SHE'S GOT ALL KINDS OF TROUBLES

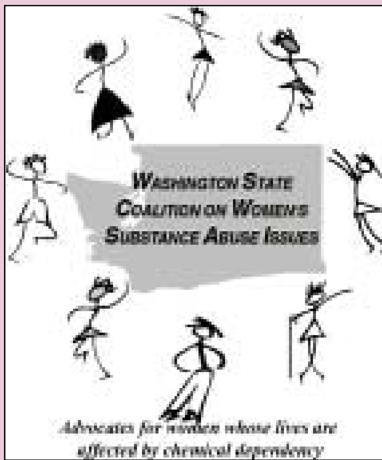
INTEGRATED TRAINING CURRICULUM

For social service workers who are helping women with multiple problems involving substance abuse and chemical dependency, domestic violence, adult sexual assault, and child sexual assault

HANDBOOK FOR TRAINERS

June 1995

A project of the Washington State Coalition on Women's Substance Abuse Issues
Funded by DSHS - Division of Alcohol and Substance Abuse
Contracted through Tacoma Community College



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EXECUTIVE SUMMARY

This report analyzes the need for integrated trainings in Washington State for service providers who are working with women with multiple problems of substance abuse, chemical dependency, domestic violence, adult sexual assault, and child sexual assault. These trainings would facilitate communication between these services to better serve the women.

BACKGROUND

The Washington State Coalition on Women's Substance Abuse Issues (WSCWSAI) recognizes that women who abuse alcohol and other drugs also need to address other problems associated with childhood sexual abuse, adult sexual abuse, domestic violence and other forms of victimization. This often requires services from various providers. The WSCWSAI realizes that cooperation and collaboration among the various fields that provide services to women must increase to improve treatment outcomes for women with substance abusing problems.

WSCWSAI subcontracted with the Tacoma Community College in December of 1994 to provide cross training to workers in the fields of chemical dependency, domestic violence, sexual assault, and child sexual assault. This project is funded by the DSHS-Division of Alcohol and Substance Abuse.

The isolation and competitiveness between providers of women's services has been identified by the WSCWSAI as a barrier to women's

recovery. The goal of this training process is to break the isolation between varying providers of women's services. It is felt that identifying specific problems within each community and helping to foster cooperation to address each problem will do this.

WSCWSAI created a curriculum advisory committee with representatives from the affected disciplines as well as DCFS and DASA. This committee was facilitated by the WSCWSAI and met for the purpose of developing a written curriculum, to include requirements of the trainers, targeted audiences, handouts, and training format. The WSCWSAI committee also developed protocols for each targeted audience and determined the learning objectives and training content for this project. These items were completed by June 1995 and reported to Tacoma Community College and submitted to DASA.

During the processes of developing the curriculum it was determined that the processes of cross training was not beneficial but that an integrated training for all parties would best suit the needs of the targeted areas. The training also became a training process rather than a statewide process. This would allow more flexibility thereby allowing each community to customize the training to meet the needs of the individuals in their community.

The pilot training communities chosen were Spokane and Tacoma. A planning session was held in each community. Invited community members helped identify the community goals to develop their integrated services for women. Invitations to the training were made to key providers of women's services in the communities.

SPOKANE TRAININGS

Three training sessions were held in Spokane. Session one was held on April 30, 1996. During this session four barriers to Spokane area integrated services were identified. The attendees believed that these barriers are the reason substance-abusing women in Spokane County do not always receive the integrated services they need.

1. Lack of informed and intentional interagency relationships that advance cooperation and trust between programs.
2. Imbalances of increasing expectations from society, employers, and oneself lead to poor self-care, a sense of being over-

whelmed, and an increasingly circumscribed view of one's role in the healing process.

3. Lack of community commitment to funding resources that fosters stability and interconnection for agencies and women's programs.
4. Lack of community awareness of the costly dynamics unhealthy values of sexual assault (child and adult), domestic violence and substance abuse within our society and culture.

Session two was held on May 20, 1996. During this session problem solving for the barriers began. The first two barriers were addressed at this session. Several solutions were identified for the first barrier. These included sharing what is working with other agencies and programs. The consensus was that valid ways to accomplish this were by touring other agencies, interagency field presentations, direct referrals, and involving CPS, mental health professionals, hospitals, and the criminal justice system, and educational sessions on adding sexual assault and domestic violence to the Law and CD conference.

Barrier two was addressed by creating a list of self-care rituals for the professional working with substance abusing women with multiple problems. It was determined that professionals must be healthy themselves to properly deal with these women and maintain appropriate boundaries while providing the needed services.

Session three held on June 24, 1996, focussed on the third and fourth barriers-community involvement, commitment, and awareness. The attendees created a coalition to address these issues. They call themselves the Women's Coalition for Integrated Services (WCIS). The focus of this group will include creating public awareness, developing a network of resources for substance abusing women with multiple issues, and lobbying for funding. They committed to meeting. Meetings and agendas were scheduled for July and September of 1996.

TACOMA TRAININGS

Three training sessions were held in Tacoma. Session one was held on May 13, 1996. During this ession four barriers to Tacoma area integrated services were identified. The attendees believe that these barriers are the reason substance-abusing women in the Tacoma area do not always receive the integrated services they need.

1. Lack of facilities to accommodate their children.
2. Services lack continuity and coordination.
3. Comprehensive case management is unavailable in most women's services.
4. Lack of funding for integrated services including providing for safety and basic needs.

This group also identified a shared vision-that communities join together in the spirit of wellness to assure every woman is safe, and empowered to meet her basic needs.

Session two was held on June 20, 1996. During this session problem solving for the barriers began. Goals for improving substance abuse women's ability to receive integrated services were defined. It was determined that a clearinghouse of integrated services must be created, comprehensive case management should be established, families should become a high priority in our society, and family service centers with one stop availability for integrated services need to be created. Recommendations were made on how to overcome each of the four barriers and reach these goals..

A list of self-care rituals for the professional working with substance abusing women with multiple problems was discussed. It was again determined that professionals must be healthy themselves to properly deal with these women and maintain proper boundaries while providing the needed services.

During session three, held on July 23, 1996, networking began. Participants shared the resources and drawbacks that their agencies had and learned of new resources for their clients. The attendees of this session agreed to continue to meet on a regular basis to continue their group focus. The focus of this group will include creating a consultation group or a provider's group for integrating women's services and striving to meet the goals outlined in these sessions. The first meeting and agenda were scheduled for the following Tuesday.

FUTURE TRAININGS

Future trainings are planed for other areas of Washington State. These two pilot projects have served as a template for other areas creating local organizations that can advocate for the substance-

abusing women of their community and help them receive more integrated services. The curriculum has shown itself to be an effective tool. It is recommended that *She's Got All Kinds of Trouble* be implemented in communities thought the state. With result similar to the pilot projects, Washington State could create a network of coalitions that are dedicated to providing integrated services to substance-abusing women and help to heal the family as well as society as a whole.

I. INTRODUCTION

We have a big problem and we are just about to undertake a solution.

"We" are the social service providers who offer a broad range of services in the fields of chemical dependency and substance abuse, domestic violence, adult sexual assault, and child sexual assault.

The "big problem" is that, by and large, we aren't trained - even in a rudimentary way - in other fields besides our own specialty. The "big problem" is that we are not encouraged organizationally, nor do we challenge ourselves as individuals, to coordinate services with other individuals and agencies. The "big problem" is that the women we try to help are complete and whole human beings, but we are a part of a system that keeps treating women as though their separate problems belong to separate people. Far and away, our biggest "big problem" is that some women who come to us seeking help are not getting better; not recovering from chemical dependency; not escaping domestic violence; not healing from adult and child sexual assault.

Clearly, we are overstating all of this to make a point. These problems may or may not exist in each community - or exist to varying degrees. But, it is probably safe to say that most service providers have days when all of these problems collide and threaten to overwhelm them. Those are the bad days.

Then, there are the good days. We realize that each problem has a solution. It is with this optimistic, solution-oriented attitude that the Washington State Coalition on Women's Substance Abuse Issues embarked on this project. The Coalition convened an advi-

sory committee to oversee the writing of an educational curriculum. The intent of the curriculum is to:

1) Break isolation. The advisory committee believes that the isolated, and in some cases competitive, atmosphere in which we currently work often fails women in their recovery. It certainly discourages many of us as workers.

2) Identify specific problems within each community. Workers are isolated from one another for reasons that are particular and unique to each community. It is one goal of this project to help communities identify the specific roots of the isolation.

3) Foster cooperation to address and resolve each problem. Although we recognize that the lack of cooperation has different causes from one community to the next, we believe that the single act of getting together to talk things out will work no matter where we go. We are not nearly as effective as individuals, or individual agencies, as we could be if we cooperated.

This handbook is a guide for you - the trainers - who will be going out to communities to facilitate problem solving sessions with service providers. This document summarizes seven months of intensive work performed by the curriculum advisory committee.

II. BACKGROUND

This curriculum was produced by the Washington State Coalition on Women's Substance Abuse Issues (WSCWSAI). Although relatively new - the Coalition was founded in March 1990 - its accomplishments are many-, including three annual statewide conferences, and a major report entitled *Women and Addiction in Washington State* published in October 1990. A copy of that report is included in your materials and should be read for a detailed account of the growing movement to address women's drug and alcohol treatment issues in Washington state.

On December 1, 1994, WSCWSAI entered into a contract with Tacoma Community College[1] to develop a curriculum to cross train workers in the fields of chemical dependency, domestic violence, sexual assault, and child sexual assault.

Here is What that Contract Said:

The purpose of this contract is to develop a training curriculum, including resource materials and handouts to cross train staff of chemical dependency programs, domestic violence programs, and adult and child sexual assault programs to better meet the needs of clients who are both chemically dependent and victims of domestic violence and sexual assault.

[1] The Tacoma Community College connection might be confusing. TCC holds the state contract to provide general education on women's substance abuse issues; that is, for a variety of audiences, not just community college students. WSCWSAI has a subcontract through TCC to develop this curriculum, and this curriculum is not being designed for use in community colleges.

WSCWSAI shall:

1. Form and facilitate a curriculum development advisory committee that will provide input to WSCWSAI and will include, but need not be limited to, representatives from the Washington State Coalition Against Domestic Violence shelter and program staff adult and child sexual abuse treatment counselors/advocates, Division of Children and Family Services, and the Division of Alcohol and Substance Abuse. Submit list of advisory committee names to TCC by December 30, 1994 and minutes of monthly meeting thereafter.

2. *Develop and submit to Tacoma Community College by June 1995 a written curriculum, ready for submission to DASA, which includes: the targeted audiences: the required expertise of the trainers; the learning objectives and training content for each of the targeted audiences; protocols for each targeted audience outlining the role of that program's staff; handouts; bibliography; and recommended training format.*

3. *Develop model protocols for each targeted training audience, by June 1995 outlining the role of the programs/agencies, the referral process, and the appropriate resources for assisting patients/clients in their chemical dependency recovery and their healing from abuse.*

4. *Report to Tacoma Community College a monthly report on progress toward accomplishing items 1-3 above.*

December 1994 Hold 1st monthly advisory committee meeting. Hire staff (curriculum coordinator and office support).
Collect current curricula and training outlines.

January 1995 Advisory committee defines curriculum outline and topics

February 1995 Complete draft of curriculum outline.
Complete draft of chemical dependency section of curriculum.

March 1995 Finalize chemical dependency section.
Complete draft of domestic violence section.

April 1995	Finalize domestic violence section. Complete draft of sexual assault section.
May 1995	Finalize sexual assault section. Complete bibliography handouts, trainer qualifications, format.
June 1995	Submit curriculum final package to Tacoma Community College

Early on, the curriculum advisory committee made several changes to the structure of the project.

First, the committee decided to meet more often than monthly. Because we were working on a short timeline, and because committee members felt dedicated to producing an extraordinary product, meetings were scheduled every three weeks for the six months of the project. See Appendix A for the reports that came from each of those meetings. Tapes and transcripts of the meetings are also available.

Second, the group went from the notion of "cross-training" to one of "integrated training." This was a major shift in the way we were thinking about doing the project. Originally, the intent was that groups of professionals in a particular field would convene to learn about the other fields (i.e., chemical dependency counselors would be trained on domestic violence and sexual assault; battered women's program staff would be trained on drug and alcohol abuse, and so on). What the advisory committee came to realize in our discussion, though, was that opportunities *already* exist for professionals to learn about each other's issues. There are excellent books, videotapes, workshops, and conferences that are readily available to everyone. It could not simply be a lack of knowledge that kept professionals from crossing the artificial lines that separated disciplines.

There had to be other factors that kept us from working more cooperatively to assist the women who were coming to us for help.

Advisory committee members used their own experiences to discuss the barriers to cooperation.[2] Many problems emerged, and more will come to light as we go out to different communities.

The committee decided that we would only be reinforcing isolation by training the four fields separately. If our goal was to foster cooperation, then we would have to model *it.* That is how this project came to be designed as it is. Where the contract called for us to develop specific training materials and outlines on chemical dependency, domestic violence, and sexual assault, we decided instead to focus on developing a training *strategy* that would involve all people who attended our trainings in a process of identifying,

Third and lastly, we changed the concept of one statewide product, to a training process that is more flexible - one that is customized to meet the needs of individual communities. Because there was broad representation on the advisory committee from all over the state, we came to realize, and appreciate, that there are a variety of ways - not just one way - to provide excellent treatment for women. We also realized that each community is different when it comes to the barriers that exist to providing comprehensive and cooperative services for women. Every community has different resources, experiences, funding, and community commitment to dealing with social problems.

[2] These are outlined in the Topics section of this manual - under "barriers to cooperation."

III. ASSIGNMENT

The following is the assignment for the training team.

Be positive and have fun.

Be courageous and explore - even the difficult issues.

Be perceptive and help communities identify all their strengths and weaknesses.

Be creative and help problem solve.

Be optimistic and instill hope.

That's all.

We are not asking you to go into a community and create model programs - to fix all the mis-communication and uncooperative dealings that have been going on in a community for perhaps decades. We want you to help service providers figure out a few completely manageable things they can undertake to improve services for chemically dependent, battered, and sexually abused women. We want community members to think about improving services - not perfecting them. When you go in to work with a community, if one key player at the sexual assault treatment agency changes his or her attitude about alcoholism, or one chemical dependency agency starts to work with the domestic violence shelter to do a support group - then you have succeeded.

To the best of our knowledge, a project of this nature has never been undertaken, so you are breaking new ground. Hopefully, when you are successful, we can use this pilot project as a model - both for

future work in Washington as well as around the country.

We will use the term "training" throughout this document, but only for lack of a better term. "Exploration" is probably more in keeping with the spirit of the advisory committee (though we don't want you to bill the trainings as explorations because that may scare some people oft). We are asking you to facilitate a long discussion among community members. Let them do most of the talking. We do not want you to dominate the trainings. If you spend three days lecturing, the community will probably be in the same shape when you leave as when you arrived. But if you spend three days cajoling, refereeing, encouraging, facilitating, challenging, leading, (following), mediating, reconciling, and otherwise cheer leading the community members to talk, argue, agree, disagree, compromise, teach, and learn with one another - then we think that will really make a difference. We want you to be the excuse for people to get together, and, once everyone is in the same room, we want you to be the catalyst for change.

We are asking you to help communities explore the answers to the difficult questions. Things like why are women under-served and treated in a piecemeal fashion when they seek help? Are women falling through the cracks? How do workers cooperate when women come to them with a long list of problems? Do agencies see the same people over and over again? Do the same clients make the rounds of social service agencies seeking help from everyone in turn? There are a lot of other questions. Find out what community members are being too polite - or too politic - to ask.

We have not put together here a package deal for you. We do not have a set agenda for the trainings - follow these four lesson plans and your problems will be solved. Every community is unique. And as such, the problems will be particular to those people and agencies. Address the real concerns, not the theoretical

Have fun. Be creative. Assume that people really want to get to know one another, and that everyone wants to come to a better understandings of how to help women solve their many problems.

Change can be scary and you may see people dig their heels in when they discover you are asking them to look at their fundamental beliefs. You may find service providers crossing their arms and

saying things like "but we've always done it this way," "oh, That's not possible," "our funders would never go along with that" Your job is to reassure people that things can be different. No matter what precedent has been set, no matter what constraints exist, service providers can create small and large changes to make things better for their clients - and to make their work more rewarding for themselves. Plant the seeds of some new ideas - some will sprout and grow.

People are burned out. No matter what community you go to, we think everyone will tell you that. Don't let them get themselves down, and don't let them get you down. Instill hope. There are solutions to every problem, and people will find them faster working together rather than struggling alone.

Only good things can come about when community members get together. You have the fun job of being there and helping it happen.

direct and respectful - in fact, showing that disagreement sometimes leads to understanding and compromise.

We want a team that grasps the basic differences between the fields and can describe those differences - either explaining how the differences are not really differences, or, alternatively, why the differences are very real and need to remain that way. The training team must be skilled in opening the door to difficult issues, bringing the issues into the open, and talking about them.

We want a team of people that models:

- ***cooperation,***
- ***respectful disagreement,***
- ***down-to-earth problem solving,***
- ***good humor,***
- ***and, hope.***

An excellent speaker and an excellent listener

The trainer must be succinct, dynamic, enthusiastic, and experienced. Depending on what is called for in a community, there will be varying needs to actually lecture on a given topic. Trainers need to be prepared to meet the needs as outlined by a community.

Ironically, we want speakers who don't mind being quiet. We want trainers who can recognize, validate and give authority to people within the community who are the true on-site experts. There is value in being an outsider, being objective, and pointing out the great resources that exist within a community - to say "Yes, this person is right. You have a treasure here - a real authority."

Cooperative

This is a training team and each member must be willing and able to work as part of a unit.

Self-motivated

Although there is a project coordinator who will serve as the team leader, each member of the team must be highly self-motivated, creative and enthusiastic. Because the Coalition steering and executive committees meet only monthly, or every other month, there are limited opportunities for contact. The training team will meet with the Coalition to get direction, and to report on progress, but

the team is on its own to carry out its mission and will not be supervised on a daily basis by Coalition personnel. (Individual Coalition representatives will always be available for telephone consults.) This project incorporates unique and innovative approaches - and requires training team members to show initiative, leadership, and problem solving skills.

Perceptive

Many things will be "said" by training participants that are not verbalized. Trainers must be skilled at picking up on body language. We are counting on trainers to help training participants acknowledge their thoughts and feelings, and articulate, as clearly as they can, their concerns.

Evocative

Trainers must be skilled in drawing people out. We want community members to do most of the talking. We want a free and lively exchange among community members.

An Excellent Negotiator

Negotiation is an art. Trainers need to be talented in helping community members listen to and understand one another. At times this will require trainers to be a combination of interpreter, referee, magician, and saint. If the goal is to help training participants to come to real agreements and to forge strong and lasting bonds, then there will undoubtedly be the need for some skilled negotiation.

Knowledgeable and Committed

Trainers must be experts in their given fields. They must be able to "talk off the top of their head" about any aspect of the core issues and philosophy. Circumstances are liable to change very quickly during the trainings so trainers need to know their fields inside out to be able to respond. Knowledge of history as well as a vision for the future is also important.

A Strong Advocate

All trainers must be, at once, a strong advocate for their own field and a strong advocate for the project. This means that a trainer must have the attitude that their issue is the more important issue, (and thus be ever alert to pointing out when and how their women are impacted). At the very same time, each trainer must under-

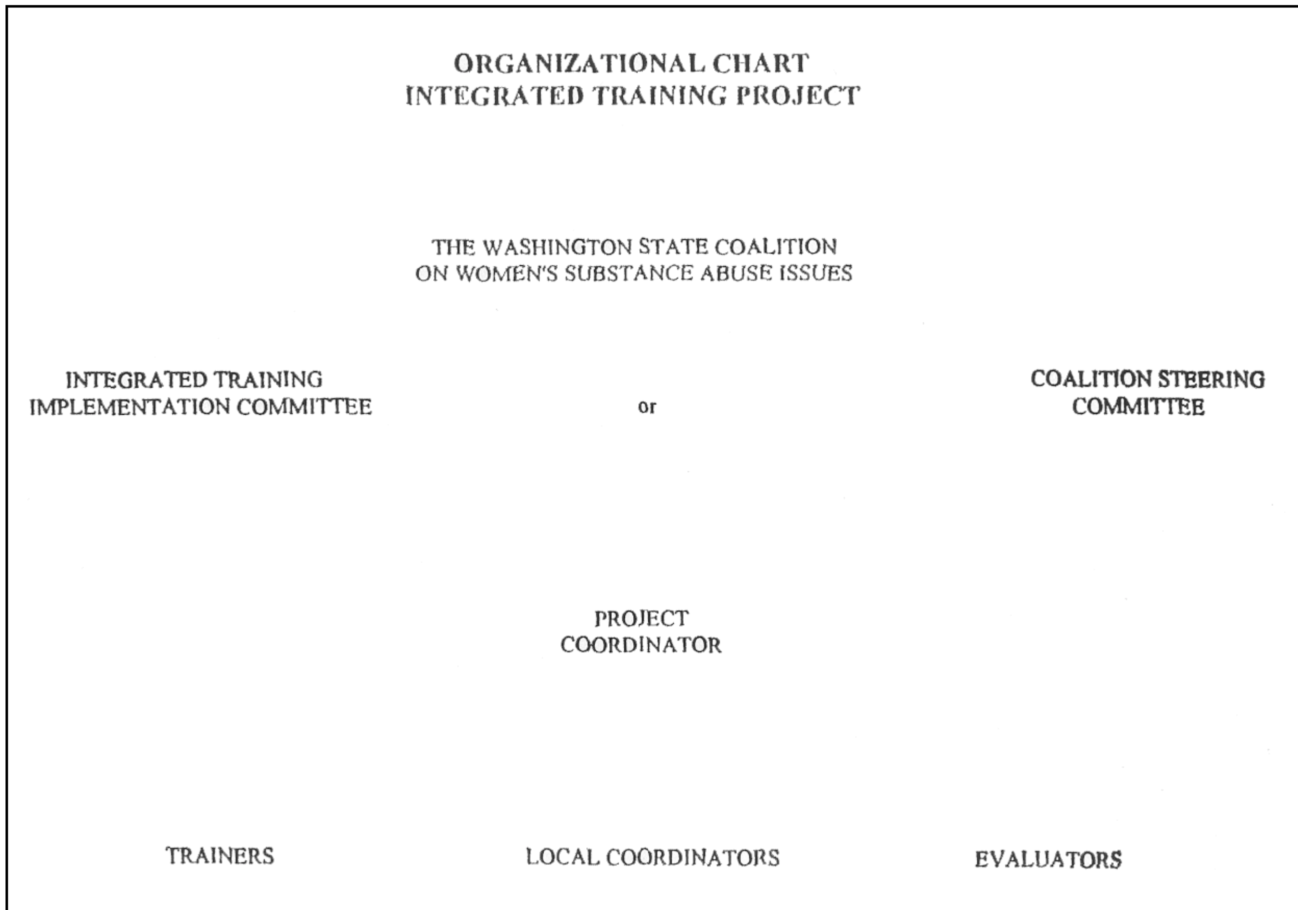
stand, and believe, that none of the issues is more important than any of the others. There is no hierarchy of suffering, no protocol that can be established that would dictate which problem gets dealt with first for every single woman. Any of the issues can be the major stumbling block for a woman in her search for recovery and health - or for survival.

The training team will model how the four fields can work together. The project will be a success if the communities want to emulate the training team after the training is over.

12) The trainers do the trainings.
13) The training team, evaluator(s), and Coalition Committee meet to discuss what happened and to give recommendations for the next phase of the project.

1) The Coalition finds a project coordinator.

The Coalition is ultimately (contractually) obligated to carry out this project in a manner specified by the finder. The Coalition is, therefore, responsible for hiring someone they feel will be capable of performing all the work necessary to ensure a successful outcome. The Coalition will find a "project coordinator" who will be accountable to the Coalition Board of Directors for the results of the project. Once the project coordinator is in place, it is up to the Coalition to set up a mechanism to monitor the progress of the project (see next step), and it is up to the project coordinator to follow each step of the process in a timely and efficient manner.



2) The Coalition appoints and empowers a committee to oversee the project.

The Coalition Board will appoint a committee whose sole purpose is to oversee this project. The committee will be called the Integrated Training Implementation Committee. (We'll refer to it as the Implementation Committee throughout this section of the manual. This Implementation Committee should not be confused with the curriculum advisory committee which is the group that produced this document. Hopefully, several of the members of the advisory committee will agree to serve on the Implementation Committee.) The Coalition will set out the roles and responsibilities of the Implementation Committee, and clear lines of authority will be put in writing by the Board of Directors (i.e., who has the authority to take what kinds of corrective actions if the project falls behind, or runs into other difficulties). The Implementation Committee will serve as the main support for the project coordinator and the training team - for problem solving and moral support. There are two meetings (outlined below) that the Implementation Committee will be required to organize or attend, but other meetings can be held as necessary.

3) The Coalition chooses two pilot sites for training.

There was discussion at the curriculum advisory committee meetings about how to choose sites for the two pilot projects.

One thought was to have the Coalition solicit applications from communities that wanted to have the training piloted in their town. Having communities meeting ahead of time, and going through an application process might indicate, or contribute to, commitment on the part of community members to putting on a successful training.

This idea may have merit at some point in the future - after we have piloted the trainings and they are successful. Theoretically, word will spread through the state coalitions and networks that these trainings are dynamic and useful, and communities will be motivated to go through an application process to have the training team come to their town. If the Coalition adopts an application process at some point in the future, they will develop guidelines and such at that time.

For now, we want to do the easiest thing possible so the two pilot trainings get off to a smooth and expeditious start.

The advisory committee recommends that the Coalition choose two sites and simply inform the training team of their decision. It's most logical to choose sites that are already known to have budding or functioning cooperative networks of some sort. Additionally, it would be simple to choose two sites from among the locations represented by people who have been serving on the advisory committee. Theoretically, members of the Implementation Committee have a vested interest in seeing the project succeed and will be eager to assist the training team to put on the trainings.

One suggestion was that we start with Spokane and Tacoma as the two pilot sites. There was objection to this, though, based on the fact that they are both urban areas. If we used them for our pilots, we would not be testing the effectiveness of our approach in rural Washington. We do want to do an east and west of the mountains distribution of the two pilots. It would be ideal for the Coalition to pick a rural and urban site, one on the west side and one on the east.

4) The project coordinator finds four or five trainers.

Following the guidelines outlined in the "Qualifications of Trainers" section of this manual, the project coordinator will find four or five trainers for the project.

5) The Project Coordinator finds a local coordinator at each pilot site.

The project coordinator will find one local coordinator at each of the two pilot sites. *The local coordinator will handle logistics only.* The local coordinator will do such jobs as: secure appropriate meeting places, coordinate the set up and tear down for each meeting, get equipment as necessary (things like TV, VCR, overhead projector), deal with food and drinks, make sure the correct numbers of copies of handouts are made for each meeting, maintain the local mailing list, do the mailing of materials and notices that are generated by the training team, be the local contact for questions concerning logistics, and take on whatever other logistical type tasks are assigned by the project coordinator and training team. This is an event coordination position only. This person will have

no responsibility for things like training content, or deciding whom within the community will be involved.

6) The Coalition decides how to do project evaluation.

Please see section entitled "Evaluation" for details about the roles and responsibilities of the Coalition and project coordinator.

Briefly, it is the responsibility of the Coalition to make sure that the evaluation is carried out. The advisory committee has made recommendations about what needs to be evaluated, and has devised a process for volunteers from the advisory committee to continue their work on this project by serving as process evaluators. If the Coalition approves the process that the advisory committee recommends, then the project coordinator will both solicit volunteers for the process evaluation job, as well as monitor the development of evaluation tools for training participants.

7) The training team meets to get oriented.

Convening an effective training team is the key to the success of this project. The project coordinator along with the four or five trainers will have an orientation meeting to start their own process of becoming a cohesive, smoothly functioning team.

All training team members will be required to have read this manual and digested the materials contained here before coming together at this meeting. Discussion about any concerns or questions about the project can start here.

8) The training team meets with Implementation Committee that is overseeing the project.

Shortly after the training team orientation meeting takes place, the training team will meet with the Implementation Committee. Both meetings could theoretically happen on the same day, with the training team meeting in the morning and the joint training team/Implementation Committee meeting in the afternoon.

There are two goals of this meeting. The first is that we want the Implementation Committee to answer any questions the training team may have about the project. The Implementation Committee wants to be sure that the training team is clear on the intent

of the trainings, and what the short and long term goals of the project are.

The second is to get firm commitments, in writing, from the training team about tasks, and time lines. The Implementation Committee can use the agreement to monitor the progress of the project. The agreement can be flexible. This is, after all, a pilot project. Depending on how things go, time lines and tasks can change to accommodate reality. Some things may go more smoothly than expected, others may be more difficult and time consuming.

9) The project coordinator ensures contact with the community leaders in the two pilot sites, and coordinates all members of the training team and the community leaders to set up a planning meeting.

We need to define a couple of terms here before we go any further.

"Community leaders" are the people who are the biggest movers and shakers in the fields of domestic violence, chemical dependency, and child and adult sexual assault within a community. The "leaders" are not necessarily the directors of local agencies, then again, they may be. Leaders are the people who are experienced in doing their work, visionary, energetic, optimistic, and enthusiastic about participating in a cooperative project. The leaders are the people who are the most knowledgeable about what is going on in their field in their community, who know the other players in the social service arena, and who can motivate those people to get involved in this process.

As somewhat of an aside - the Washington State Coalition on Women's Substance Abuse Issues (WSCWSAI), the Washington State Coalition Against Domestic Violence (WSCADV), and the Washington Coalition of Sexual Assault Program (WCSAP) are all great resources and should be tapped when we start to locate "community leaders." Community leaders cannot stop themselves from networking and no doubt they already participate in, and are known to, the coalitions.

"Community" is whatever the community leaders say it is. The training team will take their lead on this. It is not the training team's job to look at a road map, or a diagram showing DSHS

regions, or draw a circle indicating a 20-mile radius around the town where the training is taking place and say "this is the community." The training team will ask the community leaders to talk about which sexual assault, chemical dependency, and domestic violence programs serve their area. The boundaries of the community are based on the community leaders discussion of this. "Community" may be a four county area in a rural part of the state, or a four block neighborhood in a city.

Having said all that, the next step in this process is for the project coordinator to make sure that all of the community leaders in sexual assault, domestic violence, and chemical dependency at the pilot site are contacted. The project coordinator may not do all the contacting. In fact, this is one of the benefits of having a broad based training team. If, for instance, the child sexual assault expert on the training team knows the child sexual assault service providers in the pilot area, then those people will be in contact. Preliminary work will be done to inform community leaders, as many as we can possibly identify, about the project. The planning meeting will be set up.

If the local coordinator is in place at the time, that person can do the logistical part of setting up the planning meeting once the date is set.

As mentioned earlier, there is a good chance that the Coalition will choose pilot sites from among those areas represented on the curriculum advisory committee. Hopefully, whichever sites are chosen, the advisory committee members from those areas will be community leaders and will assist the training team with information about their area, introductions to other community leaders, and help of this nature.

10) A planning meeting occurs at each site. Tasks are set for the community leaders and the training team.

The training team (the project coordinator and trainers) will meet with community leaders to plan the training.

The specific goals of this planning meeting are:

Introduce the concept behind the integrated training

PROJECT TIMELINE

	MONTH 1	2	3	4	5	6	7	8	9	10	11	12
Coalition hires project coordinator	X											
Coalition appoints committee to oversee the project	X											
Coalition chooses 2 sites for pilots	X	X										
Project coordinator hires trainers		X										
Project coordinator hires local coordinators			X									
Coalition finalizes plan for project evaluation		X	X									
Training team meets to get oriented			X									
Training team meets with coalition committee overseeing the project			X									
Community leaders are contacted			X	X	X							
Planning meetings occur at two pilot sites				X	X	X						
Training team finalizes training plan					X	X	X					
Trainings happen						X	X	X	X	X	X	
Training team, evaluators and coalition meet to evaluate project												X

Identify common goals, and reasons for participating in the trainings

Identify the community

Identify all the service providers who need to be present at the trainings

Identify the major problems, the major barriers to the four fields working cooperatively within that community, and outline possible ways to find solutions

Decide when to do the trainings

Assign tasks for both the training team and the community leaders

Introduce the concept behind the integrated training

It will be important from the very beginning for the training team to be clear about what the short and long term goals are of doing this project. To this end, the project coordinator will give introductory remarks at the planning meeting telling all community members present about the history of the project, the rationale for

doing integrated vs. separate trainings for the four fields, and the hoped for outcome of providing better services for women with multiple problems.

Identify common goals, and reasons for participating in the trainings

The community leaders will be given time to talk about commonalties, shared goals - the basic and underlying reasons why it would be good for them to get together and participate in this project. This part of the discussion on the positive aspects about cooperating, and about shared vision will serve as the backdrop to the discussion later on about problems. A continual referring back to the shared vision can also help community leaders find their way past obstacles as they come up.

Identify community

See step 9 for discussion of community. The training team will help the community leaders define the area they want to include in a training.

Identify all the service providers who need to be present at the trainings.

There were several discussions at advisory committee meetings about who needs to be present at the trainings. On the one hand, it would be ideal to have *everybody* who even has peripheral contact with the women we are serving to be there because we want *everybody* to cooperate to provide better services.

On the other hand, if we get too broad a range of people and professions at the trainings, the energy may be diffused and the purpose of the training clouded.

The advisory committee decided to recommend to communities that they limit participation to people working in the four fields - adult sexual assault, child sexual assault, domestic violence, and chemical dependency. To clarify, we are talking about those workers who have direct contact with women and who provide basic services to them.

We are *not* talking about the systems people such as funders, prosecutors, judges, emergency room doctors. Clearly these people need to be drawn into a larger process of social change that will improve services to women. But including them in a training at this point may be counterproductive. Our target audience (workers in the four fields) may be reluctant to talk about problems they

are having if funders are present. Workers might feel inhibited about talking about the failings of the larger systems if representatives from those systems were present. With too many interests present, the group could go off on endless tangents, obscuring the intent of this project - which is to get sexual assault, domestic violence, and chemical dependency service providers talking to each other.

The larger social change that we are looking for, which includes the criminal justice and medical systems, will occur in a natural progression as a stronger and more unified community of service providers from the four fields is fostered.

Given all of that, the trainers will help community leaders identify *everyone in the four fields* who needs to be involved in the trainings.

To stimulate people's thinking, the following is a partial list of organizations that might be contacted to participate in the trainings:

AA and NA

Alternative AA or NA type support groups

Alcohol and drug treatment program(s) - public and private

Detox

County health department drug and alcohol program personnel

First steps

Rape crisis programs

Sexual assault centers

Private counselors or agencies that counsel child sexual assault victims (either adults or children who are survivors)

College and university counseling centers

Domestic violence hotlines

Domestic violence shelters

Religious leaders who provide counseling on domestic violence, sexual assault, or chemical dependency

Brainstorm other informal networks of helpers - cultural and religious communities that focus on one or more of the four fields

Identify the major problems, the major barriers to the four fields working cooperatively within that community and outline possible ways to find a solution;

The problems in every community will be different - that much became clear as the process for these trainings evolved at advisory committee meetings.

Because every community is different, it will be vital to the goal of improving services for women to understand the particular, and in some cases peculiar, problems that exist in a given community. The success of this project pivots on the training team's ability to elicit an honest and complete accounting of the problems from community members. Toward this end, the training team will help community members brainstorm what all the issues are. The community leaders will be asked to talk about the ways that they can imagine an outside entity - the training team - helping the community solve its problems.

In the section of this manual that follows, entitled "Topics," we have put together some materials based on possible needs that communities might express. These are only possibilities and trainers may discover that communities have problems these topics don't address. Trainers may need to scrap all of this depending on what the community members say they need. Trainers will find a way to tailor and structure each training to what the community identifies as its biggest needs. It is our intent to not avoid the hard stuff. If there is a great deal of personal animosity in a community, then the training team will work with community leaders to address that. If people have basic misunderstandings of what domestic violence or sexual assault or chemical dependency is all about, we will give them basic information so they will understand. If attitudes are the problem, we will help people challenge themselves to think about things differently. If the training team discovers that what

the community originally identified as their biggest need is really less important than something else, then they will change the agenda and address what is most important. The training team will need to be flexible and creative.

After the list of barriers and problems is generated at the planning meeting, the training team will discuss with community leaders possible ways to address the problems in a training or workshop setting. Whether it is facilitated discussion, imparting information and educating people on a specific issue, or generally engaging in problem solving exercises, the training team will work with community leaders to plan activities that will improve the situation.

Decide when to do the trainings

At the planning meeting, all the participants can use the list of problems generated above to think about how to structure and space the trainings. For the duration of this pilot project, the training team will facilitate three day-long trainings.[3] The spacing of the three days can occur at whatever intervals the community wants but preferably one month to six weeks apart. Whatever the community leaders think will be the most helpful will be accommodated. Firm dates and times for the trainings will be set at the planning meeting. (Note: The only constraint on dates is that the project must to be completed by the end of the state fiscal year - June 30, 1996. This may be negotiable.)

Note on continuing education credits: The trainers need to make arrangements with Tacoma Community College to offer formal, documented continuing education credit for chemical dependency counselors for these trainings. TCC is all set up to do this, so it should be fairly simple. Domestic violence and sexual assault counselors are required to do a certain number of ongoing training hours each year also, but those counselors need only document that they attended the training. (The training itself does not have to qualify with any government agency or professional organization to be a certified continuing education opportunity for domestic violence and sexual assault counselors.) These trainings will not satisfy the victim services portion of the domestic violence

[3] We have been calling these "trainings" for lack of a better word. Community leaders may prefer to bill them as workshops, or community gatherings, or whatever

perpetrator treatment program requirements for ongoing education. (If you have questions about continuing education requirements, contact the appropriate coalition, or DSHS.)

Assign tasks for both the training team and the community leaders.

Both community leaders and training team members will leave the planning meeting with assigned tasks. The local coordinator, if not already in place, will be brought on quickly so that person can take over all the logistics for the training(s). The project coordinator will monitor all tasks and keep track of the progress toward completion of each.

11) The training team meets to discuss the outcome of the planning meetings (one at each of the two sites) and make firm plans for trainings.

The training team will meet separately from the community leaders to debrief from the planning meeting and plan the training. The agenda will be firmed up, and the facilitation of various parts will be assigned. If information on specific issues is needed, assignments will be made to the appropriate training team member to prepare educational materials and/or a talk.

12) The trainers do the trainings.

Based on information given by the community leaders at the planning meeting, plus other feedback received afterward from community members, plus the independent planning work of the training team, a plan will be firmed up and the trainings will occur based on that plan. Adjustments will undoubtedly be made. The training team will strike a balance between sticking to the agreed upon agenda, and being flexible enough to accommodate additional and important issues that emerge during the day. (This is where working in a team really comes in handy - being able to consult with others to see what the best course of action is given the reality of the situation.)

If several days of training have been planned, part of the training team mission will be to get as many participants as possible to commit to continuing to participate - even if it gets hard - especially if it gets hard.

13) The training team, evaluator(s), and Coalition Implementation Committee meet to discuss what happened and to give recommendations for the next phase of the project

After all is said and done, how did it go?

This is a pilot project. It is critical to analyze how it went. Training team members are asked to take notes - write down impressions. What worked? What didn't? If the pilots are successful, we might be able to take the training to many other communities and help them improve their services.

The section on evaluation contains the criteria that the advisory committee established for evaluating the project.

Problem #2

Service providers don't cooperate because they misunderstand what other service providers do. Misguided or bungled referrals in the past have created mistrust or animosity.

Problem #3

Service providers don't cooperate because they misunderstand the laws, rules and principles about confidentiality. This misunderstanding leads to limited (or no) talk among service providers about a client's situation.

Problem #4

Service providers don't cooperate because they hold old-fashioned prejudices, misconceptions, or fears about domestic violence, sexual assault, or chemical dependency. Or they have new-fangled ill feelings toward the issues (otherwise known as backlash). Service providers have a difficult time cooperating because of these feelings.

Problem #5

Service providers don't cooperate because they don't know how to identify that a woman they are working with even has another problem that someone else could help her with.

Problem #1

Service providers don't cooperate because they don't know each other.

The obvious solution to this is to get training participants to tell each other about themselves.

The advisory committee drafted and tried out doing presentations based on the following questionnaire. Two advisory committee members served as guinea pigs and gave a presentation about their agencies based on this. We changed a few things and here it is.

Introductions

Each community agency that participates in our training is asked to introduce themselves. We want to do this in a fairly structured way. We are sending you the following list of questions ahead of time. Will you please look this over and use it to prepare a 20 minute presentation to give at our upcoming training? A 10 minute question and answer period will follow your presentation. The purpose of having every agency describe themselves is to give everyone a clear overview of who provides what services. The facilitators will try to limit discussion to basic introductory information only. We'll tackle the bigger issues later.

Basic information

Name of your program.

Alternate or former name for your program, other acronyms you may be known by, shorthand names, etc.

Short history - when founded, by who, major events in your organization's history.

Is the focus of your program the same now as when your organization was founded.

How big is your agency - number of staff, number of volunteers, annual operating budget

Your services

What services do you provide? Briefly describe all your services.

What is the profile of your service users - men/women, age, race, economic status, sexual orientation, etc.

How many people do you serve in any given period of time?

What are your fees? How do people typically pay for your services.

How things go when people call you for help

How do people access your services?

When a woman calls your agency for help, what happens? It would be helpful to run through several specific and typical scenarios. Fictionalize a recent encounter and walk everyone through the specifics of how the woman contacted you, what had happened to her, what you said, what she said, and so on.

How does a woman qualify for your services?

Do you disqualify anyone from your services for any reason?

What is your intake procedure?

Do you have a waiting list? How long does it take for someone to get an appointment, or to talk to a counselor, therapist, intake worker, etc.?

For how long do you typically have contact with a woman? If there is a range, describe it.

How do people exit?

Do you provide follow-up of any kind?

If people do not ."complete" your program, can they come back at a later time? Do/can people come back repeatedly as they need help? Are there restrictions on this?

The bigger picture

What is the underlying philosophy of your program? (Why do you do your services the way you do?)

How do you fit into the larger scheme of things in your community?

Who refers people to you (your major referral source or sources)?

Who do you most often refer out to?

What is the biggest strength your agency brings to this community of service providers?

You could send out, ahead of time, a questionnaire like, this to the people who are going to be participating. Have them come prepared to introduce themselves in this way.

You could also put up a large piece of butcher paper - representational of a map of the community. On the sheet, you could write key words or phrases summarizing what each agency does - you could write as they were talking, or if this is too distracting, write after each individual finishes. At the end of everyone's talk you would have a visual aid showing all services available in the community.

Problem #2

Service providers don't cooperate because they misunderstand what other service providers do. Misguided or bungled referrals in the past have created mistrust or animosity.

Referral among service providers can be extremely problematic. Keeping up with changes in the services that various agencies provide, the coming and going of complete programs (due to grants being awarded or funding lost), and just understanding the basic ongoing services that another agency offers - all of these are big tasks.

From the agency questionnaire on the previous page, probably the most important question is:

When a woman calls your agency for help, what happens? It would he helpful to run through several specific and typical scenarios. Fictionalize a recent encounter and walk everyone through the specifics of how the woman contacted you, what had happened to her, what you said, what she said, and so on.

Service providers will not have enough time in their introductory remarks to focus in detail on this area. Come back to it in a separate exercise and have agencies walk through several typical scenes. Work with people on this until everyone understands what happens when women go to another agency for help.

Don't let people get down about how limited their services may be. Funding restrictions put everyone in the position of doing

less than they'd like. Help people be proud of what they *are* able to offer.

Help people describe their service realistically. This is not pie in the sky time-not time to daydream about what ideal services would look like. This is the time to state what reality is. "When you send a woman over to us-this is what happens."

If there are bad feelings among agencies based on misunderstandings from past referrals, help people be precise in describing the problems. Not global, specific. (Remember: if people want to talk about a specific client, it will be important to safeguard confidentiality. Require that participants not use names. Ask workers to fictionalize accounts enough to guard the women's identity.)

Problem #3

Service providers don't cooperate because they misunderstand the laws, rules and principles about confidentiality. This misunderstanding lead to limited (or no) talk among service providers about a client's situation.

The advisory committee had several lengthy discussions about confidentiality. A summary of those discussions can be found in the meeting minutes for January 10, 1995 (pages 64-66) and the meeting minutes for February 16 (page 75). Please read those passages for information about what the committee thinks are the key issues around confidentiality.

There are general philosophical issues about holding confidences that everybody needs to come to terms with. Trainers might prepare a short and concise presentation about what those philosophical issues are-just so everybody is on the same wavelength about the ethical principles.

There are also laws, regulations, policies, procedures-a plethora of rules of various sorts-that everybody must understand in order to work cooperatively.

To get people to think about how to better understand *each other's* rules about confidentiality - have each agency come prepared to a training to describe the laws and rules *they* work under.

Facilitate a question and answer period and make sure everyone understands the mechanics of this issue.

Note: each trainer would be wise to review the most up-to-date laws in their own field around confidentiality so that each trainer can speak authoritatively if confusion emerges or arguments break out about what the rules actually are and how to work with them. Make copies of relevant legislation, regulations, or whatever to serve as handouts.

Problem #4

Service providers don't cooperate because they hold old-fashioned prejudices, misconceptions, or fears about domestic violence, sexual assault, or chemical dependency. Or they have new-fangled ill feelings toward the issues (otherwise known as backlash). Service providers have a difficult time cooperating because of these feelings.

Social awareness and progressive politics about one issue does not necessarily carry over to other issues. Many social service workers hold the same prejudices and misconceptions about sexual assault, domestic violence, and chemical dependency as the general public. Clearly, this has to change if the four fields are going to work together.

This is where some lecturing might be in order. Either the trainers, or a local agency speaker, need to come prepared to give a talk about whichever field they represent. A talk should include; a definition of the problem (including medical, psychological, and social components), a history of the movement to solve the problem, some sense of where the movement is now, a description of how the issue has been received in society in general and in this community in particular and the key misunderstandings or misconceptions about the problem.

A lengthy question and answer period should follow all presentations. Or presentations should include exercises that actively engage training participants. Speakers should bring other materials for people to look at, buy or borrow - books, videos, pamphlets, etc.

Problem #5

Service providers don't cooperate became they don't know how to identify that a woman they are working with even has another problem that someone else could help her with.

The curriculum advisory committee did a lot of work on this topic. See meeting minutes for March 16 for details of the discussion on identifying problems.

The process that the committee went through to come up with these guidelines might actually work as an excellent exercise in communities. The committee broke down into small groups based on the four fields. Each small group met for an hour and came up with advice for the larger group. So, for instance, the domestic violence group came up with a list of questions that a service provider at any agency could ask a woman to determine if domestic violence, in its many forms, is a problem for her. They reported these questions and some tips about domestic violence to the sexual assault and chemical dependency people, who had the chance to ask questions and get clarification. All four of the issues gave advice and at the end of the discussion the group, as a whole, had a better idea about how to screen for or identify if a woman is experiencing problems in any or all of the four areas.

It's important that the trainers have a clear idea themselves about basic advice all trainees should get from this exercise, that way the trainers could interject advice if the small groups overlooked something.

Some final thoughts about training topics

One advisory committee member suggested having a panel of women (recovering alcoholics, sexual assault and domestic violence survivors) to talk about what was helpful and what wasn't about seeking help in this or another community.

Another committee member suggested that if the community leaders present many issues, some of which are particular to administrators and some of which are relevant to case workers, that it might be possible to split groups up and work in separate tracks to meet everyone's needs.

With regard to the training team, we will want to monitor their work by having ongoing evaluation throughout the trainings so that adjustments can be made if the training team is missing the mark on our general goals. We will want to know if the training team members are working well as a team, and if the team training concept is valuable or if it needs to be modified. Is the team responsive to the needs of the community? Is the team flexible and creative in helping the community tackle its problems? Are the team members able to address concerns of community members clearly and objectively?

How are we evaluating?

Evaluating the trainings

Nancy Reid at the Division of Alcohol and Substance Abuse talked briefly about the possibility that her division may be bringing on a person with evaluation expertise. If this happens, the Coalition may be able to work with this person to mold the concepts included in the evaluation concept's chart into a written form to be used at the trainings. If this person is not available, the Coalition will need to get technical assistance to develop questionnaires for training participants to use to evaluate the trainings.

The advisory committee has made recommendations about what is being evaluated. It is the Coalition's job to see that this part of the evaluation is carried out.

Evaluating the training team

With regard to evaluating the training team, there was a suggestion that we solicit one or two people from the curriculum advisory committee to serve as volunteer evaluators for the implementation phase of this project.

We would ask the volunteer evaluators to attend each of the trainings to be observers of the *process*. The evaluator would not participate actively in the training, but rather would observe, take notes, and report back to the trainers and the Implementation Committee.

For continuity, it would be ideal for one person to attend all of the trainings that happen in a given community. That person, then, can observe the entire process that the community goes through.

Given that there are two sites, there could be two evaluators, one for each site. We discussed the fact that it would be best to have an evaluator from outside of the community where the trainings are taking place. That way, the evaluator could be more objective.

If the Coalition approves of having the training team evaluated in this way, the project coordinator will be in charge of finding one or two volunteers, keeping them informed about the dates and locations of the trainings, giving them support as necessary, and debriefing with them after each training and at the end of the project.

The evaluators will attend each training, take notes, have contact with the project coordinator, give feedback to the trainers, and attend the final evaluation meeting.

The targeted audience

The required expertise of the trainers

The learning objectives and training content for each of the targeted audiences

Protocols for each targeted audience outlining the role of that program's staff

Handouts

Bibliography

Recommended training format

The Goal

The goal of the contract and of the curriculum advisory committee is set - but what is our specific purpose in developing a curriculum?

It seems clear from the conversation at our meeting on January 20 that we do have good ideas about how to improve services for women. How would it be if we said that the goal of doing our curriculum is? : To improve services for chemically dependent women who are victims of sexual assault, domestic violence, and/or child sexual assault *by creating social change within helping communities.*

Our group does not seem interested in devising a training where participants learn "the 17 most important facts about . . . (each of our fields)." We cannot give people mere facts and hope that they will somehow change the less effective ways they work with the women who come to them for help. This group is talking about much larger social change. A more long term and deeper process needs to be undertaken if improvement in services to women is to take place.

To do that we must bring together all the practitioners who work in a given community those who are working with women in one or more of the four fields (chemical dependency, domestic

violence, sexual assault and child sexual assault). We must recognize that each one of these people is doing good work, and have good intentions, while at the same time knowing that, in some cases, women are not always well served. Women will not be well served until problems among the individuals, agencies and the fields are addressed.

For many reasons, people are working in isolation. They aren't talking to one another.

There was discussion at this meeting about the problems inherent in working in an urban environment, and those in a rural environment. Those working in cities tend to have many resources that rural people do not have. Urban people, with all their resources, have their own problems. For example territoriality issues may keep the many practitioners from cooperating with one another. Even though rural areas are sometimes thought to have no resources, there are, in fact, always people in every community who are doing the work. They may or may not have the proper training. They may or may not be credentialed. They may or may not be skilled. Regardless, we have to encourage communities to work with what they have and bring everyone into the conversation about how to improve services.

We can do this by getting members in the helping communities to either:

a) Talk with one another - this is assuming that the helpers have never had the opportunity to even meet one another
b) Patch up their relationships - if working relations have somehow been damaged in the past, the time has come to work things out, or
c) Learn to work together - even if the practitioners have more deeply felt animosities toward one another. It is vital that workers embrace a larger vision - one that will enable them to work together even when conflict is present

Training Process

We are talking about developing a training *process* that is long on teaching communication. Part of our goal is to mediate disputes about problems people have had with one another in the past. Several task force members shared stories about misunderstandings with other agencies that damaged working relations. These are the things we will attempt to bring to light and resolve.

Let's backtrack for just one moment. Why are we even taking this approach? Why are we looking at an integrated model for training? Task force members agree there is an underlying problem. Women may not benefit from any of the services we provide when they are treated in a piecemeal fashion. The group agrees that trying to get women to compartmentalize themselves and only talk about one problem at a time (and that on a predetermined time line) is not working.

Even as the awareness of all four issues has been raised, many service providers still don't recognize, validate, and prioritize the "other" problems that exist ("other" is whatever field you are not in). Chemically addicted women are vulnerable to other problems because they are chemically addicted. The vulnerability is a function of being a woman, regardless of whether sexual or domestic violence has ever been present. All of these things need to be recognized and talked about.

Many women fail to recover from drug and alcohol abuse and dependency because they are not helped when they disclose sexual assault, child sexual assault, and domestic violence. It is often the case that an arbitrary time line is imposed upon her (i.e., "you have to have two years sobriety before you can deal with your sexual assault issues"). The task force believes women need to be treated when they want to be - and not when someone else thinks they are ready.

Some treatment providers continue to believe that the "other" problem will go away when the "most important" issue is dealt with. Or worse, that if the "other" problem emerges, it will undermine or sabotage treatment for the "main" problem. The task force wants to replace these notions with a more holistic view.

We agreed that we are going to target community-based groups. We will train an integrated group of people; meaning a group that must include workers in the four fields of chemical dependency, domestic violence, sexual assault, and child sexual assault. We will train workers who are currently engaged in providing services, as opposed to academic groups or people brand new to the fields.

Topics

We agreed that the following topics will be covered in the training:

A) "Getting to know you" - what we want the training participants to tell one another about the background for each of their agencies and fields.

B) Facts and figures - who is impacted by chemical dependency, domestic violence, child and adult sexual assault - who is doubly/triply/quadruply effected?

C) For the women who have these problems, what are the causes and contributing factors (e.g., family history, chemistry, genetic predisposition, societal values and messages, sex roles, media images of women)?

D) What do women have to say about the services they are receiving?

E) What are the best ways to help? What strategies do we employ to help women? Do these strategies always mesh?

F) Safety concerns - safety of workers, and safety of the women we are helping

G) Medical issues - disease model of addiction, injury and trauma, delayed stress disorders, other diseases - and the opposite of all of these - health, including healthy sexuality

H) Mothering

I) Backlash - the politics of taking societal awareness, of all these issues, and making social change.

Several refinements were offered to the above list at the meeting. Under the topic of "What are the best ways to help?" we'll add a part on assessment (i.e., if you work for a sexual assault center, how do you determine if a woman is having problems with drugs and alcohol; if you work for a chemical dependency program, how do you screen for domestic violence). How do we each screen for the various problems? What do we ask? When do we ask? Why do

we ask? How do we ask? DO we ask (or do we wait for a woman to bring issues up herself?)

After the Training is Over

The other overriding question is how do we approach the learning process in a way that encourages individuals, agencies, and communities to do ongoing work to better meet the needs of women - that is *after the training is over*? For example, in the "getting to know you" topic, how can we introduce each of the individuals within a helping community to one another in such a way that they are interested in continuing to interact and learn even more about one another after we are gone? Another example is in the "mothering" topic. If a helping community identifies that there is a misunderstanding about interactions with CPS, how can we help the community form an action plan - a plan that may take several months, or even years, to carry out? How we help people carry on after the training may have more to do with the implementation of the curriculum, rather than the presentation of actual materials. Implementation is covered later on in this report.

One of the themes that emerged repeatedly during this meeting, and our first meeting for that matter, was how to balance the needs of "process people" with those of "product people." The process people are those who can talk endlessly - and be completely satisfied - about *how* a group interacts. The most important thing to them is feeling good about the relationships of the people in the group as they have exciting conversation about theory and philosophy. The product people, on the other hand, enter a meeting with a goal in mind - a concrete thing they want to accomplish and they will tolerate process only enough to accomplish the task they have in their mind. They want the group to accomplish something they can put their hand on - something tangible. If they spend their valuable time in a meeting, then they want the product to be worthwhile and useful. Let's face it. The world needs both process and product people.

Clearly, no one person is all one or the other (although you can probably conjure up people who are pretty close to one or the other.) The goal of this curriculum is to serve both types of individuals. We want the hands-on or product people to engage in the process of building community. And we want the process people, when the time comes to do so, to help make concrete agreements

with their fellow social service providers about how to provide more effective services.

This will be a balancing act. The curriculum requires trainers to be balanced, either as individuals or as a group, in the process/ product realm themselves. The trainers must be perceptive enough to judge how the training group is doing in this regard, and be assertive enough to keep all training participants fairly happy.

Getting to Know You

The topic we discussed during this meeting was "Getting to know you." Many interesting issues emerged and we'll incorporate these into our curriculum. They include:

- *What do you do at your agency and how do you do it?*
- *Commonalties among the fields*
- *Misunderstandings among the fields*
- *Words - what words mean*
- *Confidentiality*

What do you do at your agency and how do you do it?

There is a paramount need to spend time describing in great detail what the specific agencies within a community do and what they call it. One agency may say that they do counseling, but they need to say "and this is what counseling means to us," explaining in enough detail to be clear. We are not looking for common definitions among agencies of "counseling" and other terms. Service providers who work together just need to know that if Jane Doe goes for "counseling" at the ABC agency, she is getting a specific and known service, and if she goes to the XYZ agency, she is getting something else that is known and understood.

Commonalties among the fields

In a light-hearted vein, one thing that everyone seems to have in common is that they are called names. It might be fun to do a short exercise where the group brainstorms all the things they have been called - expletives deleted - so that everyone can see they are all in the same boat in this regard.

There is another common experience that was mentioned by committee members. That is where clients, no matter which agency they are at, ask direct questions about whether or not the counse-

lor or whoever is helping them has had direct experience with whatever the client's problem is. For example, "Are *you* an alcoholic? ", or "Have *you* ever been raped?" or "Do *you* have kids of your own?"

We talked about putting forward the concept of "wraparound services," those that embrace a woman who has multiple problems. We want to get away from "we will help you with this and only this, those people over there will help you with that, and only that. And we will not talk to each other to facilitate you getting what you need from all of us."

We also talked about focusing on the interrelated nature of all the issues rather than getting caught in discussing which problem causes the other. The relationships of all the problems are too complex to come up with a definitive answer to the question of cause.

Misunderstandings among the fields

Agencies often misunderstand what services are available from other agencies, and how those agencies decide whom they will help. Animosity is too often the result as workers make inappropriate referrals and don't understand why a client is turned away from another agency or does not receive the types of services that were expected. For example, most domestic violence shelters will not house women who are actively using drugs and alcohol. Some chemical dependency programs only serve insured or high-income women, some only serve poor women. There is a rationale for why agencies do things the way they do and this must be communicated.

There are very basic misunderstandings among the fields that result from lack of information about each other's issues. For example, sexual assault counselors see rape as violence and not as sex; power is the issue and sex is the weapon. Counselors in other fields may have a difficult time talking about sexual assault because they may not have given thought to these larger issues around sexuality, power and violence. Similarly, domestic violence counselors may be ignorant about substance abuse issues and they may not understand the different levels of treatment, or the role of relapse in recovery.

Legal issues are often misunderstood. The laws and the legal system are complicated. Each of the four fields has generated pub-

lic pressure to pass laws and mold a court system that deals with each of the four issues in a particular and idiosyncratic way. It is very important that workers in all four fields have a general sense of how the court system works to deal with each of the four issues and the rationale for why the systems and laws evolved the way they did. Women with multiple problems will, at times, be tangled up in court processes that work at cross-purposes, and service providers who work at cross-purposes. Unless everyone works together and understands the underlying reasons for the laws being the way they are, the chances are greater that a woman's involvement with the legal system will be unbeneficial.

Court mandated treatment was a big topic of conversation at this meeting. The courts mandate many things in cases involving drugs and alcohol. For example, the courts impose time lines on women whose children are in foster care to meet certain goals before they can get their kids back. The drug and alcohol treatment field sees benefit in forcing people to look at their chemical dependencies and having a chance to experience or explore the alternative. Having the courts mandate treatment is a desirable thing. On the other hand, court ordered *anything* (for victims this is, not offenders) runs counter to the philosophy of domestic violence and sexual assault programs. These programs do not want women court ordered to groups, or shelter, or any other services because they want to offer all their services on a completely voluntary basis. Underlying that is the belief that if victims are made aware of the help that is available in the community, they will know what is best for them and will seek it when they are ready. If the courts make a victim use a service she does not want, that may reduce the victim's chances of seeking the service later when she is better equipped, for whatever reason, to benefit from using the service.

Words - what words mean

Enabling, victim, co-dependency, toxic, secret, powerless, powerful, case management, counseling, and advocacy - oh, yes, and feminism-were the main words we identified that people had different ideas about. We may be able to develop handouts that cross-reference these words to describe the concepts that are being put forward. It might also be possible to get critiques from the various fields about how concepts have changed over time. For example, the notion of "co-dependency" has changed in the alcohol treat-

ment field since feminists have been involved in providing treatment.

Confidentiality

Many issues emerged about confidentiality and it is apparent that we will have to develop handouts and facilitate detailed discussion among training participants so that everyone understands the various constraints and subtleties about confidentiality. Roughly, these concepts about confidentiality can be summarized as:

1) Understanding the *ethical* and the purely human side of holding a confidence.

Someone tells you something very personal and painful to them. What does that mean to you as a person? Regardless of what rules and laws are imposed upon you by your agency and by state and federal governments, confidentiality boils down to basic respect for other human beings.

2) Understanding the *political* issues that are involved in holding a confidence.

If you betray a confidence, it can cost another person their job (prejudices against alcoholics) or their life (batterers who hunt down their partners and kill them).

3) Understanding the *government rules and regulations* as well as agency rules and policies.

(These agency rules may or may not jibe with state and federal rules.) Laws sometimes tie us in knots. The state WACs that direct sexual assault and domestic violence programs on confidentiality are literally a paragraph long. The federal regulations that are imposed on chemical dependency programs are a booklet. This is a stark juxtaposition.

There are a lot of problems with how people handle confidentiality. For example, some agencies have policies of getting blanket signatures on legal release forms without really taking into consideration the breeches of ethics and politics that may occur as a result of getting releases prior to knowing if and how they will be used. At other times, some agencies may use government rules and regulations as a means of legitimizing their misplaced sense of territoriality over the women they are helping - failing to cooperate with other workers at times when they could. This becomes an

ethical issue. If people use government rules and regulations as an excuse for not cooperating, then they are really only guarding their turf.

This may be a really good place for written materials that cross reference the various rules and regulations on confidentiality that bind the four fields. I can do an English translation of the federal regulations - or use the guidelines that Jane says she has from the legal action center - or some combination. Handouts would be really helpful here.

4) Understanding the *personal* issues that you as an individual have when you know someone else's story.

This may be the most complicated issue related to confidentiality. A counselor wants to make sure that there is an overriding understanding with a client that confidentiality will be strictly upheld because the counselor wants to create an environment where all the "nasty secrets" of the past can come out, be talked about, and be resolved. But the issue of secrets can get cloudy. "Keeping a secret" and invoking the power of secrets is a survival strategy that works (or at least maintains stasis) for many of the women we see. Some women attempt to engage us in this old pattern. So for example, an alcoholic woman will tell a secret to one counselor and beg that counselor to hold that secret (invoking confidentiality) from the woman's other counselors - even though the secret may lead to relapse or a continuation of other problems. Some people call this "manipulation" - but manipulation can have a fairly negative connotation. Again, "secrets" and "manipulation" are all survival strategies.

How a counselor chooses to deal with this behavior around secrets and confidentiality is a test of their own understanding about these issues. Some counselors who have not fully comprehended the personal issues surrounding confidentiality may become irate at clients who they view are "lying" to them, or may take it as a personal affront that a woman is attempting to manipulate them. Other counselors see the attempts to use secrets as a normal part of the healing process, and take the time to guide a woman in her exploration of what is really true and what is not, and toward a

realization that if there is a lie or if there is manipulation, the only person she is hurting is herself.

If we can lead training participants through a detailed discussion about confidentiality, we may then be able to get them to talk about how they can unify their various interests and, if at all possible, create forms that will streamline the process of getting legal releases. Perhaps we could ask the program managers and those funders who impose regulations on all four fields, to put their heads together to write a model form.

Although people tend to get tied in knots about laws and regulations about confidentiality (particularly as regulators place such heavy emphasis on these regulations and at times even threatening to fine us if we don't follow the rules), the laws still tend to be a smoke screen for the much more difficult personal, ethical and even spiritual issues that are at the core of the helping relationship. Raising people's awareness about these issues can be helpful to improving services to women.

Implementation

It is difficult to look at the goals of this project and to explore the topics without thinking about implementing them. I keep coming back, in my own mind, to "what's it going to look like? When we go to a town and set up and have people come in, how are we going to present all this great stuff?" So I have given this a little thought and have come up with some ideas to blend with those several of you mentioned at our last meeting.

Facilitate

We can facilitate a fabulous training in a community by:

1) Convening a group of trainers who are skilled in all four fields and who are also skilled facilitators and negotiators.

2) Advertising to the entire state that we are looking for a couple of communities where we can pilot our training. Include in the advertising that we are piloting a social change type of thing that incorporates a completely integrated look at the four issues. Tell people right out that we are specifically looking for communities that have visionaries within them who would jump at that kind of a training. (Theoretically, the people on our

advisory committee here are talking it up at home and would be interested in having this training happen in their town or city.)

3) Accepting applications from communities where people are willing to invest the time and energy in the training and are psyched about it.

4) Picking one urban and one rural site and piloting the project there.

5) Sending the facilitators to the two communities prior to the actual training to meet with local community leaders from all four fields to plan the training. A "community leader" is anyone who calls her/himself one. It can be anyone, and everyone, who views their role within one or more of the four fields as being a mover and shaker; someone who provides services, has experience in one of the given fields, can provide leadership within their field to get people to attend a training, and can inspire their co-workers to cooperate with workers from other community agencies.

There are a number of things we want to accomplish during the pre-training meetings between trainers and community leaders, including:

A) The facilitators make sure that all the community leaders are on board about the social change aspect of the training.

B) The facilitators lead community leaders through a process of identifying the geographical area to include, defining their own service community - their "region."

C) Community leaders identify all the people who need to attend the training -including all the cultural communities in the area, private and public services, people who run court mandated as well as not-court-mandated programs. Try to find 41 the people who work in the four fields to get them there. Think creatively to capture all these folks. Find the people in the formal and informal networks (that is the creative part, finding the informal networks).

D) The community leaders plan all the logistics for the training so participants focus completely on their job of talking with one another and learning new material

E) The facilitators help community leaders identify and establish community goals. What is missing in the community being trained? What would improve services in a given area? For example one community may have all services available but service providers don't talk to one another either because there are historic animosities or because they have never met - or something in between. Another community may not have well-developed services in a particular area - say child sexual assault. That community may need to work on upgrading that particular resource.

6) Perhaps we should be thinking about providing training over time. Could we develop three-day long workshops spaced one month to six weeks apart and consult with community leaders two months after the last training to either say "done" or offer more training or technical assistance? This is one idea.

That's it for now on implementation.

Communities identify and solve their own problems

One final note that I'm putting here because I couldn't think of where else to put it. This has to do with something I realized is vastly different about working with the curriculum advisory committee and conceptualizing what it will be like to go out into actual communities to provide the training.

We are coming from all over the state, we come to this group and we say "domestic violence shelters generally do this thing this way," and "substance abuse programs generally provide this service in this way." Because we, as a committee, are not a community unit, and we do not work together day-to-day, our conversations seem to turn into broad generalities and conjecture about what the ideal philosophy *ought* to be, not what our specific philosophy is. When we go out and train specific communities, *we will not be speaking in generalities.* We will want to get very specific. As an example of this, at our meeting last month we tripped over the terms "advocacy" and "counseling." When we go out to a community, we will not have this discussion, because "counseling" will

mean something specific, something that training facilitators can encourage participants to describe in detail. One of the things that will happen in our trainings that cannot and does not happen in our meetings here is that people will get down to the basic concrete facts about what they do. A good facilitator can encourage training participants to explain in detail any jargon they use. These details will vary tremendously from one community to another. We will not be bringing in a model for an ideal program, and ideal program interactions. We will be helping programs define what they do and decide on their own whether they are willing to change how they do business. There are almost infinite variations on how to provide any given service - never mind the added infinite number of variations to how the services interact with one another. We can't second guess this before we go into a community, but we can help people explain their chosen variation to each other once we are there.

In the best of all worlds, skilled facilitators help people *not* get defensive when they explain how they do things. Facilitators help people to understand that this is not about justifying, per Se, what you do. On the other hand, skilled facilitators also challenge people to see that there may be a good reason, an exciting reason, to do things differently. That is where it will be important for the facilitators to be skilled mediators. When they can get service providers talking with one another about how they do things, why they do things, what the unexpected (or heretofore unknown) outcome is of a particular policy or procedure, then things will change on their own, without the need for us to try to impose a model or an ideal. That's social change.

We may want to provide some models - like a confidentiality release form that meets the legal needs in all four fields. But it will be impossible for this task force to try to come up with model procedures, protocols, policies or whatever to meet all contingencies. Just when we think we've got all the bases covered, some community will present us with a problem that we've never heard of or couldn't possibly have imagined. Facilitators will have to be good. They must be quick on their feet to help communities problem solve some of the more obscure problems.

We are not going in to solve a community's problems, but to help them talk to one another to identify and solve their own problems.

Curriculum Advisory Committee Meeting

Washington State Coalition on Women's Substance Abuse Issues
February 16, 1995

Present - ***The following people contributed, in person or in writing, to the ideas expressed in this report: Marilyn Bordner, Marcia Gallucci, Jane Kennedy, Tyra Lindquist, Mary Pontarolo, Janie Sabedra, Christina Wildlake, and Sue Winskill.***

The February 16 meeting almost defies interpretation.

We find ourselves grappling with the most complex issues of feminism, victimization, responsibility, detection, "truth," cause, and effect. It seems like grappling with these things is half the fun (at least for "process types"). Let's hope we don't come to any hasty or false conclusions. If we can't come to a resolution during our discussions that people feel confident and fairly unified about, then we will at least have to be clear about what the questions and concerns are.

Feminism

We had another discussion of feminism. (There seems to be nowhere to run, nowhere to hide from this issue.) Sentiment was expressed that we need to include "feminism" in some form, as a part of the curriculum.

Although feminism is a charged and multifaceted issue, some themes emerged during the meeting.

We are working for improved services for women - not against something else. Mary put it nicely. "Every time we fight for the rights of any particular group, we're not fighting against the rights of all others. That's not what feminism is about." She went on to say "It's important to not run away from something we are intent on doing." It would be easy to sweep the issue of feminism under the rug because it is so controversial, but the controversy is part of the reason we are even attempting this project.

Bottom line: this curriculum is for and by women.

Can we agree on some basics? For example, can we agree:

-The specific treatment needs of women who are chemically dependent or who abuse substances has been ignored for a long time.

-The sexual assault and domestic violence political, social change and social service movements grew out of the women's movement. More recently, women have become vocal advocates for improved services to women and children who are survivors of child sexual abuse, and women who are struggling with chemical addiction and substance abuse.

-Work in the four fields has gone on separately and in isolation. The thought of integrating these issues and working cooperatively to improve women's lives is coming from women, for women.

Regardless of whether we undertake a discussion of feminism, per Se, feminist issues will emerge. We need to have a disciplined discussion during one of our upcoming meetings about what specific ideals and details we want to cover in the curriculum.

How materials (including feminism) will be approached.

This curriculum will not attempt to define or advocate for any one particular ideal approach. Because the resources, history and expectations are so different from one community to the next, there is no one ideal approach that will work everywhere.

Current approaches vary widely. This is true among the four fields. It is also true among the individual programs that make up any one field. You could have an alcohol treatment program, and a rape crisis center that have more in common with each other (in approach and underlying philosophy) than with programs in their own fields. The point continues to be that in order to provide better services for women, service providers within each community must get together and be direct, detailed, and honest about what services they provide, and how and why they do things the way they do.

In short, we may need to go Out and ask communities to form their own "special interest group" (another term that has gotten a bad reputation). We want communities of service providers to come up with a list of unshakable core ideals they can all agree upon and on which they will base all discussion, learning, and changing. For example, a community could agree "we all believe that it is important to cooperate with one another so women are treated in a caring, respectful, and holistic manner." All discussion would be measured against a short list of agreed upon ideals.

After establishing some overriding principles, and getting pretty well glued together by common goals, the time will come to tackle the difficult questions. The point of opening up the hard issues for discussion will not necessarily be to answer them - because the *answers* may be fairly elusive at the beginning.

Remember, never before have we (or anyone else for that matter) attempted to bring together practitioners from all four fields to cooperate to help women. This is ground-breaking work and we have to be patient and creative. Our committee is not going to solve the dilemmas and paradoxes of our separate fields, nor are the communities we bring the curriculum to going to solve these things. Our goal in opening up some of the difficulties for facilitated discussion will be to ease tensions, allow time for creative problem solving, and give some genius Out there (or the genius within each of us) the chance to tell us what the answers are!

Hard Questions

The "hard questions" that we brought up at this meeting fall roughly into the following five categories:

1) Mandated or coerced treatment

We hypothesized that women may fail to recover when they are *inappropriately* mandated to treatment of various sorts by the criminal justice system, or by CPS. But, mandated treatment, in and of itself, may not be a bad thing. Several committee members told of experiences they have had with women who were initially very resistant to being ordered to treatment, but ultimately benefitted tremendously from being forced to undergo education, treatment, counseling, or whatever.

Some communities have tried to educate judges that there are decent treatment alternatives to incarceration, which does little to help people change. It may be that in communities like this, we can help service providers and judges take the next step to refine the system so more women are ordered to the *right* kind of program.

The question still remains: When is it a good idea to use strategies, from nudging to forcing, to get someone to participate in a recovery program of some sort? Can mandating be harmful? If a woman does not even acknowledge that she has a problem, can education or treatment be useful? (There are at times very good reasons for a woman to deny that she has a problem. Psychic or physical survival may be at stake.) Is it possible that the *system* coercing her into treatment will be viewed as just one more in a long series of humiliating and dis-empowering experiences to the woman?

Some of the discussion in our group around this question included issues of passing judgment.

External factors

When *has* a woman "successfully completed" treatment, for instance treatment for her childhood sexual assault issues? Can a court of law determine what a successful completion would look like?

Internal factors

How do we help women to suspend their own judgments about themselves as survivors? How do we convince them that there is no "right way" to approach or go through "recovery" or "healing?" Some women believe, or are lead to believe, that if they don't do something in a particular way or in a particular sequence that they aren't a "good survivor?"

Is there a way to design mandated education or treatment so that it can serve, at the very least, as the "cognitive life raft," as Sue put it - the information and fact giving part of recovery - the part

that opens the door for some people to understanding whether or not they even have a problem, and, if so, what they can do about it?

Some sexual assault and domestic violence programs have firm policies that a woman must come to use their services voluntarily. Contact must be initiated by the woman and she is the one who decides which services she wants to use, when she uses them, and for how long. This comes from the belief that women need to be completely in charge of their lives and the decisions they make about ~ when, and from whom they seek help. Some programs believe that this is an empowerment issue. These programs do not want the courts to mandate women to any of their services. Some domestic violence and sexual assault programs do not have this philosophy, and work with the courts to provide services to which women are court ordered.

If it were determined that there is a way to provide excellent, eye opening, respectful, services for women (on issues ranging from parenting to dropping protection orders) would sexual assault and domestic violence programs, who may be entrenched in the perspective that all contact must be voluntary, go along with providing court ordered, and CPS mandated, services?

We had a brief discussion about courts mandating people to chemical dependency programs (which most drug and alcohol programs believe is a good idea) and how this is different from the courts ordering *victims* (not offenders) to sexual assault or domestic violence services (which most sexual assault and domestic violence programs think is a bad idea).

It is important for all social service workers in a community to have a basic understanding about how the services offered by other agencies work. If everyone understands the *underlying* reasons why services are designed the way they are, there may be fewer misunderstandings and problems with referral. For example, pretend that Agency A offers a support group that participants *voluntarily* attend. But Agency B *requires* that a particular client who gets referred over to that group *must* attend. Agency A might have the philosophy that voluntary attendance at their group yields the best results and suddenly they are faced with a participant who is being required to attend. This client may be resistant or even hostile

about being there. The client could become confused about whether attendance is voluntary or mandatory, the two agencies involved could be confused or angry over the misunderstanding - Agency A because they are faced with a hostile group participant who they may have to turn away, and Agency B because they lack information about why Agency A does their work the way they do. All of this is avoidable if everyone communicates clearly about how their services are designed, and why the services have evolved the way they have.

Another issue that falls roughly into this category is teaching those social service workers who don't currently have a good working relationship with the courts about communicating with the judicial system so that the judges will cooperate with them (and vice versa) in offering or mandating services.

2) Confidentiality

I included a fairly detailed discussion of confidentiality in my last report, but some of the issues that came up during this meeting were practical concerns about cooperation among experts in the various fields.

Say I am working at a domestic violence shelter and I think I am talking to a woman with an alcohol problem. I face several dilemmas. My biggest may be that my shelter does not allow any woman who is actively using drugs or alcohol to stay. The second dilemma may be that I just flat out have no information or training on alcoholism. What I want to do is pull someone in from the local chemical dependency program to talk to the woman and help her (and me) figure out what's happening and what all the options are. How do I approach the woman to ask her permission to bring a chemical dependency expert in - and what do I do if she says no? How do I keep myself from flipping out about an issue I am ignorant about and perhaps even afraid of? This goes for people in all four fields who may have fears about whatever issues they are not trained in.

How do I provide leadership within my organization to develop reasonable services that are truly helpful for women? It seems like an organizational hazard that groups are prone to making bad rules when the combination of one really scary incident gets mixed

in with ignorance and the perceived need to "do something quick so this never happens again!"

3) Assessment

The dilemma here is, "do I have to become an expert in everything in order to provide a good service?" How much training in each other's fields is a good amount?

Can we develop assessment processes and tools that help us determine *if* someone has a problem, and if so, how *urgent* is it that we refer her to *which* other program?

This will be a major topic for discussion at our March meeting.

4) Concurrence of treatment

All of the problems of sexual abuse (adult and child), domestic violence, drug and alcohol abuse and addiction are happening simultaneously to certain individuals. We see evidence of this every working day, no matter which field we are in.

We can pull together all the most credible studies that indicate this, in case people need statistics to convince them.

But, I doubt we will be working with people who doubt that the problems exist simultaneously. People *may* doubt that they need to be dealt with simultaneously.

Conventional wisdom in each of the four fields says you have to treat ___________ first (insert your field here). If you don't deal with her sexual assault issues *first*, she will continue to drink to medicate her pain. If you don't deal with her alcoholism *first*, she will be unable to make reasonable life choices and she will be re victimized. If you don't get her safe from domestic violence *first*, she will be dead before she even makes it to treatment. And so on.

Less conventional wisdom says that after the most toxic period is over for a woman who is using drugs and/or alcohol (opinions seem to vary about what the "toxic" period is and how long it lasts) then you have to deal with all issues simultaneously or there will most likely be relapse or re victimization. Less conventional wisdom also says communities have to rethink the regional availability of safe housing for domestic violence victims who are actively using.

How can we be available to work with women on all the problems they want to or need to work on when they want to work on them?

How communities deal with offering concurrent help is up to them. There is no magic answer or model program or protocol. Whoever comes up with the best idea gets to patent it and sell it for a million dollars.

It is clear that innovation and change will need to occur to help the women who are falling through the cracks now; the alcoholic woman who is as good as dead if she can't find shelter now; the woman who abuses drugs to medicate the pain from the horrid sexual abuse she suffered as a child.

5) Risk

Can we really say that to be a victim of sexual abuse, domestic violence, child sexual assault, or suffering from chemical dependency or substance abuse puts you more at risk for victimization as an adult - or puts you more at risk for addiction or substance abuse?

Clearly, many current victims of domestic violence and sexual assault, and many people who currently abuse substances were abused as children. But some were not. Some adults who were abused as children do not abuse substances nor are they current victims of domestic or sexual abuse. The number and complexity of the factors involved interact in a way that makes it impossible to give cause and effect status to the issue of risk. Perhaps this is all semantics. But some people feel that to say that people are at higher risk as adults because they were abused as children somehow, in some subtle way, attaches the notion of damaged goods. Or it infers increased danger for some adults that may or may not exist given the thousands of other factors that, all added together, determine the course of each individual's life.

Regardless of whether we could ever establish cause and effect, risk still exists. We have to have a clear understanding of some of the more important elements of risk.

The math of risk

Life is dangerous. Some people are simply in the wrong place at the wrong time. They are struck by lightening, in a manner of speaking. The average person has a one in six hundred thousand (1:600,000) chance of being struck by lightening. (I am not making this up.) That puts all of us at a little tiny risk. But one of us is *going* to be 100% struck by lightening. If you are the one, statistical risk, per se, means nothing.

The politics of risk

Risk and culpability (defined as "deserving blame") are very difficult issues for the average person to come to terms with, especially when thinking specifically about such loaded social issues as domestic violence, sexual assault, and substance abuse and addiction. But, we enter dangerous territory when one of those average people is someone with power; people like public policy makers, legislators, and finders. Many of these people misunderstand victimization, risk and responsibility.

If a definitive cause and effect relationship exists between prior and current "victimization" (for lack of a better word - I know this doesn't fit with substance abuse) then your average person *could* say, and many people in power *do* say: "If you know that you are at risk, and risk - in fact - leads to victimization, then you are in some way responsible for knowing you are on a dangerous path *and doing something about it.* If you do not do something about it - then you have only yourself to blame for your dilemma(s) and the larger society has no responsibility to help you. There is also no need for larger social change because this is a personal issue."

The day to day reality of risk

Again, life is dangerous. There are some things that are more predictable, and certainly more common, than being struck by lightening. Given a specific individual's history, current circumstances, resources, state of mind, etc., there are many real things that may increase or decrease their real risks.

There are internal factors, for instance, self esteem issues, which give a person the strength or rob the person of strength as the case may be, to make difficult changes. There are external factors, for

example, how *other* people behave, that a person has no control over.

To an unknown degree, we have control over these factors - to another unknown degree we do not. We, each of us, do the best we can playing the odds and trying to predict the future. Life is dangerous.

Conclusion for this report

Again, although we do not espouse any particular viewpoint or approach in doing cooperative work within a community, we are coming to an understanding of the questions that each community will have to discuss - whether they find the answers to these questions or not. We *do* believe in cooperation and open communication and we can fan the flames of enthusiasm for cooperative work in the communities where we train. We may be able to advise people about the best ways to assess for various problems. We can lead people to understand confidentiality so it becomes a guiding principle and not a barrier. All of these things are becoming clearer as we meet.

Curriculum Advisory Committee Meeting

Washington State Coalition on Women's Substance Abuse Issues
March 16, 1995

Present - ***The following people contributed, in person or in writing, to the ideas expressed in this report: Marilyn Bordner, Priya Degani, Marcia Gallucci, Jane Kennedy, Tyra Lindquist, Barbara McHenry, Mary Pontarolo, Nancy Reid, Janie Sabedra, Catherine Valdez, Loretta Vanderpol, and Sue Winskill.***

(Note: incorporated into this report are both the proceedings of the meeting on March 16, as well as important feedback that was given on this topic at our meeting on April 27)

Assessment

The main issue that was discussed at this meeting was "assessment." We talked about the ways that every service provider could learn to interact with women about our four issues

- chemical dependency, adult sexual assault, child sexual assault, and domestic violence.

Ultimately, we want women to disclose all the problems they are having so we can point them in the direction of the specialized resources that will help them resolve the difficulties.

What we came to discover, is that "assessment" is the wrong word. Assessment means different things to different people. In its most complicated form, assessment is a long and complex series of psychological and medical tests that a person goes through to be diagnosed. We aren't talking about anything like that.

Rather, we want to train social service workers in the bare essentials of each of the four fields so that workers anywhere can identify women who may have problems and who need to be referred to specialized services.

So rather than assessment, per se, we are talking about identification.

Education

But let's back up. Before any individual worker is going to be doing any *identifying* there is a process that needs to happen on a community wide and organizational level so we can be prepared to better serve women with multiple problems.

The very first thing that needs to happen for service providers is ***education***. We often make a mistake when we assume that social service workers are more broadly educated than they are. In general, workers are very narrowly trained, and most people specialize in only one issue. Chemical dependency counselors, by and large, are not trained about sexual assault. Domestic violence workers don't know much as a group about alcoholism.

In order to be effective in identifying all the problems a woman might bring to a particular setting, counselors in all four fields have to have the most up-to-date and basic information in all four areas. Practitioners may feel overwhelmed already just trying to keep up with advances in their own field and may balk at the suggestion that they become competent in other areas. Everyone needs reassurance that we aren't asking them to become experts- only proficient.

The facts are the facts. And those are fairly easily imparted. We must also do the harder job of exploring personal *attitudes* and *values*. There is a great deal of misinformation that has lead society to harshly judge the women with whom we all work. Even the most enlightened social service provider is not immune from the misguided attitudes of the larger culture. For example, domestic violence counselors do not necessarily have better information than the general public does about alcoholism. If they don't know any better, they have undoubtedly internalized the same prejudices about the disease. Similarly, chemical dependency counselors do not necessarily understand the complexities of domestic violence and sexual assault. Many counselors carry society's general attitude that it is the woman's responsibility to get out, and not the batterer's responsibility to stop choosing to behave in a violent way.

In addition to individual workers becoming more knowledgeable and exploring their personal values, organizations will need to explore the ways their collective values play themselves out in agency policies and procedures. There will be some ***fundamental program policies or components that have to be changed*** as a result of new knowledge and understanding that is gained about how our four issues interrelate.

This is really the key to the success of this entire project - fundamental change within agencies that will enable workers to better serve women.

To illustrate this point, let's look at two concrete examples.

> Many domestic violence programs have firm agency policies where they will not admit women to shelter when the women are actively using drugs and alcohol. If, through this project, we train workers at shelters about drugs and alcohol (and they are theoretically better able to detect women with substance abuse problems), but we don't assist the agency to look at modifying its policy about not taking in women who are using, what happens then? Our efforts could backfire; women could potentially be *excluded* more from receiving services. This is, obviously, not the point.

The second example has to do with traditional 12 step alcohol and drug programs. These programs may be resistant to looking at women holistically, particularly if they adhere to the notion that it is important to be sober for some period of time before looking at other problems - or if they believe sobriety, in and of itself solves problems like domestic Violence and sexual assault. How can we work with 12-step programs to help them refine their approach and look at the larger picture? This is an education issue for individual workers, as well as a policy/philosophy shift issue for agencies.

Identification

If we train workers, and if we help agencies to look at how they do things, then, and only then, comes the *identification* piece. Using the tools listed in outline form later on in this report under the heading of IDENTIFYING SPECIFIC PROBLEMS, service providers talk to women or administer some form of a questionnaire to find out if the women are having, or have had, a problem with chemical dependency, sexual abuse (as an adult or child), and domestic violence.

There are just few general things about helping women identify their problems that our group discussed at this meeting.

Questions and conversation can be used to educate women

The first was that questions and conversation can be used to educate women as well as help them identify their current problems. Being better informed can help women prevent problems in the future, and help them talk to their kids about preventing abuse. Education can also serve to "plant a seed" for a woman. She may not have figured out yet that she has a problem, but getting accurate information may get her thinking about her own life and how events have impacted her.

Why a woman won't want to admit to herself or to a counselor that she is having a problem

The second is that there are a lot of good reasons why a woman won't want to admit to herself or to a counselor that she is having a problem. Denial is a terrific survival strategy, one that a counselor will not necessarily want to confront. Particularly if there is no

immediate safety concern, talking in an open, nonjudgmental, and matter of fact way signals to a woman who is reluctant to speak of her problems, that she can talk about it at a later time.

Providers ask questions in a way that does not use jargon

Thirdly, if providers ask questions in a way that does not use jargon or labels, but more describes the behavior, there is a higher likelihood of getting accurate information. "Have you ever been verbally abused?" will most likely elicit "no." But "Has your partner ever called you names or made fun of you and hurt your feelings?" may call forth all kinds of information.

"Formula" for identifying other problems

Lastly, if we could come up with a "formula" for identifying other problems (i.e., use this language, to ask these questions, at this specific time), there is still another layer of interaction between service provider and woman that embraces rapport and trust. Those elements are difficult to put into a formula. Yet, they are critical.

Why even try to identify all the problems that exist?

The most pressing reason to identify all the problems is *safety*. Is a woman in immediate danger of being physically injured or killed by a batterer? Is her life in imminent danger from the drugs that she is using? Is she in the later stages of alcoholism? Does she need immediate help to prevent a suicide?

If there are no immediate safety concerns, should we probe further? There was some discussion about unintentionally causing damage by asking more questions - "performing surgery" as it was called. By asking questions about difficult issues, can one, in the metaphorical sense, accidentally slice open another person's feelings then be unable or unwilling to help sew the person back together again? The point of asking the questions is not to check it off a list that goes into a woman's file. "Yep, I asked her and she said yes." The point is to use the woman's response to gauge what kinds of longer-term services are going to be needed to address and resolve critical issues.

There are two dilemmas for practitioners. One is that many may fear that if they ask, the woman will tell. Practitioners may be

unprepared when they find themselves seated across from a woman who has gone into crisis as a result of being given permission - via being asked - to tell about a particular and horrible problem in her life. The second dilemma is time. Everyone is crunched for time. If counselors have a given amount of time to spend with each client, and the clients are stacked up on the schedule, then asking for information that could lead to crisis is problematic. There is a lot of pressure for workers to stay on schedule and crisis can really mess that up.

There are expeditious ways for practitioners to give a woman the sympathy and understanding that she needs so she does not feel like she is left flapping in the breeze. Counselors need to be clear with a woman - especially one who appears fragile and wants to talk at length about what's going on with her - what the intent is in asking questions. Whether a worker is simply doing a safety check, or is administering the laundry list of questions for identification and referral purposes only, the woman needs to be told that directly. "We have 50 minutes" or "I'm just going over things generally with you now -we can work together to figure out whom you might want to talk to in the near future and set up some counseling" (or shelter, or whatever is needed). If workers are direct and clear at the beginning, this may help with the "surgery" issue.

If a practitioner finds himself or herself unable to be sympathetic to any given concern a woman raises, this may signal the need for that practitioner to undertake a personal examination of why he or she might not be able to be sympathetic to a woman who discloses certain things. Are there unresolved personal or family issues for the practitioner? Is the practitioner judgmental because of ignorance or prejudice about a particular issue?

If practitioners are going to ask the questions, they must be willing to not only refer women to sources of help that specialize in whatever is troubling her, but they have to be committed to making sure that the lines of communication and cooperation are open between agencies so the woman can get help. Everyone needs to understand, from a systems point of view, what other agencies do, how to contact them, what the rules and limits are (fees, hours, waiting lists, etc.). It is not helpful to send a person in crisis on a wild goose chase seeking help from services that are not going to be able to help.

The goal of ***referral*** - the last step in this process of identifying all the problems - is to help women contact agencies and individuals who have the specific expertise to help. Whether it is accurate legal information about the laws on sexual assault, specialized in-patient treatment for chemical dependency, or safe shelter for a battered woman -cooperation among experts is the key to good referral.

Identifying Specific Problems

Let's be realistic. When we ask service providers to help women identify their problems related to sexual assault, domestic violence and chemical dependency, we are only asking the providers to make an educated guess, based on basic information they are given about the issues that are not their specialty. We are not asking people to make a diagnosis. We are not telling people that they have to be 100% sure of what is going on before they make a referral to another agency. We are only asking people to be relatively well informed about the other issues, to use their common sense to detect other problems, and to refer women to the agencies that offer the best help.

As service providers gain confidence about the issues that may be new to them, each person will develop their own way of asking questions or conversing with women. There are no hard and fast rules about how to go about helping a woman identify her problems. Some guidelines follow - but within these broad parameters, workers are free to use their own style.

Has anything really bad ever happened to you?

I was talking with a social worker who works in a medical clinic. I asked her how she gets a general overview of a patient's state of mind. She told me that when she suspects a patient is really distressed about something, she'll sometimes ask "Has anything really bad ever happened to you?" Often, detailed accounts of things like battering at home, the death of loved ones, alcoholism, child sexual abuse, suicide attempts and thoughts all come pouring out. I was impressed that she could get that kind of information from such a simple question. Sometimes it is that easy - a woman is eager to talk. Other times, she needs more help to tell her story and get help. That is what the next section of this report is about.

At this meeting, committee members came prepared to break out into smaller groups composed of people from their own field. Three small groups formed - sexual assault (child and adult), domestic violence, and substance abuse. The assignment to each of the specialty groups was to go away and make up a list of guidelines, pointers, tips, helpful hints, questions, and whatever else would help workers who are not trained in that particular field to be able to help a woman identify that she has that problem. So, for example, the sexual assault group thought about how to tell the domestic violence and chemical dependency people how to screen a client for past or present difficulties with adult or child sexual assault. And so on.

The following summarizes each group's work.

Identifying adult sexual assault and child sexual assault

Gentle and non-threatening are the watchwords.

Don't ask "have you ever been raped?" or "have you ever been sexually assaulted?" There is a lot of misunderstanding about what those terms mean. Rather than using terms, describe behavior. "Have you ever felt pressured or coerced into having sex when you didn't want to?"

Although asking "Have you ever had sex against your will?" may not be the politically correct way to ask (some people object because rape does not equal sex - rape is about violence and control, not sex), suspend "correct language" in the interest of helping a woman talk about her experiences. You can help women from there to understand what has happened to them and why they may feel the way they do about it.

It's possible to use written questionnaires as well as verbal interviews. Some women may feel more comfortable if a question about sexual abuse is in with other questions. "Have you ever been pressured or coerced into having sex when you didn't want to?" may work on a questionnaire as well as in an interview. The point is to ask in different ways if you suspect something has occurred and the person is having trouble talking about it. Be reassuring and matter of fact - say something like "I've talked to a lot of people this has happened to. People have a lot of different reactions to it. Sometimes it impacts people a lot more deeply than they think."

Be prepared for a disclosure process that happens over the course of time - weeks, months, and even years. In an initial interview or session, if a woman denies past abuse, then you can probably assume that she is not in immediate crisis about it and it can wait for future discussion. By asking, you have opened the door, she can walk through if she wants to. You have signaled to her that you can talk about it. Remember also that a woman may not remember, or feel safe to talk about incest or sexual abuse right away. Not telling is a reasonable defense mechanism.

The stigma that continues to surround sexual assault is an interesting issue and can play itself out in a variety of ways. The general public may think that the stigma has eased somewhat over the past couple of decades because of media coverage of the issue. TV, movies, books, the disclosure by famous people about incest and child sexual assault, and so on have all raised public awareness to a certain extent. But humiliation, disgrace, and feelings of responsibility run deep. Individual victims experience the stigma to varying degrees - some are incapacitated by it, others understand in an intellectual way that they are not responsible but still struggle with confusing feelings that testify to how deeply ingrained the stigma still is.

A worker needs to be sensitive to the woman who discloses immediately and in great detail, the facts of her abuse. A victim may recount her abuse with very little emotion, deadpan, as though she were describing a trip to the supermarket. If you inquire, and she cannot describe any process of resolving these issues that would explain how she came to be so casual about describing the abuse (i.e., treatment, counseling, therapy, peer counseling, support group, talking with friends, or a pastor, or a family member) then you may be looking at someone who needs to talk to a counselor trained in sexual assault.

There are two added dimensions for chemically dependent women with regard to sexual abuse. The first is that women may be reluctant to talk about their sexual assault because they were using drugs and alcohol at the time. As stated earlier, although we know that the assailant is completely responsible for the assault, the victim often takes responsibility and feels bad if she was using at the time. This can keep her from talking about it. The second is

that some women have never had sex when they *weren't* under the influence of drugs or alcohol. This makes the issue of consent and free will complicated and warrants more discussion.

Chemically dependent or not, the issue of free will may be a foreign concept to many women. Consent, understanding options, or making choices may be difficult to understand for women who have been dominated their whole lives - first by a father, mother, or both, then boyfriends or partners, then husband, sons, bosses, or whoever.

Identifying domestic violence

How you ask questions, depends on how you are having contact with a woman. If you are having a telephone conversation with her, on a crisis hotline for example, you would assess for immediate danger by asking only yes and no questions. "Are you safe right now?" or "Are you in a safe situation to talk to me?" are questions that a woman can answer even if the batterer is nearby. You can elaborate - "Is there someone there right now who you are afraid of?" "Is someone threatening you right now?"

If you are on the phone and you ascertain that she is safe, or she is in your office alone with you, then you can go on to ask other questions about immediate danger as well as domestic violence in general (current or past).

Painted with a broad brush, domestic violence falls into several major categories, all of which are made up of many specific acts.

If you ask a generalized question - in everyday descriptive language not as a label - about each of the broad categories and you get "no" for an answer, then you don't need to pursue it. Often, if a woman answers yes to your question, she will go on to tell you a lot of detail about what has transpired.

Here are the major categories you want to find out about:

Physical abuse -

Has your partner ever harmed you physically - anything from pushed you around to injured you with a weapon? Have you been shoved, kicked, slapped, and/or punched? (This is what most people think of when they think of domestic violence. This is somewhat

of a problem because women do not see themselves as victims of domestic violence when they have not been physically assaulted.)

Sexual abuse -

Has your partner ever forced you to do something sexual that you didn't want to do? This includes non-contact forms of sexual abuse - being coerced to watch pornography, being videoed. Does your partner display a lot of jealousy - of a real or imagined lover?

Control -

Does your partner try to control your movements, who you see (friends and family), where you go, even day to day things like when you eat and sleep? Does your partner control money, telephone use, the family car or other transportation like a bus pass or bus fare?

Isolation -

Does your partner try to keep you from seeing your friends or family? Does your partner try to drive away friends and family, or control when you leave the house and where you go?

Humiliation -

Does your partner ever call you names, or make fun of you or make you feel embarrassed - in public or private?

Threats -

Does your partner ever threaten to do things - to leave, to get another lover, to kill you, to harm or kill your pets, to harm the kids, to tear up your green card or immigration papers, to turn you into the police or other authorities for a real or made up infraction?

Psychological abuse -

Does your partner mess with your mind - telling you, you're crazy or words similar to that. Does your partner drive like a maniac with you or the kids in the car?

All types of abuse *may* escalate in severity and frequency over time. Many women die after just such an escalation, so an increase in the severity or frequency of abuse may be a warning sign

Abuse can also be static as well; that is, the same type of abuse at the same level and timing over the course of a lifetime. Regardless of whether abuse escalates or stays the same, death can occur at any time. Everybody who is a victim of domestic violence is in danger.

Identifying chemical dependency

Alcohol or other drug use does not cause domestic violence, sexual assault, or child sexual assault. The fact that a woman may have an alcohol or other drug problem or that she may have been using drugs preceding an assault does not excuse the perpetrator from complete responsibility for his or her actions. However, substance abuse or chemical dependency may pose an additional threat to the safety and well being of a woman who is already a domestic violence or sexual assault victim. It is, therefore, crucial that alcohol and other drug abuse be addressed when thinking about a woman's range of needed services.

Asking a woman questions about her substance use while she is participating in a domestic violence or sexual assault program can be problematic. Under the best of circumstances, people are likely to minimize their drug use or to become defensive when asked about it. Even people who do not abuse substances have a sense that alcohol or other drug use is disapproved of or viewed as unhealthy or "bad." And for women who have been abused or sexually assaulted, the shame associated with substance abuse just compounds the shame they may be already feeling. Ill-timed direct questions about substance use may elicit a response, such as, "I'm here at the shelter because I fear for my life and you are asking me about alcoholism? That's not what I'm here for."

Sometimes it's obvious that a woman is addicted to or has a problem with drugs. Maybe she will volunteer this information. Or she will go into withdrawal in your office. Short of these two scenarios, determining problematic involvement with drugs is much more difficult. There is no magic diagnostic tool - no list of 10 quick questions that will tell sexual assault or domestic violence staff or anyone for that matter that they are working with some-

one who has an alcohol or other drug problem. Accurately assessing an individual's involvement with drugs usually requires considerable specialized training, skill, and experience.

You can, however, learn to recognize potential clues by using the skills and tools you already have and if you suspect there is a problem you can make a referral. Trust your intuition! If you feel you are working with someone who has a drug problem, there is no harm in seeking expert advice. Develop a relationship with a chemical dependency group with service providers from different disciplines.

Here are some specific hints about identifying drug and alcohol problems:

1) ***Observe behavior.***
2) ***Use your current intake practices, or expand ~f necessary, to obtain as thorough a history as possible.***
3) ***Ask about drug and alcohol use.***

Remember, taken individually your observations or bits of suspicious information may mean nothing or they may be misleading, but put together over time they may make a case for chemical dependency intervention.

Observe behavior

Your first and best clue in this department is what shape the woman is in when you first meet her. Is she clearly intoxicated or high? Is she extremely fidgety, irritable, or having mood swings? Pay attention to all visual clues. Is she wearing a long sleeved shirt on a hot day to hide track marks, or sunglasses on a cloudy day to hide red, puffy eyes or dilated pupils? Is she sniffing a lot, but isn't crying and doesn't appear to have any other signs of a cold or allergies? Poor hygiene or unkempt appearance may suggest a drug problem or a mental health issue. If a woman is pregnant, she may not be at the right size for her stage of pregnancy (this presumes that you know what a woman is supposed to look like and what the normal variation is).

Use your current intake practices, or expand if necessary, to obtain as thorough a history as possible

No matter what kind of service you provide, you undoubtedly gather information in one form or another about a woman's history and current circumstances. You can expand how you look at the information you already routinely obtain and begin to identify clues to the person's involvement with alcohol or other drugs. Alcohol and other drug abuse adversely affects a person's accomplishments, stability, relationships, economic status, employment, legal status, and medical history. Look at problem areas and attempt to identify causes. Ask non-threatening questions about relationships with parents, siblings, children, and intimate partners. As you develop rapport, talk about school, friends, what they do for fun.

Legal problems are a very strong indicator of substance abuse problems. Health problems are another clue - broken bones, accidents, prescription drug use, problem pregnancies, and previous mental health or drug treatment.

When a woman has clued you into a problem by, for instance, disclosing that her partner and parents are alcoholics or drug users, it is the perfect time to ask her what she knows about drugs and alcohol. Provide her with objective and nonjudgmental information on substance abuse. This can eventually lead a woman to disclose (or discover for that matter) that she has a problem.

Ask about drug and alcohol use

It may or may not be helpful to ask specific questions about an individual's use of alcohol or other drugs. As previously stated, more often then not, people are going to minimize or deny alcohol and other drug use when asked about their own patterns of use. Women in a domestic violence or sexual assault program, in particular, may not feel it is in their best interest to admit problems with drugs. Shame, guilt, fear they might lose custody of their children or risk arrest, or an unwillingness to jeopardize their ability to continue using, are obvious reasons women do not feel safe answering your questions truthfully. If a domestic violence shelter specifically prohibits women from actively drinking or using while they are staying there, that is another reason for a woman to be silent about her use.

If you do feel the timing is right to ask specific questions about drug use, try to use open-ended questions. You are not going to get very far if you ask question that can be answered by a yes or a no. How often do you drink? How many times a week, month, year do you have something to drink? How do you feel when you use __________?

The chemical dependency small group offered the two tests that follow a quick way to remind service providers about the most important clues that will help identify a woman who is having a problem with drugs or alcohol.

The *CAGE* Test

The *CAGE* test. Ask the woman questions in these four areas.

C - Have you ever **cut back** on your drinking or use of drugs?

A - Have you ever been **annoyed** by criticisms of your drinking or drug use?

G - Have you ever felt **guilty** about your drinking or drug use?

E - Do you ever use alcohol as an **eye-opener**?

The Four P's

The four P's. Get a history in these four areas.

Is there a history of a **parent** with a drug or alcohol problem?

Does the **partner** have an alcohol or drug problem?

Did you drink during a **pregnancy**?

Do you have **previous treatment or previous history** with drug or alcohol problems?

One note about *CAGE* - the guilt question can be a problem. Many women feel guilty about almost everything. So asking directly about feeling guilty may not get you very useful information. Try instead something like "Has anything ever happened while you were drinking or drugging that might not have happened if you hadn't been?" Or, "Tell me about the most memorable drinking spree or your most memorable time that alcohol was involved in your life." Or, "Tell me about your relationship with alcohol or drugs."

It is extremely important that domestic violence and sexual assault service providers learn to screen for chemical dependency and substance abuse. Why is it important to get an accurate reading on current drug and alcohol use? Because there can be danger inherent in the use of the substance. Women become addicted to alcohol more quickly than men and suffer more severe physical consequences from all substance abuse.

Cooperation is critical

Trust needs to be established among service providers so that domestic violence and sexual assault counselors will know when to call in the drug and alcohol experts for a more accurate assessment. Refer a client out, or establish a relationship so a counselor can come in to talk to your client. In addition to doing a formal assessment, drug and alcohol counselors can assist other service providers to get a woman into treatment - which is a complicated maze in itself

Please rank the overall impact of the training on the following:

	No Effect	Little Effect	Some Effect	Moderate Effect	Strong Effect
Your skills in working with chemical dependency people	1	2	3	4	5
Your knowledge concerning chemical dependency and the care of chemically dependent people	1	2	3	4	5
Your attitudes concerning chemical dependency and working with persons who are chemically dependent	1	2	3	4	5
Your skills in working with victims of domestic violence	1	2	3	4	5
Your knowledge concerning domestic violence and the care of victims of domestic violence	1	2	3	4	5
Your attitudes concerning domestic violence and working with victims of domestic violence	1	2	3	4	5
Your skills in working with victims of adult sexual assault	1	2	3	4	5
Your knowledge concerning adult sexual assault and the care of victims of adult sexual assault	1	2	3	4	5
Your attitudes concerning adult sexual assault and working with victims of adult sexual assault	1	2	3	4	5
Your skills in working with victims of child sexual assault	1	2	3	4	5
Your knowledge concerning child sexual assault and the care of victims of child sexual assault	1	2	3	4	5
Your attitudes concerning child sexual assault and working with victims of child sexual assault	1	2	3	4	5

SHE'S GOT ALL KINDS OF TROUBLES

WE BELIEVE SERVICE PROVIDERS COOPERATE BECAUSE THEY KNOW ONE ANOTHER

PLEASE complete the following information as a step toward furthering cooperation among CD-SA- DV service providers in your area.

Basic Information

Name of your program

____

____

Alternate or former name for your program, other acronyms you may be known by, shorthand names, etc.

____

____

____

Short History—when founded, who by, major events in your organization's history.

____

____

____

____

____

____

Is the focus of your program the same now as when your organization was founded?

What is the size of your agency—number of staff, number of volunteers, annual operating budget?

Your Services

What is the profile of your service users—men/women, age, race, economic status, sexual orientation, etc.?

How many people do you serve in any given time period?

What are your fees? How do clients typically pay for your services?

How things go when people call you for help?

How do people access your services?

When a women calls for help, what happens? Fictionalize a recent encounter and walk us through the specifics of how the woman contacted you, what had happened to her, what you said, what she said, and so on .

How does a woman qualify for your services?

Do you disqualify anyone for any reason?

What is your intake procedure?

Do you have a waiting list? How long does it take for someone to get an appointment, or to talk to a counselor, therapist, intake worker etc.?

How long do you typically have contact with a women? If there is a range, describe it.

How do people exit?

Do you provide follow-up of any kind?

If people do not complete the program, can they come back at a later time? Do/can people come back repeatedly as they need help? Are there restrictions on this?

The Bigger Picture

What is the underlying philosophy of your program?(Why do you do yours services the way you do?)

How do you fit into the larger scheme of things in your community?

____

____

____

Who refers people to you? (Your major referral source or sources?)

____

____

____

Who do you most often refer out to?

____

____

____

What is the biggest strength your agency brings to this community of service providers?

____

____

____

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Thank you for your time and thoughtfulness in completing this questionnaire.