal Child Adolescent Health, Office of Family Planning, Domestic Violence Program, embarked on a three-year project to help California's domestic violence (DV) shelter agencies better serve women experiencing mental health and/or substance abuse (MH/SA) issues. The contract provided for a needs assessment and two follow-up reassessments, 16 regional trainings and at least 2 tailored individual or group technical assistance sessions to each of the 94 DPH-funded DV shelter agencies.

Agency assessments were conducted in 2006 (baseline), in 2008 (midterm), and 2009 (final). The purpose of the follow-up assessments was to assess the impact of the technical assistance and training (TAT) project on DV agencies' capacity to increase access and more effectively serve women with MH/SA issues.

FINDINGS

This report presents findings from the reassessment surveys to which 100% of the agencies responded at each of the three assessment intervals. In order to present the information in a digestible manner, the findings and highlights are grouped by objective.

Objective 1: To deliver high quality technical assistance and training (TAT) to 94 domestic violence shelters on topics to increase knowledge and understanding around mental health (MH) and substance abuse (SA) issues

TAT Delivery:

- 460 Sessions of Technical Assistance were delivered to 94 agencies (mean = 4.89 sessions)
- 1561 Hours of Technical Assistance were delivered to 94 agencies (mean=16.61 hours)
- Average participant satisfaction for all trainings was 4.83 out of a possible 5.00 (n=2430)

Increased Knowledge:

- **94.5%** of participating agencies indicate that their staff knowledge of mental health has increased
- **91.4%** of participating agencies indicate that their staff knowledge of substance abuse has increased

Increased Confidence and Ability:

- **92.5%** report that staff *confidence* to work effectively with MH/SA clients has improved
- **87.1%** agencies feel that staff *ability* to work effectively with MH/SA clients has improved as a result of the TAT

What's Next:

- **94.7%** of agencies plan to continue to increase staff training on how to work with clients with mental health and or substance abuse issues

Objective 2: To support domestic violence shelters in increasing outreach and access to clients with MH/SA issues

Policy Changes:

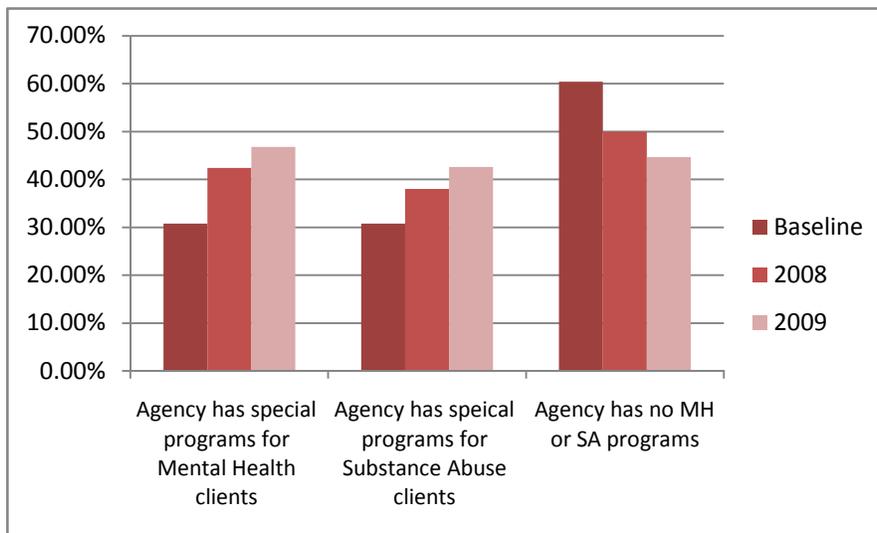
- **68.1%** have made changes to Policy and Procedures as a result of the TAT
- **60.6%** of agencies have loosened their rules or reduced their threshold pertaining to substance abuse
- Among those, **53.7%** believe they are serving more women with substance abuse issues as a result
- **53.2%** of agencies have loosened their rules or reduced their threshold pertaining to mental health
- Among those, **73.2%** believe they are serving more women with MH issues as a result

What's Next:

- **21.3%** of agencies have future plans to reduce the threshold or loosen rules regarding clients with substance abuse issues
- **46.9%** plan to make other policy changes in the future to increase access to MH/SA clients

Objective 3: To help domestic violence shelters develop more effective approaches to working with clients with MH/SA issues

Special Staff, Programming and Services for Populations



Before TAT began, approximately 30% of agencies reported having special programs for clients presenting mental health issues, and a similar number reported having special programs for clients with substance abuse issues. Now approximately **47%** report having special mental health programs, and nearly **43%** have special substance abuse programs.

In spite of a statewide budgetary crisis, since the technical assistance and training project began, more agencies have changed staffing so that they now have specialized personnel to meet the needs of clients with mental health and/or substance issues.

Agencies with specialized MH and/or SA staff	Baseline	2008	2009
For Mental Health clients	20.5%	41.9%	37.3%
For Substance Abuse clients	17.9%	30.1%	34.1%
For neither	61.5%	52.7%	50.0%

MH/SA treatment in case planning

- **81.9%** of agencies now use mental health information collected at intake to create appropriate accommodation while clients are in the shelter
- **76.6%** of agencies now use substance use information collected at intake to create appropriate accommodation while clients are in the shelter
- **76.6%** of agencies now incorporate MH/SA treatment into case planning

Use of Evidence-Based Trauma-Informed Curricula

At baseline, **64.5%** of agency executive directors had no *knowledge* of any trauma-informed curriculum. Now:

- **62.8%** are actually using at least one trauma-informed curriculum in their shelter
- **18.1% of agencies plan to increase gender-specific or trauma-informed substance abuse programs**

Objective 4: To help domestic violence shelters improve linkages with community agencies

- The number of agencies with any formal relationship with a provider of substance abuse services leapt from **49** at baseline to **63** at the project's end.
- The number of agencies with any formal relationship with a provider of mental health services went up from **61** at baseline to **69** at the project's end.

Agencies reported experiencing several problems when referring clients to MH/SA service providers. Below are the five most frequently identified problems:

- 84.0% indicated that a basic lack of psychiatric services presents a common barrier
- 76.6% indicated that clients sometimes do not follow through on referrals
- 75.5% indicated that clients are often denied services because they are ineligible
- 69.1% indicated that waiting lists for substance abuse programs present a barrier
- 62.8% indicated that inadequate funding for psychiatric medications is a barrier

CONCLUSION

The evaluation shows that the MH/SA TAT project made a significant difference in DV agencies' ability to screen in and more effectively serve clients with mental health and substance use issues. External factors, such as a lack of slots in mental health programs and decreased funding, continue to present barriers to referring clients out for specialized services, but a very large majority of agencies identify multiple ways that the project has increased DV agency staff awareness of and responsiveness to the needs of MH/SA clients.

INTRODUCTION

In 2006 the California Department of Public Health (CDPH), Maternal Child Adolescent Health, Office of Family Planning contracted with ONTRACK Program Resources, Inc., to help increase access and quality of service to women experiencing mental health and/or substance abuse (MH/SA) issues at 94 CDPH-funded domestic violence (DV) shelter agencies. In fulfillment of this contract, ONTRACK conducted an initial needs assessment, a thorough review of existing research, 16 regional trainings, and a minimum of 2 tailored individual or group technical assistance sessions per DV shelter agency. ONTRACK employed independent evaluators to conduct and analyze second and third year reassessments to measure the impact the Technical Assistance and Training (TAT) project had on the practices and approaches at participating DV agencies. The following report is the final evaluation of the three-year \$1.1 million project. Analysis is provided at state-wide and regional levels, with individual agency-level analysis included as an appendix.

BACKGROUND AND PROJECT DESIGN

The Unserved/Underserved Domestic Violence Mental Health/Substance Abuse Technical assistance and training Project emerged from legislation aimed at increasing access to DV shelters for unserved/underserved populations. In 2005, the CDPH Domestic Violence Program/Office of Family Planning Branch undertook a survey of 94 agencies to identify service needs for hard-to-serve populations.¹ In priority order, the Department identified the following high-need populations: 1) mentally ill and substance abusers; 2) disabled and developmentally delayed; and 3) LGBT community.

Recommended efforts to increase access to these unserved/underserved communities included technical assistance, training, consultation and other strategies to better serve the populations. In the survey agencies identified their three top technical assistance needs as 1) information and education materials on the best practices for effective service delivery, 2) technical assistance/consultation, and 3) training.

In response to the identified needs around MH/SA, ONTRACK designed a project of technical assistance and training, drawing largely from the following three information sources:

- 1) The aforementioned 2005 CDPH study that identified MH/SA clients as unserved/underserved,
- 2) The extensive 94 on-site agency assessments conducted by ONTRACK in 2006-2007, and
- 3) The growing body of research on co-occurring disorders and trauma-informed approaches (discussed below).

The prioritized technical assistance topics, developed through the needs assessment process, included:

- Integrated trauma-informed services and treatment;
- Mental health signs and symptoms for depression, PTSD, bi-polar disorder;

¹ CA Dept. of Health Services, MCAH/OFP/DV Programs, "Targeted Activities for Special Populations Served by Domestic Violence Shelters," April 22, 2005. Response rate 77%.

- Substance abuse signs and symptoms for methamphetamine, cocaine, heroin, alcohol, marijuana, or prescription drug misuse;
- The intersection of mental health and substance abuse issues or co-occurring disorders;
- Development of model policies and procedures for screening, admitting, tracking and review of current policies;
- Motivational interviewing for hotline and intake workers;
- Organizational development related to MH/SA expansion including capacity-building, grant writing, and resource development;
- Local resource mapping, to help them identify nearby MH/SA agencies and resources;² and
- Cross-trainings, where personnel from local MH/SA providers would convene with DV shelter staff to share information and perspectives.³

Regional trainings lasted from May 2007 to April 2008 and, in a 3.5 hour segment, covered basic information on the connection between domestic violence and mental health/substance abuse issues. Starting in July 2007, customized technical assistance was also provided via on-site single agency or group trainings, over-the-phone consultation, expert tele-seminars, and through the provision of research and materials.

LITERATURE REVIEW

Over the past 20 years, numerous studies have shown high rates of the co-occurrence of mental health and substance abuse issues; for example, in the National Co-Morbidity Survey, 59% of persons with a lifetime history of illicit drug abuse or dependence had a lifetime mental disorder (Kessler, 2003). Over the last decade, there has been increased attention to the co-occurrence of mental health, substance abuse and trauma, which most commonly occurs as child abuse, child sexual abuse, adult sexual assault, and/or domestic violence. In a review of rates from numerous studies, 48-90% of women with co-occurring disorders also have histories of interpersonal violence (Becker, et al., 2004). Further evidence from California shows how these issues are intertwined. In a 2002 study of women who received CalWorks benefits, 33-45% had a persistent co-occurring mental health/substance abuse issue. Of those, 28-34% also reported serious domestic violence. Of those women with domestic violence, mental health and substance abuse issues, one-third also reported having learning disabilities.

Most significant to the development of the field of trauma-specific and trauma-informed services for co-occurring disorders was the 1998-2004 SAMHSA-funded 9-site evaluative study titled "Women with Co-Occurring Disorders and Violence Study." This study evaluated sites on client outcomes as well as process and found that combining a trauma-specific curriculum with a trauma-informed program design saw significantly improved outcomes, compared with treatment as usual (WCDVS, 2003).

² The local resource maps/inventories proved difficult to organize and did not take place, but the project emphasized that each agency should task at least one person with updating local resources, which 76.3% of agencies said they have.

³ The TAT project was limited by the CDPH contract scope and was therefore able to organize only one cross-training in San Diego County, attended by close to 100 people, which brought into being the San Diego Integrated Services Guide Team, currently developing integrated trauma-informed services in San Diego County.

After evaluating and researching one of the nine sites, Newmann and Sallmann (2004) made numerous recommendations for policy change in this area:

1. Service providers need to be appropriately trained to explore women's abuse histories as well as their co-occurring mental health and substance abuse problems.
2. Current safety concerns are more immediate and should be dealt with first – domestic violence, housing, food, child care and reunification with children.
3. To be broadly effective in women's lives, providers should have familiarity and facility moving across issues and systems of care and services. Services need to be better integrated at the individual level.
4. An appreciation of the diversity that women present must be central to efforts to improve services – race, age, sexual orientation, work circumstances, parental and marital status.
5. Research is also suggesting that trauma must be expanded beyond histories of physical and sexual abuse to include other events and conditions and experiences that may equally trouble women.

While the mental health and substance abuse fields have been grappling with trauma, the domestic violence field has equally been struggling with issues related to mental health and/or substance abuse. While most DV service providers recognize that MH/SA issues affect women's safety, they generally feel unprepared to deal with these issues. For example, in a survey of domestic violence programs (Collins & Spencer, 1999), DV program directors gave the following as reasons for not providing complementary substance abuse services to their victim clients:

- Limited financial resources (76%)
- Limited staff resources (72%)
- Not part of agency/program mission (66%)
- Lack of experience in substance abuse (60%)
- View that complementary services are better provided independent of program (54%)

Despite these reasons for not building in complementary services, there are several states and individual DV programs that have been integrating substance abuse and mental health issues into the DV service provision, including Massachusetts, Washington, and Alaska. The innovative techniques developed include Patti Bland's "Real Tools You Can Use" and a series of Washington state articles written by shelter staff on how to increase access by reducing rules and moving away from punitive approaches (Bland, 2008).

EVALUATION METHODOLOGY

The final evaluation of the MH/SA TAT project was based primarily on the online reassessment surveys completed by all 94 DV agencies at the two aforementioned data collection points, as well as the original 2006-2007 needs assessment. Data are also drawn from ONTRACK's technical assistance tracking records, TAT participant evaluation forms, completed TAT follow-up forms, and, to a lesser degree, Measurable Performance Outcome Indicators.

AGENCY ASSESSMENT AND REASSESSMENT INSTRUMENTS

The project began with an initial assessment of all 94 agencies. The assessment was conducted to help inform the design of the Technical Assistance and Training (TAT) project and to provide some baseline data from which progress could be measured. Follow-up assessments were conducted at the conclusion of year 2, after the TAT had begun, and at the conclusion of year 3, when the project was closing.

The questions for the reassessment surveys were based on the goals and outcomes of the MH/SA TAT Project, including delivering TAT to increase staff understanding and competence around MH/SA issues, increasing access, increasing the quality of MH/SA programming in the shelters, and helping agencies expand their resources and capacity to serve clients with MH/SA needs.

Reassessments were designed recognizing that as their understanding of mental health, substance abuse and trauma increased, shelter administrators might think differently about their original responses – many questions in the follow-up assessments, therefore, asked respondents to reflect on progress rather than to only answer the same questions again.

The questionnaire was administered online and included both open-ended and forced-choice items. All 94 agencies responded to both follow-up reassessment questionnaires, resulting in a 100% response rate. Strategies undertaken to assure this successful administration included identifying the best responder for each agency prior to launching the online questionnaire, allowing agencies with less online access or comfort to send in paper copies, and email and telephone follow-up with the agencies. A good working relationship between ONTRACK and participating DV agencies also increased agency participation.

TAT PARTICIPANT EVALUATIONS

At the conclusion of every technical assistance and training session, all participants were handed a paper evaluation form to rate the session on a number of criteria, including: usefulness of the materials provided, relevance of the training, if practical examples were provided, if suggestions for applying the materials were provided, if the participant would recommend the training, and how competent the trainer appeared to be in his or her field. Completed questionnaires were entered into an excel spreadsheet by ONTRACK personnel, and analyzed by the outside evaluators in SPSS.

TAT FOLLOW-UP EVALUATIONS

ONTRACK Program Resources pursues a 30-day follow-up information from training participants for all of its TAT projects, including this effort. The standard form includes both open and closed-ended questions about the utility of the training, how it has affected service provision, and quality of trainer items. The initial approach for survey administration in the first year of TAT provision (Year 2 of this project) was to send agencies a follow-up form and request that it be completed and returned. This resulted in very few returned surveys. In the third year of this project the survey was distributed online through SurveyMonkey and resulted in 71 completed forms. It should be noted that these do not necessarily reflect 71 different agencies as some agencies received multiple technical assistance sessions and provided separate responses.

MPOI

Measurable Performance Outcome Indicators (MPOI) are one component of a comprehensive Continuous Quality Improvement (CQI) process associated with the Tri-Project efforts to increase access and high quality services for un-served and underserved (U/U) DV subpopulations (MH/SA, LGBTQ, and People with Disabilities). CQI was conceived as a process to allow agencies to engage in ongoing self-evaluation of their efforts to increase access to the three unserved/underserved populations. The MPOI indicators reflect areas where the California Department of Public Health anticipated seeing increases in access and included the following: number of clients served, referrals made for clients, referrals for crisis calls, new partnerships with community organizations providing specialized services for the U/U populations, and agency modifications to increase access. Agencies were permitted to select which MPOI(s) to report and requested to provide that data for two time periods: January to June, 2008 and July-December 2008. A full joint discussion of MPOI results for all three U/U populations is presented in a separate MPOI Year 3 report. MPOI results relevant to discussion of findings are presented here as well.

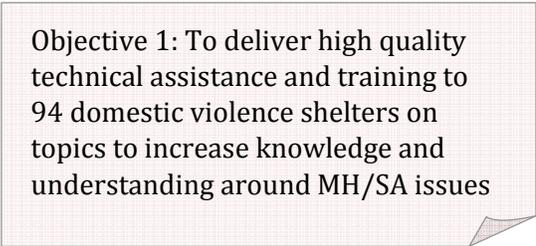
ANALYSIS

The reassessment data were imported from the Survey Monkey-generated Excel spreadsheet into Statistical Package for the Social Sciences (SPSS) for analysis. Survey records were linked with corresponding agency technical assistance data and saved in a single data file. For cross-tabulations and comparisons of means, tests of statistical significance were carried out – unless noted with an asterisk and a p value, differences between sub-groups can be assumed to be not significant. Qualitative data were delivered in the form of comments on open-ended questions on the reassessment, open-ended questions on participant evaluations administered at technical assistance and training sessions, and the follow-up questionnaire administered some weeks after a session took place. Examples of participant commentary are included where they add to the analysis or help explain a quantitative finding. Aside from participation records, all data used in this analysis are self-report, generally collected from shelter directors or shelter mid-management.

STATEWIDE FINDINGS

DELIVERY OF HIGH QUALITY TECHNICAL ASSISTANCE AND TRAINING

The first objective of the project was to deliver high quality technical assistance and training sessions to all 94 agencies in order to increase knowledge and understanding around mental health and substance abuse issues. The records show that every agency was indeed offered technical assistance and training, that participants found the quality of the trainings to be high, and that by attending these trainings, shelter staff and administrators increased their knowledge around the issues as well as their confidence and ability to work with clients presenting either or both mental health and substance abuse histories.



Objective 1: To deliver high quality technical assistance and training to 94 domestic violence shelters on topics to increase knowledge and understanding around MH/SA issues

AMOUNT AND QUALITY OF TAT DELIVERED

The participant records show that 460 TAT sessions were delivered, for a total of 1561.5 hours of TAT among all 94 agencies. Agencies participated in an average of 4.89 sessions or 16.61 hours over the two years that TAT was offered. The minimum number of TAT sessions an agency took advantage of was 2, or 2 hours, and the maximum was 19 sessions or 70 hours.

The TAT topic attended by the highest number of agencies was Motivational Interviewing. The next most attended TAT topic was Trauma-Informed Services. All trainings received high participant ratings on the participant evaluation, and the TAT follow-up survey found that 66% agencies thought the TAT was “very timely” and 76% thought it was “very responsive” to their needs. On participant evaluations, trainees were asked to rate each session on a five point scale on the following six criteria; the overall average is listed in parentheses after each criteria:

- The usefulness of materials (4.86)
- The relevance of the training (4.85)
- Whether the trainer provided practical examples (4.77)
- Whether the trainer provided suggestions for applying the materials (4.69)
- If the training was worth recommending to a colleague (4.85)
- How competent the trainer appeared to be in his or her field (4.95)

The scores on all of these questions were combined into a composite mean, with a possible high score of 5, which would indicate no room for improvement on any of the criteria.

Topic	Hours Delivered	Mean Participant Rating
Motivational Interviewing	480.0	4.86 (514)
Trauma-Informed Services	442.0	4.84 (929)
Mental Health/Substance Abuse	235.0	4.81 (470)
Effective Policies & Procedures	130.0	4.88 (166)
Substance Abuse Issues	122.5	4.88 (178)
Cultural Competency	105.0	4.84 (111)
Cross-Training	20.0	n/a ⁴
Organizational Development	16.5	4.43 (32)
Mental Health Issues	10.5	4.49 (30)
TOTAL	1561.5	4.83 (2430)

Over the two years of TAT, there were 2430 participants who completed evaluation forms – these participants gave the project an overall rating of 4.83. The highest rated training topics were Effective Policies and Procedures and Substance Abuse Issues, followed closely by Motivational Interviewing, Trauma Informed Services, and Cultural Competency.

Type	Mean	N
In-Person	4.84*	2309
Tele-TA	4.63*	121
Total	4.83	2430

*p<.05

⁴ Cross-training was offered only once, for which there were 40 completed participant questionnaires. These questionnaires were constructed somewhat differently so there is no composite mean provided for this TAT category. Briefly, a very small percentage of participants found the training did not meet their expectations, while over 92% found it met or exceeded their expectations. The vast majority (82.5%) found the training met (did not exceed) expectations.

Participant ratings were significantly higher for in-person TAT than for TAT offered by telephone. Many agencies chose telephone-based trainings due to staffing and coverage issues, but these results show that, while more convenient, telephone-delivered TAT is less satisfying to participants. It should be noted that the CDPH contract was designed to have as much as 75% of TAT delivered via phone, but, in response to early analysis of participant feedback and agency preference, only 41% of the MH/SA custom TAT was conducted over the phone.

Below are some comments that illustrate why the telephone-delivered TAT might have gotten lower scores:

- “Would be better in person”
- “Conference call trainings are difficult to follow.”
- “It's difficult to receive a training over the phone due to long pauses...presentation felt slow at points.”
- “Would have been better in person if it was possible but still very good.”
- “...It's hard to give advice on this via the phone.”

Follow-up technical assistance surveys also point to the efficacy of the trainings. The overwhelming majority of respondents (92%) indicated that they had made use of the TAT consultant's information and assistance. When asked to specify, agencies offered many examples of how they have reviewed and rewritten shelter rules, adopted a trauma-informed approach, and taken a different approach to screening and treatment planning. Agencies also referred to specific handouts, tools or approaches they had incorporated.

- “We are rethinking our intake packets, we have been screening more women into the shelter and the staff feel more confident as a result.”
- “We have changed our hot-line interview, our process of questioning, our motivation for obtaining answers and our policy and procedures for acceptance to the shelter.”
- “In spending more time with the person if there are substance abuse issues to develop a relapse prevention plan that works for the person.”

Further evidence of the level of participant satisfaction with the TAT is the overwhelming desire among agencies to continue and build upon what they have learned. The reassessment found that 94.7% of agencies plan to continue to increase staff training on how to work with clients with mental health and or substance abuse issues.

INCREASED KNOWLEDGE

In terms of substance abuse, baseline measures showed 9.1% of agencies felt their staff was not at all or not very knowledgeable about substance abuse issues, 59.1% felt staff was somewhat knowledgeable, and 31.8% felt staff was knowledgeable or very knowledgeable. As the TAT project was likely to increase awareness of baseline deficiencies, the follow-up assessment questions were not presented in the same format but with retrospective construction, asking respondents to reflect upon how much staff had learned as a result of the trainings and technical assistance.

Knowledge Increases Since TAT Began	2008	2009	Overall, just under 11% estimated in 2008 that the TAT had had little to no effect on staff knowledge of substance abuse issues. In 2009 that was reduced to just under 9%. Now over 91% indicate that their staff knowledge of substance abuse has increased, up from 89% in 2008.
Knowledge of substance abuse increased not at all/very little	10.8%	8.7%	
Knowledge of substance abuse increased somewhat/a great deal	89.2%	91.4%	
Knowledge of mental health increased not at all/very little	10.8%	5.4%	
Knowledge of mental health increased somewhat/a great deal	89.2%	94.5%	

issues. In 2009 that was reduced to just under 9%. Now over 91% indicate that their staff knowledge of substance abuse has increased, up from 89% in 2008.

On knowledge of mental health issues, baseline measures showed 15.7% of agencies felt their staff was not at all or not very knowledgeable about MH issues, 49.4% felt staff was somewhat knowledgeable, and 34.8% felt staff was knowledgeable or very knowledgeable.

Overall, 11% estimated in 2008 that the TAT had had little to no effect on staff knowledge of MH issues. In 2009 that was reduced to just over 5%. Now 94.5% indicate that their staff knowledge of MH has increased, up from 89% in 2008.

The perceived increase in staff knowledge of substance abuse between 2008 and 2009 is less marked the increase in knowledge around mental health, but baseline figures demonstrate that staff were perceived as more knowledgeable around substance abuse to begin with. In terms of specific mental health conditions, clinical directors and other shelter management identified the four most common conditions as Depression, Post-Traumatic Stress Disorder (PTSD), Anxiety, and Bipolar Disorder. TAT was designed accordingly, and the 2009 reassessment data show a very high percentage of agencies indicating that staff knowledge around these specific mental health conditions has increased.

Top Mental Health Issues among DV clients	% of Clinical Directors identifying this MH issue at Baseline	% of agencies indicating that staff knowledge around this MH condition has increased as a result of TAT
Depression	84%	79.8%
PTSD	73%	81.9%
Anxiety	67%	74.5%
Bipolar	25%	67.0%

The increased knowledge afforded by the TAT appears to have translated into increased confidence and ability in working with clients who present mental health and substance abuse issues. In 2008, 83% of agencies reported that as a result of the TAT staff confidence in working with MHSA clients had improved – now 92.5% report improved confidence, with more than a third reporting that staff confidence has increased a great deal. Furthermore, 87.1% agencies feel that staff *ability* to work effectively with MH/SA clients has improved as a result of the TAT.

CONCLUSIONS:

The evaluation shows that the project met this objective. TAT was provided to all 94 agencies, with some taking clear advantage of the opportunity by participating in a large number of sessions.

Participant evaluations reveal that TAT was received very well – trainer competency was reviewed as nearly perfect. In addition to being satisfying to participants, the evaluation of the TAT increased staff ability and confidence, and imparted knowledge in a way that was responsive to the needs identified in the initial assessment. There still exists a desire for continued trainings in the same vein, with nearly all agencies (94.7%) expressing an intention to continue staff training in these areas. The only suggestion that emerges from these data is that future trainings should include more concrete suggestions for applying the materials.

INCREASING OUTREACH AND ACCESS

A primary objective of the project was to help make changes in attitudes and practices that would result in increases in outreach and access for clients with mental health and/or substance abuse issues. The reassessment finds that the technical assistance and training resulted in a majority of agencies making policy changes, including reductions of threshold at intake and more flexibility in terms of rule-making and

Objective 2: To support domestic violence shelters in increasing outreach and access to clients with MH/SA issues

enforcement. Many agencies have increased outreach efforts, many are serving more women with MH/SA issues, and many that have not seen an increase in numbers have seen an increase in the quality of services (Objective 3). It should be noted that all changes agencies made to policies, procedures, intake, and hotline procedures were voluntary – the contractor and its trainers only provided information on effective practices – they had no enforcement authority.

POLICY CHANGES

At the time of the 2008 reassessment, 41.4% of agencies had made voluntary changes to their policies and procedures. By the end of the TAT project 68.1% had made policy changes in response to the MH/SA focused technical assistance and training. Among those agencies that made changes because of the TAT:

- 43.6% felt the changes had resulted in improved client outcomes
- 39.4% felt the changes had resulted in improved shelter functioning
- 24.5% felt the changes had resulted in improved staff morale

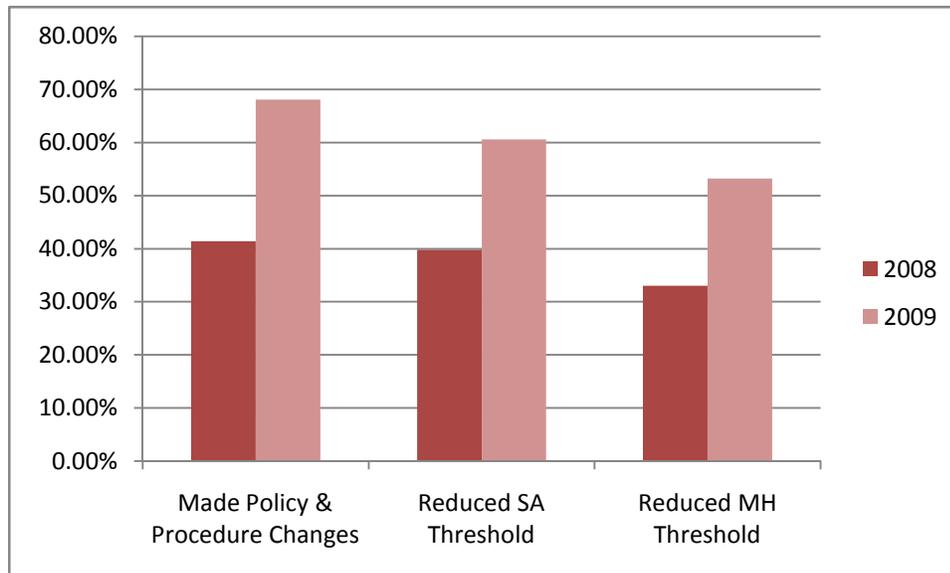
Substance Abuse

In terms of substance abuse, over the course of the project, 60.6% of agencies reported loosening their rules or reducing their threshold pertaining to substance abuse, in other words they have shortened or eliminated the time a client must have remained sober in order to be admitted to the shelter, stopped screening out altogether, or made other changes so that rules are less restrictive. This is up from 39.8% in 2008. In addition, the 2009 reassessment found that currently:

- 73.1% of agencies do not automatically exit a client from the shelter for drug use
- 38.5% of agencies categorically do not screen women out for drug use
- 26.9% have a zero-tolerance no drug use policy

Many agencies stated that they may screen out or exit a client for drug use on a case-by-case basis, rather than use their previous, more inflexible policy. Many agencies mentioned requiring clients to sign contract agreeing not to use drugs. Some of the agencies that still deny services to clients on the basis of drug use stated that they refer clients out for detox or that they have no substance

abuse specialists on staff.



More than half (53.7%) of the agencies that loosened the rules for substance abuse report that they are now serving more women with substance abuse issues as a result. Many agencies that did not indicate larger numbers being served do indicate that they are serving

substance abuse clients with more quality and understanding. Below are some typical comments offered in response to this question:

- Well, it may not be more women, but I think we are serving them for longer. they are getting support here at shelter and are not asked to leave the program due to relapse or other unsafe behavior
- I don't know if we are serving more women with substance abuse issues or if just more women feel comfortable in sharing their issues without fear of retaliation or judgment.
- I suspect we serve more women, but since we stopped the police efforts, the issue has dropped out of our sight unless it relates to safety. Many women don't disclose, but we suspect there are AOD issues present and contained during their shelter stay.
- We have always served clients with substance abuse issues, we just approach their situations slightly differently.
- Numbers of clients with substance abuse issues that are accessing services seem to be the same but we are attempting to be more accommodating to these issues.

Mental Health

In terms of mental health, over the course of the project 53.2% of agencies have noted a reduction in their screening threshold or loosening of the rules for mental health conditions, up from 33% at the time of the 2008 reassessment (43% among agencies that had received TAT). Currently:

- 68.1% of agencies do not screen women out for specific mental health conditions

Many of the agencies that do screen out note that they do so only if a client is unable to live in a communal setting, is a danger to herself or others, or has a condition that is not being managed.

~ Case Study #1: Women's Center of San Joaquin ~
Most Improved Agency

At the outset of the TAT project, The Women's Center of San Joaquin operated on a heavily rules-based philosophy. With the exception of the Shelter Manager, staff had been working at the shelter from 5 to 25 years. These "long-timers" were very settled and secure in their counseling style. Staff viewed mental health and substance abuse issues as distinct from the woman's domestic violence situation, requiring resolution before DV counseling could take place. Staff screened women out if they had used any drugs for up to 30 days prior to entry and a relapse while in the program triggered immediate expulsion. Women with active substance abuse issues were referred out to other programs.

After attending their first regional training, the Shelter Manager and Domestic Violence Program Director discussed how the shelter operated, realizing that, inconsistent with their own vision for the shelter, they tended to be punitive. Upon her return, the Shelter Manager ripped up the client welcome packet and began to rewrite it from scratch. Overall, WCSJ staff participated in a total of 36 hours of technical assistance on assessing MH/SA women, screening women with substance abuse issues into shelters, policies and procedures, trauma, Motivational Interviewing, and Seeking Safety.

There was some staff resistance to change, resulting from concerns of losing control (and being blamed) as well as discomfort with the new, alternative approaches. Recognizing their concerns, the Shelter Manager introduced transformation slowly in small steps and engaged staff in conversations regarding changes. The trainings and materials provided staff with language and tools to slowly put into place the shared vision of the shelter. Through training, staff began to recognize these issues as interwoven. Over time, the trainings began to provide validation to staff that these new practices they had incorporated into their work was on track.

A pivotal moment came when the shelter accepted a client with a 20-year alcohol problem that had resulted in her losing custody of her daughter. She had a bottle hidden in her purse during the intake and under the old rules would have been exited immediately. Instead, the intake staff had a long conversation with her about her goals. *The client made the choice to stop using alcohol.* The entire shelter worked with this woman to support her on her plan, including bringing treatment services into the shelter. As a result, the client was extremely successful at reaching her own goals: regaining custody of her daughter and securing her own home after leaving the shelter. She helped staff learn how to support a woman at her own pace on her self-defined goals. As a result of this success, staff has become very open to change and appreciates the benefits that can come from a client-centered approach.

Now the shelter is able to serve women with MH/SA issues more effectively. WCSJ had always served these clients, but never really talked about the issues and their relationship to trauma. After the first year of training this program had begun to treat each woman individually based on her needs. Rules were limited to no violence. The shelter loosened its rules and no longer screens out for drug use. They increased groups that assist in women's life planning and brought in a life-coach who facilitates a monthly client group. Drug treatment services are brought into the shelter and relapse planning is discussed openly. If a woman requires detox, staff continues to see her at the facility and welcomes her back into the shelter when she is able. They will soon be adding a Seeking Safety group.

Among those agencies that loosened their rules regarding clients with mental health conditions, 73.2% believe they are serving more women with MH issues as a result. Some note that the number did not go up because they were serving a large number of clients with MH conditions at baseline, and, again, many agencies note that even if the number has not gone up, the quality of care and sensitivity around these issues have:

- We still see about the same number coming for services but we are attempting to be more accommodating to these issues.
- I think that we have always served women with mental health issues. Our ability to address the issue has improved and we no longer screen women out if they do disclose MH issues up front.
- We are not serving more women with MH issues because we never screened out.

The number of clients served with mental health or substance abuse issues is one of the MPOI measures. In January-June, 2008 sixty agencies reported that they served 4,547 clients with mental health and/or substance abuse issues and in July to December of that year sixty-six agencies reported that they served 3,546 MH/SA clients. The data are hard to analyze for many reasons: 1) there are not multiple years of data for comparison, so it is difficult to know if this is a seasonal pattern; 2) the data may not have been reported correctly in the first place (e.g., one agency reported serving a large proportion of MH/SA clients in the first period and fewer the second); and 3) definitions and parameters were not standardized.

The impact of the TAT on agency policies may go well beyond the period of the project. A large number of agencies report intentions to make additional voluntary policy changes to increase access:

- 46.9% of agencies plan to make policy changes in the future to increase access to MH/SA clients
- 21.3% of agencies have future plans to reduce the threshold or loosen rules regarding clients with substance abuse issues
- 23.4% of agencies have future plans to reduce the threshold or loosen rules regarding clients with mental health conditions

OUTREACH/ACCESS IMPROVEMENTS

The CDPH report that established a need for greater access and service delivery to MH/SA clients stated that only 2 of the 94 agencies targeted the mentally ill and 7 targeted substance abusers as underserved populations. Currently, 44%, or 41 agencies, report that as a result of TAT *outreach* to clients with MH or substance abuse issues has increased. Several of the agencies are making concrete efforts to increase their agency's exposure to clients with MH/SA issues as they interact with other organizations and with the community. Below are some comments that illustrate this:

- During presentations and collaborations with other community agencies, we have made it clear we will serve all victims in our emergency shelter. The community is aware to call our agency since we provide intake screening 24/7.
- We are collaborating more with agencies that provide support to those populations.
- Brochures at new mental health peer center. Also increased awareness with our collaborative community agency partners on who we'll take into shelter.

Several other agencies commented that their changed screening and hotline processes, in effect, represent greater outreach to MH/SA clients. Some of the agencies that provided the sort of

comments listed below indicated that their outreach had increased, while others indicated that their outreach had not increased, so there may have been multiple interpretations of the term “outreach:”

- Screening and applicable training for shelter staff has changed to better meet the needs of individuals in this category. (Yes, outreach has increased)
- I would not say outreach but we have changed our intake process and we are not screening out. We have always had a steady flow of clients with mental health and substance abuse issues. It's how we have become inclusive rather than exclusive that has changed. (No, outreach has not increased)

Finally, among the agencies that indicated that outreach had not increased, some statede that such outreach is beyond their agency’s capacity, and others that quality of services had improved, even if outreach had not.

- We have not had the capacity to due outreach specifically to clients with MH or substance abuse issues.
- We do not really do outreach.
- Due to lack of personnel
- For the past two years, our outreach has been focusing on increasing access to the LGBTQ community.
- Our services delivery has changed but our outreach has not.
- Our outreach hasn't increased, but staff has a much better understanding of MH/SA and aren't as fearful of assisting clients.

CONCLUSIONS

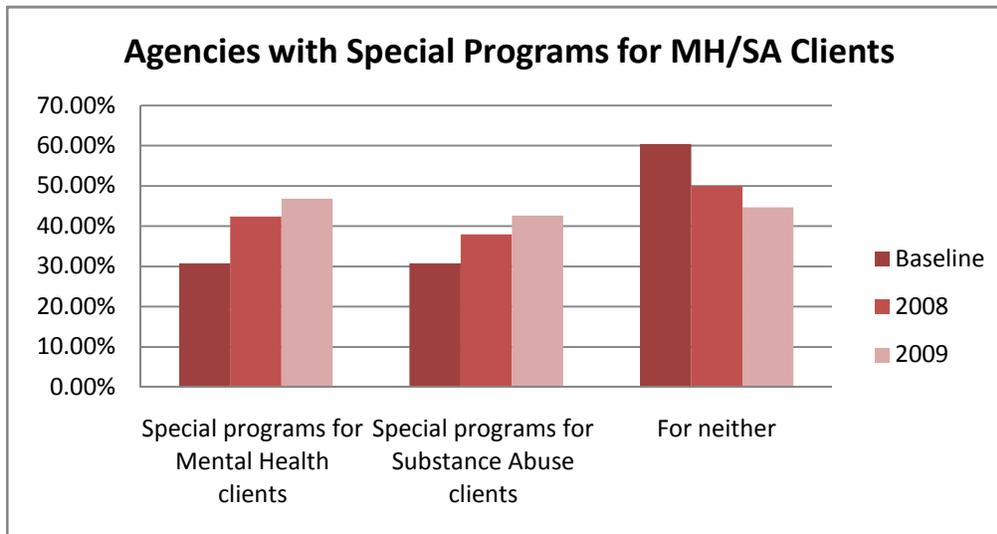
A majority of agencies made voluntary policy changes in response to the TAT, including reductions in screening threshold for both mental health conditions and drug use. The increases in agencies making policy changes between the 2008 and 2009 reassessments were similar for mental health and substance abuse, although screening policies pertaining to mental health issues appear in general to be a good deal more liberal than those around substance use. A majority of agencies that made policy changes are seeing more clients with MH/SA conditions, but even those that did not are aware that they are delivering more responsive services to MH/SA clients. Outreach has increased for many agencies, while others either do not have the capacity. Many have made changes to their screening process.

DEVELOPING MORE EFFECTIVE APPROACHES

As evidenced by the statements above pertaining to more sensitivity and responsiveness to MH/SA clients, the impact of the TAT project was not only going to be felt by measuring increases in outreach and numbers served, but also by measuring the development and delivery of more effective and responsive services.

Objective 3: To help domestic violence shelters develop more effective approaches to working with clients with MH/SA issues

The reassessment finds that there has been a significant increase in the number of agencies that now offer specific programs and services to MH/SA clients,



and have specialized staff. Agencies are also now using more integrated approaches to MH/SA and DV, and a large number are employing evidence-based trauma-informed curricula as a way to address

the interconnectedness of all three issues.

INCREASE IN MH/SA-SPECIFIC PROGRAMS, STAFF, AND FUNDING

At baseline, a majority of agencies (60.4%) had no programs for clients presenting either mental health or substance abuse issues. Currently, a majority of agencies do have specialized programs or services for either mental health or substance abuse (55.3%), and from program beginning to the 2009 reassessment, increases were seen in special programming for both mental health (from 30.8% at baseline to 46.8% in 2009) and substance abuse (from 30.8% at baseline to 42.6% in 2009).

In addition to program specialization, many agencies have made efforts to increase specialized staff, despite the statewide budgetary crisis. Reassessment data show that since the TAT began, more agencies have specialized personnel to meet the needs of clients with mental health and/or substance issues. Overall, since the baseline measure was taken, the difference has been statistically significant. Currently, 50% of the agencies have either or both a MH and/or a substance abuse specialist, and 23.4% intend to hire more specialized staff in the future. There has been a slight decrease over the past year in the percentage of agencies that had mental health staff, while the percentage of agencies with substance abuse specialists has increased. The drop may have resulted from the fiscal crunch under which most of these agencies now find themselves.

Does your agency have specialized staff or case managers for mental health and/or substance abuse clients?	Baseline	2008	2009
For Mental Health clients	20.5%	41.9%	37.3%
For Substance Abuse clients	17.9%	30.1%	34.1%
For neither	61.5%	52.7%	50.0%

Does your agency receive MH or SA specific funding?	Baseline	2008	2009
Receive funding for MH services	18.5%	14.9%	18.1%
Receive funding for SA services	10.9%	4.3%	8.5%
Receive no MH or SA specific funding	77.2%	76.6%	74.5%

In terms of funding, there has been no clear measurable change since the project began. No more agencies

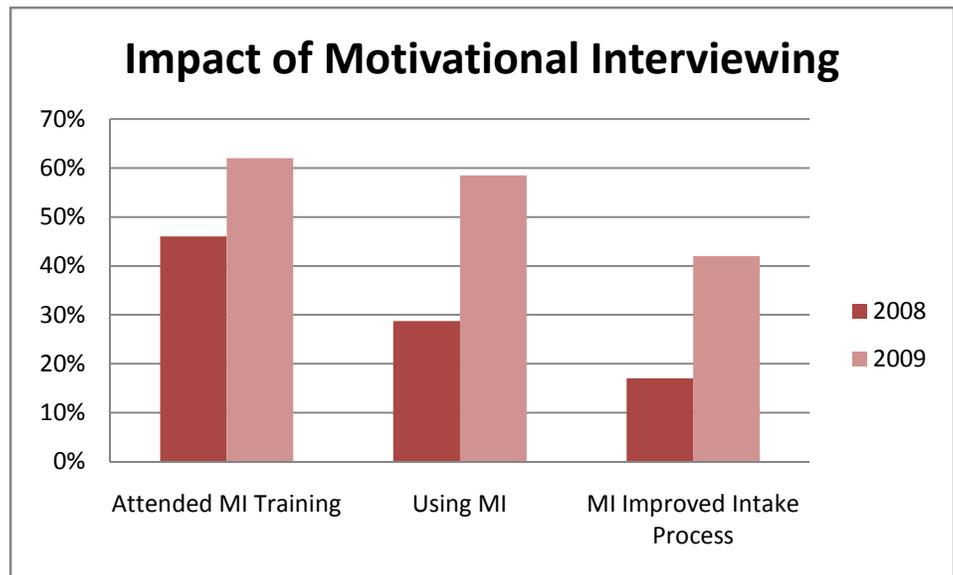
receive MH or substance abuse specific funds now than did in 2006. Since the TAT was not designed to increase monetary resource building, but to develop low-cost internal capacity and organizational change, this finding is not unexpected. It does, however, indicate that, budgetary crisis notwithstanding, service delivery at DV agencies would benefit from more MH/SA funds.

MOTIVATIONAL INTERVIEWING AND SHELTER IMPROVEMENTS

As noted above, over the course of the project, TAT on the topic of Motivational Interviewing (MI) was the most highly attended. The focus on MI matches the scope of the TAT project, as MI is a method by which staff can get past client resistance and work through client ambivalence without judgment or confrontation – it is commonly used in substance abuse counseling, domestic violence advocacy, and other forms of work with at-risk clients. By June 2008, 46% of agencies had received staff training in Motivational Interviewing, up to 62% in 2009. In 2008, 28.7% of agencies were using Motivational Interviewing. By May 2009, that percentage increased to 58.5%. When asked in 2008, 17% of those agencies that undergone MI training said the MI training had improved their intake process. By 2009, 42% of those agencies that had had staff training in Motivational Interviewing felt it had improved their intake process.

Below are comments from some agency managers, describing how MI has made a difference:

- Staff are more open to hearing the client where they are at and meeting them at that level for services and referrals.
- Staff has a better understanding of how to get information without coming right out and asking questions around mental health and substance abuse.
- It seems staff is getting a lot more information and is better able to communicate and really is working at strength based goal setting.

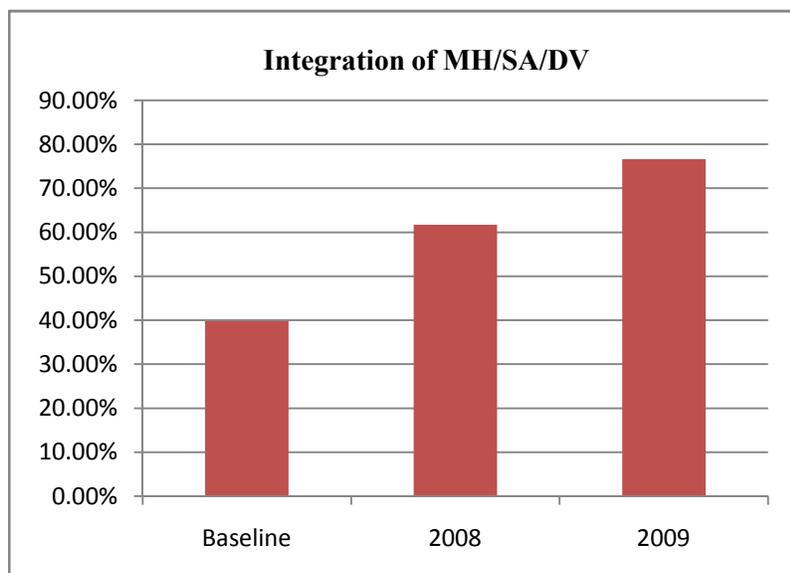


- The techniques have allowed both the crisis call line specialist and the caller to ask and share information that in the past or prior to learning these skills may have been missed or misused.
- A lot of the rigidity of our questioning has been removed .
- One staff got motivational interviewing. Others got non-violence communication training. All are now more open and non-judgmental about substance abuse and mental health issues.
- The crisis line has improved, we have developed an easier format that is helpful to the community. We want women to come into the shelter and not [be] rejected.
- We try to encourage and empower our clients to make decisions on their own. We create a trustful environment. We appreciate our callers/clients contacting us or making the first step.

- The crisis line staff who attended the training are better able to gauge what the client needs depending on their stage of change.
- Our staff is generally able to come from a strengths-based perspective with almost any client. We even added intro to Motivational Interviewing to our 40-hour Training curriculum!

INTEGRATED APPROACH TO MH, SA AND DV

Overall the agency assessment data show movement in the direction of greater integration of the three issues of substance abuse, mental health and domestic violence, as well as a higher degree of



accommodation of women with MH/SA issues among the agencies. Before the project began, 37 agencies (40%) indicated that they “integrated” MH/SA and DV counseling. On the 2008 reassessment, nearly 62% said that they incorporate MH/SA treatment into client plans. Now, over three-quarters (76.6%) incorporate MH/SA.

Agencies are also using MH/SA histories taken at intake to better accommodate clients, rather than to exit them. Some agencies are also incorporating Relapse

Planning into their DV work. All of these things are happening to a greater degree now than at the time of the 2008 reassessment.

Another indication that mental health and substance abuse treatment are more integrated into DV counseling and advocacy is the increased use of evidence-based and other trauma-informed curricula. The curricula

Use of MH/SA Information	2008	2009
Agency collects MH information at intake to create appropriate accommodation while clients are in the shelter	78.7%	81.9%
Agency collects SA information at intake to create appropriate accommodation while clients are in the shelter	69.1%	76.6%
Agency does Relapse Planning	18.1%	28.7%

listed on the adjacent table are approaches that put trauma at the center of interpreting and addressing behavioral health issues. The underlying theory of trauma-informed approaches is that by recognizing the role of trauma, staff working with clients that present multiple risk factors will better understand the source of behavioral health issues and will have more tools to guide recovery and reduce the symptoms of trauma.

Agencies Using Trauma-Informed Curricula	2008	2009
Seeking Safety	33%	50%
TRIAD	1.1%	5.3%
Trauma Recovery and Empowerment (TREM)	9.6%	11.7%
Beyond Trauma	7.4%	20.2%
Addictions and Trauma Recovery Integration Model (ATRIUM)	2.1%	5.3%
Helping Women Recover	10.6%	10.6%
Other Trauma-Informed curriculum	17.0%	10.6%

At baseline, 64.5% of agency executive directors had *no knowledge of any* trauma-informed curriculum. Although the question was not asked at the time, very few of the agency directors that had heard of the trauma-informed curricula had benefited from actual training or were incorporating any aspects of the curricula. Now, 62.8% are actually using at least one trauma-informed curriculum in their shelter. Between 2008 and 2009, the data show an increase in the use of most of the

evidence-based trauma-informed curricula listed, with Seeking Safety emerging as the most commonly used curriculum.

From the initial needs assessment, it emerged that many agencies thought the lack of single-sex support groups was a barrier to effective MH/SA

Women-only MH/SA support/ peer/12-step groups	2008	2009
Yes we have women only support groups on site	33.7%	46.4%
Yes we arrange for women only support groups through linkages	24.5%	22.7%
No we do not have woman only support groups	41.6%	30.7%
TOTAL	100.0%	100.0%

treatment; for example, women struggling with domestic violence situations may feel unsafe around men and therefore reluctant to join a co-ed 12-step meeting. At the time of the 2009 reassessment, a large number of agencies had made changes so that now a majority (nearly 70%) of agencies provide women with single-sex support groups for MH/SA issues, either onsite or through linkages with partner agencies, with the bulk of changes happening in the area of onsite groups – as agency staff undergo training, the agencies’ capacity to offer groups onsite increases. Agencies were also asked if they provided trauma-informed substance abuse groups – more than one third of agencies use a substance abuse treatment provider that is both gender-specific and trauma informed, and an additional 11% use a provider that has one of these qualifications. In addition, 18.1% of the agencies plan to increase use of gender-specific or trauma-informed substance abuse treatment.

SUCSESSES AND BARRIERS

Agencies were invited to provide examples of successes that have resulted from applying the lessons of the TAT in their work with MH/SA clients. Several agencies offered comments to illustrate how they have changed regular shelter practices in order to serve the MH/SA population more effectively, for instance:

- We have implemented Seeking Safety techniques in our one-on-one peer counseling and support groups. Advocates feel more competent in working effectively on these issues with participants due to a better understanding of how DV survivors are impacted by MH/SA. We have seen participants feel empowered more quickly due to having safe coping skills.
- This helped us to understand our clients' perspectives better. Our clients felt being heard and were more willingly to share with you their experience. This helped them walk out of their trauma and move on.
- Many of our clients have mental health/substance abuse issues. In terms of mental health, staff is more understanding and competent in working with their needs. I have observed one of our staff, previously intimidated by MH issues, display tremendous confidence and empathy in working with clients with mental health issues. As far as substance abuse, in the past staff recommended immediate exit of clients discovered using during their stay. Now, they advocate for said clients to remain in the shelter and speak candidly with

~ Case Study #2: South Bay Community Services ~ Most Advanced/Integrated Agency

South Bay Community Services (SBCS) operates a short-term shelter as well as a transitional housing facility. A trauma-informed approach has been a core philosophy of the agency for the past 5 years. After receiving a grant to research evidence-based practices that are appropriate for women in DV shelters, SBCS decided to reject a punitive rules-based approach, stopped screening out for mental health conditions or substance abuse issues, and started screening universally for trauma. Now, staff collects information at intake with the understanding that these issues usually co-occur and compromise safety if not discussed and planned for. While the expectation is that women will not use substances during their stay, if they do, the program continues to work with them. SBCS provides mental health services on-site and uses Motivational Interviewing, TREM, Beyond Trauma, Helping Women Recover and TARGET and will soon be establishing a Seeking Safety group. If necessary, they will refer a woman to inpatient substance abuse treatment.

During the MH/SA TAT project SBCS continued to obtain training for staff in Motivational Interviewing and integrated trauma-informed services. As a result there was improved staff morale, continued increases in positive client outcomes, and improved functioning in the shelter. Shifts in attitude and practice are reflected in how staff speaks with women and focuses on clients' goals. SBCS uses a tool to assess for stages of change and staff spends time with clients to help them understand where they are on this continuum.

It is the experience of SBCS that when making the transition to a trauma-informed approach it is useful to have 'trauma champions' in the organization. These trauma champions should operate at three agency levels: management, clinical supervision, and day-to-day operations. It is also important to start small and start slow when making a shift to a paradigm that recognizes that the trauma is the core event around which clients organize themselves. Staff may be fearful that they will lose control and not be able handle situations. However, everyone can acknowledge their fears and grow beyond them, especially since this posture may deter agencies from taking in certain clients.

A future direction for SBCS is to work with their substance abuse treatment providers to ensure that they really understand the trauma-informed approach. Providing cross-training and encouraging the use of a curriculum such as Seeking Safety is the role SBCS sees for itself as it works actively on the San Diego Integrated Services Guide Team.

them regarding resources and support.

- Advocates keep in mind that the woman is a victim/survivor first and work with her on safety planning. The other domestic violence agencies in Santa Clara County turn to Next Door to serve women with MH/SA conditions. One particular woman came to us and had been drinking, the alcohol was in her breath, clothes and it was obvious she had drinking. We will ask her to rest, eat and then after will we do case management with her. We will not turn away for substance abuse or mental health issues. I have worked with staff and remind them are mission "Ending Domestic Violence in the moment and for all time" this means every woman and if we did not accept and advocate on their behalf what will happen to them? I pride myself on my staff and our agency to meet the needs of women in our community.
- The majority of women are staying longer in shelter and because we are non-judgmental, feel more supported in making recovery or advocacy for the needs around mental health part of their case management. They are at choice on what steps they want to take.
- We are not screening out MH/SA clients and have changed to a strength-based goal-setting case management [approach] versus what we did before...[before we] screened out MH/SA clients due to fear of not knowing how to work with MH/SA clients...Also, fear of saying the wrong thing and making things worse.
- Clients actively participating in a recovery program as well as mental health treatment are more likely to maintain a life independent of their abuser.

Other agencies chose to provide examples of specific client success stories. This is only a selection of these stories:

- There are so many... one example, a woman came to NEWS after leaving her batterer she no longer had health insurance and needed medication for her schizophrenia. We were able to get her a same day apt. for meds and pay for her prescription. We also helped her apply for social security and county medical services. With some "success under her belt" she started attending the county AOD treatment program. She has been clean and sober for several months and has received on going support from our Safe Solutions program manager. She has not returned to her abuser.
- We accepted a woman who was severely alcoholic and who needed to attend a detoxification center in order to be medically assisted as a result of her drinking. Rather than "exit" her as would have been done before, the staff worked with the client to link to a sobering center, wrote her a letter promising to hold her bed, drove her to the detox facility, and kept in contact with her while she stayed a week there. She returned to the shelter and spent three months working toward her goals.
- We had a 42 yr old woman with 2 children that graduated from Genesis House, with prior history of abuse. Upon completion of her Substance Abuse Program, and counseling at the YWCA, we admitted the client into the Lawson Safe house for an extended stay of 10 weeks. Creating a transition plan for the client we partnered with Salvation Army and were able to coordinate another 90 days at their facility, and then move into long term transitional housing. YWCA Monterey continues to provide counseling services and support group services to the client.
- Our greatest recent success has been our shelter client who struggled with severe PTSD and panic attacks. We worked with her for 8 months and she went from sleeping in the day/awake at night with all lights on to sleeping soundly. We were able to transition her successfully to second-step program panic-attack free! She learned coping skills for her anxiety and was able to see a clear path for her future with her son.

- We've had success helping a few women who used alcohol to negatively cope to reduce their use as opposed to exiting [them] from the shelter. We had a very resistant client with AOD issues who was able to be safe at the shelter and stabilize during her stay. (We suspect she was using as well, but it never became dangerous.) We've had a few women who when we gently confront them about our concern about unsafe behaviors take initiative to find a better place to stay without our staff even mentioning an exit. We have also completely stopped screening out women with mental health issues and realized that often a woman's presentation at the time of intake has little to no prediction of what behaviors she might exhibit later!

Some agencies' greatest accomplishment was to redefine success, using the insights provided by expert TAT presentations:

- One example of success is the understanding that the definition for success may be different for women with mental health or substance abuse issues - we may be talking about smaller steps.
- We make it quite clear that DVSAC can offer treatment both for mental health issues and substance abuse. We let the shelter clients know that sometimes relapse is part of substance abuse. We find that once clients know this that they are not afraid to come to us and work on a relapse plan. Most of the clients that we see have mental health and substance abuse issues. We have been able to offer trauma based treatment for both issues at the shelter.
- I feel that just taking in more clients has been a success. We haven't had too many "successes" as clients with AOD or MH disorders have either relapsed and left or engaged in violent behaviors we didn't know how to work around so they had to leave. But that we are more open is huge and I'm happy with that progress for now.

While the successes mentioned above demonstrate earnest efforts and impressive strides being made by a good number of agencies, change can be difficult. Agencies were asked to describe some of the barriers they have encountered that interfere with their ability to have an impact with MH/SA clients. In response to this question there were:

- 34 comments about inadequate funding or the desire to obtain additional money to make shelter more equipped to address MH/SA issues
- 7 comments about difficulties accessing services from specialized service providers because they do not exist nearby (especially true for rural and suburban agencies)
- 7 comments about being understaffed to provide comprehensive services
- 7 comments that there is a need or desire for more training
- 5 comments about staff resistance to change and staff discouragement in the face of such difficult issues
- 4 comments that housing and physical accommodations are inadequate (MH client may need single rooms)
- 4 comments about mental health services specifically being difficult to access because of waiting lists and budget cuts to state-provided service providers
- 1 comment about culturally and linguistically MH services being scarce

The budget issue raised by so many of the respondents appears again during the discussion about partnering with local MH/SA treatment providers. The desire for increased training is also a theme that respondents consistently conveyed throughout the reassessment, participant evaluations and follow-up questionnaire. And staff resistance to change, while only appearing 7 times in agency descriptions is a common and anticipated, though not insurmountable barrier to agency change.

CONCLUSIONS

Since the TAT project began, agencies have made a number of changes to increase the quality of services to MH/SA clients, including increasing specialized programs, staffing, and a greater integration of the three issues, including the use of evidence-based trauma-informed curricula. Agencies easily provide concrete examples of the impact that these changes have had on the delivery of services. Given that MH/SA-specific funding did not increase among the agencies during this period, it is reasonable to interpret these improvements as a direct result of the technical assistance and training delivered through this project.

EXPANDING LINKAGES WITH COMMUNITY AGENCIES

Another area identified in the original assessment and a part of the contract design was assistance in developing linkages to mental health and substance abuse services providers in the community. In this area the project had the least amount of measurable impact. Agencies were able to increase the number of mental health service providers with whom they had formal relationships, and the number of agencies reporting that they had any formal relationship with both mental health and substance abuse service providers increased, but the average number of formal and informal relationships with substance abuse providers per DV agency, according to the reassessment survey, remained the same or declined slightly between the second and third year of the project; MPOI data show some increases.

Objective 4: To help domestic violence shelters improve linkages with community agencies

INCREASED RELATIONSHIPS WITH MH/SA PROVIDERS

The project had initially identified resource mapping as an individual technical assistance area. This proved to be impractical – no consultant could be identified to investigate the local substance abuse and mental health landscape for each agency within project resources. Nevertheless, the increased

Relationships with MH/SA providers	Baseline	2008	2009
Number of agencies with any formal relationship with MH service provider	61	62	69
Number of agencies with any formal relationship with SA service provider	49	70	63
Average number of <i>formal</i> relationships with MH providers	--	2.36	2.28
Average number of <i>informal</i> relationships with MH providers	--	3.56	4.37
Average number of <i>formal</i> relationships with SA providers	--	1.84	1.65
Average number of <i>informal</i> relationships with SA providers	--	3.27	3.22

awareness and dedication to substance abuse issues did translate into an increase in the number of agencies holding formal relationships with substance abuse treatment providers.

The number of agencies with formal relationships with MH providers also increased over the course of the project, but not as dramatically. Between 2008 and 2009, the average number of formal and informal relationships with MH/SA providers

did not generally increase significantly, although there was an increase in the average number of informal relationships with MH providers.

Referrals to MHSA Providers (MPOI)	Jan-Jun 2008	Jul-Dec 2008
Number of referrals for clients	966	960
(Number of agencies reporting referrals for clients)	(27)	(29)
Number of referrals from crisis calls	1,747	2,149
(Number of agencies reporting referrals for crisis calls)	(25)	(24)

The MPOI on this measure, however, indicates that some progress was made on this objective. In 2008, 99 new partnerships with mental health or substance abuse treatment providers were

formed and reported on by one-quarter of the funded agencies. A related MPOI, number of referrals made for clients and crisis calls, though reported on by a small proportion of all funded agencies, demonstrates the importance of having these referral relationships.

Even if the number of relationships has not necessarily increased, an important accomplishment of the TAT project lies in the increased confidence DV staff feel working with MH/SA treatment providers. In 2008 85.8% of agencies reported that staff felt more confident working with providers because of the TAT – by 2009 that number went up to 91%.

CROSS-TRAINING

Another area that was initially identified in the needs assessment but was not carried out as extensively as anticipated was cross-training, where DV agency staff would have an opportunity to meet with substance abuse and mental health providers to share knowledge, investigate common threads, and uncover unspoken assumptions that create misunderstandings and barriers to delivering effective service to clients. The cross-trainings might have been another way for DV agencies to increase and deepen their linkages. But because the project’s state-mandated focus was on delivering TAT to DV agencies, and cross-trainings would involve staff from mental health and substance abuse agencies as well, this valuable mode of learning was largely bypassed.

One cross-training did take place in December 2008 in San Diego, attended by staff from all five San Diego DV agencies and nearly one hundred staff from regional MH/SA providers. Over 92% of participants stated that their expectations were met or exceeded. A volunteer “guide team” was created at that event that remains actively working on integration and trauma-informed services in San Diego. On the final reassessment, 56.7% of agencies indicated a desire for additional assistance in cross-training with local mental health and substance abuse service providers.

BARRIERS TO MH/SA LINKAGES

There are many factors outside the control of the TAT project, including geographic barriers, the current economic slump, and a public behavioral health system that is very backed up. Among participating DV agencies there was a high degree of consensus on the most common barriers to accessing MH/SA services for clients:

- 84.0% indicated that a basic lack of psychiatric services presents a frequent barrier
- 76.6% indicated that clients sometimes do not follow through on referrals
- 75.5% indicated that clients are often denied services because they are ineligible
- 69.1% indicated that waiting lists for substance abuse programs present a barrier
- 62.8% indicated that inadequate funding for psychiatric medications is a barrier
- 48.9% indicated that a lack of availability of women-only substance abuse programs presents a barrier to clients

- 45.7% indicated that many programs to which they refer are not trauma-informed and this is a problem
- 39.4% indicated that agencies are not responsive to the clients that are referred

In 2008 Medi-Cal experienced budget cuts, and many counties and municipalities across the county had to make cuts to both mental health and substance abuse programs. These cuts, because they diminish already under-resourced providers, prevent DV agencies from effectively overcoming many of the barriers listed above.

In the 2009 reassessment, 69.1% of agencies indicated that they plan to increase linkages to other agencies. Unfortunately, continued cuts are likely to affect these efforts. In fiscal year 2009-10 the following MH/SA related budget cuts are anticipated at the state level:

- Reduce Mental Health Managed Care and Early and Periodic Screening, Diagnosis and Treatment services for savings of \$92.0 million in 2009-10.
- Cut state funding for Maternal, Child and Adolescent Health by \$20.2 million in 2009-10.
- Eliminate state funding for the Substance Abuse and Crime Prevention Act (Proposition 36 of 2000) and the Substance Abuse Offender Treatment Program for combined savings of \$108 million in 2009-10.
- Reduce rates for substance abuse treatment services for individuals who are eligible for Medi-Cal by 10 percent for savings of \$8.8 million in 2009-10.

CONCLUSIONS

The data show an increase from baseline to the 2009 reassessment on the number of agencies that have any formal relationships with MH/SA agencies. The reassessment data do not, however, show an increase in the average number of MH/SA agency linkages per DV agency. Staff confidence in working with these sorts of specialists has increased, and most agencies plan to continue efforts to increase linkages, but budget cuts may interfere with the success of these efforts. Cross-training continues to be a relatively unexplored mechanism by which linkages and knowledge could be built, but the success of the San Diego cross-training may point to a model for future efforts.

REGIONAL FINDINGS

The following is a breakdown of TAT delivery and impact by region.

DELIVERY OF HIGH QUALITY TECHNICAL ASSISTANCE AND TRAINING

Region	# of Agencies in Region	Mean # of TAT sessions per agency	Mean total TAT hours per agency
Bay Area	21	4	13.05
Central	16	5.69	17.41
Los Angeles	20	5.6	20.00
North	20	3.7	13.00
South	17	5.82	20.53
Total	94	4.89	16.61

Agencies located in the Southern, Central, and Los Angeles regions took advantage of the greatest number of sessions and hours of TA.

Although the average number of TAT hours and sessions utilized by agencies in the North was not high, the impact on staff knowledge, confidence and ability to work with clients presenting mental health and substance abuse needs was well above the average. Nearly all the agencies in the North reported that staff capacity had increased as a result of the TAT.

Impact of TAT on Staff Knowledge & Ability	Bay Area	Central	Los Angeles	North	South	Total
Agency's knowledge around Substance Abuse has increased since TAT	95.20%	81.30%	89.50%	95.00%	94.10%	91.40%
Agency's knowledge around Mental Health has increased since TAT	90.50%	93.80%	94.70%	100.00%	94.10%	94.50%
Staff confidence in working with MH/SA clients has increased as a result of TAT	90.50%	87.60%	84.20%	100.00%	100.00%	92.50%
Staff ability to work with MH/SA clients effectively has increased as a result of TAT	85.7%	81.3%	84.2%	95.0%	88.2%	87.1%

The number of agencies across all regions reporting increases in knowledge, confidence and ability was generally very high, so there was not significant variation by region.

INCREASING OUTREACH AND ACCESS

Shelter Policy	Bay Area	Central	Los Angeles	North	South	Total
Agency categorically does not screen women out of our program on the basis of drug	60.0%	25.0%	36.8%	31.6%	35.3%	38.5%
Agency does not necessarily exit a client for drug use	85%*	75%*	55%	90%*	58.8%	73.1%
Agency does not screen women out of our program for specific mental health	76.2%	62.5%	60.0%	75.0%	64.7%	68.1%

p<.01

These data show that a significantly higher percentage of DV agencies in the Bay Area and in the North report having more tolerant policies in terms of screening clients out for mental health conditions and exiting clients for drug use while in the shelter. The Bay Area stands out at the region with the greatest percentage of programs (60%) reporting they do not screen women out of the program based on drug use. While these numbers help clarify which regions have more tolerant policies, they do not reveal if policies have been affected by the TAT project. The table below shows the percentage of agencies in each region reporting that the TAT project resulted in policy changes.

Policy Changes Resulting from TAT:	Bay Area	Central	Los Angeles	North	South	Total
Policy & Procedures Changes	57.1%	87.5%	60.0%	65.0%	76.5%	68.1%
Threshold Reduction for Substance Abuse	47.6%	37.5%	45.0%	65.0%	70.6%	60.6%
Threshold Reduction for Mental Health Conditions	42.9%	68.8%	50.0%	45.0%	64.7%	53.2%

The percentage of agencies making policy changes as a result of the TAT project was above average in the Central and Southern regions. The percentage of agencies specifically loosening the rules or reducing thresholds for admittance into their shelters based on a client’s substance use was above average in the Northern and Southern regions. The percentage of agencies specifically loosening the rules or reducing thresholds for admittance into their shelters based on a client’s mental health conditions was above average in the Central and Southern regions. From these data, it appears that the greatest amount of policy change took place in the Central region, with a high degree of threshold reduction in the South.

As a result of these Policy changes agencies are:	Bay Area	Central	Los Angeles	North	South	Total
Serving more women with substance abuse issues	55.6%	55.6%	36.4%	53.8%	66.7%	53.7%
Serving more women with mental health conditions	71.4%	54.5%	83.3%	83.3%	81.8%	73.2%

According to these responses, the greatest increase in clients served resulting from the TAT took place in the Southern region. As earlier data revealed, however, the impact of policy changes was often felt among agencies as improved service delivery rather than increased numbers served – many agencies felt they had always served high numbers of these clients, just less effectively.

DEVELOPING MORE EFFECTIVE APPROACHES

Accommodation	Bay Area	Central	Los Angeles	North	South	Total
Agency uses SA information to create appropriate accommodation while they are in the shelter	76.2%	62.5%	75.0%	85.0%	82.4%	76.6%
Agency uses MH information to create appropriate accommodation while they are in the shelter	76.2%	68.8%	85.0%	85.0%	94.1%	81.9%

Agencies most likely to respond that they use MH/SA information obtained at intake to accommodate clients while in the shelter (rather than exiting them) were located in the South and in the North, with Los Angeles agencies using MH information to accommodate clients. Similarly, agencies in the South were most likely to have specific services or programs for MH/SA clients, with Los Angeles, once again, more accommodating around MH issues.

Agency has specific services or programs for clients with MH/SA issues	Bay Area	Central	Los Angeles	North	South	Total
For MH	38.1%	37.5%	50%	40%	47.1%	42.6%
For SA	38.1%	43.8%	25%	50%	59%	42.6%
For Neither	52.4%	43.8%	50%	45.0%	29.4%	44.7%
Count	21	16	20	20	17	94
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Agencies in the North were most likely to demonstrate integrated approaches to MH/SA/DV, with a higher percentage incorporating MH/SA treatment into case planning, and with three-quarters of all Northern agencies using a trauma-informed curriculum. The South began with one of the lowest rates of integration of MH/SA in DV counseling, and ended with one of the highest rates, marking this region as probably the most changed. Interestingly, while the Bay Area is the least likely to screen women out, they are also the least likely to have MH/SA services.

Integration	Bay Area	Central	Los Angeles	North	South	Total
Baseline Integration of MH/SA/DV	33.3%	41.2%	47.1%	50.0%	33.3%	39.8%
Currently incorporating mental health or substance abuse treatment into the client plan	71.4%	75.0%	70.0%	85.0%	82.4%	76.6%
Currently using a Trauma-Informed curriculum	61.9%	50.0%	60.0%	75.0%	64.7%	62.8%

EXPANDING LINKAGES WITH COMMUNITY AGENCIES

Region	SA Agency Formal relationship*	SA Agency Informal relationship	MH Agency Formal relationship	MH Agency Informal relationship	
Bay Area	1.50	3.13	2.00	5.06	While the Bay Area appears to have a higher number of informal relationships with MH agencies, and Los Angeles appears to have a higher
Central	1.90	2.58	2.25	3.00	
Los Angeles	1.81	4.71	2.47	5.56	
North	1.29	2.08	3.13	4.00	
South	1.77	3.13	1.17	3.50	
Total	1.65	3.22	2.28	4.37	

number of informal and formal relationships with agencies in general, these differences are not statistically significant. Furthermore, since the Bay Area and Los Angeles have more urban centers, a higher number of linkages can be anticipated.

DISCUSSION

The overall statewide analysis of third year data shows that the TAT project made marked progress on each of its objectives. It should be noted here that in the 2008 reassessment, all agencies had participated in regional trainings, but about half had not yet participated in any individual or group technical assistance on topics of their choice. At the time, a significant difference was found between the groups having received custom TAT and those not having received it, with agencies having received custom TAT significantly more likely to demonstrate policy changes and greater integration of MH/SA/DV issues in their shelter practices. For example, agencies that had received custom TAT were significantly more likely to have the following:

- Policies NOT to screen clients out for drug use: 54% vs. 37% (p<.05)
- Policies NOT to exit clients automatically for drug use: 50% vs. 34% (p<.05)
- Policies NOT to screen clients out for mental health conditions: 73% vs. 53% (p<.05)

They were also more likely to report the following changes resulted from TAT:

- Increased staff MH knowledge “a great deal”: 36% vs. 11% (p<.05)
- Increased staff SA knowledge “a great deal”: 40% vs. 15% (p<.05)
- Changed policies as a result of TAT: 56% vs. 19% (p<.01)
- Reduced screening threshold for substance use: 54% vs. 19% (p<.01)
- Reduced screening threshold for mental health conditions: 42% vs. 21% (p<.05)
- Working more effectively with MH/SA issues: 71% vs. 34% (p<.01)

By the final 2009 reassessment, all agencies had participated in custom TA, and the difference among agencies had disappeared, demonstrating that the statistically significant association found in 2008 was in fact an authentic representation of TAT project impact.

On the first objective, knowledge-enhancing, high-quality technical assistance and training was indeed delivered to all 94 agencies – with many agencies taking clear advantage of the opportunity by participating in multiple sessions. Technical assistance and training were rated very well by participants, a majority of whom appear to have gained knowledge, confidence and ability as a direct result of the TAT.

On the second objective, to increase access, the reassessment and training follow-up data indicate that a large majority of agencies made changes to their policies in order to allow a greater degree of accommodation for MH/SA populations, including reductions in screening threshold for both mental health conditions and drug use. The increases in agencies making policy changes between the 2008 and 2009 reassessments were similar for mental health and substance abuse, although screening policies pertaining to mental health issues tend to be a more liberal than those for substance use. A majority of agencies that made policy changes are seeing more clients with MH/SA conditions, but even those that did not increase numbers are delivering more responsive services to MH/SA clients. Outreach has increased for many agencies, while others either do not have the capacity.

On the third objective, to increase the quality of services delivered to MH/SA clients, the reassessment shows that practices at most agencies now reflect a more integrated approach, recognizing the interconnection among MH, SA and DV. As a result of the TAT project, agencies have adjusted practices to be more responsive to MH/SA clients by increasing specialized programming

and staffing, and by making efforts to integrate the three issues, including the adoption of evidence-based trauma-informed curricula. The stories and examples provided by agencies illustrate the powerful impact these changes have had on the delivery of services. As already noted, **these service delivery improvements have occurred without a corresponding increase in MH/SA-specific funding, leading to the conclusion that technical assistance and training alone, even without additional funding, can result in transformational changes to an agency's approach and philosophy.**

In terms of the fourth objective of the project, to help agencies expand and strengthen their ties to providers of mental health and substance abuse services in the community, the TAT project made progress, but had a less transformational effect. As a result of the TAT, agency staff are more confident in their interactions with providers of MH/SA services, and it appears that more agencies have formal memoranda of understanding with both MH/SA service providers than they did before the project began. Most agencies (69.1%) plan to continue efforts to increase linkages, but due to the current budget crisis, both MH/SA providers are cutting services, leaving already overwhelmed agencies with even fewer slots – some agencies have even closed their doors completely. These events have compromised DV agency efforts to develop more effective relationships.

The regional level analysis revealed some differences among the five regions of California: Bay Area, Central, Los Angeles, North, and South. The Bay Area and the North appear to have the most liberal policies when it comes to working with clients presenting mental health and substance abuse issues. But the greatest degree of change appears to have taken place in the Southern and Central regions, both of which had above average rates of changes to policies and procedures. These policy changes seem to have had the greatest impact on numbers served in the South, as compared with other regions. The largest proportion of highly accommodating shelters appear to be in the North and in the South of the state, which is where agencies are also more likely to be integrating MH/SA into case planning and using trauma-informed curricula. The North started with the highest level of integration of MH/SA issues with DV counseling, but even so agencies in the North experienced a good deal of change on this count. The most dramatic change, across the board, was in the Southern region. In sum, the South appears most changed as a result of the TAT, but the project appears to have had a good deal of impact in all regions, particularly in terms of increased knowledge.

FUTURE DIRECTIONS

This project has demonstrated that providing TAT on unserved and underserved DV shelter populations can be a very successful endeavor, even without additional funding for services to those populations. The overwhelming majority of agencies recognized the need for training, welcomed the opportunity to train their staff, implemented some or all of the recommendations, and observed benefits from these shifts in practice to more effectively serve their clients. The decision by CDPH to invest in this TAT effort was sound as it has resulted in improved access, knowledge and quality of service for MH/SA clients statewide. This is a key finding in the field and the State of California should make efforts to disseminate the successes of the effort.

Below are additional points to help guide future technical assistance and training planning:

- 1) The feedback received from agencies indicates that in-person technical assistance and training is superior to telephone training. It may remain important to offer the option of telephone trainings in response to agency desires for TAT that does not require staff to

travel long distances. Striking a balance between in-person and telephone trainings should be considered when designing future training efforts and corresponding budgets.

- 2) Agencies overwhelmingly expressed a desire to continue to improve access and the quality of service delivered to the MH/SA population, with 94.7% expressing a plan to increase staff training on MH/SA topics. Many also plan to continue to make changes to policies and procedures. These forward looking agencies would benefit greatly from continued support in their efforts. The only suggestion that emerges from these data is that future trainings should be sure to include concrete suggestions for applying the materials.
- 3) Some of the agencies served by this project made major shifts in practice which, in turn, present staff with a large and new set of philosophies, procedures, and approaches. The field of organizational development has documented how organizations successfully integrate and transition to new practices. Agency leadership might benefit greatly from some of this existing research or even additional TAT on the process of change. The specific experiences of the participating agencies could also be documented to join the body of literature. Alternatively, participating agencies could be assembled to share anecdotes and stories that illustrate concepts would and potentially increase the likelihood that other agencies can make and institute desired changes.
- 4) One of the objectives of this effort was to increase agencies' linkages with service providers in each of the underserved areas (MHSA, DDD, LGBT). Cross-training continues to be a relatively unexplored mechanism by which these linkages could be built. Future efforts should include greater outreach to these collateral agencies as well as the possibility of additional cross-training. The state should consider providing incentives and facilitation for cross-training and cross-agency support. Support for regional cross training conferences is one possible approach.

Finally, this project laid a foundation upon which the state can now build greater opportunities for true integration of mental health, substance abuse and domestic violence services. At the state level, incentives and opportunities should be created to support increased collaboration and cooperation among these three fields. County behavioral health agencies and administrations should be encouraged to invite DV agencies into planning processes, and the state should present more funding for joint MH/SA/DV programs.

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APPENDIX
