The Special Needs of Women with Co-Occurring Disorders Diverted from the Criminal Justice System

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The National GAINS Center for People with Co-Occurring Disorders in Contact with the Justice System

TAPA Center for Jail Diversion

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Abstract

Women are an ever increasing presence in the criminal justice system, with an associated rise in the number of women diverted into pre- and post-booking jail diversion programs, and specialty courts such as mental health courts and drug courts. The proliferation of jail diversion programs and specialty courts reflects the move to address the underlying issues that initially bring people into contact with the criminal justice system. When addressing the unique needs of women through these diversion programs/specialty courts, it is important to take into consideration the complex, gender-specific, and trauma-specific issues that they present. This document is intended to provide diversion program and specialty court staff with an overview of the issues specific to women involved with diversion programs/specialty courts, as well as to provide key areas of modification to services to improve and enhance services for women.

Justice-Involved Women and Diversion

Women are a rapidly increasing presence in the justice system. In 1998, women constituted 22 percent (3.2 million) of annual arrests in the U.S. Between 1990 and 1998, the number of women in prison increased by 88 percent, on probation by 40 percent, and on parole by 80 percent (Chesney-Lind, 2000). Today, women account for 11 percent of the U.S. jail population (Beck & Karberg, 2001). Among women entering jails, 12.2 percent are diagnosed with serious mental illness, almost twice the rate of males at intake (Teplin, 2001), and 72 percent present a co-occurring substance use disorder. They are often mothers with multiple children, have little education or vocational training, and bring long-standing histories of physical and sexual abuse. Their involvement in the criminal justice system presents a great challenge to the legal, child protection, and treatment systems that are trying to support their personal recovery and reunification with their children.

Many women are involved in the justice system through diversion programs/specialty courts and often present with co-occurring mental and substance use disorders. While there have not been any studies that specifically look at women in diversion programs/specialty courts, it is clear that many women are diverted from incarceration through involvement in these programs and courts. The statistics presented in this monograph that represent women in jail are equally applicable to women in diversion programs/specialty courts since the women would be incarcerated had there not been the opportunity to be involved in diversion programs/specialty courts.

It is critical that criminal justice system professionals and treatment professionals understand, identify, and accommodate their procedures to the unique needs of women with co-occurring disorders. This document is intended to provide a basic understanding of the unique issues women with co-occurring disorders face and how to incorporate gender-specific and trauma-specific services into diversion/specialty court programs. For the purpose of this document, we define diversion/specialty court programs as:

- pre-booking jail diversion programs
- post-booking jail diversion programs
- mental health courts
- drug courts

In order to contextualize issues faced by justice-involved women, it is important to first discuss co-occurring disorders due to the high rates among this population.

Section 1
Co-Occurring Disorders

Over the past decade, epidemiological studies and clinical programs have recognized that a growing number of persons served have both serious mental illness (non-addictive) and, concurrently, report a history of significant substance (alcohol, cocaine, marijuana, other amphetamine) dependence. Empirical investigations have confirmed that, in the group of persons with serious mental illness, this "co-occurrence" is common—across categories of serious mental illness, more than half of the persons encountered likely have a simultaneous substance use disorder, or addiction. When asked, most people interviewed in a large-scale sample perceived that their mental illness predated the onset of their difficulties with substance abuse (Kessler et al., 1993). Regardless, once an addiction to a substance is established, an individual is confronted with addressing two difficult and interactive mental disorders.

Though the literature has focused on the major mental illnesses of schizophrenia, bipolar disorder, and major depression as they interact with substance abuse or dependence, it is clear that other forms of mental illness, especially post-traumatic stress disorder (typically rising from a history of chronic abuse), are commonly found in women served in public settings.

Schizophrenia and Substance Use Disorders: Persons who develop schizophrenia sometimes begin to display symptoms in early adolescence. These behaviors might include being more withdrawn, discussing odd or unusual beliefs, or having morbid fascinations. They may have poor hygiene patterns, limited contact with their peers, display poor eye contact, and appear to have a limited range of emotion. Persons with schizophrenia may have recurring hallucinations (e.g., hearing things that are not there) and/or delusions (e.g., believing persons are talking about them or chasing them) and have been described as having low motivation. They may also have cognitive difficulties that make it difficult for them to concentrate and retain information. More frequently found in males than in females, symptoms of schizophrenia typically appear more clearly in the later teens and early twenties. When comorbid substance use is present, symptoms are thought to present earlier and may be more severe.

In all cases, use of substances is thought to exacerbate symptom experience. Clients may report that they use drugs to reduce medication side effects or to facilitate connections to peer groups. While these explanations may be true, persons who have been using on a regular basis likely have a true addiction, and they are unlikely to discontinue their use readily, even if facing legal consequences. They may choose to use any drug that is available, and no consistent pattern of drug use (choosing cocaine over alcohol, for example) has been found. When asked about their drug use, persons with schizophrenia report using drugs for many common reasons—to relax, reduce boredom, and/or engage with peers.

Persons who have schizophrenia will be faced with confronting symptoms over several decades of their lives; similarly, if a person develops an addictive disorder, they will confront these cravings and challenges over the course of their adult life.

Bipolar Disorder (Manic Depression) and Major Depression (Unipolar Depression; Clinical Depression) with Co-Occurring Substance Use Disorders: Persons with bipolar disorder experience two "poles" in their symptom experience: mania and depression. In an episode of mania, people may feel irritable, distractible, have grandiose or racing thoughts, euphoric feelings, and rapid pressured speech. During periods of mania, judgment can be compromised, and persons with co-occurring addictive disorders may increase their drug use. Correspondingly, persons will experience

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depressive episodes that can include feelings of sadness, worthlessness, hopelessness, guilt, disturbances in sleep, and fatigue. Suicidality is an ongoing concern. Persons with bipolar disorder may develop ongoing episodes of the illness with alternating episodes of mania and depression. Use of substances in adolescence has been suggested as a precipitate of bipolar illness.

Symptoms of both bipolar disorder and major depression are exacerbated by substance use. As with schizophrenia, there is no particular "drug of choice" (either alcohol, cocaine, or marijuana) that has been identified to be uniformly associated with bipolar disorder or major depression. Bipolar disorder and severe forms of major depression are typically lifelong illnesses that will require ongoing care during the course of a person's adult life; the presence of a concurrent addictive disorder complicates their symptom presentation and exacerbates their illness.

A common clinical scenario would involve a woman who has had a childhood history of sexual abuse, an adult history of physical abuse, has limited education, developed substance dependence in her late teens to early twenties, and has two children who are not now in her custody. She may have received some attention for her mental disorder (depression) **or** substance use disorder—but likely has never received treatment that addressed her co-occurring disorders in an integrated fashion. Furthermore, attention to her experience of trauma and its relationship to her symptom experience is not likely to have been a focus of her treatment.

Women with any of these serious mental illness can also develop *posttraumatic stress disorder (PTSD)* in response to their experience of often chronic traumatic events. A history of trauma, and the possible co-occurrence of PTSD, complicates making accurate psychiatric diagnoses.

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Treating Persons with Co-Occurring Disorders

Historically, persons with co-occurring disorders have not fared well in the traditionally separate treatment systems. The lack of comprehensive, integrated care to treat their co-occurring disorders has resulted in the association of the following negative outcomes with substance use disorders among persons with mental illness:

- increased vulnerability to relapse and rehospitalization (Caton et al., 1993; Haywood et al., 1995; Seibel et al., 1993)
- more psychotic symptoms (Carey et al., 1991; Drake et al., 1989; Osher et al., 1994)
- greater depression and suicidality (Bartels et al., 1993)
- episodic violence (Cuffel et al., 1994)
- incarceration (Abram & Teplin, 1991; Beck & Karberg, 2001)
- inability to manage finances and daily needs (Drake & Wallach, 1989)
- housing instability and homelessness (Caton et al., 1994; Drake & Wallach, 1989; Osher et al., 1994)
- noncompliance with medications and other treatments (Drake et al., 1989; Owen et al., 1996)
- increased risk behavior and vulnerability to HIV infection (Cournos & McKinnon, 1997; Cournos et al., 1991) and hepatitis (Rosenberg et al., 2000)
- lower satisfaction with familial relationships (Clark, 1994)
- higher service utilization and costs (Bartels et al., 1993; Dickey & Azeni, 1996)

Evolving research perspectives and clinical consensus point to the need for **integrated** mental health and substance abuse treatment services. In the past, persons with mental illness and substance use disorders would have received mental health treatment in a **sequential** fashion—where clients would be told they could or should receive treatment for their substance use problem after they completed their treatment for their mental illness or vice versa. This rarely was effective as people often found contradictions in the messages that were given. More recently, **parallel** interventions (usually characterized by receiving treatment in two different treatment settings—one mental health, one substance abuse), by differently trained professionals (who have limited or no communication) have been attempted. These attempts, similarly, have not been found to be effective. Clients, especially those with limited resources and lots of burden, have not been able to comply with complicated, competing, or redundant efforts of two treatment plans.

Looking for an Integrated Model of Intervention for Women with Co-Occurring Disorders

As diversion programs/specialty courts look to community-based programs to provide treatment for women with co-occurring disorders, finding programs that offer an integrated model of care should be the goal.

In this model, treatment that attends to each of the women's disorders is treated simultaneously in the same service setting and is developed and delivered by cross-trained (mental health and substance abuse) staff. Service delivery staff is completely engaged in the treatment planning for both categories of disorder. Service is typically delivered by a multidisciplinary treatment team that includes mental health and substance abuse professionals. In this model "caregivers take responsibility for combining interventions into one coherent package" (Drake et al., 2001).

This monograph will discuss a variety of special needs of women that may not be traditionally addressed by diversion programs/specialty courts. However, in order to effectively serve women, diversion programs/specialty courts must be aware of the issues they face and incorporate a woman's unique needs into treatment planning.

Special Needs of Women with Co-Occurring Disorders

Women with co-occurring disorders are a diverse group and treatment of their complex, interactive disorders will span a several year period and involve admissions to hospitals, participation in

community programs, and may include episodic incarcerations.

The pathway women take into the criminal justice system typically involves the use or possession of drugs. Their contact with the criminal justice system may include the following:

- arrests for misdemeanors or felonies related to solicitation for prostitution, drug possession and distribution;
- implication in property crimes; and/or
- responsibility under criminal statutes for child abuse and neglect, often related to the symptoms, behaviors, and cognitions associated with their mental and substance use disorders. It is important to note that many women are also held responsible under civil statutes for child abuse and neglect, which should be taken into consideration when planning for services.

Women with co-occurring disorders present unique challenges to diversion programs/specialty courts:

- most have been victims of *physical and sexual trauma,* and their frequent involvement in destructive relationships in adulthood makes their course of treatment more challenging—for example, their relationships may have contributed to their involvement in criminal activity;
- many come to the attention of social service systems never having had adequate medical care, during pregnancies or otherwise, and they present with a myriad of medical problems that need attention;
- most have minor children in their care, and the care of these children exists as a major issue in their recovery process.

If a woman's history of trauma, her medical problems, and issues in her relationships with children and significant others are not addressed, they will distract her from focusing on necessary cognitive and behavioral changes that will help her achieve symptom stabilization.

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Cultural Competency

Inadequate consideration of culture and ethnicity, as well as frequent misdiagnosis of behavioral disorders, are common phenomena experienced by persons of color in the justice system. In a consumer/family-oriented system for persons with co-occurring disorders, the service goal is to ensure that each contact is welcoming, empathetic, hopeful, culturally sensitive, and consumer-centered. Special efforts should be made to engage women who may be unwilling to accept or participate in recommended services, or who do not fit into the available program models. The Substance Abuse and Mental Health Services Administration (SAMHSA) within the Department of Health and Human Services has defined cultural competency as:

> *an acceptance and respect for difference, a continuing self-assessment regarding culture, a regard for and attention to the dynamics of difference, engagement in ongoing development of cultural knowledge, and resources and flexibility within service models to work towards better meeting the needs of minority populations.*

Diversion programs/specialty courts should implement strategies to recruit, retain, and promote a diverse staff and leadership that represent the demographics of the service area. They should also ensure that staff receives ongoing education and training in culturally and linguistically appropriate service delivery.

Diversion programs/specialty courts should facilitate the full participation of consumers in program design and service delivery and in the evaluation of programs. There are many ways to foster consumer participation. Consumers should be actively engaged in program planning and oversight through meaningful membership on planning task forces and oversight committees. Consumer staff hired by programs can serve in a number of roles, including case management, peer support, and role modeling. Successful program graduates can become peer mentors to current program participants, create and run peer support groups, and join consumer advisory boards. Programs should invite the involvement of many individuals who have a real voice and a substantial role, rather than one "token" consumer.

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Section 2
Addressing the Special Needs of Women with Children

Most incarcerated women have, at the time of their arrest, one or more children in their custody (BJS, 1994). The number of children that this affects is overwhelming: In 1998, more than 1.3 million minor children had mothers who were in the care, custody, or control of federal, state, or local corrections (BJS, 1999). While struggling to negotiate the justice system, these women are confronted with the possibility that they may be separated from their children, who may go to grandparents, aunts, fathers, or foster care placements. Out-of-home placement, without a stable permanency disposition, creates further risk for the child's future involvement in the juvenile justice system.

Under the Adoption and Safe Families Act (ASFA), there is a requirement of a permanent placement for their child within a mandatory one-year period (Adoption and Safe Families Act, 1997). This becomes important for diversion programs/specialty courts that serve women with children who are not in their custody. Instead of focusing on participation in the diversion program, the women's focus may be on solving issues related to their children, dramatically affecting their ability to engage in treatment. Diversion programs/specialty courts must, therefore, make active and sustained attempts to engage women and match their treatment plans to their goals related to their children, as well as to the goals established by the diversion program.

Integrating treatment goals for a mother with co-occurring disorders requires a well coordinated effort among the diversion program, social services, and treatment providers. In order to meet the requirements under ASFA (e.g., establish a stable living situation and a reliable source of income in a year's time) and to achieve symptom stabilization, women must be actively engaged from their first moments in contact with the diversion program. The treatment they are offered must comprehensively address their social, psychological, and physical health needs. They must be assisted in negotiating necessary service systems so that they can create a child-rearing environment that is acceptable to the family court. This requires a tremendous commitment from the diversion staff, treatment providers, and the individual. The following section describes ASFA and the implications it has on women with co-occurring disorders and their children.

Understanding the Adoption and Safe Families Act (ASFA)

In an effort to reduce the amount of time children spend in foster care, Congress passed the Adoption and Safe Families Act of 1997. Listed below are the highlights of that legislation (American Bar Association Network, 2001). The law subsequently was renamed the *Promoting Safe and Stable Families Act.*

States are required to initiate or join termination of parental rights proceedings for children who have been in foster care for 15 of the most recent 22 months. In certain cases, states are required to initiate such proceedings upon placement (i.e., where the parent committed murder, involuntary manslaughter, or felony assault resulting in serious bodily injury of a sibling). Exceptions to this requirement include:

- at the option of the state, the child is cared for by a relative;
- the state agency has documented that there is a compelling reason that filing a termination petition is not in the best interest of the child; and
- the state has not delivered services it deems necessary for the child's safe return, in cases where reunification efforts are required.

In calculating whether 15 months have passed since the child's entry into foster care (and a termination petition is therefore required), the state is now to refer to the earliest of the following two dates:

- the date of the first judicial finding that the child has been subjected to abuse or neglect, or
- 60 days after the child is removed from home (see timeline below).

For example, if the adjudication of child abuse or neglect takes place one month after the child's removal from home, the state will have 16 months after the child's removal to file a termination petition (or join a termination proceeding filed by others) after the child's removal. Importantly, this time limit is not imposed if an exception applies, as described above. If the adjudication takes longer than 60 days from the child's removal, the state would have 15 months plus 60 days after the child's removal from home to file or join in the termination petition (Hills, Rugs, & Young, 2002).

States are required to provide notice and the opportunity to be heard to foster parents, pre-adoptive parents, and relatives caring for children in all reviews and hearings. This does not require, however, that foster parents, pre-adoptive parents, and relative caretakers be made parties to the review or hearing.

The Push for Earlier and More Decisive Permanency Hearings: In place of the current requirement that states hold "dispositional" hearings within 18 months after placement of the child in foster care, the law:

- renamed the hearing a "permanency" hearing;
- tightened the statutory language to require that the hearing includes a decision whether to return the child home, initiate termination proceedings, or place the child in another permanent living arrangement; and
- required that the hearing take place within 12 months of the child's "original placement." *(Note: The 12-month period begins to run not from the time of the child's actual removal from home, but rather from the earliest of the following: a judicial finding of abuse or neglect OR 60 days after the child's removal from home. The 12-month period for the permanency hearing begins to run at the same time the 15-month period for initiating termination of parental rights proceedings begins to run (see above).*

Time-Limited Family Reunification Services: Services to reunify families (funded under Subpart 2 of Title IV-B of

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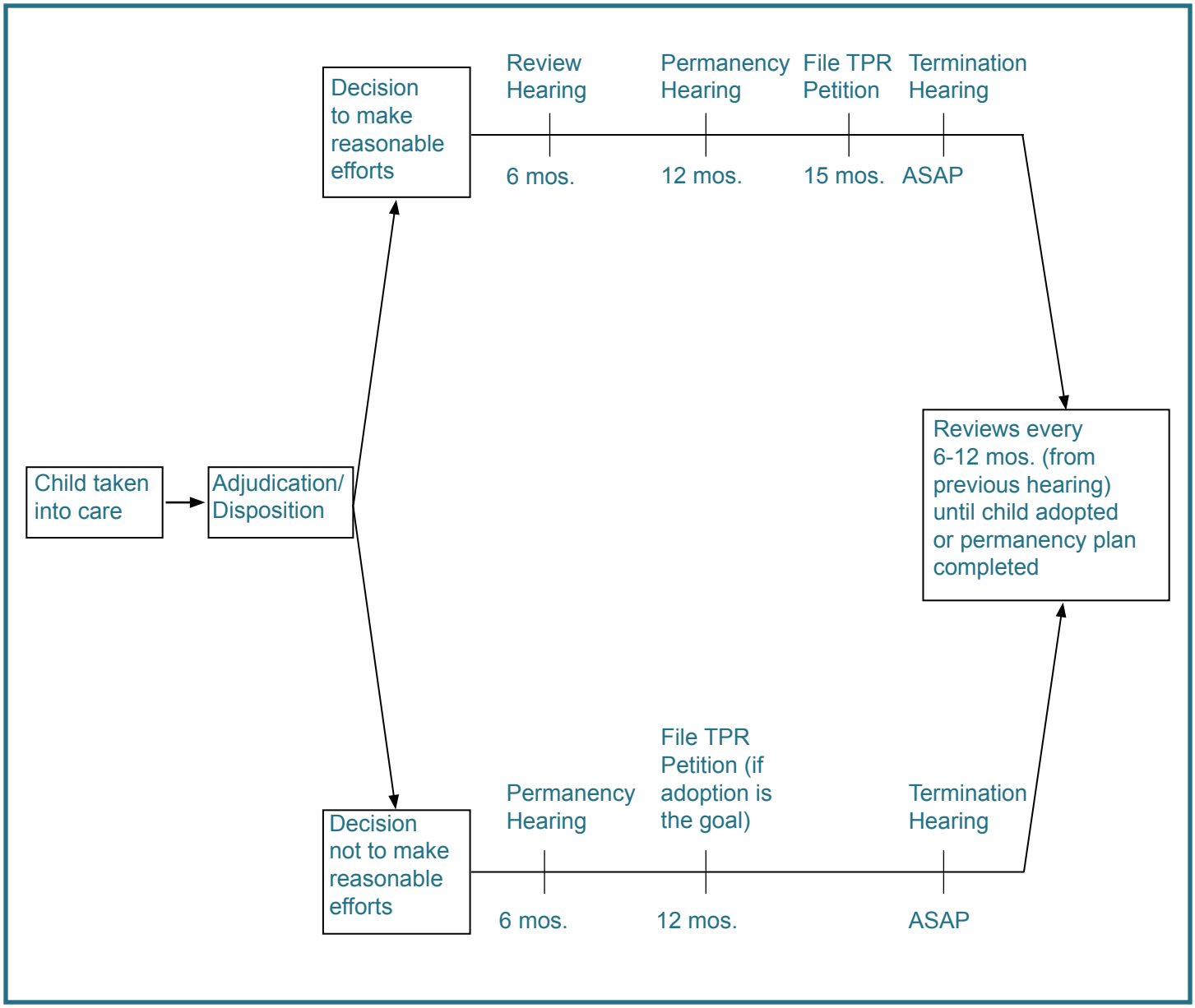
the Social Security Act) are to extend no more than 15 months after placement (the time period begins to run at the same time as the time period for termination petitions and permanency hearings). These services include:

- counseling
- substance abuse treatment services
- domestic violence services
- temporary child care and related services, including crisis nurseries and transportation for such services

***Adoption and Safe Families Act Timeline*© (American Bar Association, 2001)**



Section 3
Women and Trauma

Diversion programs/specialty courts should screen and assess for trauma and PTSD using validated structured interview or self-report methods that have been derived from and used with female samples (see appendix for examples). This information should be used to match women to appropriate community-based services that take into consideration the importance of relationships and the role of trauma in women's lives.

Rates of trauma and PTSD are under diagnosed in clinical settings serving women. Women are often misdiagnosed as having other severe disorders (major depression, bipolar disorder) that result in inappropriate and often ineffective treatment. Treatment engagement and outcomes are affected by a woman's history of trauma and may be expressed through inappropriate interactions with figures of authority, insomnia or other sleep problems, and self-injurious behavior.

Core assumptions regarding the impact of trauma include (Harris, 2003):

- the impact of abuse is experienced throughout life;
- the impact of abuse is felt in areas of functioning seemingly unrelated to the abuse itself;
- current problematic behaviors or symptoms may have originated as attempts to cope with, process, and defend against trauma.

It is clear that women have had many more traumatic experiences than was previously recognized or addressed. These experiences have a profound impact on:

- their intimate relationships,
- the development of substance use and mental disorders,
- their confidence in their ability to parent, and
- their self-esteem.

As can be seen in the work of Browne et al. (1999), women who find themselves incarcerated report significantly higher rates of these experiences. In fact, 94 percent of incarcerated women reported that they had experienced at least one physical or sexual act of violence against them during their lifetime (Browne et al., 1999). While these numbers speak to the experiences of incarcerated women, it is important to note that these numbers are applicable to women involved in diversion programs/specialty courts. With that in mind, ***trauma histories can be considered the norm among women with co-occurring disorders in diversion programs/specialty courts***.

Symptoms and Diagnosis of Trauma and PTSD

It is important to note that not every woman who experiences a traumatic event in her life will develop trauma-related issues or PSTD. The question then becomes: *How does abuse turn into "symptom experience*?" Common situations relating to trauma include:

- violation of trust
- being forced to tell lies
- holding in feelings to survive

These experiences can result in:

- confusion over attachment
- never feeling safe
- confusion about intimacy
- feelings of powerlessness
- overwhelming emotional pain

In the literature, the experience of PTSD in women has been described as resulting primarily from sexual trauma, whereas in men, the etiology that has been studied has been combat-related. Data from the National Comorbidity Survey (Kessler et al., 1995) suggests that while men are somewhat more likely to experience a traumatic event (60 percent vs. 50 percent) across the course of

their lifetime, women develop PTSD more often and are found to have greater lifetime prevalence rates (10 percent vs. 5 percent in men). These numbers significantly increase when we look at justice-involved women.

The reasons why women are more likely to develop a traumatic reaction are not known, but are likely due to complex interactions between social, physiological, and biological differences (Foa, Keene, & Friedman, 2000). Racial differences in the development of trauma reactions also appear to exist, with nonwhites appearing twice as likely to develop PTSD following exposure to a traumatic event (Breslau et al., 1998).

Gender differences exist in the type of trauma experienced, with women being 10 times more likely to be raped, while men are twice as likely to be involved in a dangerous accident. Almost no data has been collected about men who have experienced trauma related to physical or sexual abuse, and therefore, treatment modalities have largely been developed with women as their focus and may or may not generalize to male populations. Persons with PTSD have high rates of comorbidity (80 percent) with other disorders, most commonly depression, other anxiety disorders, and substance abuse or dependence (Foa, Keene, & Friedman, 2000).

Part of becoming trauma-informed is being able to recognize symptoms that can be the result of chronic abuse. These include:

- *disorders of thought*
  - guilt, negativity, memory difficulties, intrusive/obsessive thoughts, impaired attention/concentration
- *disorders of emotion*
  - wide range of affective/anxiety symptoms
- *disorders of behavior*
  - as children, truancy/promiscuity
  - can include self-injury, rage episodes
- *disorders of personality*
  - unstable interpersonal relationships
  - issues with abandonment
  - suicidal gestures
  - identity disturbance
  - paranoia
  - emptiness
  - intense anger
  - dissociative symptoms

In women with co-occurring disorders, these symptoms can be initially difficult to distinguish from symptoms that may arise from a broad range of serious mental illness. Evaluation by a mental health professional will result in greater diagnostic clarity and assist diversion staff with service planning.

Posttraumatic Stress Disorder (PTSD)

In some persons, exposure to trauma can lead to the development and sustained experience of a constellation of symptoms described as posttraumatic stress disorder. Specific elements include the experiencing of a traumatic event, followed by the persistent re-experiencing of it in different ways.

The symptom constellation of PTSD is broad and may include:

- depression
- grief and loss
- isolation
- interpersonal distancing
- mistrust
- futility
- anxiety
- over stimulation
- sleep disturbances
- rejection and betrayal
- anger, irritability, rage
- low self-esteem
- alienation, avoidance

- fear of loss of control
- guilt, shame
- intrusive thoughts
- psychosis
- substance abuse

Lifetime rates for developing PTSD are two times higher in women than in men. Further, women with co-occurring PTSD and substance use disorders have a more severe clinical profile including (Najavits et al., 1999):

- worse life conditions (physical appearance, opportunities in life) during childhood and adulthood
- greater likelihood of criminal behavior
- higher number of lifetime suicide attempts
- fewer outpatient psychiatric treatments

Section 4

Gender-Specific and Trauma-Informed Diversion Programs/ Specialty Courts

Services that take into account the special needs of women in relation to their gender and experiences of trauma are referred to as gender-specific and trauma-informed. Diversion programs/specialty courts and community-based services should strive to become gender-specific and trauma-informed. Trauma-informed services incorporate an awareness of trauma and abuse into all aspects of the program procedures. This awareness can also be used to modify procedures for working with women in diversion programs/ specialty courts. Just as drug treatment best occurs in a drug-free environment, trauma treatment is best accomplished in as trauma-free an environment as possible. Some abuse survivors, especially those with histories of severe or prolonged abuse, may experience angry outbursts, self-destructive or self-mutilating behaviors, or other apparently irrational behaviors that can be considered disruptive in service settings.

A trauma-informed approach suggests alternative procedures that are not only less likely to make symptoms worse, but are also more effective as behavioral management techniques. As such, programs have been designed to increase the awareness of trauma for those working with women and to provide trauma-informed and trauma-specific services in service settings.

Diversion programs/specialty courts that provide gender-specific and trauma-sensitive services to women:

- include staff training and hiring practices that recognize issues of empathy and safety
- contain content that addresses the multiple roles of women
- select materials that have specific relevance to women
- focus on social issues (poverty, race, class, gender inequity)
- focus on cultural variables (sex roles, communication)
- address issues related to violence, abuse, family relationships, in addition to mental illness and substance abuse
- deliver service that is "trauma-informed"
- build skills and look for strengths
- emphasize self-care and self-efficacy (Bloom, Covington, & Owen, 2002)

With research evidence demonstrating that a preponderance of women involved in community and jail-based substance abuse and mental health treatment have been victims of physical or sexual abuse in child and adulthood, the need for trauma-informed treatment has never been more apparent. Similarly, investigations looking at women diagnosed with co-occurring disorders have commonly found this same history.

While this is increasingly evident in epidemiological studies, service settings are just beginning to comprehensively reorganize their programs and policies around this concept. Initial evaluations have found that many programs still contain policies or procedures that are contraindicated when serving women with histories of significant trauma.

Incorporating trauma-sensitive services into diversion programs/specialty courts requires:

- incorporating awareness of trauma and abuse into all aspects of treatment and treatment environment,
- modifying procedures for working with women in diversion programs/specialty courts,
- creating alternative, trauma-sensitive procedures that are less likely to exacerbate symptoms and are also more effective as behavioral management techniques.

Trauma and Re-Trauamatization

It is important for diversion programs/specialty courts to be aware that many routine procedures, court-ordered and voluntary mental health and substance abuse services contain coercive elements that can be perceived and experienced by women with abuse histories as dangerous and threatening. Their response to these perceived threats might be to withdraw, fight back, have a strong emotional outburst, display worsening psychiatric symptoms, and experience physical health problems. The result of these reactions can lead to safety issues for individuals and staff members and the need for more intensive and expensive services (Veysey et al., 1998).

Model Interventions Addressing Trauma

Diversion programs/specialty courts should develop relationships with community providers of trauma services. Over the past five years, there has been a dramatic increase in the availability of clinical materials that address the interaction between trauma or PTSD and other mental and substance use disorders. More and more programs are applying elements of trauma-informed practice. It is the responsibility of the diversion program/specialty court to be aware of treatment providers within the community who offer trauma-informed services and address the needs of women. When referring program participants to services and a treatment provider, the following questions should be considered (Bloom, Covington and Owen, 2002):

- Does the staffing pattern reflect the population (gender, race, language, sexual orientation) served?
- Does staff training provide information on women, the importance of relationships, child-related issues?
- Is treatment staff trained to recognize the symptoms of PTSD?
- Is there evidence of specific program content that focuses on trauma recovery?
- Are assessments specific to gender?
- Are concepts of personal safety incorporated into the design and in daily operations of the program?
- Are continued relationships with children encouraged by the program? What is the policy regarding visitation and opportunities for contact?
- Is there specific program content that focuses on improving parenting skills?
- Does the program offer housing and long-term support for women and their children?

Program Examples

Women's Treatment and Support Diversion Program in Hartford, CT
Women's Jail Diversion Program in Bristol and New Britain, CT

The Women's Treatment and Support Diversion Program (WTSD) targets women with histories of physical, sexual, and/or psychological trauma, resulting in psychiatric disorders, as well as histories of substance abuse. Under the auspices of the Connecticut Department of Mental Health and Addiction Services (DMHAS) with funding provided by the Substance Abuse and Mental Health Services Administration (SAMHSA), the program is operated by Capitol Region Mental Health Center in Hartford and by Community Mental Health Affiliates, Inc., in Bristol and New Britain. Jail diversion programs are operated statewide by DMHAS, and the WTSD program represents an expansion of its jail diversion efforts, focusing on the special needs of women and trauma survivors.

The program provides psychotherapeutic and psychoeducational groups, individual counseling, and intensive case management services. Groups focus on decreasing the symptoms of PTSD, utilizing the Trauma Adaptive Recovery Group Education and Treatment model (TARGET), developed by Julian Ford, PhD, of the University of Connecticut Health Center. The goals of TARGET include teaching a practical new perspective on trauma and addiction and teaching participants specific skills to deal with stress, anxiety, hurt, and anger without avoidance and relapse. Skills taught include learning to focus, slow down, and evaluate thoughts, feelings, and needs when experiencing strong emotional reactions and identifying triggers that contribute to strong reactions and addictive behaviors. In addition, participants are taught to set, test, and maintain personal recovery goals and to develop coping strategies for expectable setbacks. The groups are 90-minute sessions held over a period of nine weeks. Additional gender-specific groups are available, as well as peer support groups to assist in developing positive leisure/social activities to help sustain recovery post-treatment.

For more information, contact: Rocio Chang at (860) 297-0852 or rocio.p.chang@po.state.ct.us
Loel Meckel at (860) 826-4985 or lmeckel@cmhacc.org.

Implementation of *Seeking Safety* in Tampa, FL

In August 2001, substance abuse treatment providers in the Tampa community who were participating in a CSAT-funded Practice Improvement Collaborative began to formalize their plans for increasing attention on the interaction between the co-occurring disorders of PTSD and substance use in the female populations they served. After a review of the literature and discussion with a national expert panel, consensus was achieved on the implementation of Seeking Safety (Najavits, 2002). Najavits' newly published manualized intervention was implemented in 10 treatment settings, including community-based outpatient, day treatment, residential settings, and a jail-based substance abuse treatment program.

Women participating in the programs across settings have reported high levels of satisfaction with the program and would recommend it to others. Clinicians have reported that the numerous clients have asked to continue in the program beyond the 25-session cycle (Rugs, Young, Hills, & Moore, 2003). One participant consumer was quoted as saying "I have always behaved as a victim, what I never understood was that I was a victim." Women treated in the jail setting are able to continue the program in the community-based settings to which they are referred; men in the Hillsborough County jail have now begun to receive the intervention, reportedly with very positive acceptance (Hills, personal communication, 2003).

For more information, contact: Joel Pietsch at (813) 247-8489 or jpietsch@hcso.tampa.fl.us

Section 5

Core Modifications for Developing a Trauma-Informed Diversion Program

Many diversion programs/specialty courts recognize that women have different health and relationship issues. However, operationally, most programs do not consider women to have substantially different issues than men. Since most diversion programs/specialty courts do not provide treatment services, referral to appropriate community-based services is essential for a woman to be successful in a diversion program.

To achieve this, programming for women with co-occurring disorders in diversion programs/specialty courts should contain the following elements:

- examination of program policies and procedures
- screening and assessment
- treatment plan negotiation
- linkage to community-based services

Although the ability of diversion programs/specialty courts to address these issues will vary according to the availability of program resources, access to appropriate community-based services, and the functioning level of participants with co-occurring disorders, all diversion programs/specialty courts should provide services for women that address their unique needs. Four key areas for diversion program modification are the following:

1 *Examination of formal and informal policies and procedures*

A review of policies and procedures should be undertaken to ensure that they are gender- and trauma-sensitive. The goal of this effort is to put a critical eye to methods and rules that may have been designed, in a historical sense, for men and do not take into account roles and elements of personal history that are unique to women. At a minimum, environments and therapeutic techniques should be evaluated for their potential to be re-traumatizing.

To be able to understand the population being served, diversion program administrators should strongly consider providing training on cultural competence and on gender and trauma issues.

2 *Screening and assessment approaches*

Incorporating screening and assessment approaches that are gender-specific should examine the presence of:

- mental and substance use disorders;
- histories of trauma and abuse;
- whether a woman has children and, if so, related needs (e.g. custody issues); and
- health risks (such as HIV/AIDS, STD's, hepatitis, and other chronic medical problems).

These methods should include validated structured interview or self-report methods that have been derived from and used with female samples. It is essential that screening and assessment be comprehensive, as undetected, and therefore untreated, mental illness and substance use disorders will lead to continued symptom experience and increase the likelihood that the person will drop out of the program. Descriptions of available methods are described in the appendix.

3 *Treatment plan negotiation*

Addressing the complex needs of women with co-occurring disorders necessitates that diversion programs/specialty courts form community-based linkages and refer women to organizations that provide services such as:

- *Medical evaluations for self and children*: Many women come into treatment for their mental or substance use disorders, never having had any routine medical care for themselves or their children. Both as a quality of life issue and to

ensure that they can be successfully engaged in treatment, routine medical care must be integrated into any continuum for comprehensive care.

- *Transportation/childcare/housing/clothing*: Women entering diversion programs/specialty courts may be homeless or coming directly out of shelters, violent relationships, or other unstable housing situations. They may not have reliable transportation to get to service programming or to a job. Higher-order goals of cognitive or behavioral changes are difficult to accomplish if one cannot get to an appointment because one does not have a car, money for a bus pass, or anyone to watch the children. These basic needs must be addressed at the beginning of any service relationship if women are to be successfully engaged.
- *Educational and vocational needs*: For many women, early involvement in abusive relationships may have caused them to leave home and drop out of school. In their adult lives, involvement in abusive relationships may have contributed to not receiving vocational training or ever having had a period of sustained employment. Diversion staff must consider early on the kind of sustained commitment and support that a woman, especially one with co-occurring disorders, will require in order to acquire the job skills necessary to support herself and her children.
- *Co-occurring disorder treatment services*: Over the past decade, mental health and substance abuse treatment providers have recognized that persons with co-occurring disorders have difficulty being engaged and sustained in treatment. This is primarily due to the fact that all of their symptoms/functional difficulties were not being addressed and they were often left to fend for themselves in establishing connections to housing and entitlement programs. Appropriate services for persons with co-occurring disorders must address both categories of disorder in the same treatment program with interventions developed by a multidisciplinary staff.
- *Trauma-specific services*: As the impact of trauma has been acknowledged and programs are increasingly aware of the role of all potential co-

Women entering diversion programs/ specialty courts may be homeless or coming directly out of shelters, violent relationships, or other unstable housing situations … These basic needs must be addressed at the beginning of any service relationship if women are to be successfully engaged.

occurring disorders, methods for intervention are being better defined and more "user-friendly." In the past five years, manualized interventions have become available that readily organize and highlight the interrelationship between disorders (some examples are described in the appendix). Diversion programs/specialty courts should identify community-based service providers that offer trauma services and refer women to these programs.

- *Peer support and counseling programs*: Peer counseling programs, in coordination with existing services, show promise in helping women address mental health problems and traumatic events in their lives. Peer support programs offer an opportunity to connect the woman with her community and have support from others that have had similar life experiences.
- *Sexual abuse groups*: The range of these interventions can include process groups and structured manualized interventions. Depending on where the woman is at in the process of understanding the impact of her experience on her current functioning, the content may vary. Several structured interventions are available and are briefly described in the appendix to this document.
- *Domestic violence groups*: The content of these groups may be integrated into the discussion of trauma or may exist independently. Typically they focus on the individual's current life situation and attempt to help the person evaluate whether they are in healthy or unhealthy relationships.
- *Parenting classes*: Skills around discipline, offering appropriate praise, modeling desired behavior and issues surrounding reunification are offered in this content area. Numerous workbooks are available.
- *Assistance in dealing with school system*: For parents who may been absent from the child's life for a period, or if a parent has cognitive or emotional resource limitations, assistance may be required to negotiate their child's re-entry into a school system, record transfer or retrieval, or provide assistance with absences necessitated by the mother's needs.

4 *Linkages to community-based treatment*

Studies have shown that if retained in treatment, women benefit most from "long-term continuous care" (Brown et al, 1995). This continuity of care is critical in the development of bonds, service plan adherence (including treatment recommendations), and breaking the cycle of recidivism. Services provided in diversion programs/specialty courts have not been conceptualized either as long-term or continuous, in most cases. However, by developing treatment plans that incorporate community-based treatment services, diversion programs/specialty courts can achieve the goal of transitioning women into long-term, continuous care.

As a woman completes her involvement in the diversion program/specialty court, it is important that she will have access to the services she will need in the community. To accomplish this, diversion programs/specialty courts may choose to provide a distinct time frame (e.g., one month) during which follow-up services will be provided, by the diversion program, to ensure that referrals and linkages have been successful and to assist the participant with problem-solving, if they have not.

Section 6
Conclusion

Women with co-occurring disorders with histories of trauma require comprehensive and integrated services that address their mental health and substance abuse issues, childcare and relationship conditions, and socioeconomic concerns. They have unmet medical needs and, often, have been living in unstable living conditions that put them at risk for homelessness. Justice-involved women with co-occurring disorders often have multiple children and may be facing the termination of their parental rights, resting on their successful engagement in a treatment program. A significant burden exists, not only for the woman, but for service systems that are attempting to create a safe and positive environment where needs can be addressed and children can be nurtured.

Diversion programs/specialty courts, therefore, face many challenges when working with women with co-occurring disorders and must be aware of their needs in order to make an impact. Some of these challenges include frequent "high-end" service utilization, severe episodes of depression, intermittent suicidality, historical or current involvement in destructive and threatening relationships, and difficulty in complying with complicated treatment regimes.

When working with women in public service settings, a history of trauma is a clinical expectation. Combined with frequent histories of substance dependence, the comorbid experience of mental disorders, assessment and treatment of these chronic relapsing conditions is very complex. Since lifetime experiences of abuse and violence are especially high for women served in public service systems, and 94 percent of incarcerated women report the experience of violence or sexual assault by intimates over the course of their lifetime (Browne et al., 1999), it is apparent that trauma-sensitive services must be incorporated into the structure of all programs that serve women.

Diversion programs/specialty courts present an opportunity to assist women by addressing their unique needs through collaboration with both traditional and non-traditional systems of care such as the court, child protection, treatment and supervision systems, and above all others, addressing the needs identified by the woman herself. Through these collaborations, diversion programs/specialty courts can provide women with a safe environment to begin the process of recovery from co-occurring mental and substance use disorders and histories of trauma and abuse. The National GAINS Center, The TAPA Center for Jail Diversion, and federal agencies that support the Centers are committed to assisting the efforts of diversion programs/specialty courts in developing program modifications and enhancements for women with co-occurring disorders, and look forward to collaborating in pursuit of these goals.

Appendix

Assessment Measures and Methods.

Structured Clinical Interview for DSM (SCID): *This interview measure assesses both Axis I and Axis II disorders. The module that measures PTSD has been found to be reliable (Keane et al., 1998). This measure can be ordered from the American Psychiatric Association at www.psych.org.*

Structured Interview for PTSD (SI-PTSD) (Davidson, Smith, & Kudler, 1989): *Unlike the SCID, which allows for a presence/absence diagnosis only, this interview measure allows for both the assessment of a diagnosis and a symptom severity rating.*

Posttraumatic Diagnostic Scale (PTDS) (Foa, Cashman, Jaycox, & Perry, 1997): *This self-report questionnaire assesses the types of traumatic events that an individual might have been exposed to and asks them to rate which have bothered them the most in the past 30 days. A rating of symptom severity is also elicited. Psychometric properties of the scale (both sensitivity and specificity) have been found to be very good.*

PTSD Checklist (PCL): *This self-report measure assesses the DSM criteria for PTSD and offers both civilian and military versions. This measure, as well as many others, is described on the National Center for PTSD's website at www.ncptsd.org. This site also includes information on where to obtain most of well recognized measures of PTSD.*

Available Treatment Manuals.

- ***Seeking Safety Manual (Najavits, 2001)***
  - Structured intervention in manualized format
  - Organized around 25 trauma-related topics
  - Integrates the treatment of PTSD and substance use disorders
  - Source material is titled: *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse* (Guilford Press, 2002)
  - More information can be found at www.seekingsafety.org

- ***Trauma, Recovery and Empowerment (TREM) (Harris, 1998)***
  - This gender-specific model integrates recovery from trauma with mental illness and substance abuse treatment
  - Designed to be delivered in 21-30 weekly group sessions in community-based setting
  - Developed by Maxine Harris, Community Connections D.C.
  - For information on program outcomes contact: rfallot@communityconnectionsdc.org

- ***TRIAD Women's Project: Integrated Services for Women: Treatment Manual***
  - Developed as part of a SAMHSA Women and Violence project, this manualized intervention offers 16 sessions in four modules of four sessions each
  - Addresses mental health, substance abuse, and trauma
  - Emphasis on skills building
  - Combines elements from the work of M. Linehan, M. Harris (TREM), and the substance abuse recovery and co-occurring disorder literature.
  - For information, contact: Colleen Clark at cclark@fmhi.usf.edu

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