Relational Systems Change

Implementing a Model of Change in Integrating Services for Women With Substance Abuse and Mental Health Disorders and Histories of Trauma

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Abstract

This article describes the "relational systems change" model developed by the Institute for Health and Recovery, and the implementation of the model in Massachusetts from 1998–2002 to facilitate systems change to support the delivery of integrated and trauma-informed services for women with co-occurring substance abuse and mental health disorders and histories of violence and empirical evidence of resulting systems changes. The federally funded Women Embracing Life and Living (WELL) Project utilized relational strategies to facilitate systems change within and across 3 systems levels: local treatment providers, community (or region), and state. The WELL Project demonstrates that a highly collaborative, inclusive, and facilitated change process can effect services integration within agencies (intra-agency), strengthen integration within a regional network of agencies (interagency), and foster state support for services integration.

The Relational Systems Change Model

As 1 of 14 original and 9 continuation grantees in the Substance Abuse and Mental Health Services Administration's Women, Co-occurring Disorders, and Violence (WCDV) cooperative agreement, the WELL (Women Embracing Life and Living) Project facilitated systems change from 1998–2002 to support delivery of integrated and trauma-informed services for women with co-occurring substance abuse and mental health disorders and histories of being physically or sexually abused.

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The procedures used were based on a model of systems change derived from relational theory that the Institute for Health and Recovery (IHR) has been developing through its work since 1990 to improve services for women and their families. This article will describe the principles and strategies of the model, methods used to document and evaluate implementation of the model, WELL Project implementation, and evidence of resulting systems change.

"Relational systems change" brings about changes in systems using relationships as a vehicle. This approach is built on a foundation of "relational practice,"[1] which has its theoretical underpinnings in the relational model of psychological development pioneered by researchers and practitioners at the Stone Center, Wellesley College.[2–4] The relational model proposes that the best environment for emotional growth and change is within the context of one or more mutual, empathic, authentic relationships. Such relationships allow individuals to better understand themselves and others, lead to the desire for more connection, and create a feeling of excitement and zest that stimulates people to action.[5]

Literature describing the relational model as applied to the prevention and treatment of substance abuse in women emphasizes the importance of encompassing women's relational histories and women's relationships within the treatment environment, including building healthy connections as well as addressing "disconnections" such as violence and trauma.[6,7]

Systems development work is relational work that supports and guides changes in service delivery systems. Relational systems work recognizes that service delivery systems, whether federal, state, or local, are made up of people and that people are "relational," and therefore they develop, grow, and change in the context of connections to others.[2,6–9] Consequently, "relational systems" work creates environments and structures that build connection and thereby encourage, facilitate, and inspire people to engage in change. The relational systems change model posits that the principles that guide healthy individual relationships also are basic to creating systemic change: mutuality, authenticity, empathy, and empowerment.

The WELL Project Context

The goal of the WELL Project systems change work was to create conditions so women in the study could receive integrated services to address their substance abuse, mental illness, and trauma, within an environment that was trauma-informed, that is, took into account the impact of violence on women's lives. Study women would be receiving most of their services, including services added by the WELL Project, at 3 large human service agencies that served women in 3 different communities in eastern Massachusetts. The 3 WELL Project partner agencies all began as substance abuse providers and later became dually licensed as mental health providers also. Despite their ability to provide mental health services, at the start of the WELL Project none had a strong capacity to provide trauma-informed services. None of the agencies asked women at intake about their current safety or routinely offered groups specifically to address the sequelae of trauma, and only one of the agencies asked women about their history of physical and sexual abuse. In all 3 localities, existing violence services were primarily delivered by community agencies that had varying degrees of relationship with substance abuse and mental health organizations.

The state context was also not a model for integrated care, since there were separate state agencies for substance abuse, mental health, domestic violence, and sexual assault services. Each agency and service area was associated with a body of professional knowledge, a culture of practice, and a set of policies, procedures, and requirements. Before the WELL Project, a few collaborative projects at both the state and local level had been implemented, but a large gap still existed across the 3 disciplines of substance abuse, mental health, and trauma at both state and community-based agencies. The constant stress to provide appropriate services and the quick turnover of clients allow little enough time to develop relationships between agencies in the same service sector, let alone across sectors, even though they are serving the same women. As one service provider stated, "interagency collaboration is not a priority. It should be."

This sentiment was repeatedly echoed by consumers who recounted the frustration of having to tell their histories in differing clinical terms, depending on the type of agency or practitioner they were addressing. Consumers learned over time what portions of their history or current needs had to be omitted or denied so as to obtain particular services. While often becoming quite adept at how to frame their story to successfully access services, such as omitting prior substance abuse history to domestic violence shelters or trauma history in substance abuse settings, consumers complained about having to do this. In their view, rather than promoting wholeness and recovery, the experience recreated the secrecy of abuse and fed the stigma associated with each of the 3 issues. Consumers involved with the WELL Project described such experiences: "I would lie to get into treatment. And then issues come up and they throw you out. What happens to women with trauma [then] happens to them in [service] systems." For consumers, integration of services represented an approach to wholeness, a place where they could allow all parts of themselves and their history to coexist.

The WELL Project worked within 3 communities to address this fragmentation and to increase awareness of the importance of integrating an understanding of trauma into services offered to women. Using principles and strategies suggested by relational theory, the WELL Project worked to build/enhance relationships among providers within and across disciplines, encouraging them to work collaboratively to build an integrated, trauma-informed system of care.

Relational Systems Change

Although there is no published literature on the application of relational theory to systems change, principles and strategies can be extracted from relational research in other areas. Hartling[10] described applying relational theory to reduce alcohol and other drug use and abuse among women on college campuses. Her intervention involved building connection at multiple levels. She developed relationships with individual at-risk women at a particular college, formed a group within that college that included representatives from a wide variety of diverse campus constituencies to develop consensus-based policies to address substance use on campus, and also convened an interscholastic group to develop a shared agreement for improving practices in response to high-risk drinking. Within the 2 group structures, "relational practices" were used to create a collaborative atmosphere in which all members could impact the group's eventual findings. From the outset, members were encouraged to openly and respectfully discuss their differences, approaching conflict in a way that leads to positive change.

Additional explication of the application of relational practices comes from research by Fletcher[11] on the workplace. Fletcher employed structured observation to identify relational practices used by female design engineers to achieve organizational outcomes. She interviewed engineers to discover the underlying principles these behaviors were based on. One principle identified was that a collective understanding of problems or situations, in which everyone's points of view are fully explored and built upon, will enhance effectiveness. A second principle is that relationships need to be in good working order for work to go smoothly. One important category of behavior observed, "creating team," has as its intended outcome the creation of an atmosphere that leads to cooperation, collaboration, trust, respect, and collective achievement. "Creating team" includes activities such as responding/respecting, empathic listening, and smoothing conflicts between others.

The following strategies for promoting systems change were developed by IHR, based on relational theory:

Build connection at multiple levels with information flowing between them

Policies related to funding, licensing, documentation, and contract requirements have enormous influence on how services are delivered. As policies change, information must flow from the policy level to the service level for new policies to be implemented as they are intended. At the same time, feedback from the service level on the impact of particular policies must be channeled back to policymakers to determine whether new policies are having the desired effect as well as to adjust

them as necessary. For example, some policy changes create the need for additional supports, such as training and technical assistance, at the service level. If policymakers are aware of this, they can build in needed supports, making implementation easier for service providers. Policies also have an impact on the understanding of individual service providers. For example, clinicians providing substance abuse treatment services, with some notable exceptions primarily among staff at programs that are gender-specific and evidence-based, have tended not to be sensitive to trauma/violence issues, because they are unaware of the significant overlap between these 2 issues. This lack of awareness had been reinforced by reporting requirements, which did not mandate that programs screen for histories of or current experiences of violence. It had also been reinforced at the community level by weak relationships between substance abuse treatment providers and trauma/violence service providers. Should a service provider discover that a client was dealing with both issues, lack of familiarity with services and providers in the other service system made it difficult for an appropriate referral to be made. The understanding of service providers can and should influence policy as well. For example, substance abuse and mental health clinicians who have been cross-trained in each other's specialty and sensitized to trauma/violence issues, typically seek to provide a broader and more coordinated range of services to consumers. In doing so, they often encounter restrictions embedded in existing procedures, forms, and documentation requirements that make providing integrated care more difficult. They may then take actions to attempt to bring about change in these procedures.

The WELL Project focused on 3 levels of systems and services change: local treatment providers, community (or region), and state, because all 3 levels played a role in maintaining the separation of substance abuse, mental health, and violence service system areas. Working at the state level is crucial, because Massachusetts has a statewide system for policy and funding. Therefore, the WELL Project created a mechanism for promoting change at the state level. A task force called the State Leadership Council (SLC) was convened by IHR to address state-level barriers to integrated care. Similarly, Local Leadership Councils (LLCs) were developed to promote integrated care in each of the targeted communities surrounding the core agencies.

At the agency level, it was believed that dedicated change agents or "product champions" working within an agency were necessary to bring about change.[12] This meant that only persons working consistently at each local agency could generate both the information needed and the trust from clinical and administrative staff so essential to planning for and implementing services and systems changes. A change agent can make critical alliances with staff as well as assist in developing the leadership of other local staff to become "trauma champions," necessary for project sustainability. WELL Project staff called Integrated Care Facilitators (ICFs), housed at each of the 3 core agencies, worked to develop relationships with agency staff by participating in staff meetings, case conferences, and other agency activities. They organized WELL Project cross-training, so staff would have the necessary knowledge for delivering trauma-informed, integrated care. After coming to understand the agency context, they suggested changes in policies and procedures that would make care more trauma-informed and integrated. The ICFs were also hosts of the LLCs, using relational skills to promote systems change in the community. In the second, implementation phase of the WCDV Study, each ICF continued her systems change facilitator role while she also provided integrated resource coordination and advocacy for consumers receiving WELL Project services.

Bring together diverse constituencies affected by proposed changes

This strategy is based on the principle discussed by Fletcher[11] that collective understanding of problems and situations in which everyone's point of view is explored and built upon will enhance effectiveness. Changes in service systems may have significant impact upon providers of services as well as consumers. Involving those who will be most affected in developing systems change plans can both enlist their cooperation and ensure that the plan is properly configured to take into account the day-to-day environment of those involved.[13] For the WELL Project, at the community

level, the LLCs brought together service providers from substance abuse, mental health, and violence service agencies, along with consumers who utilize these services. At the state level, the SLC brought together policy-level representatives from state agencies that fund and regulate these services, along with consumer advocacy and service-providing organizations. IHR's long history of developing relationships with many of Massachusetts' state human services agencies, as well as community-based treatment providers, was instrumental in achieving active participation from key stakeholders on all 3 levels.

Because the ultimate aim of making changes within a service system is to enable services to be more useful for consumers, consumers are a crucial constituency that must be involved in any systems change effort. Although providers and policymakers have knowledge about the impact of services on consumers, it is consumers themselves who are in the best position to provide information about their experiences in the service system. Ability to tap this crucial source of knowledge can markedly increase the effectiveness of any changes that are implemented.

The assumption here is that a full understanding of the problem and the potential solutions lie in including everyone's points of view. As members share their experiences, mandates, frustrations, and goals, a bidirectional sense of understanding is developed, promoting mutual empathy. This increases the likelihood that plans and solutions will be developed that meet everyone's needs.

Openly and respectfully discuss differences from the outset

Often, systems change involves cross-system work. That is, it requires groups of individuals from different parts of a service system to work together. These individuals may be trained in different disciplines with different histories and points of view. Such differences have the potential to sabotage the collaborative process if they are not addressed.[14] It is important, therefore, to identify potential sources of disagreement and tension prior to attempting collaborative work. In the WELL Project, this was done at the community level, by bringing everyone to the table for the LLCs, dividing them by system and having each group list their core values and beliefs. Similarities and differences were then explored and discussed with the entire group. Identifying differences in points of view and making them explicit from the beginning can allow these differences to be effectively addressed when they emerge in the planning process.

Create a collaborative and mutually empowering environment in which all members have an impact on the group's eventual findings

Individuals working in health and human services want the best for the populations they serve. Frequently, freedom to make change at any given moment is limited by system mandates and restrictions. Exploring reasons why an individual or system is resistant to change can provide invaluable information about what is necessary to bring about change. However, honest exploration of beliefs and attitudes can only be done in a safe environment, that is, one in which every individual believes her point of view will be taken seriously. To create this environment, it is essential that every individual contribution be respected. For example, when talking about improving services, it is important to both acknowledge the good that is already being done and honor the experiences and feedback of consumers, so that providers, policymakers and consumers do not feel undervalued. Only in an environment that respects all points of view can participants come to understand each other well enough to find creative solutions that are mutually acceptable and beneficial.

Creating a safe environment involves the behaviors discussed by Fletcher[11] as "creating team." These include empathic listening, responding/respecting, and smoothing conflict between others. WELL Project staff that chaired meetings at both the state and community levels were responsible for using relational skills to create a safe environment so that members would feel free to share, disagree, and engage in conflict in a positive way.

The Women, Co-occurring Disorders, and Violence Study

The aims of the federally funded, 2-phased WCDV Study, of which the WELL Project was part, were to design, deliver, and test the effectiveness of specialized services for women with substance abuse and mental health disorders who have experienced physical and/or sexual abuse. During Phase I (1998–2000), 14 sites applied systems and services integration strategies in their local contexts to prepare for the delivery of the experimental interventions in Phase II. In addition, through the mechanism of a national Steering Committee and with assistance from a federally funded Coordinating Center, representatives of the 14 sites, federal project officers, and Coordinating Center staff reached consensus on shared elements of the experimental interventions and designed the Phase II quasi-experimental treatment effectiveness study.

During Phase II (2000–2003), 9 sites participated in a repeated-measures cross-site study with shared participant eligibility criteria, measures, and measurement points. The sites administered a common interview in English or Spanish at baseline and 6- and 12-month follow-ups to collect demographic and other descriptive data with which to characterize the study sample and, in some cases, to use as covariates in outcome analyses, information on service utilization, and outcome measures. At interim follow-up points (3 and 9 months), a shorter common interview was administered to collect information on service utilization. All women who participated in the outcomes study met the eligibility criteria: they were 18 or older, had 2 or more previous episodes of treatment for substance abuse or mental health issues, had diagnoses for substance abuse and mental health disorders (one current and the other within the past 5 years), and had experienced physical and/or sexual abuse. Major outcomes were substance use, trauma symptoms, and other mental health symptoms, as measured on the Addiction Severity Index, Posttraumatic Symptom Scale, and Brief Symptom Inventory, respectively.[15–17] Oversight of participant protection at each site was done by an institutional review board, and all participants signed an informed consent form to enter the study. Additional detail about the study design and methodology and the 6-month outcomes are available elsewhere (G. J. McHugo et al, unpublished data, J. C. Cocozza et al, unpublished data).

Methods

During Phase I, the WELL Project's independent research subcontractor collaborated with IHR to conduct a systematic process evaluation that served 2 purposes: (1) to collect information relevant to the design and delivery of the Phase II experimental interventions and (2) to document the implementation and assess the effectiveness of IHR's model of relational systems change. During Phase II, the research organization was responsible not only for continuing to document implementation and assess effectiveness of the WELL Project systems change strategies but also for conducting a quasi-experimental, repeat-measures study of individual outcomes among women recruited into the experimental and comparison conditions. Women in the experimental condition had access to integrated, trauma-informed interventions at the WELL Project's 3 partnering agencies, whereas women in the comparison condition had access to services as usual at a similar dually licensed substance abuse and mental health services agency.

The WELL Project's Phase I process evaluation included a number of data collection techniques. To gather information relevant to the design and delivery of integrated, trauma-informed services, focus groups, informal and formal interviews, and participant observation were employed. Two types of focus groups were conducted at each of the 3 partnering agencies: one with service providers to elicit their perspectives on current services and possible service improvements and one with women clients who met the Phase II study eligibility criteria to elicit their views on service needs, and the barriers to and facilitators of appropriate services. In addition, members of the evaluation team made a site visit to and interviewed key staff at each of the 3 partnering agencies.

To gather information on the refinement and implementation of WELL Project systems change strategies during both phases of the study, the key methods used were in-depth interviews and

participant observation. [An experienced process evaluator attended meetings of the WELL Project Steering Committee, IHR staff, and expert consultants at which the cross-training curriculum was developed, the 3 LLCs and the SLC. She also attended the leadership training for consumers and integrated supervision at sites, 2 innovations in the model made in response to feedback from collaborators.] Besides the local process evaluations conducted by each funded site, the Coordinating Center conducted a cross-site process evaluation. The major mechanism of data collection was annual site visits. Members of the WELL Project evaluation team augmented the site-specific process evaluation by observing the meetings held by Coordinating Center staff with agency directors and clinical staff as part of annual site visits.

Descriptions and quotations included as documentation of the implementation and impact of WELL Project systems change efforts are drawn from Phase I and Phase II process evaluations, including observation of yearly cross-site process evaluation site visits conducted by the Coordinating Center. Empirical evidence of the impact of relational systems change at the community level is based on 2 waves of interorganizational network analysis interviews conducted at the 3 WELL Project experimental study condition sites.

For each of the 3 WELL sites, a network was identified of organizations that play a prominent role in service provision for women with co-occurring mental health and substance abuse disorders and a history of trauma and for their children. Following Morrissey,[18] both snowball sampling and fixed list approaches were employed to bind each network. Semistructured interviews were conducted with an informant from each organization during June and July 1999 and again during November 2002–January 2003. Informants were given a list of other organizations in the network and were asked to indicate to which of these organizations their organization sent clients and from which it received clients, to which it sent funding and from which it received funding, and to which it sent information regarding clients and from which it received such information during the previous year. Responses ranged from 0 ("not at all") to 4 ("a lot"). Thus, for each network, information about 6 different kinds of interagency ties was recorded. Only confirmed ties were used in the analyses; that is, only ties that were independently specified by both the sending and receiving organization.[19] The use of confirmed ties is a conservative and more reliable approach to measuring interagency links.[20] The smaller value of the 2 confirming responses was used to measure the strength of the tie. The instrument and interview protocol have been described elsewhere.[21] Network data were analyzed using UCINET VI.[22]

Although the research techniques employed in the process evaluation (focus groups, formal and informal interviews, and participant observation) yielded qualitative data that are descriptive in nature, the interorganizational network analysis interviews were designed to yield quantifiable data on the structure, density, and strength of specific types of ties between agencies. Integrating qualitative and quantitative methods resulted in a more complex and nuanced understanding of systems change resulting from the WELL Project than the use of either method independently would have produced. Increasingly, the complementarity of these 2 methodologies has been recognized in research about health problems, services, and client outcomes, and use of both has enriched knowledge of such diverse topics as risk behavior, service utilization, fidelity of program implementation, and the impact of such fidelity on individual outcomes.[23–25] The WELL Project example shows, as has the application of dual methods to the more limited context of the adoption of new medical technologies,[26] that integration of qualitative and quantitative methods strengthens analysis of organizational change.

Relational Systems Change: WELL Project Findings

Process evaluation findings

Fostering agency-level integration

A major barrier to integrated care is that professionals tend to be well trained in their own fields or specialty areas but lack knowledge of other disciplines and service systems. Service providers

may be reluctant to screen for problems they do not feel qualified to address. To achieve service integration, providers must have basic knowledge in the areas of substance abuse, mental health and violence, as well as the impact and interaction of these issues on women. Therefore, the WELL Project developed a cross-training curriculum. Focus groups conducted with treatment providers and consumers as part of the Phase I process evaluation helped to identify existing gaps in knowledge. Service providers were asked what they needed to know to deliver better services to women with co-occurring disorders and histories of trauma and consumers were asked what providers needed to know to improve services.

Based on focus group results, training modules were developed by a panel of experts. Topics covered included domestic violence, trauma, the impact of violence on children, PTSD and substance abuse, cultural competence, the trajectory of recovery from multiple issues, and gender-specific treatment. The modules were later compiled into a curriculum entitled *WELL Project Training Curriculum for Providers: Developing Integrated Services for Women with Substance Abuse, Mental Illness and Trauma.*

One WELL Project partnering agency operates in both Massachusetts and an adjacent state. This agency's executive director reported that she is easily able to identify the impact of the WELL Project by comparing the 2 branches of her agency. At the branch outside Massachusetts, staff discharge women for cutting, whereas at the one inside Massachusetts, staff no longer discharge women for self-inflicted violence because they now understand such behavior as related to trauma. Indeed, the head of the women's residential facility at another partnering agency noted that since the introduction of the WELL Project, it is "very abnormal for us to have cutting and burning." She attributed this change to specialized services and sensitized staff. In her view, women in treatment who are supported by trauma-informed staff and trauma-specific services infrequently resort to cutting or burning. She also reported that, because of WELL Project cross-training, staff at the residential facility do not have the same level of "hysteria" about self-harming behaviors they previously did; instead, they are "up front about trauma—it's a normalized conversation." Staff that are cross-trained no longer see self-inflicted violence as the same as suicidal behavior or as necessarily indicating the need for psychiatric hospitalization. According to the WELL Project ICF based at this facility, both residents and staff now have an understanding of how the cycle of abuse becomes internalized.

Fostering community-level integration

To facilitate cross-system collaboration, each ICF convened and chaired an LLC. After engaging in values clarification, members of each LLC participated in cross-training based on the *WELL Project Training Curriculum for Providers*. Each LLC then developed a model for an ideal integrated continuum of care, with both service components and their necessary characteristics. Following this, each LLC created a service map that included all existing services and contact information. Finally, LLC members compared service maps to the ideal integrated continuum to identify gaps in service components. Each LLC developed a set of recommendations, which included policy changes that would assist in developing integrated care and pilot projects to fill gaps in services. These policy recommendations were forwarded to the SLC. Each LLC then prioritized one recommendation to be addressed locally and began work on that issue. In this way, changes effected by the WELL Project in how LLC members understood appropriate services became translated into structural changes in local service provision.

Providers initially feared that addressing issues outside their primary field would present an increasing burden to an already overtaxed system. If they asked about issues beyond their expertise, they would then have to address those issues. Providers felt ill equipped to do so and were not comfortable making referrals to providers or agencies they did not know well. Many clinicians had trained and practiced in a particular discipline for their entire career. Entrenched in its language and

perspective, they did not have the desire to introduce other disciplines into treatment. A consumer articulated how this affected her:

"In my case, my mental health issues were acute so that even if I told them about domestic violence, they just said 'schizoid.' I was misdiagnosed. They didn't take me seriously. Trauma was completely overlooked. [There was] no real system to treat me for trauma."

Through coming together at monthly meetings of the WELL Project LLCs, representatives of various agencies forged and strengthened relationships with one another and across their agencies. These meetings fostered an understanding of the benefits to consumers of integrated services and of how the commonality and differences of provider approaches benefited treatment, as well as clarified the practice of integrating services. Over time, it became clear to providers that integration of services did not demand, as feared, that each clinician become an expert in all 3 disciplines. Rather, it required that they develop enough awareness of all 3 issues to be able to identify them, acknowledge their coexistence and interaction in the history of the women they serve and make appropriate referrals.

An interchange at an LLC illustrates the airing of difficulties and building of relationships that are possible within a safe environment such as that created within LLC meetings. It also illustrates how relational practice can play a role in strengthening new understandings and linkages. A probation officer stated, "When I deal with the shelter I might as well be the batterer. We should be able to work together." A shelter staff member then asked if he was talking about her shelter or shelters in general. When he replied that he was referring to her shelter, she responded that she would be "Glad to sit and talk with you." At the end of the meeting, they scheduled time to meet. The ICF facilitated the strengthening of the relationship and mutual understanding not only by convening the LLC but also by following up with the officer to ascertain whether his concerns had been addressed.

Clinicians commented that developing interagency relationships and building trust with individuals from other agencies allowed them to refer clients with the confidence that they were doing the right thing. As relationships developed over time, both service providers and consumers became increasingly comfortable in acknowledging the overlap of all 3 issues. Clinicians on each LLC noted the importance of being reminded of consumer perspectives. At one meeting, a consumer underscored how important it is for consumers to be addressed and validated as whole persons by telling her story:

> I am an incest survivor and never dealt with it—left treatment, did drugs. The most important thing is to integrate [services]. I'm a slicer [self-inflicted violence] and I go to staff and they take me to [name of inpatient facility].

After emphasizing that substance abuse, mental health, and trauma are key issues for her—"all three for me are so important"—she continued:

> Before, no place would take me and if I say I've been sexually abused they boot you. I thought here we go again: substance abuse identified and you're welcome. What a relief it was to have [a WELL Project partnering agency]. Need to work all three areas, and [partnering agency] is the only place I know that does it. Others throw you out because they are afraid. Forty years doing drugs and [partnering agency] saved my life.

Her story vividly demonstrated to LLC members what is gained when they take the challenging and often difficult steps that are required to effect systems change.

Fostering state-level integration

Just as treatment providers are divided by their training and specialization, so also are representatives of state agencies. Policymakers may not understand how their work may intersect with that of another state agency. Like treatment providers, policymakers in agencies whose work involve women affected by co-occurring disorders and trauma must have a basic knowledge of the areas of substance abuse, mental health, and violence and their interactions. Consequently, SLC members were cross-trained using the *WELL Project Training Curriculum for Providers*. Next, members

brainstormed about the needs of the women and of their children and then about statewide policy barriers to providing integrated, trauma-informed care.

Recommendations submitted to the SLC by the LLCs covered a wide range of issues, including comprehensive assessment for consumers, cross-training for staff, enhanced reimbursement rates, competency requirements for licensing of individual providers, coordinating licensing requirements for programs across state agencies, expanding certain existing programs, and piloting programs to fill service gaps. The SLC supported individual members in working toward implementing recommendations within their agencies and also developed a group strategy for promoting change. The initial strategy consisted of developing a set of principles that explicated the need for trauma-informed care and outlined the specifics of such care. These *Principles for the Trauma-Informed Care of Women with Co-occurring Mental Health and Substance Abuse Disorders* were distributed to state agencies and treatment agencies, and 38 organizations, including all major state agencies involved in delivering services to women and children, signed on to them. To assist organizations in implementing the *Principles*, SLC members developed a companion *Tool Kit*, which contains self-assessment tools for both health and human service organizations and for state agencies, along with instructions for using such an assessment to move toward the provision of trauma-informed, integrated services.

Barriers encountered and strategies to address them

After a year of cross-training, executive directors of the 3 core agencies complained that agency employees were more knowledgeable about the interaction between trauma, mental health, and substance abuse, but this knowledge was not changing their actual practice. That is, direct care providers were not necessarily able to implement what they had learned. To address this, a strategy of providing on-site "integrated supervision" was implemented, replacing cross-training with clinical consultation. An expert on integrated treatment spent 2 hours per month at each of the 3 partnering agencies, meeting with clinical staff. Site clinicians could request a didactic presentation on a relevant topic, explore challenging cases, or discuss systems issues in developing and delivering integrated care. Both executive directors and site clinicians found this strategy to be effective in moving from knowledge to practice.

Recruiting and retaining consumers to participate in the LLCs was more difficult than anticipated. A number of strategies were instituted to support consumer involvement. A consumer coordinator was hired as a paid employee, and recruitment and retention of consumers became one of her responsibilities. Leadership training for consumers was developed and provided by the consumer coordinator, a leadership consultant, and the consumers on the WELL Project Steering Committee to help consumers feel more comfortable and competent in an advocacy role with professionals. Consumers also requested time to meet with other consumers, to provide support for each other and develop their own projects. Consumers were paid for their time, and transportation was often provided.

Increased awareness of the impact of violence on women with mental health and substance abuse disorders

WELL Project activities directed at changing the understanding of appropriate services and addressing structural barriers to integrated, trauma-informed services had an impact within all 3 levels. The changes set in motion also interacted across levels. In a number of instances, a tipping point appears to have been reached, leading to statewide and local changes beyond the WELL Project.[27] For example, at public events focused on substance abuse or mental health, it is increasingly common that issues of trauma are discussed. At Recovery Day, an event held each year at the Massachusetts statehouse celebrating recovery from substance abuse, WELL Project consumers began speaking openly about their trauma histories. Now, consumers routinely mention recovery from violence in their speeches, as do many of the state agency directors/commissioners. A recent conference sponsored by the New England Association for Addiction Recovery, a New England–wide consumer

organization, also paid considerable attention to issues of violence and trauma. On the local level, providers at agencies that participated in the LLCs are acknowledging the importance of trauma-informed care, and it is becoming routine in most service settings to ask women during intake about their history of physical and sexual abuse as well as current domestic violence, with many agencies using screening instruments that were featured at cross-trainings.

Increased availability of trauma-specific and trauma-informed services

A major impact of the WELL Project has been an increase in the availability of group interventions that address trauma. One successful strategy was the provision of statewide training on 2 different trauma group curricula. Another was working with the Department of Public Health, Bureau of Substance Abuse Services (BSAS), to highlight several trauma group curricula in their annual Women and Substance Abuse Conference. Consequently, a number of substance abuse treatment programs, domestic violence agencies, and homeless shelters across the state included those trauma groups as part of their programming. At all 3 local agencies involved with the WELL Project, many clinicians in both residential and outpatient settings have been trained by Project staff to conduct trauma groups. Other treatment modalities have also begun trauma services. For example, an adult drug court for which one WELL Project partnering agency is the provider of substance abuse services now includes trauma groups in its programming for both women and men, although such groups were not included in the original design.

Multilevel systems work also contributed to BSAS adding to their terms and conditions for all contracts the requirement that services be trauma-informed. Trauma-informed services are defined in these terms and conditions as meaning "that even if a BSAS funded agency is not treating an AOD (alcohol or other drugs) client for trauma, the clinician is able to screen for trauma, understands the diagnosis, and the AOD treatment plan and counseling techniques include an approach that is sensitive to the client's issues." The terms and conditions then go on to explicate more specifically important characteristics of trauma-informed services, and require that trauma-specific services be provided on-site or by referral. BSAS also now funds a position responsible for building the capacity of BSAS programs statewide to work with trauma survivors. In addition, BSAS has been working with treatment providers and the state Medicaid agency to develop reimbursement for trauma group services for women in outpatient substance abuse treatment, which is expected to increase availability of this service statewide.

Increased collaboration at both state and service provider levels to meet the needs of women with substance abuse and mental health problems in domestic violence situations

Participation by the WELL project director in a new Substance Abuse Working Group of the Governor's Commission on Domestic Violence further extended multilevel systems change. Discussions at meetings of this Working Group stimulated BSAS to provide funding to conduct regional Substance Abuse-Domestic Violence Summits throughout the state, with the Working Group serving as the Planning Committee. These summits provided cross-training for substance abuse and violence service providers, along with an opportunity to begin developing linkages for the provision of cross-system services. They also resulted in a set of policy recommendations for state agencies to support the provision of appropriate services for individuals facing both issues.

Network Survey Findings

Changes in relationships among service providers

To directly compare aspects of service area integration at the community, or interorganizational level, at the 2 data points, we constructed networks consisting of all the respondent agencies that

Table 1
Relative positions of trauma/violence service providers in client referral networks for the 3 WELL sites at Phase I (1998–2000; interviews, June–July 1999) and Phase II (2000–2003; interviews, November 2002–January 2003)

	Matched respondents at each phase (valued networks) Site					
	Northeast ($n = 22$)		Cape Cod ($n = 28$)		Fall River ($n = 25$)	
	Phase I (1999)	Phase II (2002–2003)	Phase I (1999)	Phase II (2002–2003)	Phase I (1999)	Phase II (2002–2003)
Mean centrality for trauma/ violence service providers*	9.7	13.7†	19.0	22.2‡	23.8	29.0
Mean centrality rank (1 most central) for trauma/ violence service providers*	8.9	5.1†	15.2	13.2	12.7	10.8
Number of trauma/violence service providers in network core	0	3‡	3	6‡	1	2
Number of trauma/violence service providers in network	5	5	6	6	3	3
Number of trauma/violence service providers as a proportion of network core	0	1.0‡	0.20	0.24‡	0.08	0.14

*Centrality is averaged across providers and for both sending and receiving clients.
†$P < .05$.
‡$P < .10$.

were the same at both times. Because the project focused on including trauma/violence services, a relatively neglected area in the array of services available to clients, we examined the extent to which providers at each site whose primary service area was trauma/violence became more central in each client referral provider network. For each site, at the 2 times, Table 1 displays (1) the mean centrality of the trauma/violence service providers (Freeman degree centrality); (2) their mean centrality rank (where 1 represents the most central); (3) the number of trauma/violence providers in the network core, based on a simple core-periphery algorithm[22]; and (4) the proportion of the core agencies that were trauma/violence service providers.

The provider networks at the 3 sites are quite different in their density of linkages, overall network centralization, and proportion of agencies in the network core.[28] Nevertheless, at each site, there is a shift toward greater centrality of the trauma/violence service providers in the client referral network. At the Northeast site, this shift is statistically significant ($P < .05$), whereas at the Cape Cod site, it is marginally significant ($P < .10$). The shift in centrality is corroborated by the increased proportion of core agencies that are trauma/violence service providers at each site. Because of the relatively low numbers of trauma/violence service providers involved, the latter measure only attains marginal significance at 2 of the sites. Thus, there is evidence at the interorganizational level of greater integration of trauma/violence service provision into the overall mix of services that clients are provided.

Implications for Behavioral Health

The WELL Project's successful implementation of a relational systems change model demonstrates that a trauma-informed, integrated system of care for women with co-occurring substance abuse and mental health disorders and histories of violence can be facilitated by a collaborative process in which consumers, providers, and policymakers work together on both state and local levels. Implementation plans should include appropriate, ongoing support for an extended period of time for consumers and for agencies and staff at the service level. State policies that encourage integration and the provision of resources for cross-training, integrated supervision, and development of cross-systems services are also necessary to establish trauma-informed, integrated care as the norm.

The effects of state-funding streams segregated by service area often appear clearly at the community level, where agencies providing different primary services tend to restrict client referrals between service areas, traditionally to the detriment of clients who could benefit from services in multiple areas. In the case of mental health, substance abuse, and trauma/violence services, segregation of funding streams has historically been reinforced by distinct professional training and treatment orientations. A crucial change at all 3 of the WELL Project's sites, then, has been a shift in the client referral networks toward greater centrality of trauma/violence service providers. This shift occurred in provider networks that ranged from relatively sparse in client referrals to quite dense, and in networks in which most providers were concentrated in a few service areas as well as those in which providers were spread evenly across many service areas. This shift may consequently represent change that is robust to a variety of provider network starting points.

The increased centrality of trauma/violence service providers is important in 2 other ways. First, it reflects an increase in both referrals from trauma/violence service providers to substance abuse, mental health, and other service providers, and, conversely, from providers in each of these other service areas to trauma/violence service providers. It appears to reflect a shift in clinician and program staff behaviors in each of the service areas represented, resulting in clients receiving services that address all 3 clinical issues. Therefore, the WELL Project change strategies appear effective in increasing referrals across multiple service areas. Second, centrality is a global measure of a network. Change in centrality reflects a change in collective behavior among the providers in a network. Future research should examine the extent to which such change in collective behavior represents changed mind-sets on the part of clinicians, program staff, and consumers, and the extent to which a new understanding of service integration is shared across all groups.

As was clear during the project's implementation, a trauma-informed, integrated system of care is not a static endpoint but represents a dynamic relationship among evolving service systems. In such situations, the change process itself needs to model this desired dynamic relationship.[29] The relational systems change model exemplifies such a change process. By virtue of its highly collaborative, respectful nature, it facilitates the coordination of change within and across multiple system levels. The model's strategies could be used to facilitate other types of desired change within and across behavioral health service systems.

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