



Gender-Specific Treatment For Clients With Co-Occurring Disorders

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Approximately 10 million people in the United States have co-occurring addictive and mental disorders (SAMHSA, 1997). The most common term used to identify treatment programs for people with co-occurring disorders is “dual diagnosis,” which most frequently is used to describe the presence of two co-occurring illnesses — substance abuse or dependence and a severe and persistent clinical syndrome such as major depression, bipolar disorder or schizophrenia (Hills, 2000).

For a number of reasons, the concentration of people with mental health and substance use disorders in correctional settings has risen dramatically (Abram and Teplin, 1991). A significant factor contributing to that growth is the large number of drug law violators.

The heterogeneity of those with co-occurring addictive and mental dis-

orders only recently has begun to be recognized, and treatment strategies for different segments of this population are being developed. As public and mental health agencies are threatened by budget cuts, it is crucial that initial gains in acknowledging and addressing their needs not be lost or abandoned (Alexander, 1996).

Treatment Response

In response to identified needs, the First Judicial Department of Correctional Services in Waterloo, Iowa, established in September 1998 a community-based treatment program in its correctional facility. The structured treatment program is designed to identify, educate and treat offenders under the supervision of the First Judicial District who suffer from co-occurring substance abuse/dependence and severe and chronic mental illness dis-

orders. The Waterloo Residential Correctional Facility established a 16-bed unit for male clients. The overall goal of the Dual Diagnosis Offender Program is to enhance the client’s potential to establish and live a law-abiding lifestyle with a stabilized mental condition, free of chemical dependency. Program objectives include diverting dually diagnosed clients from lengthy incarcerations in local and state institutions, as well as enhancing communication, coordination of services and understanding of client needs between agencies involved in services with this population.

According to Hammett and Daugherty (1990), women are typically underserved in correctional settings in all types of jail programming, even though millions of American women suffer from co-occurring substance abuse and mental health conditions (Center on Addiction and Substance



Abuse, 1996). Admissions of individuals with co-occurring disorders were more likely to be female than substance abuse-only admissions. They were also more likely to be white and less likely to be in the labor force than substance abuse-only admissions (Dasis, 2002).

In addition, a substantial majority of women with a co-existing condition has also experienced violence. Women who struggle to overcome these problems are likely to have more severe difficulties and use services more often than women with any one of these problems alone (Harris, 1994). Because services tend to be fragmented and treatment philosophies inconsistent, these women face barriers to adequate care (Grella, 1996).

It became apparent to Correctional Services staff that many of the female clients at the facility appeared to be suffering from co-occurring disorders. In response to that need, the department established a gender-specific residential and community-based program for females who suffer from co-occurring diagnosis issues this past January.

DELIVERING SERVICES IN A MEANINGFUL MANNER

Best practice indicates that integrating treatment services maximizes intervention efforts aimed at addressing the specific symptoms and behavior patterns associated with the experience of both classes of disorder (Hills, 2000). Since integrated treatment focused on both disorders simultaneously — within the same service setting — is thought to be best practice, in 1998, Correctional Services partnered with a local mental health agency and a community substance abuse treatment program to address those issues. Contracting with Black Hawk-Grundy Mental Health Center and Pathways Behavioral Services created the ability for the “synergy that produces services well beyond the scope of what any single system could have hoped to mobilize on its own” (SAMHSA, 2001). Both providers have employees working directly out of the Correctional Services setting, creating a confluence of services for the client. Clients are afforded intensive treatment in the correctional milieu by the

treatment team, which includes a probation/parole officer, mental health counselor, substance abuse counselor, residential officer supervisor, program supervisor, continuing care probation/parole officer and a psychologist. The team participates in cross-training, which requires clinicians and programs rather than clients to make treatment compatible (Drake et al., 1996).

Similarly, the gender-specific female program was initiated to provide integration of treatment services designed to focus on both disorders simultaneously in the same service setting. Since only recently attention has been drawn to co-occurring illnesses issues among women, treatment-recognized issues needing to be addressed, included poverty, residential instability, social isolation associated with severe mental illness, and exposure to physical and sexual abuse (Alexander, 1996).

Program components that are important for women in both the addiction and psychiatric literature include adequate and early identification of associated problems and a treatment philosophy based on competency-building and empowerment in safe, accessible, community-based treatment (Abbot, 1994; Burman, 1994; Finkelstein, 1993; Hagan, Fennegan and Nelson-Zlupko, 1994; Harris, 1994; Wilke, 1994).

The close association among co-occurring illnesses, victimization and homelessness suggests that both residential needs and victimization must be addressed in treating these women. Provision of safe space for women with abuse histories may range from physical privacy to accommodating unusual sleeping times and places in supported residences. Because women with co-occurring disorders are at risk for violence from a partner, they need to develop “safe plans” that include strategies for resolving abuse. They should be aware of shelters for battered women that accept dually diagnosed women, and they should know how to obtain and use restraining orders and hotlines (Hagan et al., 1994). In addition, women with co-occurring disorders need to understand what abuse is and how it affects their psychiatric symptoms, addictive behaviors and living circumstances (Harris, 1994).

Funding streams and financial struc-

tures were modified to facilitate service coordination. The resources available to multiple systems are blended and/or shared to ensure that services are configured in a way that meets the individualized needs of clients rather than the needs of the system or providers offering care (SAMHSA, 1997). The Dual Diagnosis Offender Program is funded through federal, state and county funding. Ongoing communication with the local central point of coordination providers continues to ensure best funding efforts with individualized clients.

Treatment and Supervision

Most individuals with co-occurring disorders generally face poor prognosis for involvement in treatment. They tend to experience difficulty complying with medication recommendations, are more frequently hospitalized because of suicidal behaviors and also tend to experience difficulties in overall relational and social functioning.

Accurate assessment of co-existing disorders also presents difficult challenges due to residual effects of addictive substances that may mask or mimic psychiatric symptoms. Dually diagnosed individuals may present acute psychiatric symptoms, such as anxiety and depression, which may interfere with traditional forms of substance abuse treatment and more often require hospitalization or participation in intensive mental health services (Evans and Sullivan, 1990). Involvement and retention of offenders with co-occurring disorders in treatment is often difficult because of their rationalization and blaming others for their difficulties, distrust of service providers and sudden changes in psychiatric symptoms (Peters and Hills, 1997).

This population is also thought to be at greater risk for relapse following release from custody (Weiss, 1992). Therefore, treatment tailoring through reassessment requires the consideration that offenders with two concurrent diagnoses may become defiant, depending on the length of their incarceration, time since last use of drugs and/or alcohol, evolution of their disorder and impact of treatment programming. These circumstances require that individuals be regularly

reassessed to determine what is working in their treatment efforts and what still requires significant intervention. Treatment tailoring acknowledges the varying levels of motivation, ambivalence and treatment readiness of individuals and conceptualizes current treatment needs accordingly (Hills, 2000).

It is recognized that poor prognosis for positive outcomes occurs in the following areas for this population (Hills, 2000): engagement and involvement in treatment, compliance with medication, greater rates of hospitalization, more frequent suicidal behaviors, and difficulties in social functioning. Therefore, the Dual Diagnosis Offender Program is working toward the following solutions to address these barriers:

- Enhance the potential of each individual to find a way to live in the world productively within a law-abiding lifestyle with stabilized mental health and freedom from chemical dependency.
- Divert individuals who would serve lengthy sentences in local jails or state institutions.
- Determine those who can best be assisted within a structured, community-based treatment milieu.
- Develop enhanced communication, coordination, and understanding among agencies and professionals. This should facilitate the client's readiness to engage in establishing a vision.
- Within the treatment milieu, the residential officers and the mental health provider work closely together to monitor medication compliance. The client regularly sees a psychiatrist to modulate medication effects.
- Increase self-understanding and self-soothing behaviors along with medication compliance and remaining clean and sober. This appears to be lessening hospitalizations and, to some degree, suicidal ideation.
- Create opportunities for positive interpersonal interactions.
- Increase sense of self-confidence and self-control.

Program Components. A series of core principles have emerged to focus treatment providers on how to optimize treatment outcomes for offenders with co-occurring disorders. Participants have to become invested in treatment, understand the need to continue their connection with treatment over time and be offered services that meet their needs. This can be achieved by focusing on the following concepts: treatment engagement, treatment continuity, treatment comprehensiveness and continued treatment tailoring through reassessment (Hills, 2000).

Potential participants are referred to and screened by the program's psychologist to determine eligibility for placement and county funding for rent maintenance, medication and medical bills. Appropriate clients are then court-ordered to the program for one year or until maximum benefits are achieved. Clients may also be ordered to the program by the Board of Parole. The minimum treatment period is 180 days.

The high prevalence of physical and sexual victimization among women and the known sequelae of abuse and trauma make it important that women's experience of trauma be included in the assessment and treatment decisions (Friedman and Schnurr, 1995).

From the clinical and research literature, several key principles have recently emerged to guide the design of treatment programs for individuals with co-occurring disorders in the justice system (Hills, 2000). They include the following:

Individualized Programming to Address Symptom Severity and Skill Deficits. Following screening, the client is placed on a waiting list while his or her history is reviewed with the treatment team in preparation for entry into the program.

The multidisciplinary treatment team should meet prior to the development of an individualized treatment plan to review different perspectives of diagnosis, onset of disorders and interactive effects of disorders. The proposed treatment plan is then discussed with the offender to incorporate his or her impressions and to receive comments and suggestions that are consistent with his or her own therapeutic goals (Hills, 2000).

"Phased" Treatment Interventions With Graduated Intensity. Offenders

with co-occurring disorders appear to achieve the greatest benefit from highly structured psychoeducational treatment approaches. Early phases include emphasis on orientation, assessment, development of treatment plan, motivation, engagement and persuasion. Didactic secondary phases focus more on coping skills, life skills, lifestyle change issues and cognitive-behavioral interventions. Later phases may include mentor activities, vocational training and linkage with community peer support and treatment group (Hills, 2000).

Similar to other treatment programs designed to treat co-occurring illnesses, the phases developed in the Dual Diagnosis Offender Program are designed to establish a long-term plan for treatment that meets the requirements of the legal system and promotes individuals' understanding of the relationship between their co-occurring disorders and their criminal history (Hills, 2000).

Individualized Service Plans. Individualized service plans arise out of intensive evaluations and interactive consultation with multidisciplinary input. Conclusions generated from differing disciplinary perspectives must be reconciled so that a comprehensive, integrated treatment plan can be created. Decisions can then be made about the initial therapy goals (Hills, 2000).

Varied Treatment Approaches. Treatment approaches include motivational interviewing that is focused on prompt responses to difficulties in thinking, as well as changes in response due to withdrawal or incremental acclimation to psychotropic medication. Educational components focus on understanding how major mental illnesses affect individuals and their family systems, including poor self-image that leads to tendencies to withdraw from social contacts and engage in dysfunctional behaviors, including controlling fantasies (Peters and Hills, 1997).

During the initial 30 days, the client is assessed by the treatment team. An extensive social history is completed by the mental health provider, which includes assessment of the current psychopharmacological interventions. The substance abuse counselor is also meeting regularly with the client to address his or her current or recent

What Should Effective Treatment Involve?

pattern of alcohol or drug use and develop treatment goals. The probation officer completes a Level of Service Inventory Revised form to determine the client's dynamic and static risks and needs.

Treatment services should address individualized cognitive abilities, as well as level of motivation, and be comprehensive and flexible (Hills, in press). Integrated, comprehensive approaches have evolved in the mental health sectors that, when disseminated into the treatment culture, should consider sexuality, relationship, victimization and depression. Empowerment will be necessary if assessment of and services for women with co-occurring illnesses are to address women's needs effectively (Alexander, 1996).

Many women with co-occurring conditions and trauma histories have not had constructive preparation for parenting (Harmer, Sanderson and Merten, 1999). Growing up in families with a substance-abusing or violent parent, or without consistent nurturing and discipline, they lack positive parenting role models. Because of their experiences as children, they may feel ambivalent about their own children and unsure of their abilities as parents (Grella, 1996). The nature of their complicated histories suggests that these women have needs for multidimensional support and treatment modifications (Morris and Schinke, 1999). Gender-specific individual and group treatment address emotional attachment issues.

Treatment and Delivery. Phase 1 begins when the client is oriented to the facility setting, structure and expectations with a residential officer. The client also meets with the probation officer to begin initial orientation to the program goals and expectations.

The psychologist schedules a meeting with the client and the treatment team 30 days after the client has entered the program. The team and the client then create an integrated and individualized treatment plan. During this orientation phase, the client also becomes involved in the daily group treatment schedule.

While an understanding of the interaction between the co-occurring disorders may be an initial focus of treatment, later interventions are likely

to deal with complex interpersonal skills and vocational difficulties (Peters and Hills, 1997).

The male-specific program integrates the following agenda. The orientation phase is followed by two treatment phases, each lasting approximately 60 days. The client is able to move through these phases upon completion of self-directed goals based on the individualized treatment plan. The client takes the initiative to have each treatment provider sign off on a checklist agreeing that the client has met his specific goals. Treatment intensifies during the two treatment phases as patterned problematic behaviors become evident. Then, hopefully, the client is able to gain an understanding of his previous choices that have caused problems and learn new behaviors. Focus on supportive relationships becomes critical.

There is an emerging consensus from the past 20 years of studies that treatment must focus on building cognitive and interpersonal skills; treatment plans must address the individual's specific deficits (Hills, 2000). Therefore, the Dual Diagnosis Offender Program offers structured individual and group treatment provided by the treatment team. Group content includes cognitive-behavioral treatment and psychoeducational groups designed to create greater awareness of both substance abuse and mental health issues. Process/issue groups allow focus on immediate issues. Clients also participate in community awareness/recreation groups.

Clients also are involved in community services, including Alcoholics Anonymous/Narcotics Anonymous meetings, GED courses, vocational rehabilitation services, community service work, church activities, and psychiatric and medical appointments. The individualized treatment plan drives all services.

Available family/support contacts are encouraged to participate in family therapy with the psychologist and are invited to family educational groups,

which are provided periodically with team members.

These groups are designed to provide support and education regarding issues surrounding co-occurring illnesses as well as community resources. Family members may also

be referred to a weekly family group provided by Pathways Behavioral Services, which focuses on education and peer support.

For women with co-occurring disorders, treatment programs should be multidisciplinary, comprehensive and coordinated to address the full range of their needs as they progress toward and remain in recovery (Alexander, 1996). The attitude that recovery must come first and that women need their own space to recover and cannot concentrate on their recovery with children present reflects a lack of understanding of access issues, maternal and child health issues, and the fact that true recovery for a mother usually works only when it includes her children (Finkelstein, 1994).

Treatment Linkages. Since most offenders are eventually returned to the community, treatment planning must consider linkage issues, and post-release planning must begin at the point of contact of any individual (Hills, 2000). The initial treatment plan includes short-term goals focused on stabilization and adjustment, as well as long-term goals that are planning for discharge and transition into the community. It is hoped that most short-term goals are completed near transition so that when the client enters the Continuing Care Component, focus is upon maintaining a healthy lifestyle, which would include adequate housing, positive companions, support groups, etc.

Peters and Hills (1997) point out that the need for a broad range of services available over several years offers the best hope for achieving symptom stabilization and early abstinence. Therefore, a grant was secured to hire a probation officer to oversee male clients' discharge and aftercare planning. The key activities of the Dually Diagnosed Continuing Care Project are to provide intensive supervision of the high-risk/high-need dually diagnosed clients as they transition into the community. The probation/parole officer participates in regular reviews of the client's progress through each phase as the client nears transition and assists the client through supportive case management, which includes individual counseling, group treatment and extensive partnering with community services. The clients are familiar with the transition-

al probation/parole officer since he conducts one of the treatment groups during their residential treatment program. This officer is well-acquainted with local supporters of dually diagnosed clients. Working closely with the entire team, this officer is able to bring transitional clients back in the facility via "respite beds" should the client relapse and/or demonstrate behaviors that suggest he needs structure to stabilize.

This year, a grant was secured to hire a female probation officer and a female mental health staff member to deal specifically with high-risk/high-need dually diagnosed females. The needs of women with co-occurring illnesses include physical health care, a recognition of their adult sexuality, preventive education regarding pregnancy and sexually transmitted diseases, and help in dealing with role loss, including their role as parents (Alexander, 1996). These needs are currently being addressed by a human sexuality and relationships class that is provided by community resources, including Planned Parenthood, public health resources, local police forces and a private therapist, along with Correctional Services providers. Classes are gender specific. The mental health provider also addresses the above issues in daily group treatment.

Many women with co-occurring mental health and substance abuse disorders and histories of trauma are parents who value their roles as mothers and bring skills to the task (SAMHSA, 2000). Historically, treatment for these women has neither considered the importance of women's roles as mothers nor included their children (SAMHSA, 2000). Treatment can be optimized by acknowledging their roles as parents and incorporating this reality into service design and delivery (SAMHSA, 2000). Skills are needed for even noncustodial parents to adequately cope with the complexities of their relationships with their children and their caretakers both within and outside of the foster care system (Alexander, 1996).

These issues are being addressed by the mental health provider in both individual and group treatment. Clients also will be referred to community providers to specifically address parenting skills, complexity of relation-

ships with their children and grief issues regarding losses in their parental role.

Treatment for women with co-occurring conditions and histories of violence is optimized when it:

- Focuses on a woman's strengths;
- Acknowledges a woman's role as a parent;
- Improves interactions between the parent and child; and
- Provides comprehensive, coordinated services for a mother and her children (SAMHSA, 2000).

In general, this female co-occurring disorder program is substantially based on the same format as the male program, with the following differences:

- Movement of clients from community to residential supervision is not time limited;
- The same probation officer remains with the client during her duration of supervision; and
- Benefits/entitlements are not lost due to a regimented, time-limited residential placement.

Outcomes/Continuing Care Project

For the first four fiscal years of data compiled for the male program, approximately 43 to 49 clients participated in treatment per year. Of the 45 total participants during 2001, 29 clients were discharged from the program. Of those, 10 of the clients were removed from the program, three escaped and 16 were discharged successfully. Those successfully discharged served an average of 239 days. Individuals who escaped served an average of 43 days and those who were removed were residents for approximately 116 days. It seems that those who were not well-suited to the program knew that by the end of the orientation phase. Those who were removed had actually started treatment but were uncooperative for any number of reasons, including arrests for new criminal charges while in the program.

The data suggest that unsuccessful discharges may have been related to screening of clients with issues that

this program is not capable of addressing adequately. For example, those who escaped or were removed, in general, tended not to have engaged in the program initially.

During the first five months of 2002, 61 clients were served, eight of whom escaped after an average of 84 days, and nine were removed after an average of 89 days. This suggests that clients who may not have been appropriate for this program are generally out of the program in approximately three months. It also appears that as the screening process is refined to rule out clients whose needs may not be met by the program, those who are unsuccessfully leaving the program are becoming fewer. Also, those clients can then be redirected to facilities better suited to their needs.

Of the remaining 44 clients served during that period, 27 were successfully discharged, serving an average of 197 days. Of those successfully discharged, a greater percentage of them were able to work productively in the community at least part time.

Approximately 25 women have participated in the women's program during the first five months of 2002. Statistical analysis of data is currently being compiled for assessment of this program.

A key component of the Dual Diagnosis Program consists of the Continuing Care Project, where the success rate of supervision of clients transitioned from a structured care setting into integrated and varied status supervision within the community is approximately 60 percent. Given the obstacles of this population, the success rate is above the norm.

Current Barriers

Confidentiality Issues/Parallel Treatment. While the barrier of providing services in multiple service settings is overcome with all treatment providers working out of the same office setting, this process often becomes complicated by service providers' reluctance to share information from their clinical records, most often because of reasonable clinically based concerns about the appropriate use of records (Peters and Hills, 1997).

Even though licensing regulations have previously caused these con-

SOLUTIONS AND Future Endeavors

tracted agencies to express concern about sharing client collateral information, communication gaps are narrowing. Each providing entity now includes its paperwork in a united file, has access to united e-mail and is able to access the summary log, which is a detailed summary of the current activities of the clients on its unit. Each entity also is able to read the chronological compilation of services/interactions generated by Correctional Services, all of which have enhanced overall communication and updating of client progress.

Reliance on Publicly Funded, Community-Based Services to Pay for Rent, Medication and Psychiatric Appointments. Offenders with co-occurring disorders often rely on these services because they lack the resources to pay for treatment. As a result, they must compete with other low-income individuals to receive adequate and timely service. As public dollars for community services have become more scarce, dual-diagnosis treatment services have become more difficult to obtain (Peters and Hills, 1997).

While emergency clients are usually funded, the majority of others are placed on a waiting list, which includes a larger list of many needing funding within the community. Those placed on that waiting list usually were not funded initially during their treatment time in this treatment milieu. This is changing as financial providers become partners in treatment provision with a view to treatment continuum. Funding for placement becomes crucial to pay for psychiatric evaluations and cost for medications.

Additionally, clients who are placed in either dual-diagnosis program immediately lose all benefits/entitlements upon entrance to the correctional facility for an extended placement. Also, the reapplication process for those services can begin while the client is still in residence but continues to require an extended time frame to reinstate benefits upon the client's release to the community, which directly threatens medication compliance and other pertinent treatment issues. Sharing of financial resources between community entities continues to be an issue.

Limitations Imposed by Grants. Current grant regulations disallow the

use of overnight furloughs while male clients are in the residential component of treatment. All treatment is funded by grants. Therefore, when clients actually transition to the community, they have not been able to put into practice their new healthy coping behaviors.

Current grant regulations also insist that male clients remain in the treatment milieu for at least six months, while it is increasingly recognized that many of the same people are capable of and willing to be released in a reduced amount of time.

Lack of Current Gender-Specific Research. Information and innovative treatment models are emerging from both the mental health and the addiction treatment sectors that lead to the next level of concerns (Alexander, 1996):

- More must be known about the rates of co-occurring disorders among women with severe mental illness, their profiles of substance use and their service-use patterns;
- More must be known about the social networks of dually diagnosed women — to what degree do they support recovery or promote relapse?;
- More must be known about whether women with severe psychiatric diagnoses experience violence differently from women with less serious psychiatric disabilities;
- More must be known about how early and ongoing experiences of violence and abuse affect the course of treatment for both severe psychiatric disorders and co-occurring addictive disorders; and
- With respect to services, it must be asked to what degree existing models adequately address the broad range of service needs of dually diagnosed women.

Continued regular communication with treatment service providers will enhance individualized treatment presentation. Monthly meetings will continue the collaboration between local point-of-coordination persons and statewide central point-of-coordination providers to prioritize client needs and explore options.

The treatment team will continue to research and consider possible solutions that other communities have pursued and adopted to treat this population, as well as continue research/practice in gender-specific treatment options.

Future plans include integrated treatment plans that will continue to focus on client engagement and individualized goals. In addition, publicly funded community-based services will continue to be pursued, and gender-specific treatment options will continue to be researched.

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