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A pilot of a tripartite prevention program for homeless young women in the transition to adulthood

Suzanne L. Wenzel, PhD, **Elizabeth J. D'Amico, PhD**, **Dionne Barnes, MSW**, and **Mary Lou Gilbert, JD, MA**
All authors are with the RAND Corporation in Santa Monica, California

Abstract

Background—Among young women who are impoverished and homeless, the transition to adulthood (ages 18 through 25) is associated with alcohol and drug (AOD) use, risky sexual activity, and increased risk of being victimized by intimate partner violence (IPV).

Methods—"The Power of YOU", a program using motivational interviewing, was designed to address these problems. We tested the "Power of YOU" with 31 homeless women (ages 18 - 25) in seven focus groups. Women completed questionnaires assessing background characteristics and satisfaction at the end of each group. Each group was followed by a feedback session which was audiorecorded and transcribed. Key themes were identified.

Results—During a past-6 month period, 38.7% of women reported alcohol intoxication, 19.3% reported two to three male sex partners, and 22.2% reported major physical violence from a partner. Women expressed satisfaction and provided consistently positive feedback on the intervention, reporting, for example, that it was "helpful to know how to put a condom on" and that they appreciated the attention paid to safety planning.

Conclusions—Results from this pilot suggest that "The Power of YOU" may hold promise in helping homeless young women in the transition to adulthood make healthier choices and plan and prepare for high risk situations, and that the non-confrontational, non-judgmental approach of motivational interviewing appeared appropriate for this population.

Keywords

homeless women; intervention; drugs and alcohol; HIV risk behaviors; domestic violence

Introduction

The transition to adulthood, spanning ages 18 through 25 (Arnett, 2000), has typically been described as a time of opportunity when young people experience increasing autonomy and develop or deepen intimate relationships (Bachman et al., 2002). This stage may also be associated with risk-taking behaviors such as alcohol and drug (AOD) use (Windle, Mun, & Windle, 2005), risky sexual activity (Halpern, Waller, Spriggs, & Hallfors, 2006), and, among young women, increased risk of being victimized by intimate partner violence (IPV)

Mailing and correspondence address: Suzanne L. Wenzel, Ph.D., RAND, 1776 Main Street, P.O. Box 2138, Santa Monica, CA 90407-2138, 310-393-0411, x6415, (fax) 310-260-8152, e-mail: slwenzel@rand.org.

(Rosewater, 2003). Surveillance data indicate, for example, that adolescents and young women between the ages of 16 and 24 are at greater risk of domestic violence than any other age and gender group (Rosewater, 2003; Tjaden & Thoennes, 2000).

Risks and risk-taking behavior during the transition to adulthood are more pronounced for young women who are impoverished and homeless (D'Amico, Barnes, Gilbert, Ryan, & Wenzel, in press; Osgood, Foster, Flanagan, & Roth, 2005; Wenzel, Hambarsoomians, D'Amico, Ellison, & Tucker, 2006). In a study in Los Angeles, 44% of women ages 18 to 25 who were staying in homeless shelters used marijuana during the past year (Wenzel et al., 2006), compared to 23% of adolescents and young women ages 18 to 25 in the National Survey on Drug Use and Health (SAMHSA, 2006). Sexual risk-taking, such as having multiple partners and not using condoms, is more common among women who are homeless or staying in shelters compared to low-income housed women (Wenzel et al., 2006). In addition, homeless women currently in shelters have experienced more victimization by intimate partner violence than relatively more advantaged women living in low-income housing (Wenzel et al., 2006; Wenzel, Tucker, Elliott, Marshall, & Williamson, 2004).

The problems of AOD use, risky sexual behaviors, and IPV co-occur (Amaro, Raj, Vega, Mangione, & Perez, 2001; Maman, Campbell, Sweat, & Gielen, 2000; Wenzel et al., 2006). For example, violence can interfere with a woman's ability to negotiate condom use (Kalichman, Williams, Cherry, Belcher, & Nachimson, 1998), and AOD use may occur to cope with victimization by violence (Tucker et al., 2005). The co-occurrence of AOD use, HIV risk behaviors, and IPV highlights the need for interventions addressing all three issues in homeless young women (El-Bassel, Gilbert, Rajah, Foleno, & Frye, 2000; El-Bassel et al., 2003; Sanders-Phillips, 1998; Wenzel, Tucker, Elliott, Hambarsoomian et al., 2004), yet evidence-based approaches addressing these problems concurrently are lacking.

To address this gap, we developed “The Power of YOU”, a program targeting AOD use, HIV risk behaviors, and IPV among homeless young women ages 18 through 25 who are staying in shelters. “The Power of YOU” was developed through collaboration with homeless young women and service providers, and was guided by a theoretical framework based on Social Learning Theory (SLT) (Bandura, 1986), Decision Making Theory (DMT) (Kahneman, Slovic, & Tversky, 1992; Kahneman & Tversky, 2000), and Motivational Interviewing (MI) (Miller & Rollnick, 2002). This framework has informed our other intervention work with youth (D'Amico et al., 2005; Stern, Meredith, Gholson, Gore, & D'Amico, 2007). SLT suggests that beliefs impact subsequent behavior (Bandura, 1986; Maisto, Carey, & Bradizza, 1999). For example, women tend to underestimate condom use among their peers (Latkin, Forman, Knowlton, & Sherman, 2003), which may lead to increased sexual risk-taking. Thus, we provide normative information as well as skills training for all three risk behaviors. DMT suggests that many youth do not see long-term consequences as relevant (Fischhoff et al., 2000) and this is particularly true of homeless youth (Rew, Chambers, & Kulkarni, 2002). Thus, our program focused more on short-term probabilistic consequences. Finally, we used a nonjudgmental, MI approach (Miller & Rollnick, 2002) focused on helping people begin to voice arguments for change versus telling them how to change. Findings from prior focus groups and interviews supported our theoretical framework and approach, and highlighted the importance of addressing these sensitive issues (D'Amico et al., in press). In the current paper, we describe results from a pilot of “The Power of YOU” in which we presented the program to young women staying in homeless shelters and sought feedback on program content and delivery. Additional detail on the development and content of the program is provided elsewhere (D'Amico et al., in press).

Methods

Participants and procedures

Participants were 31 women ages 18 through 25 who were staying in five different homeless shelters in Los Angeles County. Women were eligible if they spoke and understood English, were 18 to 25 years of age, and provided written informed consent. Because our intervention was prevention focused, we excluded shelters for domestic violence and residential substance abuse treatment centers. Participating shelters were provided a $100 honorarium. Within each shelter, we worked with the director to schedule a focus group, and we posted a flyer and sign-up sheet one week in advance of the group. The flyer indicated the date of the group, that information would be provided on HIV risk behavior, AOD use, and IPV, and that as many as eight young women between the ages of 18 and 25 would be participating. The sign-up sheet directed women to provide their first names only.

Over a five-month period, all three sessions (AOD, HIV risk behaviors and IPV) were piloted in groups with young women ages 18 to 25 from the 5 selected shelters. Each session was tested in a minimum of two groups of women to control for idiosyncratic responses (Krueger, 1988). Because some differences emerged between the first and second groups on the intimate partner violence session, we conducted a third group for that session (Krueger, 1988). We therefore conducted a total of seven focus groups. Three to seven women at each of the five shelters participated in each of the seven groups, with an average of four women per group. Each group lasted approximately one and one-half hours. The groups were conducted by a moderator and co-moderator. The moderators were white women in their mid-thirties to early forties who had previous experience working with homeless women in shelter settings and conducting such groups. Written informed consent was obtained from women before each group commenced.

At the beginning of each session, we provided an introduction of the material, explained the purpose of the group, and discussed guidelines (e.g., confidentiality). Other components that each session had in common were: providing normative feedback on that particular risk behavior (e.g., percentage of homeless women who drink alcohol), conducting role plays to help with skills training, and discussing resources in the community. Table 1 provides further information on the specifics that were addressed in each session. For example, in the AOD session, internal and external triggers were discussed, and in the HIV session, we defined sexual behavior and HIV/AIDS (D'Amico et al., in press). We also provided a color brochure to the women that contained information discussed in the session (e.g., how to make a safety plan) that women could keep and use as a resource.

Each group was immediately followed by a feedback session conducted by another member of our team who was not present during the focus group. This team member was an African American woman in her early 30s who had previous experience working with homeless women in shelters and conducting such sessions. The feedback session leader engaged the women in discussion surrounding questions to solicit what the women liked and did not like about the program. The feedback portion of each session lasted approximately 20-30 minutes and was audio recorded. At the conclusion of the feedback session, each woman anonymously completed two brief, self-administered questionnaires, one assessing women's satisfaction with the program and recall of key information, and the other assessing demographics and personal experiences with AOD, HIV risk behavior, and IPV during the past 6 months. At the conclusion of the feedback session, women were given $30 for their participation. They were also provided with a resource and referral guide that included information on low cost and no cost sources of health care, mental health care, and other services in Los Angeles County.

Measures

Questionnaires

Satisfaction items asked women to rate, for example, the extent to which the discussion was helpful and was the right length (1=completely disagree, 5=completely agree) (D'Amico & Orlando, 2005). Items assessing recall of key topics were specific to each of the three sessions. For example, women were asked about the extent to which the group discussed ways to plan ahead for high risk situations (1=completely disagree, 5=completely agree). The personal experiences questionnaire is based on our previous work with homeless women (Tucker et al., 2005; Wenzel, Tucker, Elliott, & Hambarsoomians, 2007) and included whether they had a male sexual partner, how many partners they had, how often they used condoms when they had sex, any experience of physical, sexual or emotional violence, and use of alcohol to intoxication and use of other drugs in the past 6 months. “Minor” (e.g., slapped) and “major” physical violence (e.g., threatened with a weapon) each consisted of a single item based on the Conflict Tactics Scale (Straus, Boney-McCoy, & Sugarman, 1996) and our previous work (Wenzel, Leake, & Gelberg, 2000). Emotional abuse was assessed by a single item based on the Psychological Maltreatment of Women Inventory (Tolman, 1999) and our previous work (Wenzel, 1999). We also asked women if they currently had concerns about having an AOD problem or felt they needed treatment, and whether they had ever received outpatient or residential alcohol or drug treatment (Wenzel, 1999).

Feedback session

Upon completion of each group, women met with a research staff member who asked them to provide feedback on intervention content and the brochure. During the feedback session the following questions were discussed: 1) how did you feel about participating in this group and talking about these issues? was it comfortable? uncomfortable?, 2) what did you like/not like about this discussion?, 3) what did you like/not like about the brochure?, what changes would you make to improve it?, 4) were there other things that you think would have been important to talk about that you didn't get to discuss?, 5) would you recommend this type of discussion to a friend? why or why not?, and 6) what do you think would encourage other women to participate in this or make them feel more comfortable?

Data Analysis

Within 24 hours of the completion of each feedback session, the moderator and co-moderator listened to the audiotapes and independently took notes on what the women said in response to each question posed by the feedback session leader. The moderators subsequently shared and discussed their notes with each other, and then with the feedback session leader. During discussions between the moderators, and subsequently with the feedback session leader, care was taken to ensure that notes documenting women's responses to questions were consistent. No discrepancies arose among the parties in their documentation (in the case of the moderators) or recollection (in the case of the feedback discussion leader) of the women's responses to questions in the feedback session. To code feedback sessions we then used classic content analysis (Krippendorf, 1980; Miles & Huberman, 1994) to identify key themes for the different questions. We first identified the range of themes for each of the different questions by looking at the responses and sorting them into similar types of responses (Miles & Huberman, 1994; Ryan & Bernard, 2003). Next, we examined the degree to which themes were shared across participants by conducting a cross-case analysis (Miles & Huberman 1994). Here we built simple participant-by-theme tables that allowed us to determine which themes were most frequently mentioned and by whom. A theme was determined to be key if it was mentioned by several participants. We then reviewed notes and audiotapes to highlight quotes that represented each key theme.

Results

Table 2 depicts demographics and women's personal experiences with AOD use, sexual risk behaviors, and IPV. The majority of the women (51.6%) were African American. Most of the participants (58.1%) reported at least one male sex partner in the previous 6 months. Six of the 31 women (19.3%) reported two or three male sex partners; no one reported having more than 3 partners in the past 6 months. Calculations from data in Table 2 show that only 16.7% of these women reported always using a condom when they had sex. More than one-fifth (22.2%) reported major violence from a partner in the last 6 months, such as being beaten up or threatened with a knife or gun. Emotional abuse from a partner was reported by 35.5% of the sample. A number of the women (38.7%) reported alcohol intoxication during the past 6 months, and 22.6% reported using other drugs.

Table 3 provides women's feedback about the program, organized by question topic (i.e., likes vs. dislikes). We combined feedback in this table into “likes” and “dislikes”, each of which combines, respectively, the likes/comforts women expressed about the intervention and brochure and the dislikes/discomforts expressed, plus additional topics women said they would like to discuss. Likes and dislikes are organized by program component (i.e., HIV, violence, alcohol and drugs). Table 3 also provides representative responses to queries about whether women would recommend the program to a friend, and what would encourage other women to participate. Responses to these two items are combined across program components given the generality and similarity of the responses.

Overall, we received positive feedback about intervention content and the brochure. The women did not feel judged and they appreciated having an opportunity to discuss these issues. Consistent with our expectation that the motivational interviewing approach would be well received, respondents noted that the moderators made them feel comfortable so that they wanted to participate. Of note, based on feedback from the first group of women who participated in the violence component (e.g., “wanted to express our current situations”), we modified our introduction to each session to more strongly emphasize that the group was not meant to be a therapy session and we did not wish that they tell us personal stories, but rather that the group was an informational session in which we hoped they would participate at a level comfortable for them.

Across all three sessions, women commented positively about the role play opportunity that was presented. They also appreciated the brochure (e.g., “loved the information,” “liked safety planning”). During each of the three sessions and during each feedback session, many women expressed initial doubts and raised questions about the normative information we presented. For example, some women expressed the belief that every homeless woman uses alcohol and drugs. Although many women thought the percentages of other women using alcohol and drugs were not as “low” as we had stated, after discussion with the moderators about how their immediate environments (e.g., Skid Row) and influence of their peers might shape their perceptions, they agreed that their personal estimates (e.g., 90-99%) were too high. As a result of participants' feedback about the role play opportunities, the moderators conducted a role play first to model how one might handle a particular challenging situation and to increase the comfort level of women, and then the moderators invited and encouraged the women to role play with each other. In addition, many women asked for more discussion of the specific challenges of being homeless (e.g., “being in the streets is not a comfort zone”) and resources for obtaining housing. We therefore developed a housing resource guide for women that complemented the brochure and the information discussed during the sessions.

Women provided specific feedback for each session. First, women who participated in the two focus groups in which the HIV component was piloted commented on the value of

understanding more about HIV risk (e.g., “risks when you don't use condoms”) and learning how to use condoms (“helpful to know how to put a condom on”). Participants in the three focus groups addressing violence appreciated the attention paid to understanding what a caring relationship is (as compared to a battering relationship), and how to plan for one's safety. They also requested information on “what the woman is lacking that makes men do that.” In response, we added a section titled, “why does it happen”, in which we placed additional emphasis on how women are not to blame for the violence that happens to them, and that violence can happen to other people, not just them. We also discussed how individuals can try to stop the cycle of violence by guiding children in their relationships with others. Women in the first group addressing violence expressed some concerns about being able to do safety planning. Thus, in the next two groups addressing violence, we spent more time discussing safety planning with the women and how it could be helpful in both higher risk and lower risk situations.

Women in the groups addressing AOD use found the normative information useful. In addition, they indicated that discussion of external and internal triggers helped them better identify high risk situations in which they might be more likely to use alcohol or drugs. Women enjoyed both the moderators' role playing of how to handle high risk situations and sharing their own role play examples. Participants in all three sessions endorsed the program as valuable for their friends. The women indicated that the welcoming nature of the program and the importance of the topics would be sufficient to encourage other young women to participate.

Satisfaction scores ranged from 3.9 to 5.0, indicating agreement with statements that the discussions and group leaders were helpful, the information was useful and understandable, and the style and length of the discussions were appropriate (results not depicted). Information recall scores ranged from 4.5 to 5.0 and were indicative of the participants' agreement that key topics were discussed during each session (e.g., reasons that women may choose not to use condoms, what HIV/AIDS is and how infection may occur, ways to plan ahead for high risk situations, what a caring relationship might look like, warning signs of abuse, safety planning, and reasons that people may choose to use alcohol and drugs). (A table depicting results on satisfaction and topic recall are available from the author at slwenzel@rand.org.)

Discussion

Results of this pilot suggest that “The Power of YOU” may hold promise in helping homeless young women in the transition to adulthood make healthier choices and plan and prepare for a variety of high risk situations. Although evidence for program efficacy was not collected in this study, the young women commented positively about the program in terms of the value of the information and their comfort with the material and the moderators, thus supporting the importance of further research to rigorously evaluate the program.

Consistent with recommendations of homeless service providers in the formative stage of this work (D'Amico, Barnes, Gilbert, Ryan, & Wenzel, in press), the non-confrontational, non-judgmental approach of motivational interviewing appeared appropriate for this population. Our motivational approach was well received by women and likely contributed to the comfort and openness of the groups and women's positive perception of the information. Homeless women have sometimes been inappropriately characterized as “service resistant,” yet in some instances their experiences with service settings and service providers are stigmatizing and characterized by inadequate sensitivity to homeless women's situations and their need to be respected as consumers (Barrow, 2004).

Women's constructive feedback about the program was critical as it helped us make early improvements in the explanation of the program's purpose, increasing comfort in role playing,

dispelling the notion that women are to blame for violence perpetrated against them, and in providing information relevant to homelessness. It also helped us emphasize more clearly that the program was not a group therapy session but rather an informational program. Our overall approach of actively soliciting and then acting upon the feedback of homeless women in these sessions is consistent with a community-based participatory approach (Minkler & Wallerstein, 2003) and thus enhances the likelihood that this program will prove relevant and successful in helping women reduce their risks for IPV, AOD use, and HIV.

One of the most interesting observations from this work was women's responses to the normative information. The majority of women expressed doubts about presented rates of AOD use, violence, and sexual risk behavior; however, they simultaneously expressed liking of this component because it encouraged them to think carefully about the circumstances surrounding them. Presentation of this component initiated the very important discussion of how the environment in which they live can often impact the women's views. Many women said that they are surrounded by people who experience violence every day or who drink or use drugs daily, which made their estimates of these behaviors very high. Many women acknowledged that it was not realistic to assume that all homeless women used drugs, for example, and that it was important to search for positive role models.

A limitation of this study is that participants were self-selected, and thus it is possible that enthusiasm in participating and positive remarks about the program may have been moderated if women had been systematically (e.g., randomly) sampled. The design and testing of our program with self-selected samples would pose a potential challenge only if program participation is required among women at shelters, an approach we do not recommend because it is inconsistent with the important concept of consumer choice (Tsemberis, Gulcur, & Nakae, 2004). We designed “The Power of YOU” to be provided to homeless women on a voluntary basis. Additionally, although the women were self-selected, they resemble the women who have participated in our previous work in Los Angeles County. For example, more than 50% of a recent probability sample of 460 women ages 18 to 55 who were sampled from homeless shelters in Los Angeles County self-reported as African American or Black (Wenzel, Tucker, Elliott, Hambarsoomian et al., 2004). Between 23% and 28% of these women had had more than two sex partners, and 19% to 29% had experienced physical violence within the prior six months (Wenzel et al., 2007).

A further limitation is that this intervention as currently designed does not include a focus on lesbian and bisexual young women. Research has shown that lesbian, gay and bisexual young people are disproportionately represented among youth who are homeless (Cochran et al., 2002; Van Leeuwen et al., 2006), that lesbian and bisexual young women report more alcohol and other drug use than other young women (Noell & Ochs, 2001), and that intimate partner violence also occurs in same-gender relationships (Halpern et al., 2004). More research and intervention development is needed that focuses on the experiences of lesbian and bisexual young women.

To our knowledge, “The Power of YOU” is the first intervention designed to reduce AOD use, HIV risk behavior, and IPV among homeless young women in the transition to adulthood. The need for such interventions is critical given the pronounced levels of risk among these women. Focusing on all three behaviors is key as it can help women better identify how these behaviors are interrelated and how changes in one behavior (e.g. decreasing alcohol use) may lead to changes in other behaviors (e.g., decreased risky sex).

A brief intervention such as “The Power of YOU” cannot directly address ongoing structural barriers to well-being, such as homelessness and poverty. The program is also not intended to achieve change in the behavior of intimate partners who batter women. Nevertheless, the

program was designed to provide women with information and guide them in their ongoing efforts to make healthier choices where possible, including obtaining more help if they feel that this is the appropriate next step. The protective influence of housing could only enhance a potential, beneficial impact of “The Power of YOU,” while also satisfying a basic human need and right.

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Table 1

Key components of tripartite prevention program

Session themes	Content	Session
Abuse ≠ love: caring vs. harmful relationships	-define caring relationship and relationships that may be harmful	IPV
How common is it? (normative feedback) (D'Amico & Fromme, 2002; Latkin et al., 2003)	-provide graphic information depicting frequency of behaviors -discussion of why overestimation may occur	IPV, AOD, HIV risk behaviors
How does abuse impact me? (Latkin et al., 2003)	-discuss potential impact of abuse	IPV
Know the warning signs (www.breakthecycle.org)	-discuss warning signs that may lead to abusive or dangerous situations	IPV
Make a safety plan (Warshaw, Ganley, & Salber, 1995)	-help women stop V&V by providing them with skills through role-play and discussion	IPV
Why or why not? (pros/cons) (Beyth-Marom & Fischhoff, 1997)	-discuss reasons people may or may not engage in these behaviors	AOD and HIV risk behaviors
External and internal triggers	-discussion of triggers and learning how to avoid triggers	AOD
Define sexual behavior	-understand what is meant by sexual behavior	HIV risk behaviors
Definitions of HIV and AIDS	-discuss the difference between HIV and AIDS and ways in which one can and cannot be exposed	HIV risk behaviors
Know the risks	-discuss how alcohol and drug use might contribute to unsafe sex	AOD and HIV risk behaviors
Role plays and evaluation of plan (D'Amico & Fromme, 2002; Rotheram-Borus, Cantwell, & Newman, 2000)	-role play scenarios that depict the session content to increase skills -anticipate, plan, prepare, and evaluate your plan	IPV, AOD, HIV risk behaviors
Where can women get help?	-provide women with resources	IPV, AOD, HIV risk behaviors

Note: IPV = intimate partner violence session, AOD= alcohol and other drug use session

Table 2

Demographic characteristics and personal experiences of women who participated in focus groups and feedback sessions (n=31)

Demographics	Number (and percent) of women with characteristic
Ethnicity	
Black or African American	16 (51.6)
Hispanic or Latina	9 (29.0)
White (not Hispanic)	2 (6.4)
Other or mixed	4 (12.9)
Age	Mean = 21.3; sd = 2.2
Personal experiences	
Sexual risk behaviors	
Had a male sex partners past 6 months	18 (58.1)
Number of sex partners (among 18 women who had sex partners past 6 months)	
1 partner	12 (66.7)
2 partners	4 (22.2)
3 partners	2 (11.1)
Used condoms when had sex (among 18 women who had sex partners past 6 months)	
Never	4 (22.2)
Less than half the time	4 (22.2)
About half the time	4 (22.2)
More than half the time	3 (16.7)
Always	3 (16.7)
Intimate partner violence	
“Minor” physical violence past 6 months *	5 (18.5)
“Major” physical violence past 6 months *	6 (22.2)
Rape past 6 months *	4 (12.9)
Emotional abuse past 6 months *	11 (35.5)
Alcohol and drug use	
Used alcohol to intoxication past 6 months	12 (38.7)
Used drugs past 6 months	7 (22.6)
Current alcohol or drug problem, or need treatment	1 (3.2)
Ever had outpatient or residential alcohol or drug treatment	6 (19.3)

* 4 of 31 women did not respond to the question

Table 3

Question topics, representative responses from feedback sessions conducted after HIV, Violence, and AOD discussion groups

Question topics	Representative responses
What did you like / what were you comfortable with about the discussion group	*HIV intervention* • General statements about group: “liked that it wasn't sugar coated” • Moderators: “made it comfortable so you wanted to talk;” “not like a lecture” • Role play: “role play was fun” • Brochure: “loved the information; numbers for everything;” “informative” • Understanding risks: “why people do what they do;” “risks when you don't use condoms” • Condom skills and self-protection: “helpful to know how to put a condom on;” “show young people protection” *Violence intervention* • General statements: “Overall, I like the program.” • Moderators: “felt like you could speak out;” “not like I was talking with someone that didn't have a clue what they were talking about;” “knowing that you guys are trying to make it comfortable so you wanted to talk;” • Role play: “I liked it; would like to do a role play” • Brochure: “liked safety planning;” “liked statistics;” “could understand the pie charts” • Caring: “what is a caring relationship;” “really stood out what a caring relationship should be;” “the beginning, caring relationships” • Planning: “how to handle different situations;” “helpful to have the plan” *AOD intervention* • General statements: “Man we had fun;” “It was alright, it was cool;” “Being together talking about it was good;” “It's a good idea, lots of people need help” • Moderators: “the way they worked, attitudes, made us feel comfortable;” • Role play: “role play was good” • Brochure: “Liked it;” “everything was interesting, diseases too, sex is as bad as drugs” • Normative information: “The ratings; what percent use;” “made me aware of how many people out of 100 use and how many don't;” “what was really impressive was the alcohol and drugs and stuff because we all went so high in the percentages” • Confidentiality: “Like that what we say won't be spread around”
What did you not like / was uncomfortable/ suggestions for change	*HIV intervention* • Normative information: “don't like the percentages part; don't believe it is true about sex without condoms; it is higher;” “those are people who admitted it; let's be realistic” • Role play: “want moderators to act it out first; want chance to role play in the group” • Additional material/intervention: “more on rape; sexual abuse – it's another reason girls have sexual partners;” “didn't bring up how your kids would turn out if you are promiscuous in front of them” *Violence intervention* • Normative information: “uncomfortable with statistics;” “I don't pay attention to statistics” • Confidentiality: “wanted to express our current situations and couldn't in the open group;” “just uncomfortable talking about some things” • Planning: “safety planning - we can't do the plan [hard to do the plan]” • Additional material/intervention: “has to be longer;” “want more of how to fix this;” “being homeless and a woman; a woman with family;” “didn't provide information on batterer intervention programs;” “there needs to be a program for men or it will never stop;” “what is the woman lacking that makes men do that;” “shelter is temporary – need a house for battered women, a permanent place to go to stay away

Question topics	Representative responses
	from men and get yourself together;" "one-on-one would be nice:" "more time to discuss feelings and personal issues;" "would help to have survivors"
	AOD intervention
	• Normative information: "I thought the stats were prettylow from what I was expecting, especially with the drug use;" shocked at the difference;" "lots of people are in denial and don't admit to it"
	• Additional materials/intervention: "Even good for older people;" "go one-on-one because some people are shy;" "being in the streets is not a comfort zone;" "being in LA is not easy with all this stuff around"
Recommend to a friend?	• "Definitely"
	• "People need to know about this; all my friends need to know about it;"
	• "Yes." "There is knowledge they may not know."