Strengthening the Success to Recovery: Treating Trauma as a Primary Symptom in Women’s Recovery Residences

by
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We certify that in this Final Project all research involving human subjects complies with the Policies and Procedures for Research involving Human Subjects, Saint Mary-of-the-Woods College, Saint Mary-of-the-Woods, Indiana 47876
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Abstract

The process of recovery is a person-centered holistic approach that allows an individual to take control of their mental health and addiction. The Substance Abuse and Mental Health Services Administration created a working definition of recovery that included guiding principles with recovery as the primary goal (Substance Abuse and Mental Health Services Administration, 2018). These principles intend to help with the design, measurement and reimbursement of services for individuals seeking recovery. Although the use of these principles are a successful approach to treatment, the percentage of those who recover successfully remains at a mere twenty percent (SAMHSA’s Guiding Principles of Recovery, 2018).

The secondary research conducted in this study creates a structured plan to increase the recovery rates in women who reside in recovery residences that use a trauma-specific approach. Exploration from similar studies involving this type of treatment shows efficacy in recovery rates with the implementation of an evidence-based practice (Berkowitz, 2013). The positive data outcomes provide a degree of success not otherwise found in the absence of treating trauma as a primary symptom.

This thesis shows that while trauma is specifically ascertained as an ongoing issue in effective recovery, treatment for this mental health issue is not used widely in the recovery communities (Covington, 2015). Further analyses conclude that treating trauma as a primary symptom will increase the rates of success for women in recovery.
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Background

Substance Use Disorder (SUD) plagues the United States with 20.8 million people meeting the diagnostic criteria for SUD in 2015 (United State Department of Health and Human Services, 2016). The prevalence of SUD differs within demographics such as race, ethnicity, and gender.

Figure 1: Graph of gender, age, and race differences with substance use disorder

These factors alone can influence access to healthcare and treatment for SUD. Health and social problems have been linked to the manifestation of elevated SUD revealing the relationship to addiction. These findings show that SUD is a secondary problem linked to health
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and social issues and treatment of the primary issue can be effective for recovery (United State Department of Health and Human Services, 2016).

According to the Substance Abuse and Mental Health Services Administration, nearly two million women suffer from a dual-diagnosis of mental illness and addiction. In the past, the focus remained stagnant for treating addiction as a stand-alone symptom with hopes that mental illness, specifically trauma, will just “fall away” or require secondary treatment from additional providers. The American Psychological Association reports that one half of all individuals will experience trauma in their lifetime (American Psychological Association, 2017). A significant milestone for treatment in women’s addiction and recovery has been the evolution of the need for gender specific treatment (Covington, 2015).

A dual-diagnosis is defined as a coexisting relationship with one or more mental illnesses and SUD. Dual-diagnosis is associated with higher rates of relapse, hospitalizations, poorer compliance to treatment, and increased suicide risk (Pinderup, Thylstrup, & Hesse, 2016). Failure to identify and treat dual-diagnosis disorders results in a higher prevalence of lifetime SUD with severe consequences of both client and society. Although there is evidence of treating both disorders of mental illness and substance use with an integrated approach, mostly clients are treated for only one symptom (Pinderup, Thylstrup, & Hesse, 2016).

Over the past thirty years, knowledge of women and how they recover has increased dramatically. In the 1970s and 1980s clinicians and researchers began to call attention to the lack of knowledge when providing suitable care for women with substance use issues. Research
historically focused on men and treatment programs were not properly equipped to assist women in recovery. Women were more likely to seek treatment from their primary care doctor than turning to an addiction or mental health treatment facility (Greenfield, 2016). In response to this issue, government organizations have created milestones for requirements focused on women’s services. With newly supported research and treatment for women, the attention of practitioners was drawn to understanding and addressing gender differences in treatment access, treatment provision, and outcomes (Greenfield, 2016).

Over the past few decades heightened acknowledgment of trauma as a social issue has played a large part in identification of health and mental health problems in women (Smyth, 2013). The experience of trauma is multifaceted, referring to a series of events, an acute event, or responses to sociocultural factors. A non-clinical sample of 2,953 United States adults found that 89.7 percent were exposed to one or more traumas. The most commonly stated traumas are physical or sexual assault (52 percent), accident or fire (50 percent), death of a close family member or friend due to violence (49 percent), natural disaster (48 percent), threat or injury to a close family member or friend (32 percent), and witnessing physical or sexual assault (31 percent). The study also revealed that differences of the prevalence of trauma exist between genders (Giordano, et al., 2016).

When trauma is experienced, it forms a deep wound in the memory and continues to cause havoc if left untreated. While at times, women can address the negative effects associated with trauma, most try to ignore it or do not even realize that damage was done. Women will respond to trauma with emotions such as anger, dissociation, depression, and
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anxiety, but then turn to substance use to mask these unwanted feelings and symptoms (Ruisard, 2015). After avoiding these issues for so long and using substances as numbing agents to ease symptoms, unknowingly addiction takes its course making matters worse. Females will use this course of addiction to connect in relationships or fill a void. Research shows that addicted women will progress in their addiction much more quickly than men. This is due to the result of challenges associated with gender differences (Women Get Addicted More Easily Than Men, 2013).

A woman will complicate the issue of trauma by blaming herself and increase the likelihood of developing Post-Traumatic Stress Disorder (PTSD). Individuals with co-occurring symptoms of PTSD and SUD tend to relapse more quickly and experience more intense cravings for drugs/alcohol (DeCou, Cole, Lynch, & Wong, 2017). Currently, there is no “gold standard” of care for those who present both symptoms. It is important to acknowledge that once criteria are met for both disorders, they will influence each other. Studies have shown that increases in symptoms of PTSD are associated with increases in cravings for drugs/alcohol (Maercker & Hecker, 2015). Patients that present both conditions perceive a strong relationship with one condition worsening and then the other to follow. Likewise, when one condition improves, so does the other. Although the nature of these co-occurring symptoms is still unknown, it is well-defined that these individuals represent a group that calls for unique treatment needs and modalities (Maercker & Hecker, 2015).

In order to create treatment services that will be effective for women experiencing both trauma and substance abuse, acknowledgment and understanding of life experiences relating
to gender differences must be a factor. Gender outlines the framework in women’s lives. Research shows that social and environmental factors account for the differences that are experienced between men and women. Studies have shown that success for women with co-occurring symptoms relate to certain guiding principles (Berkowitz, 2013). The first principle to follow is the acknowledgement that gender makes a difference. First, the biology of a woman’s body allows them to become addicted faster than men. A woman’s body contains less water than men, more fatty tissue, and lower enzyme levels. As a result, women will progress into addiction faster than men since their bodies are exposed longer and at higher concentration levels (National Council on Alcohol and Drug Dependence, 2015). Women also are more susceptible to stress and oftentimes are the primary care providers for the children while additionally juggling a demanding job or career. Women will more likely turn to stimulants to help them keep up their appearance and manage weight. It is also more difficult for women to make the first call for help, due to feelings of shame and guilt associated with abandoning family roles or barriers to seeking treatment (Covington, 2015).

Next is the environment. Treatment environments are often coed and lack appropriate concepts of needs based on safety, respect, and dignity. Often women feel unsafe especially in relation to other people. Women may not feel safe in recovery groups that include men. Women-only groups should be the model of choice in early stages of recovery. A woman will feel more comfortable sharing her experiences and ideas in a group of other women. This helps women to feel validated in their experiences and lets them know they are not alone. This will
also create a sense of bonding and empowerment that is missing when treatment groups are mixed gender (Greenfield, 2016).

Women are more likely to experience trauma from a loved one or someone that they trust and this tends to heighten the stigma related to trauma and SUD. It is possible that this accounts for the increase in mental health problems for women. It is more confusing and distressing to have the person who is supposed to love and care for you do harm to you than it is to be harmed by someone who dislikes you or is a stranger.

Very few studies show the relationship of trauma and substance use in women’s addiction. Women are more likely to use drugs or alcohol due to emotional distress and self-medicate to cover feelings of shame, guilt, inferiority, and low self-esteem. However, many treatment modalities simply focus on the addiction and women experience an eighty percent chance of relapse when attempting long term recovery (Bowers & Blakely, 2014). If trauma is ignored by the provider then it will also be ignored by the patient and the underlying yet dominant issue remains. Women are different than men psychologically and physiologically and using the same treatment modalities for both has proven to be ineffective in recovery (Bowers & Blakely, 2014). Women experience different needs in environment, relationships, and treatment programming. The need for a trauma-specific model in conjunction with social supports remains an area that is unclaimed for the success of long term recovery. This approach is beneficial to offering a continuity of care that will increase rates of efficacy in total abstinence from drugs thus claiming better outcomes in women’s holistic health.
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In 2014, Hamilton Center, Inc., was funded by a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) to open two dual-diagnosis transitional living facilities in Terre Haute, In. Each is gender specific and follows the same set of rules, policies and procedures. The houses have a maximum capacity of thirteen beds, six men, and seven women. The program for transitional living revolves around the concept of treating both the addiction and the mental illness thus deeming it a dual-diagnosis program. However, the rate of relapse and recidivism continues to grow after the completion of the 90-day program. The program includes case management, therapy, group therapy, social skills, independent living skills, social connectedness, employment coaching services, peer recovery, and finally placing the client in a sober, stable living environment with continuity of care involving Hamilton Center services. The success rate for clients graduating the program is above 75 percent. However, the efficacy of long term recovery and the absence of recidivism still proves to be an issue. The program follows the guiding principles of recovery, but the missing piece to the therapeutic environment is the trauma first treatment approach.

For the purpose of this study I will be focusing solely on the women’s transition house. Although both genders are important in recovery, women have less resources and more complex issues when diagnosed with dual disorders. Sober living programs for women cannot be “one size fits all” (Breckenridge & Salter, 2014).

Problem
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The problem is an identifiable gap in the use of a trauma-specific approach for women seeking help for addictions. This gap is due to lack of knowledge and education from mental health providers and the scarcity of utilization of trauma-specific models of treatment (Giordano, et al., 2016). Historically, clinicians have focused on one symptom, one treatment, and one result. Although the use of an evidence-based practice for addiction can result in certain successful periods of sobriety, relapse is always a high-risk due to the lack of focus and misdirection of the primary symptom.

Treating trauma first will increase the efficacy of recovery rates in women by redirecting the focus of treatment to the correct symptomology. Addiction should be defined as the secondary problem to the order of dual-diagnosis treatment. Additionally, the implementation of social supports for women’s recovery is imperative. Women need social supports, specifically those found in residencies with other women sharing similar experiences of life trauma and addiction (Breckenridge & Salter, 2014).

**Literature Review**

According to Wise and Marich, outcomes are improved when treating both trauma and SUD concurrently (Wise & Marich, 2016). The high rate of comorbidity between the two issues is well established. The symptoms of trauma disorders and SUD are cyclic and interact with each other. Trauma will trigger substance abuse and substance abuse will increase the risk of traumatic episodes (Wise & Marich, 2016). This study used Eye Movement Desensitization and Reprocessing (EMDR) Therapy as a methodology for dealing with trauma in combination with
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SUD. The purpose was to provide possible positive outcomes for clinicians to better understand the importance of dealing with both diagnoses concurrently. All participants in the study recognized how unresolved traumas and SUD was interrelated. Thoughts and behaviors changed as a result from making this connection (Wise & Marich, 2016).

Findings from the International Journal of Mental Health and Addiction show a lack of training for dual-diagnosis disorders to be problematic. Authors of this study suggest training in dual-diagnosis and dual-diagnosis treatment so the coexisting symptoms can be understood to modify or develop an educational approach to clients through skills, attitudes, and learning experience. This training should focus on not only enhancing the professional’s knowledge of mental illness and SUD, but also assist the client to reduce counterproductive attitudes (Pinderup, Thylstrup, & Hesse, 2016). Mental health professionals should receive continuous training in dual-diagnosis and treatment according to the clinical guidelines on psychosis and coexisting substance use. One of the most widely used models for the evaluation of training programs is Kirkpatrick’s Training Evaluation Model (Pinderup, Thylstrup, & Hesse, 2016). This model includes four levels of evaluation criteria that are used to measure related impacts of training. Level one, reaction, gauges the client’s perception of the dual-diagnosis training program and coaches the participant to become motivated to learn. Level two, learning, references the client’s improvements in professional knowledge, skills, and abilities. The third level, behavior, refers to the transfer of training through changes in work place practices and behaviors of the professional. Level four, results, refers to the organizational outcomes, and recommends the evaluation strategy begin at level one and move up sequentially as levels are
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completed. It is operationalized as improvements for the client’s symptoms of behavioral health and substance use (Pinderup, Thylstrup, & Hesse, 2016).

Figure 2: Training Evaluation Model for Dual-Diagnosis Disorders (Pinderup, Thylstrup, & Hesse, 2016)

In a 2015, William White, Emeritus Senior Research Consultant at Chestnut Health Systems, conducted an interview with Dr. Stephanie Covington. Covington is a clinician who is recognized for her pioneering work in women’s issues. She specializes in the development and implementation of gender-responsive and trauma-informed services (Covington, 2015). Covington explains that treatment services for women cannot just focus on the addiction. Research shows that a clear majority of addicted women have also suffered from extreme acts of violence and other forms of abuse. Covington states that many issues in addicted women are universal including shame and stigma, physical and sexual abuse, relationship issues, treatment
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issues, and systemic issues. Due to this recurring theme, a multifaceted approach for services is needed for successful recovery. The author developed a treatment model known as Women’s Integrated Treatment (WIT). This model is based on gender specific services and multidimensional therapeutic interventions (Covington, 2015). There was a significant decrease in depression and trauma symptoms from those who participated in the study. She notes the important components in treating women’s trauma is to educate women on their trauma, normalize their reactions, and provide coping skills. The women in this study showed further improvement with ongoing continuity of care using curriculum to engage them in trauma-informed and gender responsive treatment (Covington, 2015).

Individuals who suffer from both trauma and substance use are documented to use one as a coping mechanism for the other. A 2014 study called, Associations between Post-Traumatic Stress Symptoms, Stimulant Use, and Treatment Outcomes: A Secondary Analysis of NIDA’s Women and Trauma, used two methodologies to predict improvements in trauma related disorders and SUD. These evidence-based practices are Seeking Safety and Women’s Health Education (Ruglass, Hien, Hu, & Campbell, 2014). Seeking Safety is an integrated cognitive behavioral treatment designed to reduce co-occurring trauma and SUD. Women’s Health Education is a psychoeducational comparison intervention focused on general health topics relevant to women. Results showed that heavy drug users had greater symptoms for trauma that light users. Those who received the Seeking Safety treatment showed a significant decline in trauma symptoms and substance use, but only for the heavy users (Ruglass, Hien, Hu, & Campbell, 2014). Seeking Safety provided psychoeducation and coping skills needed for higher
success rates in women presenting dual diagnoses. The increase in success rates were barely detectable in the Women’s Health Education groups. This intervention focused only on health topics related to women and the absence of a substance use intervention proved to be less effective. Women showed some improvement in trauma severity, but little decrease in substance use (Ruglass, Hien, Hu, & Campbell, 2014).

In a study from the Journal of Dual-diagnosis, 65 percent of women who suffer from addiction also suffer from a mental health disorder. This study used the four-quadrant model to identify dominant issues with mental health issues such as trauma in conjunction with SUD as identified by the Diagnostic and Statistical Manual (DSM). Women presenting both disorders have shown lower levels of social supports which lead to greater symptoms of mental health disorders and more severe substance use (Brown, Jun, Min, & Tracey, 2013). The excessive occurrence of trauma-related symptomology in women with dual diagnoses could impact their ability to identify and utilize social supports. Thus, making it more difficult for women with these disabilities to fully participate in recovery support groups. Results show that women with a greater social support for recovery were less likely to turn to substance abuse (Brown, Jun, Min, & Tracey, 2013).

Although many researchers indicate that trauma interventions should be integral for women suffering from substance abuse, many clinicians do not adequately address the issues of trauma (Polcin, Nayak, & Blacksher, 2013). The authors have tested an intervention for these issues called “Beyond Trauma.” This intervention is said to have several benefits to treating women with dual-diagnosis issues. Some advantages include a theoretical foundation on
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relational theory, a broad-based approach used by a variety of professionals, a focus beyond treating women specifically for trauma, and the gender appropriate curriculum. Most clinicians define trauma according the DSM criteria for post-traumatic stress disorder, this study uses a broader definition for trauma related issues associated with women and SUD. Four different manualized treatment models were mentioned in the study, and said to provide significant positive outcomes in the treatment of SUD and trauma. These interventions include: Trauma Recovery and Empowerment Model (TREM), Seeking Safety, Addiction and Trauma Recovery Integrated Model (ATRIUM), and TRIAD Women’s Group. All interventions were delivered in group format (Polcin, Nayak, & Blacksher, 2013). Although these modalities have shown successful outcomes, the authors were concerned about the adaptation of such interventions and how they may have been manipulated to fit the setting at hand. Authors focused on the design of “Beyond Trauma” and implemented the intervention within a community based “social model.” Some research shows significant improvements with participants and some show no change at all. The authors mention that additional studies are underway to provide better outcomes of this curriculum (Polcin, Nayak, & Blacksher, 2013).

Mueller and Jason explain the importance of social supports in successful recovery. Given the evidence of increased recovery rates with social supports, individuals must know where to find these supports (Mueller & Jason, 2014). Two of these sources are identified in this study as self-help groups and sober living houses. In this study participants were divided into two groups. One group was assigned to reside in a sober living facility and the other group was assigned to community based aftercare. The participants in the study were 60 percent
women. The increase of stay in sober living as well as increase in personal networks showed significant increase for those in recovery. The study also showed the importance of the first six months in recovery being most beneficial in a sober living facility. The participants in the self-help group showed authors that social supports alone in an outpatient setting were not effective in proving long-term recovery. Overall, the authors concluded that social supports alone in any recovery setting are not substantial enough to provide positive outcomes for long term sobriety (Mueller & Jason, 2014).

In a 2013 case study by Heather Larkin, extensive research on adverse childhood traumas (ACE) demonstrates a strong bond between early life adversity and substance abuse along with other health related issues (Larkin, 2013). Individuals are experiencing fragmented systems of care when the approach should be simultaneous and holistic. This study focuses on the need for social supports to identify with peers and identify “information sharing and communication” as well as “cooperation and coordination” (Larkin, 2013). Participants were separated into an intensive outpatient therapy group and a residential sober living facility. Outcomes show that integrated services for SUD, mental health disorders, and overall physical health concerns can assist an individual with better navigating their recovery instead of having to find piece meal services to treat multiple issues. These issues include personal supports for assisting people with multiple and complex problems (Larkin, 2013).

From the Journal of Substance Abuse Treatment, most providers do not receive training on dual diagnoses although trauma appears to be a risk factor for substance abuse (Torchalla, Nosen, Rostam, & Allen, 2012). The purpose of this study is to show empirical tests of
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integrated treatment models to treat trauma related symptoms and addiction concurrently. The authors point out that there have been several studies to show the importance of treating these diagnoses together and create an evidence-based model for integrated treatment, however, no studies define these using systematic and empirical methods (Torchalla, Nosen, Rostam, & Allen, 2012). The focus was to answer two research questions. Are integrated treatment models effective in reducing trauma related symptoms and substance abuse? Do integrated treatment programs reduce these symptoms and behaviors to a greater extent than traditional nonintegrated programs? Of the seventeen trials, studies found that integrated treatment effectively reduced trauma and substance abuse symptoms. However, there was insufficient evidence to show that integrated treatment for these issues was more effective than nonintegrated treatment (Torchalla, Nosen, Rostam, & Allen, 2012).

This literature review concentrates on trauma, SUD, integrated care and social supports. Many studies focus on treating trauma and substance abuse concurrently, but few show the importance of treating trauma first in conjunction with a social model of support. Evidence shows that there is efficacy when treating trauma and substance abuse simultaneously, however, the long-term effects of recovery are missing from most studies. Social supports, such as residential living facilities, are shown to be effective in long term recovery outcomes, but no recent studies have integrated the two models, therefore leaving a gap in treatment.
Program Overview

Currently, there are only two recovery residences in the state of Indiana that promote a trauma-specific approach for women’s recovery; Fresh Start Recovery Center, Indianapolis, Indiana and Dove Recovery House, Indianapolis, Indiana. Fresh Start Recovery Center is a program that includes two phases, the first being a minimum of 21 days and lasting up to four months, and the second phase is for home based coaching lasting up to one year (Fresh Start Recovery, 2018). This program offers treatment for women who are mothers or expecting and focuses on addiction treatment using therapy and other holistic approaches. Although the program offers care from trauma informed staff, there is no evidence that the program applies trauma-specific modalities for recovery (Fresh Start Recovery, 2018).

The second Indiana residential women’s recovery facility that promotes trauma-specific care is Dove Recovery House. This program provides services for both mental health and substance abuse and offers treatment for trauma related events, such as domestic violence. The Dove Recovery House is the largest women’s transitional recovery residence in Marion County. This residence serves 38 women nightly and uses trauma informed therapy along with case management focused on goal outcomes and behavior modification. The minimum stay is 90 days or up to 2 years. The Dove Recovery House uses the Trauma Recovery Empowerment Model (TREM). TREM is a psychoeducational and skills-building approach that will increase a woman’s understanding of the associations among addiction, trauma, mental health disorders,
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and sexual risk behaviors. This model teaches coping skills that are both positive and protective to assist with healing from abuse and reducing trauma symptoms (Noe & Mitchell, 2017). The rate of success for this program serving 52 women in 2016 was 77 percent with a rate of 94 percent not recidivating (Dove Recovery House, 2018).

The women’s dual-diagnosis facility at Hamilton Center, Inc. has been operating under grant funding for the past three years. In the latter part of 2017, grant funds ran out and the facility was expected to be sufficient and sustainable. However, this residential facility remains far under budget and continues to lose money. The success rate of those graduating the program is well above 70 percent, but in 2017, between the months of August-December, six graduating residents experienced relapse and requested readmission back into the home.

The facility needs revamped starting with the programming and responsibilities of staff. The home is gender specific in living arrangements, but not in the way of program implementation. Dr. Stephanie Covington, an expert in the field for gender-specific treatment and trauma related care, states in an interview with William White, “Well, the terms “holistic” and “comprehensive” suggest a common thread. With women, you can’t just focus on the addiction; it has to be a much more broad brush. When we talk about continuing care, what’s really important is continuity of relationship. If a woman can start working with someone and have this person as a support person over a long period of time, that really enhances her recovery options. We are recognizing the importance of treating women across multiple issues and challenges in their lives.” (Covington, 2015).
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To meet the needs for women in recovery, Hamilton Center, Inc. needs to revisit the current programming and implement additional treatment modalities with a focus on trauma-specific care. There are seven women in the facility at any given time, all with different needs and plans for recovery, but there is a common thread, most have experienced trauma at some point in their lives. This is true for 90 percent of the population that suffer from addiction issues (Substance Abuse and Mental Health Services Administration, 2018). The positive outcomes for the Hamilton Center transitional living program completion identify with best results for short term successful recovery measures.

Treatment Modalities

The program is a ninety-day program with the first thirty days of the client’s stay being on restriction. The wording of this phase in recovery sounds punitive in nature and is not trauma informed. Calling a phase of recovery “restriction” will only create a negative outlook for the client during that portion of the programming. Changing the language for those in recovery is imperative. Jessica Neville, Licensed Clinical Social Worker and Chair of Trauma Informed Care at Hamilton Center, Inc, said, “Being trauma-informed means using a language that drives positivity and cancels out the feelings of shame and guilt. Recovery should be gratifying and beautiful, not negative and shameful” (Neville, 2017).
The gender specificity also lacks in programming and currently the focus is gender neutral. The residents of Phoenix Recovery Center participate in groups and work with staff to learn coping skills, cooking, cleaning, mindfulness, reflections, depression, parenting, relapse prevention, intensive outpatient, and recovery/narcotics/alcoholics anonymous as part of required programming. Although these programs can all be effective for treating both mental health and addictions, they do not have a specific approach for women or trauma. Recently, the women’s house has implemented a group with the curriculum for Seeking Safety. This is a curriculum that focuses on substance use and trauma, but additional therapeutic programming and language is fundamental in successful recovery.
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With this new model of recovery for the women’s residence more gender and trauma-specific models will be implemented. Current programming will remain in effect with the addition of trauma and social supports. The programs will be labeled in phases of recovery instead of using terms such as “restriction”. The first phase will be called orientation and will last for the first 30 days. Orientation will allow residents to leave the facility and navigate the community and support groups with staff supervision. After the first 30 days, the women will move into Phase II. This phase will be less restrictive and allow the residents to take a daily two-hour pass throughout the week, only if it does not interfere with programming, and it will give the women two eight hour passes on the weekends for the first two weeks. The second two weeks of Phase II will allow the women one overnight pass with prior authorization and confirmation of the location where the women will stay. The implementation of passes will allow the women to reconnect with their families and seek outside supports on their own. Encouraging independence for women in this phase will assist in the transition from the home to successful, long-term recovery upon completion of the program. Phase III is the last month of the thirty-day program and will allow the women to take full, overnight weekend passes to be with their family and loved ones and assist with transitioning the women into their next step of recovery.

Aside from new phases for transitional living the program schedule will need a complete overhaul. Women need to feel safe and secure in their surroundings and not all support groups promote healthy environments for women. Women are underrepresented in most recovery groups such as narcotics and alcoholics anonymous (Kruk & Sandberg, 2013). Women who
experience comorbid diseases such as trauma and substance use feel not only outnumbered, but also marginalized with their own life experiences. These groups do not directly address trauma or PTSD and focus mainly on the harm the addict has done to one’s self and others, instead of the harm done to the addict (Najavits, Haan, & Kok, 2015). The outcomes for women in recovery can be more successful with the creation of an in-house recovery group known as Self-Management and Recovery Training (SMART). SMART is a cognitive-behavioral based, mutual-help program. The goal for SMART is abstinence based and relies on the principles of rational-emotive behavioral therapy and other cognitive-behavioral and motivational methods (Penna, Brookeb, Brooks, Gallagher, & Bernard, 2016). This type of group aims to increase the participant’s ability to maintain motivation, identify and cope with cravings, and find balance in the adaptation of short-term and long-term goals. When addiction is addressed in this practice, it is considered to be a maladaptive, learned habit. SMART encourages participants to recover and live satisfying lives. This model teaches self-directed change, empowerment and self-reliance (Penna, Brookeb, Brooks, Gallagher, & Bernard, 2016). These groups can be led by trained facilitators instead of licensed professionals, allowing those who can disclose a lived-experience to run the group.

Another addition to programming will be a 12-step yoga group. The 12-steps are an evidence-based practice. Implementing this practice of mindfulness in accordance with spirituality can increase the level of awareness of the addiction and trauma in recovery. Yoga and mindfulness are becoming increasingly popular in the addictions area and are now implemented for a more effective form of relapse prevention (Khanna & Greeson, 2013). Yoga
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and mindfulness help participants become aware of experiences and emotions as they arise. Addiction can happen in a "mindless" state that involves attitudes of escape, thinking on "autopilot", and emotional reactions as well as social isolation (Khanna & Greeson, 2013). The loss of self-worth and emotions that occurs during addiction is filled by substance use. The practice of yoga alone can help with attention, concentration, enhancement of emotional regulation, and assist with the facilitation of personal and spiritual growth through self-observation. Implementing the 12-step recovery model in combination with yoga takes a cognitive approach to regulate the stress hormones of cortisol and adrenaline (Stuken, 2012).

Peer recovery is a service for treatment of individuals with a mental illness/SUD. Peer support services are delivered by individuals with a lived experience relatable to those they are serving. Research shows that this type of support facilitates recovery and promotes a sense of belonging within the community (Peer Support and Social Inclusion, 2015). Peer support is a way for individuals with diverse backgrounds to share common experiences and come together to build relationships that share strengths and supports for healing and growth. This type of intervention allows for one to learn and grow through a mutual past and does not focus on "diagnoses or deficits" (Blanch, Filson, & Penney, 2012). The women participating in the transitional living program at Hamilton Center, Inc. will pair up with a Certified Recovery Specialist (CRS) to create an in-depth relationship for additional social supports outside the home. Currently, Hamilton Center employs three female recovery specialists and will train three additional employees in February 2018.
Motivational Interviewing is an evidence-based practice in the National Registry through the Substance Use and Mental Health Services Administration that focuses on a participant's stages of change. This is not specific to recovery, but specific to changing a pattern of behavior in their lives that will facilitate change. The components of motivational interviewing allow for providers to "meet the person where they are". This type of intervention uses a wheel of change to assist the participant in identifying a level of readiness for bettering themselves and their behaviors. There are five principles to motivational interviewing that include: expressing and showing empathy, supporting and developing discrepancy, dealing with resistance, supporting self-efficacy, and autonomy (Campbell, 2018). Motivational Interviewing is a method that helps individuals resolve feelings of ambivalence and insecurity to find internal motivation needed to change behavior. This intervention is measured by a tool called the readiness ruler and the wheel of change includes phases that range from pre-contemplation to maintenance of the overall issue (Motivational Interviewing, 2018).

The Wellness Recovery Action Plan (WRAP) is another evidenced based model that works on a holistic approach of recovery from addiction and mental illness. This curriculum will be useful in the home because it is not specific to recovery from a certain diagnosis, but recovery as a whole. The WRAP was developed in 1997 by Mary Ellen Copeland and further developed by a group of Copeland's colleagues during a recovery skills seminar. The fundamentals of this practice are personal responsibility, education, hope, self-advocacy, peer-support and future planning (Horan & Fox, 2016). The participants create an individual recovery plan that is realistic to their needs for the success of their recovery. This can be demonstrated in a group
Strengthening the Success to Recovery: Treating Trauma as a Primary Symptom in Women's Recovery Residences

setting or individually with a peer facilitator. The components for the WRAP are making a daily maintenance plan, learning strategies to identify and respond to triggers, learning strategies to identify and respond to early warning signs, recognizing a crisis, and creating a post-crisis plan (Horan & Fox, 2016).

Additionally, a model for recovery that will be utilized at the women’s transitional recovery home will be women’s relapse prevention. This is another cognitive behavioral model that focuses specifically on women and the prevention of a relapse into addiction. Relapse is known as the return to heavy substance use after a period of abstinence. Most residential recovery homes offer relapse prevention as a coed group and do not focus on the specific needs for women with trauma and SUD. This model is based on principles that drug use had provided a “valuable function” in the lives of addicts even in the presence of sickness, legal issues, criminalization, and loss of relationships (Jackson, 2014). The purpose is to see this as outweighing the benefits of using. If the user is to reach a level of abstinence and remain there they must identify the values of drug use and anticipate these values as being tempting to put them at risk of having the impulse to use (Jackson, 2014).

Eye Movement Desensitization and Reprocessing (EMDR) will be implemented by a licensed therapist. EMDR includes eight phases of treatment. The amount of time spent on each of these phases of treatment depends on the history of the client (EMDRIA, 2017). The goal of this treatment modality is to process the events that have caused the client issues resulting in negative effects of trauma and SUD. “Process” is more than just talking about the issues, it is the manner of a learning state that allows the events to be stored in the brain. The
Strengthening the Success to Recovery: Treating Trauma as a Primary Symptom in Women's Recovery Residences

inappropriate beliefs, emotions, and state of the body will be abandoned by the client and the emotions, understanding, and objectives that remain will be used to identify health behaviors that will lead to success in recovery (EMDRIA, 2017). The phases include:

**Phase 1: History and Treatment Planning**

This phase generally takes 1-2 sessions. The therapist takes a history of the client and develops a treatment plan. The behaviors that have caused the problem are addressed, and with this information the therapist defines specific objectives for the client (EMDRIA, 2017).

**Phase 2: Preparation**

This phase usually takes 1-4 sessions depending on the severity of the trauma. The therapist will teach specific techniques to deal with emotional disturbances. The primary goal is to establish a relationship of trust between the client and therapist. During this phase the therapist will explain the theory of EMDR and what to expect during and after treatment (EMDRIA, 2017).

**Phase 3: Assessment**

Phase three the therapist will assist the client with identifying the target emotions to be processed. The client will be asked to picture a certain event from the identified problem from phase one that best represents the memory. The negative beliefs are verbalizations of the disturbing emotions that still exist. The client will rate the disturbance and reprocess the event (EMDRIA, 2017).
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**Phase 4: Desensitization**

This phase will focus on the client’s emotions and sensations that are causing the disturbance as measured by the SUDs rating. Phase four deals with all responses to the event including memories, insights, and associations. The therapist will lead the person in sets of eye movements that focuses to reduce the SUD scale to zero. The client is then guided to a complete resolution of the target (EMDRIA, 2017).

**Phase 5: Installation**

The goal during this phase is to increase the strength of the positive belief that has been identified by the client. The client will fully accept the positive truth about this belief and coach the client to become aware that they need to learn a new skill to control the situation (EMDRIA, 2017).

**Phase 6: Body scan**

Upon completion of accepting the positive belief, a therapist will ask the client to bring back the original event and assess whether the client notices any tension in the body. If the client reports tension the sensations are targets for reprocessing. This technique is supported by independent studies of memory when a client is negatively affected by trauma the information is stored in the body systems memory and retains the emotions through physical sensations of the original event. The session is considered successful when the client brings up the event without any body tension (EMDRIA, 2017).
Phase 7: Closure

This phase ends the treatment session. It ensures that the person feels better than the beginning of treatment. If the event is not processed completely, the therapist will assist the client by using self-claiming techniques. The client should continue to feel in control during the session and outside of the office. The therapist will assist the client to identify techniques to use in order to feel calmer (EMDRIA, 2017).

Phase 8: Reevaluation

The final phase opens each new session with the therapist checking to make sure that results are staying positive, being maintained, and identifying any new areas of necessary treatment. This phase guides the clinician through the treatment plan that is needed for continued success of the client. Phase eight is vital to determine the success of EMDR treatment (EMDRIA, 2017).
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Table 1: Weekly Proposed Schedule of Programming for Phoenix Recovery Center for Women

<table>
<thead>
<tr>
<th>Time</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:00 AM</td>
<td>Meds</td>
<td>Meds</td>
<td>Meds</td>
<td>Meds</td>
<td>Meds</td>
<td>Meds</td>
<td>Meds</td>
</tr>
<tr>
<td>8:00 AM</td>
<td>Reflections</td>
<td>Reflections</td>
<td>Reflections</td>
<td>Reflections</td>
<td>Reflections</td>
<td>Reflections</td>
<td>Reflections</td>
</tr>
<tr>
<td></td>
<td>Morning Meditation</td>
<td>Morning Meditation</td>
<td>Morning Meditation</td>
<td>Morning Meditation</td>
<td>Morning Meditation</td>
<td>Morning Meditation</td>
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</tr>
<tr>
<td>9:00 AM</td>
<td>Household Management</td>
<td>Household Management</td>
<td>Household Management</td>
<td>Household Management</td>
<td>Household Management</td>
<td>Household Management</td>
<td>Household Management</td>
</tr>
<tr>
<td>10:00 AM</td>
<td>Dual Diagnosis</td>
<td>Appointments</td>
<td>Appointments</td>
<td>Motivational Interviewing</td>
<td>NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:30 AM</td>
<td>EMDR</td>
<td>Lunch</td>
<td>Therapy</td>
<td>Lunch</td>
<td>Lunch</td>
<td>Lunch</td>
<td>Lunch</td>
</tr>
<tr>
<td>11:30 AM</td>
<td>Free Time</td>
<td>Peer Recovery</td>
<td>12-Step Yoga</td>
<td>Peer Recovery</td>
<td>12-Step Yoga</td>
<td>Visiting Hours</td>
<td>Visiting Hours</td>
</tr>
<tr>
<td>12:00 PM</td>
<td>Lunch</td>
<td>NA</td>
<td>NA</td>
<td>Lunch</td>
<td>Lunch</td>
<td>Lunch</td>
<td>Lunch</td>
</tr>
<tr>
<td>1:00 PM</td>
<td>Group Recovery</td>
<td>Depression</td>
<td>WRAP</td>
<td>Seeking Safety</td>
<td>Visiting Hours</td>
<td>Social Skills Groups</td>
<td>Outing</td>
</tr>
<tr>
<td>2:00 PM</td>
<td>Re-Entry</td>
<td>Mindfulness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3:00 PM</td>
<td>SMART</td>
<td>SMART</td>
<td>NA/AA</td>
<td>SMART</td>
<td>SMART</td>
<td>SMART</td>
<td>SMART</td>
</tr>
<tr>
<td>3:30 PM</td>
<td>Reflections</td>
<td>Reflections</td>
<td>Reflections</td>
<td>Reflections</td>
<td>Reflections</td>
<td>Reflections</td>
<td>Reflections</td>
</tr>
<tr>
<td>7:00 PM</td>
<td>Meds</td>
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<td>Meds</td>
<td>Meds</td>
<td>Meds</td>
<td>Meds</td>
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<tr>
<td>8:00 PM</td>
<td>Reflections</td>
<td>Reflections</td>
<td>Reflections</td>
<td>Reflections</td>
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<tr>
<td>9:00 PM</td>
<td>Reflections</td>
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<tr>
<td>10:00 PM</td>
<td>Reflections</td>
<td>Reflections</td>
<td>Reflections</td>
<td>Reflections</td>
<td>Reflections</td>
<td>Reflections</td>
<td>Reflections</td>
</tr>
</tbody>
</table>

Impact of Cost

In 2007, the cost of addiction was $200 billion. In 2017, this number increased to over $740 billion in lost workplace productivity, healthcare, and crime rates (National Institute on Drug Abuse, 2017). The average number of those effected by addiction in the United States is 23 million (Schneider & Quartaro, 2016). The breakdown of cost per person annually is $32,173 for addiction costs alone. The cost of imprisonment is $24,000/person annually and inpatient hospitalization is $18,500/person annually (National Institute on Drug Abuse, 2017).
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Phoenix Recovery Center for women houses approximately 28 women each year. Research shows that twenty percent of those who seek treatment will remain in long term recovery (United State Department of Health and Human Services, 2016). This shows that of the 28 women who are involved in the program, only 4 will make it successfully in recovery for extended periods of time. This leaves 24 women to relapse, recidivate, or require intensive inpatient hospitalization beyond the scope of treatment at Phoenix Recovery Center. The average costs of the women who will turn back to addiction is $739,000, incarceration will cost $552,000, and inpatient hospitalization will cost $425,500 annually. The expected outcome of the implementation of the trauma-specific recovery model will increase the long-term recovery rate to thirty percent. Raising this number by only ten percent will decrease the number of women who are unsuccessful in recovery to 15 percent and save the state approximately $595,905 annually. This number may seem small, but this is only one recovery center in the state of Indiana. To date there are 1,700 available beds in Indiana for individuals needing support with long term recovery (Noe & Mitchell, 2017). Calculating these numbers at a thirty percent increased success rate for the state of Indiana, the state would save approximately $12.7 million annually.

Funding

Recovery homes typically depend on the resident to pay a weekly fee for the duration of their stay. However, most individuals seeking treatment do not have the resources to provide funding in early recovery. Research shows that addiction rates run twice as high for those that are unemployed (Szalavitz, 2016). For this reason, even the most affordable sober living
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residences are a luxury for those who are seeking services. Phoenix Recovery Center will use this trauma recovery model to provide evidenced-based practices that are reimbursable through the Medicaid Rehabilitation Option and Recovery Works payor sources. Using this funding will alleviate the pressure for residents to focus on recovery first before taking on employment and provide the coverage needed to pay staff salaries and overhead expenses.

The Medicaid Rehabilitation Option (MRO) includes services provided to individuals that fit a specific diagnosis and level of need under the approved Division of Mental Health and Addiction assessment tool or those who submit prior authorization. The Adult Needs and Strengths Assessment (ANSA) is the required tool used to determine the level of need for those receiving MRO services. The assessment is initially provided to clients by a master's level therapist and reassessments can be determined by other behavioral health professionals.

The services in the MRO package include community-based behavioral healthcare for those with serious mental illness and/or SUDs. MRO services are provided by a qualified behavioral health professional (Medicaid Rehabilitation Option, 2017). For those that qualify for MRO services a package is assigned based on their level of need. Units are then assigned per the individual to meet these needs. The units include 15-minute increments for services such as intensive outpatient therapy, group therapy, individual therapy, case management, skills training and development individual/group, inpatient hospitalization, etc. A qualified provider is a staff member that either holds a degree in human services or has worked or volunteered in an addictions or behavioral health setting for at least one year (Medicaid Rehabilitation Option, 2017).
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MRO reimburses services at a rate of $144.00 for one hour of individual skills and approximately $44.00 per individual for one and a half hours of skills group (Medicaid Rehabilitation Option, 2017).

The other source of funding conducive to the services provided is Recovery Works. Recovery Works is a forensic treatment program specific to the state of Indiana. In 2015, House Enrolled Act 1006 passed in the Indiana General Assembly to provide criminal justice funding. From this funding came the Forensic Treatment Services Grant Program through the Division of Mental Health and Addiction Services. The grant program is currently funding a voucher based program that offers vouchers to providers for services to those struggling with mental health and/or addiction issues (Recovery Works, 2018). The purpose is to reduce recidivism and promote recovery. Recovery Works will reimburse the cost of services to those who are not insured or do not receive Medicaid. To date the grant has provided over $30 million to individuals who qualify for the Recovery Works reimbursement.

Funding for the voucher program works solely with entities that are certified by the Department of Mental Health and Addictions and are competent in the treatment of populations with criminogenic factors (Recovery Works, 2018). Research shows that over half of the individuals who are incarcerated present conditions for mental health concerns and/or SUD. Of this population the rate of those who return to incarceration reaches 75 percent (Recovery Works, 2018). The focus of Recovery Works is to provide services for pre- and post-incarceration diversion. Promoting recovery thorough community support and
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treatment/intervention will assist in reducing the number of individuals who are entering the criminal justice system (Recovery Works, 2018).

Additional services paid for by Recovery Works that will be utilized in Phoenix Recovery Center are case management, skills individual/group, and peer recovery as well as the housing option. Recovery works reimburses individual skills at approximately $136.00/hour, group skills at approximately $25.00/hour, case management $75.56/hour and peer recovery at approximately $44.00/hour. Recovery Works has a lifetime cap on an individual receiving services at $7500.00 per person. An individual who meets the lifetime capacity of their services through Recovery Works will be considered for additional units on a case by case basis (Recovery Works, 2018).
Table 2: Recovery Works Reimbursement Rates

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Amount of Reimbursement</th>
<th>Who Can Claim this Service?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Management</td>
<td>$18.89/Unit (Unit=1/4 hour)</td>
<td>OBHP, Licensed Professionals</td>
</tr>
<tr>
<td>Housing Assistance</td>
<td>$32.00/Unit (Unit=1 day)</td>
<td>DMHA certified providers</td>
</tr>
<tr>
<td>Mental Health Counseling – Individual</td>
<td>$37.25/Unit (Unit=1/4 hour)</td>
<td>Licensed Professionals</td>
</tr>
<tr>
<td>Mental Health Counseling – Group</td>
<td>$9.31/Unit (Unit=1/4 hour)</td>
<td>Licensed Professionals</td>
</tr>
<tr>
<td>Peer Recovery Support Services</td>
<td>$11.12/Unit (Unit=1/4 hour)</td>
<td>Certified Recovery Specialists</td>
</tr>
<tr>
<td>Skills Training and Development – Individual</td>
<td>$33.98/Unit (Unit=1/4 hour)</td>
<td>OBHP, Licensed Professionals</td>
</tr>
<tr>
<td>Skills Training and Development – Group</td>
<td>$6.12/Unit (Unit=1/4 hour)</td>
<td>OBHP, Licensed Professionals</td>
</tr>
</tbody>
</table>

The billable services for Recovery Works are similar to the services covered by MRO with the exception of the housing option. Recovery Works will provide a daily reimbursement for those residing in a certified sober living facility at $32/day. The facility must be accredited by the Indiana Association of Recovery Residences (INARR) and be in full compliance of the procedures defined in the Recovery Works manual (Recovery Works, 2018). The Indiana House of Representatives amended House Bill 1006 in 2017 to include language that mandates
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accreditation through INARR if a recovery residence is interested in receiving state funding through programs such as Recovery Works (Steuerwald, 2015).

The accreditation for INARR includes:

- Step One: Familiarize yourself and determine your level

*Figure 4: Level of Recovery Residences from INARR (Levels of Recovery Residences, 2018).*

- Step two: Application and certification
- Step three: Application review
- Step four: Peer review and inspection
- Step five: Renewal

Once these steps are completed and the recovery residence is deemed appropriate for accreditation the next process begins for compliance with the Recovery Works manual.
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Seventy-five percent of the women that reside at Phoenix Recovery Center qualify for Recovery Works funding. Due to the severity of symptoms 90 percent of the women qualify for an MRO package.

**Staff Model**

The organization of the staff model and productivity expectation will assist Phoenix Recovery Center in producing the funds needed to implement an effective trauma-specific recovery model. The Phoenix Recovery Center for women holds a maximum capacity of seven women who stay in the facility for a projected ninety-day period. There are three, eight-hour shifts: days, evenings, and nights. During the day the expectation for productivity is four hours per provider, evenings is three hours per provider, and nights is one hour per provider. By implementing this expectation, revenue generated per client could reach up to $1,100 using skills, case management, and peer recovery services for a total of eight daily hours of engagement.

Staff will need training for seeking safety, motivational interviewing, WRAP, 12 step recovery and women's relapse prevention. A licensed in-house therapist can provide training to staff for most of these evidence-based practices excluding the 12-step yoga. The cost of training for this model is $199 for the pre-requisite certification and $350 for the yoga leadership training (Y12SR, 2018).

The house will employ eight mental health technicians (MHT), one community care coordinator, and an onsite therapist. The mental health technicians will interact, educate, and
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supervise mentally ill residents, individually or in a group setting. The expectation of this position is to provide a therapeutic environment within the women's home for Phoenix Recovery Center. The responsibilities are to perform the job successfully and include the following functions:

- Interact monitor, educate, and assist clients in the performance of activities of daily living according to the objectives identified on the treatment plan
- Monitor medication for self-administration and document in the Medication Administration Registrar
- Provide direct care to client’s needs including but not limited to assistance with personal hygiene tasks, bathing, feeding, and mobility
- Utilize safety management, emergency procedures, and nonviolent crisis prevention intervention in crisis situations
- Assist with inventory and general maintenance supplies, facilities, and equipment
- Complete housekeeping duties as assigned to maintain a clean, orderly, and safe environment
- Transport clients to and from appointments and community outings
- Observe, communicate, and document behaviors
- Complete errands related to consumer care and facility maintenance
- Participate in consumer treatment planning and implementation under the direction of professional staff involved in patient care
- Work under the direction of professional staff to ensure that all duties are completed
- Attend and participate in any required staff meetings and trainings
- Assist with admission and discharge of consumers as assigned using the electronic medical record
- Perform other duties as assigned

The position of community care coordinator will provide individualized and medically necessary case management services on behalf of clients and skills training directly to clients. Case management consists of services that help clients gain access to needed medical, social,
educational, housing, and other services. The responsibilities are to perform the job successfully and include the following functions:

- Consistently exercises discretion and judgment to analyze, interpret, make deductions and then decide what actions are necessary based on the varying facts and circumstances of each individual case.
- Works with minimal daily and immediate supervision, evaluating possible courses of conduct and making decisions where there is no opportunity to seek supervisory assistance.
- Maintains an active caseload providing referrals and linkage as needed within area of expertise and limits of credentials; assures procurement of additional services as needed.
- Acquires and provides to the team the detailed information regarding an assigned client to establish the foundation for the Treatment Plan.
- Works with the client on a day-to-day basis using professional judgment and discretion to implement the team determined Treatment Plan.
- Assists in development, implementation and revision of individual treatment plans; assures that services provided are specified in the Treatment Plan and monitors progress toward treatment goals.
- Consults and cooperates with community systems to facilitate linkage, referral, crisis management, advocacy, and follow up with the focus on attaining treatment goals.
- Maintain a waitlist for the home.
- Follow up with outpatient team on clients that have graduated.
- Follow clients for a minimum of 90 days post-graduation.
- Provides individual and group Skills Training and Development (STD) training.
- Provides face to face skill training and mental health interventions to clients in accordance with the treatment plan.
- Teaching age appropriate life skills training to clients individually or in groups.
- Completion of required CANS and/or ANSA training and ongoing certification.
- Timely completion of HAP paperwork and reassessments within specified deadlines.
- Performs other duties as assigned.

An onsite therapist will provide individual and group therapy as well as the initial assessments for programming. A master’s level therapist will provide weekly therapy and three
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clinical groups weekly. This position will provide a wide range of clinical services to the residents of the house including Eye Movement Desensitization and Reprocessing (EMDR). The therapist will have a certification in EMDR and implement this technique with the residents of Phoenix Recovery Center. This approach is proven effective for treatment of trauma and SUD (EMDRIA, 2017). The onsite therapist will continue to provide services to the clients on her caseload after they graduate the program as well. The responsibilities are to perform the job successfully and include the following functions:

- Conduct initial evaluation and client intake interviews; assess client's presenting problems and formulate diagnosis.
- Develop, implement and modify, as necessary, client treatment plans.
- Maintain an active caseload, providing individual, group, family, marital, child, and adjunctive therapies as needed and within area of expertise and limits of credentials; assure procurement of additional services as needed.
- Provide crisis management for clients
- Follow Center procedures regarding the provision of client care and documentation
- Maintain client and program records in accordance with applicable standards and regulations
- Participate in continuing education activities, remaining knowledgeable in area(s) of expertise, and meet requirements for professional staff membership
- Attend meetings as appropriate and meet regularly with supervisor to exchange pertinent information and receive supervision.
- Serve as a resource person to Center and community in area(s) of expertise, including presenting classes, speaking engagements and agency consultation.
- Maintain a high level of ethical conduct regarding confidentiality, dual-relationships and professional stature.
- Ability to demonstrate competent use of Essentia
- Perform any other duties as assigned.
- Completion of required ANSA training and ongoing certification
- Timely completion of HAP paperwork and reassessments within specified deadlines
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The position of mental health technician will be used to cover the house for twenty-four hours, seven days per week. The cost for eight MHTs is $304,000 per year. With the productivity expectation the generated revenue will meet or exceed $962,000 with a plus/negative of $658,000. The community care coordinator position will be used to cover the house for forty plus hours per week Monday through Friday and as needed for weekends. The salary for the community care coordinator is $38,000. The total cost for this position with benefits is $50,500. The productivity expectation will generate revenue of $71,000 with a plus/negative of $20,500. The base pay for a master's level therapist with benefits is $65,000. This position will generate revenue of $193,000 based on a payor source of 50 percent Recovery Works and 50 percent MRO. The plus/negative of this position is $128,000. All expectations for productivity are based on services provided at 50 percent MRO and 50 percent Recovery Works reimbursements (Medicaid Rehabilitation Option, 2017) (Recovery Works, 2018).

This staff model will ensure that the client's needs are met based on an individualized recovery plan. This structured model trains staff within the home to provide services to the clients. Having a mental health technician and community care coordinator provide the groups and skills trainings in-house allows the clients to build relationships within the home. The onsite therapist will provide structure to the women's continuity of care. Women that experience trauma show better outcomes with long-term, consistent providers (Covington, 2015). A team of women will staff Phoenix Recovery Center to take a trauma-informed approach to holistic care. All staff members are trained in trauma-informed care during the first week of Hamilton Center orientation.
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Referral Process

Phoenix Recovery Center relies on staff, community partners, and self-referrals to assist women in obtaining residency in the dual-diagnosis, transitional living home. Not all women who are seeking recovery are good candidates for the home. A dual-diagnosis is required through either a self-disclosure or DSM diagnosis from a licensed therapist. Community partners such as the criminal justice system, recovery residences, and other behavioral health systems will follow the procedures for referral to admit the client into the program. The client will need to meet certain criteria according to the admission requirements. Admission to the program is dependent on the following criteria:

- Age 18 years or older
- Presently free from alcohol and all non-prescribed mood-altering or addictive substances (a client can have a positive initial screen for program admission except for opiates. In this case, the potential resident will be asked to participate in a medical detox for at least seven days)
- Voluntarily seeking services with an expressed desire for sobriety
- Free of indications of possible harmful behavior towards self or others
- Able to comply with house requirements and manage daily living
- Mental or emotional state is sufficiently stable for participation in the program
- Meets criteria for diagnosis of SUD and mental illness
- Is unable to maintain abstinence in a less restrictive environment
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- Make at least a 90-day commitment to Phoenix Recovery Center
- Comply with community agreements
- Agree to random urine screens and breathalyzer testing
- Agree to financial responsibility
- Respect the confidentiality of all other clients of Phoenix Recovery Center

Once this criterion has been determined by the referral source or transitional living manager the client will be placed on a waiting list according to date of acceptance and level of need for priority of admission.

**Intake Process**

The client is selected from the waitlist and is admitted into the program. The client is required to have a Tuberculosis screen completed within the past 90 days. Once documentation is submitted residents will begin the intake process. Staff will welcome the resident and oversee the following procedure.

1. Orientation
   a. House Rules
   b. Meet your mentor
   c. Expectations
   d. Review of client handbook
   e. Review and accept treatment agreement
   f. Explain house chores and laundry days
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g. Complete admission survey

h. Review and accept community agreements and statement of confidentiality

i. Sign releases of information regarding communication with client’s outside providers, family members, and the criminal justice system

j. Provide a thorough explanation of Phase One (orientation phase) to the client

Orientation is the time to learn everyone’s name, and learn the community agreements and house chores. This phase is an opportunity to develop support and structure within the house. Rushing into the program is discouraged and completion of phase one will be reviewed by the transitional living manager according to the house requirements. Not following guidelines can result in extension of the orientation phase or possibly discharge from the program. If the resident is not compliant with employment, sponsorship, treatment or community agreements, client will return to orientation phase and complete a new individualized recovery plan. This phase highlights the importance of creating relationships within the home. According to the International Journal of Self Help Self Care, the social model for support will promote community engagement and assist with short and long-term care for the individual (Wittman & Polcin, 2015).

2. Schedule appointments
   a. Schedule appointment with therapist for ANSA (build a housing assessment in Essentia)
   b. Create a plan for individual recovery
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c. Review daily programming and additional needs of client (i.e. anger management, depression and anxiety, Matrix, etc.)
d. Schedule appointment with Certified Recovery Specialist
e. Create a calendar of daily scheduled appointments and needs with community care coordinator and mental health technicians

3. Medication

a. Pack medications with client present
b. Medications may only be packed that are prescribed by Hamilton Center physician or client has prescription in hand or bottle with appropriate name and medication
c. Create a MAR for the client to be entered daily

Proposed Budget

**Total Annual Budget**
Revenue
Recovery Works Funding 613,000.00
Medicaid Rehab Option 613,000.00
Total Revenue 1,226,000.00

**Donated Services**
Services donated by Hamilton Center for clients without insurance
Total Donated Services 16,430.00

**Expenses**

**Salaries**
Mental Health Technicians (8) 304,000.00
In-House Therapist (1) 65,000.00
Community Care Coordinator (1) 38,000.00
Benefits (Health, Vision, Dental Insurance, PTO, HSA) 154,660.00
Total Salaries 561,660.00

**Office and Operations**
Employee Relations 200.00
Copier Expense 230.00
Office Supplies 500.00
Postage and Delivery Services 49.00
License 500.00
Curriculum (seeking safety, WRAP, SMART, relapse prevention) 500.00
Dietary Supplies 5,000.00
Program Supplies 750.00
Total Office and Operations 7,729.00

**Building**
Security 38,372.00
Electrical 6,000.00
Water and Sewage 1,620.00
Cable 1,321.00
Building Maintenance 2,880.00
Snow Removal 500.00
Building Supplies 2,000.00
Mowing 1,098.00
Total Building Expenses 53,791.00

**Communication**
Telephone 1,844.00
Cell Phone Stipend 1,150.00
Total Communication 2,994.00

**Travel and Transportation**
Mileage (Use of personal vehicle for client appointments) 2,500.00
Commercial Auto (Company Van for transport) 1,145.00
Auto Repairs and Maintenance 450.00
Auto Fuel 1,430.00
Total Travel and Transportation 5,525.00

**Purchased Services**
Laboratory fees for drug screens 6,000.00
Total Purchased Services 6,000.00
Depreciation of Building 1,680.00

**Non-service Revenue**
DMHA/Government Funds 124,615.00

Total Budget 655,809.00
Conclusion

Addiction continues to be an issue in society, however, the knowledge, training, and implementation of treating trauma first in women's recovery will reduce the cost of addiction and mental illness and increase the success rates of long-term recovery. For more than two decades, the solution to the war on drugs has been prison, inpatient hospitalization, or behavioral health modalities that overlook the primary problem (Szalavitz, 2016). In order to correct the issue of relapse and recidivism it is necessary to look closely at what drives the individuals to despair. Gender specific, trauma-informed care needs to be the rule, not the exception, in women's recovery residences.

Based on the research conducted in this thesis, a problem exists with lack of knowledge from clinicians when treating a dual-diagnosis disorder. Trauma is the root cause of most SUDs and mental illness. Trauma will trigger symptoms of depression, anger, anxiety, and dissociation. These symptoms increase the likelihood of SUD and cause the cycle of addiction with one feeding off the other. It is imperative to treat trauma first to help identify the main issue. This research concludes that trauma is a symptom that is overlooked or treated by clinicians only after treatment of SUD. Women in recovery will benefit from services that address their trauma through EMDR therapy, social supports, and groups that associate the disease of addiction with the effects of trauma. Women have different physiological,
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environmental, and emotional needs than men. Therefore treating women the same as men has proven to be ineffective for long term recovery without the proper modalities for efficacy.

Stephanie Covington states that within the last few decades, providers have lived by the rule that trauma could not be treated until the individual is at least one year sober (Covington, 2015). Providers have been afraid to address this issue early on due to lack of knowledge and training in trauma-specific care with dual-diagnosis disorders (Covington, 2015). Using evidence-based practices including training for dual-diagnosis disorders will improve the outcomes of success in women’s recovery.

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