

## Justice-Involved Women with Co-occurring Disorders and Their Children *Series*

women account for 11% of the U.S. jail population (Beck & Karberg, 2001). The facts are compelling: women are a rapidly increasing presence in a male oriented justice system. Women offenders present multiple problems: mental illness and substance use disorders, child-rearing, parenting and custodial difficulties, health problems, histories of violence, sexual abuse and corresponding trauma (Veysey, 1998). Among women entering jails, 12.2% are diagnosed with serious mental illnesses, almost double the rate of males at intake (Teplin, 2001), and 72% present a co-occurring substance use disorder. Many women in jail have been victims; a staggering 33% are diagnosed with post-traumatic stress disorder (Teplin et al., 1996). In a recent jail survey, 48% of women reported a history of physical or sexual abuse and 27% reported rape (BJS, 2001).

Women entering jail may be pregnant, post-partum or leave children in the community. More than 100,000 minor children have a mother in jail (Bloom & Owen, 2002). History of abuse is known as a correlate of behavior leading to contact with the justice system; the cycle of intergenerational violence is well documented. Early identification of this history is critical in treatment decisions, planning for community re-entry and the return of the ex-offender mother to a parenting role.

Though many correctional facilities recognize that women bring different health and relationship issues to their period of incarceration, operationally most have not adjusted practices already established for male inmates. Jails present a challenge to service provision due to their 'short-term' nature where lengths of stay may range from overnight detention to a sentence of up to one year. This series discusses topical issues relating to women in jails and highlights promising programs from around the nation.

Women in jail have often been the victims of physical or sexual abuse in childhood and/or adulthood (ACA, 2001). Consistent with the finding that most women with co-occurring mental and substance use disorders have histories of abuse (Alexander, 1996), trauma histories can be considered the norm among women with co-occurring disorders in jail.

The impact of this violence can affect all areas of a woman's life and the lives of her children and contributes to the development of, and impairs the recovery from, mental and substance use disorders. In the last few years, survivors, clinicians and other service providers have worked together to develop principles, procedures and techniques to assist women in their recovery from trauma, even in the face of coexisting mental health, substance abuse and criminal justice issues.

### Trauma-Sensitive Treatment

Trauma-sensitive treatment (Harris, 1998) refers to incorporating an awareness of trauma and abuse into all aspects of treatment and the treatment environment. This awareness can be used to modify procedures for working with women in jail.

Just as drug treatment best occurs in a drug-free environment, trauma treatment is best accomplished in as trauma-free 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 jail. Traditional responses include seclusion, at times with little clothing to prevent further harm; direct physical restraint; intense observation; use of straps or cloth limb

restraints; or heavy dosages of major tranquilizers. These approaches may mimic traumatic assaults or abuses experienced under different circumstances. A previously incarcerated woman described her experience as follows: "Very, very rarely did I have, for instance, women physicians and women guards. And I think that in terms of somebody who is scared, that makes a big difference. A lot of the staff that I interacted with seemed to be directly out of the military. ... I mean, a medical exam was not a safe situation ..." (National GAINS Center, 1998).

A trauma-sensitive approach suggests alternative procedures that are not only less likely to exacerbate symptoms, but are also more effective as behavioral management techniques. The TAMAR project in Maryland is designed to increase the awareness of trauma for those

working with incarcerated women and to provide trauma-sensitive and trauma-specific services in criminal justice settings. They offer alternative approaches, such as talking the detainee through a “pat down” to explain when, how and why there will be physical contact during the procedure.

In a review of jail practices and female detainees with abuse histories, Veysey, De Cou and Prescott (1998) point out that procedures developed for practical security and treatment purposes have historically not accommodated gender-differences. A gender-and trauma-sensitive environment may include the use of female staff; minimizing procedures that require removal of clothing; incorporating trauma issues into other treatment modalities; and maximizing access to trauma-specific therapies. Training should be provided to all staff involved with the incarcerated women, including correctional and social services staff (TAMAR, 1998). As one trauma survivor replied when asked what helps, “... someone who can help me to see I have choices—who can help me to stay in the present, keep me from going way down. There is a lot of knowledge about how to do this. It needs to be shared.” (Maine DMH, 1997)

### Identifying Trauma

Assessing a woman’s history of abuse can be very straightforward and should be included in all routine mental health and substance abuse assessments. Women with adequate reading skills can complete a simple checklist or a questionnaire can be completed by interview. Questions should be worded in a concrete, behaviorally-anchored fashion to avoid misunderstanding, as might arise from people’s differing definitions of abuse. For example, in seeking to learn if a respondent has been physically abused, the question is best posed as follows:

*Did you ever receive punishment that resulted in bruises, cuts, burns, or other injuries?*

1- Yes  2- No At what age: \_\_\_\_

*If Yes, do you want to discuss it?*

1- Yes  2- No

Generally, it is recommended that terms such as “physical abuse,” “sexual abuse” and “perpetrator” be avoided in traumatic assessment interviews as they are not words that the individual likely uses to describe or understand their experiences—and may be misinterpreted. A basic history usually includes questions about the experience of physical, sexual, and

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emotional abuse in childhood and adulthood as well as the witnessing of such acts. Separate questions are usually asked regarding “domestic violence” and rape in adulthood.

A trained intake worker can conduct a basic trauma assessment—an advanced professional degree is not required. Staff training, however, is important to increase staff comfort and competence in conducting assessments and in eliciting informative trauma histories. Effective staff training addresses concerns, provides evidence that asking about violence is helpful to clients, addresses client reticence to discuss violence, and emphasizes client choice in answering questions. Training in sensitivity to cultural issues is also important; for example, cultural norms may inhibit willingness to reveal victimization to people outside the family (Fearday et al., 2001).

If clinical services or a professional clinician are available, the basic history should be followed by a more detailed examination that covers issues such as the duration and intensity of the violence and whether the woman would like to talk more about her abuse. It can also be helpful to determine if the woman experiences symptoms that are often the result of trauma and signs of post-traumatic stress disorder (PTSD), such as flashbacks, nightmares, insomnia, fearfulness, or numbness. If there are no trauma-specific services available in the jail, information from a woman’s history can still be helpful in creating a trauma-sensitive environment and for discharge planning.

Service providers sometimes express reluctance to ask about abuse and violence. Reasons may include fear of re-traumatizing clients or being intrusive, or knowing the staff/program is unequipped to offer follow-up support. Trauma survivors often

appreciate being asked about their history when it is done in a respectful manner, but women should always be given the option of not answering these or any other personal questions. With few exceptions, the emotional responses elicited by such an assessment require the same basic counseling skills needed for any mental health or substance abuse assessment.

### Trauma-Specific Service Planning and Program Development

Trauma -responsive planning has evolved in the context of therapeutic community-based programs and shelters serving women in crisis, at risk, or presenting mental illnesses or substance use disorders. The SAMHSA Women, Co-Occurring Disorder and Violence KDA Study identified eight program components critical to the development of successful trauma-focused models (Salasin, 2000).

These components are also applicable within the context of a jail setting:

- outreach and engagement
- screening and assessment
- parenting skills
- peer-run services
- treatment
- crisis interventions
- trauma-specific services.

### **Trauma-Specific Therapies and Treatment Approaches**

Full recovery from trauma and its sequelae can be a lengthy process that occurs over several years. Interventions are being developed that address initial goals of establishing safety in relationships and the home environment as well as understanding symptom experience related to trauma. An evidence-base for gender sensitive treatment is being established—along with some “user-friendly” clinical manuals that will facilitate their translation from research to practice settings. Examples of ongoing work in this area are outlined below.

**Seeking Safety** is a present-focused 25-topic manualized intervention that integrates the treatment of PTSD and substance abuse (Najavits, 2001).

**Trauma Recovery and Empowerment (TREM)** (Harris, 1998) offers (30-plus) manualized sessions that integrate recovery from trauma with mental illness and substance abuse treatment.

**Treating concurrent PTSD and Cocaine Dependence** (Brady et al., 2001) uses manual-guided imaginal and in-vivo exposure with cognitive behavioral relapse prevention techniques.

**Substance Dependence Posttraumatic Stress Disorder Therapy** (Triffleman et al., 1999) is a 5 month, twice weekly manualized cognitive behavioral intervention.

**Triad Women’s Project** (C. Clark, PI) has developed a 16-session manualized psychoeducational intervention that builds skills to facilitate recovery from trauma and mental illness.

Importantly, these interventions were designed to be implemented by front-line counselor-level staff in jail and community-based treatment settings. To address the experience of abuse and violence, counseling staff must recognize that trauma can result in a range of behavioral, emotional, physical, and cognitive disorders. Most trauma-informed interventions cover three primary areas:

- 1) Identifying the *nature and extent of the trauma*, including symptom development; strengths used for survival; distortion of feelings and behavior due to trauma; and how ongoing-symptom experiences (dissociation, substance abuse) may function to numb the pain of abuse history.
- 2) The creation of a *safe haven* for trauma survivors can be the most healing aspect of any intervention. Certain basic rules help to establish this environment, including confidentiality; opportunity to speak or “pass”; and a group norm disallowing advice-giving, criticism, or confrontation. Common responses among women experiencing such an environment include increased self esteem at knowing what they have to say is heard and valued, relief at finding they are not alone or “crazy” or “bad” because of their experiences, and increased empowerment.
- 3) Women with trauma histories are encouraged to *develop skills needed to recover* from traumatic experiences and build healthy lives. These may include cognitive, problem-solving, relaxation, stress coping, relapse prevention and short- or long-term safety planning skills.

### **Re-entry**

To effectively plan the transition from jail to community-based treatment, community treatment programs should be reviewed for “trauma awareness.” This program review should identify whether the program offers trauma-specific

treatment, incorporates trauma awareness into substance abuse and mental health treatment, provides staff training in trauma sensitivity and offers women-only programs.

For any given woman, more detailed examinations may be necessary to determine a program’s capability to address issues identified but not addressed in jail. For example, there is no standard protocol for medication of trauma-related disorders, and the added complexity of medication management for women with mental illnesses and substance abuse histories can make this a very difficult task. Even when an appropriate psychiatrist in the community is identified, questions of access and paying for treatment remain. Community programs that either initiate contact while the women are incarcerated or provide groups within the jails that are also provided in the community are ideal for developing trust and providing continuity (TAMAR, 1998; Triad, 2000).

Consistent with in-jail interventions, the most important discharge planning consideration is establishing safety. No trauma treatment can truly be effective if a woman returns to or remains in an abusive or violent environment. If safe placement is not immediately possible, priority attention should be placed on giving women information on options and resources, such as domestic violence shelters. Obtaining the woman’s permission to communicate information about her trauma history with the follow-up providers can be very beneficial. This alerts the community provider to issues they may not regularly assess and helps the woman not have to repeat the telling of her history.

Over the next several years, it seems likely that most in-jail and community-based programs will increase their emphasis on trauma-sensitive and gender-specific treatment interventions.

## Promising program...

## Tools & Resources

**TIR (Traumatic Incident Reduction)** The Department of Women's Justice Services of the Cook County Sheriff's Office was formed in 1999 to administer gender and culturally appropriate services to female drug offenders in Cook County, Illinois. The three phase program consists of a pre-treatment, treatment education, and a relapse prevention component, each lasting 20-30 days. Services include mental health, education, life skills, training, and community reintegration components. The Cook County Sheriff's Office subcontracts with TIR, a nonprofit educational foundation composed of community partners, a mental health practitioner, university faculty and researchers. TIR is committed to providing effective treatment for those suffering from the effects of trauma. TIR employs a systematically focused memory recovery technique for permanently reducing or eliminating the effects of traumatic events.

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- 1) **TAMAR Project, MD\***  
Program information  
Joan Gillece: [gillecej@dhhm.state.md.us](mailto:gillecej@dhhm.state.md.us)
- 2) **TRIAD Women's Project, FL\***  
Group Facilitator's Manual (2000)  
Integrated Biopsychosocial Assessment Instruments for (non)/clinical settings (includes trauma questions)  
Colleen Clark: [cclark@fmhi.usf.edu](mailto:cclark@fmhi.usf.edu)
- 3) **TREM: Community Connections**  
Approaches to Trauma Services (1997)  
Maxine Harris: [mharris@ncemi.org](mailto:mharris@ncemi.org)
- 4) **Maine Trauma Advisory Group: Report (1997)**  
Dept. of Mental Health, Office of Trauma Services:  
(207) 287-4250
- 5) **Trauma Assessment and Resource Book**  
NYS OMH: Trauma Initiative Design Center\*  
Fax requests to: (518) 473-2684

\* Sample screening forms available upon request.

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